



# **Briefing: Health and Care of Older People in England 2019**

July 2019

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## **GLOSSARY**

ACSC	Ambulatory Care Sensitive conditions
ADASS	Association of Directors of Adult Social Services
ADL	Activities of Daily Living
BMA	British Medical Association
CDEL	Capital Departmental Expenditure Limit
CLGC	Communities and Local Government Committee
CMA	Competition and Markets Authority
DfLE	Disability-free Life Expectancy
DHSC	Department of Health and Social Care
DPA	Deferred Payment Agreement
DTOC	Delayed Transfer of Care
ELSA	English Longitudinal Study of Ageing
HCHS	Health and Community Health Services
HLE	Healthy Life Expectancy
HSCHC	Health and Social Care and Housing Committee
IADL	Instrumental Activities of Daily Living
IAPT	Improving Access to Psychological Therapies
IFS	Institute for Fiscal Studies
LE	Life Expectancy
LGSCO	Local Government and Social Care Ombudsman
NAO	National Audit Office
NEPP	National Emergency Pressures Panel
NICE	National Institute for Health and Care Excellence
NLW	National Living Wage
OBR	Office for Budget Responsibility
ONS	Office for National Statistics
PHE	Public Health England
RDEL	Revenue Departmental Expenditure Limit
STP	Sustainability and Transformation Plan
TDEL	Total Departmental Expenditure Limit

## SUMMARY

Health and social care services are a perfect storm of limited financial resources, significant workforce challenges, and increasingly complex population needs. This report provides an overview of how health and social care services are struggling to individually and collectively provide care and support for older people.

The NHS Long Term Plan has now set out a new and ambitious trajectory for health services for older people living with frailty and multiple long term conditions. This is matched by fairly significant investment. We hope, over time, this will bear fruit and address some of the limitations of NHS services for older people as they stand today. However much will depend on the willingness of a future government to match investment in health services with a commensurate commitment to delivering the workforce and capital investment required to realise this potential.

The social care system, however, remains stuck in purgatory. Investment and service activity can, at best, be described as 'flat'. Yet older people's need for care and support is rising by the day. Growing levels of desperation described by those individuals, families and professionals on the sharp end bear testament to a system working at full pelt, stretched to its limit and still failing people left, right and centre. Short term succour and a proper long term plan for social care must be a top priority for any incoming government.

### **The Health and Care Needs of our Ageing Population**

Between 2017 and 2040 the population of people aged over 65 is projected to increase by 49 per cent. The numbers of people aged over 85 – the group most likely to need health and care services – is projected to rise even more rapidly, nearly doubling from 1.4 to 2.7 million over the same period. However, in recent years improvements in life expectancy and healthy life expectancy have flat-lined.

Most people experience the majority of years spent living with poor health after the age of 65, and can, on average, expect to spend around half of their later years living with a life-limiting health condition or disability. There is significant regional disparity between areas with the highest and lowest levels of disability-free life expectancy at 65, with over 2 year's difference for men and 2 and a half years for women.

Around 15 per cent of people aged 65-69 experience difficulty with at least one Activity of Daily Living; amongst those aged 85 and over, this rises to 1 in 3. By 2040 the total number of disabled older people is projected to increase by 67 per cent to 5.9 million.

Just over half of people aged 65-74 live with at least one long term health condition, increasing to nearly two thirds of those aged 85 and over. Meanwhile frailty affects 6.5 per cent of people aged 60 to 69, rising to 65 per cent of those aged over 90.

An ageing population means increasing numbers of carers over 60; around two thirds of whom also experience long-term health problems or a disability. At the same time, nearly a third of people aged 65 and over live alone and 1.4 million describe themselves as often or always lonely.

### **Social Care**

This report highlights the growing social care crisis in England, which is leaving older people without access to the high-quality provision which they need.

Older people account for around two thirds of recipients of care provided, or arranged by, a local authority, and around half of total public spending on adult social care. However it is worth noting that the majority of care overall is actually delivered by friends and family, or through privately funded services.



In 2017/18 total net expenditure on adult social care from local authority funds was £15.5 billion – an 8 per cent reduction since 2010/11. Reductions in local authority funding has resulted in an increased reliance on funding from the NHS and means-tested client contributions; taking into account additional funding total spending on adult social care in 2017/18 stood at £21.7 billion, which still represents a real terms cut of more than £500 million since 2010/11.

A growing and ageing population means demand for care services is increasing and, as funding has not kept pace, spending per head of the adult population fell by 17.5 per cent in real terms between 2010/11 and 2017/18. At the same time the cost of providing care is rising. Directors of Adult Social Services still planned to make savings of £700 million in 2018/19. The 'stand still' gap in funding is now an estimated £1.5 billion a year by 2020/21 and £6.1 billion by 2030/31, while restoring the system to levels of expenditure in 2010/11 would require an additional £8 billion by 2020/21.

In total, the number of older people in need of care and support – whether publicly or privately funded – will increase to nearly 1.2 million by 2040.

There were 1.32 million new requests for support from older people in 2017/18 – 71 per cent of all requests received. Of those over half resulted in either no services provided or people being sign posted elsewhere. While new requests for support and service provision have been broadly stable, the numbers of older people receiving long term services over the course of the year has declined by 5.7 per cent since 2015. Support for carers has also declined since 2015 as a fifth fewer carers benefiting from access to respite care or direct support for the person they care for.

Levels of unmet need have been rising. In 2016, nearly 1 in 8 people aged over 65 were estimated to be struggling without all the help they needed to carry out at least one essential Activity of Daily Living. By 2018 this had increased to 1 in 7 – or 1.4 million – older people, of which 300,000 are estimated to need help with 3 or more activities.

Older people and families are increasingly making up the shortfall in public funding. Amounts raised through client contributions have increased in recent years, while the number of older people receiving long-term services has declined. People paying privately for services are also significantly cross-subsidising the system with care home fees 41 per cent higher on average for self-funders.

System failures are having an adverse impact on the care market with a recent report concluding *'the current model has broken down in some areas of the country and is no longer capable of delivering care to people in need'*. The total amount of home care delivered has declined by 3 million hours 2015 and 2018 while the worst hit local authority lost 58 per cent of their nursing home beds between 2016 and 2018. In 2018 alone Directors of Adult Social Services in 58 local authorities reported at least one care home closure, and nearly a third reported seeing home care providers cease trading.

The social care workforce experiences high turnover, estimated at 30.7 percent. Alongside this, an estimated 18 per cent of the workforce have EU and non-EU nationality, yet for immigration purposes care work is classified as 'low-skilled', making it difficult for migrants to the UK to work in this field.

## **Healthcare**

The NHS has fared better in terms of funding in recent years but nonetheless this report still paints a picture of a service struggling to keep pace with the needs of growing numbers of people living with complex conditions and frailty.

In 2017/18, the Department of Health and Social Care (DHSC) budget stood at £125.15 billion, £109.83 billion of which was directed to NHS services. Funding growth averaged 1.1 per cent a year between 2010/11 and 2014/15, and just under 2 per cent between 2014/15 and 2017/18. However over the course of the three Parliaments between 1996/97 and 2009/10, the UK healthcare budget grew at an average of 5.9 per cent a year.

It is also important to note that despite increased spending on NHS services, funding for wider DHSC responsibilities including public health, education and training, and infrastructure such as IT fell between 2010/11 and 2017/18. Public health funding alone fell by £300 million between 2014/15 and 2017/18. Central investment in education and training of the healthcare workforce is also £2 billion lower in 2018/19 than it would have been if 2006/7 investment levels had been maintained.

In June 2018, the Government announced a five year funding settlement for the NHS which equates to an average 3.4 per cent year-on-year increase to 2023/24. While this is a step in the right direction, it falls short of the 4 per cent identified as the minimum required to redress the pressures caused by eight years of stalled growth. Nor does it address future funding for workforce development, public health or capital investment.

The health workforce is under severe strain. At the beginning of 2019, 1 in 11 NHS posts were vacant and £5.5 billion was spent on temporary staff to cover vacancies and other short term absences in 2017/18. Experts estimate that there is a shortage of around 100,000 staff in the NHS in England, rising to 250,000 by 2030 if current trends continue. England also continues to have fewer doctors per head than any other EU country.

Investment in primary and community services has not kept pace with demand. Spending on primary care as a whole only rose modestly between 2013/14 and 2017/18, and the proportion of centrally allocated funding directed towards general practice fell from 7.3 per cent in 2015/16 to 7.1 per cent in 2018/19. GP workforce numbers have broadly tracked increases in the population, rather than patient need.

Hospital admissions for acute conditions that should not usually require admission – such as UTIs – have risen across all older age groups over the past decade, while access to essential community services such as mental health support remains below targets and the current proportion of people receiving reablement or rehabilitation services is below that of 2013/14.

Emergency admissions from care homes increased by 62 per cent from 2010/11 to 2016/17, and emergency readmissions to hospital within 30 days of discharge for all patients rose 22 per cent between 2013/14 and 2017/18.

A&E attendances rose across all age groups between 2010/11 and 2017/18, however rates increased particularly sharply amongst those aged 65 to 79 – by 50 per cent – and aged over 80 – by 45 per cent. People are also more likely to wait more than 4 hours, with one in six A&E attendees waiting more than four hours in 2017/18, compared with one in sixteen in 2012/13.

Emergency admissions have also risen substantially over the past decade, increasing by an average of 2.4 per cent a year between 2007/09 and 2016/17 with older people accounting for over half of that growth. In 2017/18 there were over 6.1 million emergency admissions, a 3.5 per cent increase on the previous year alone.

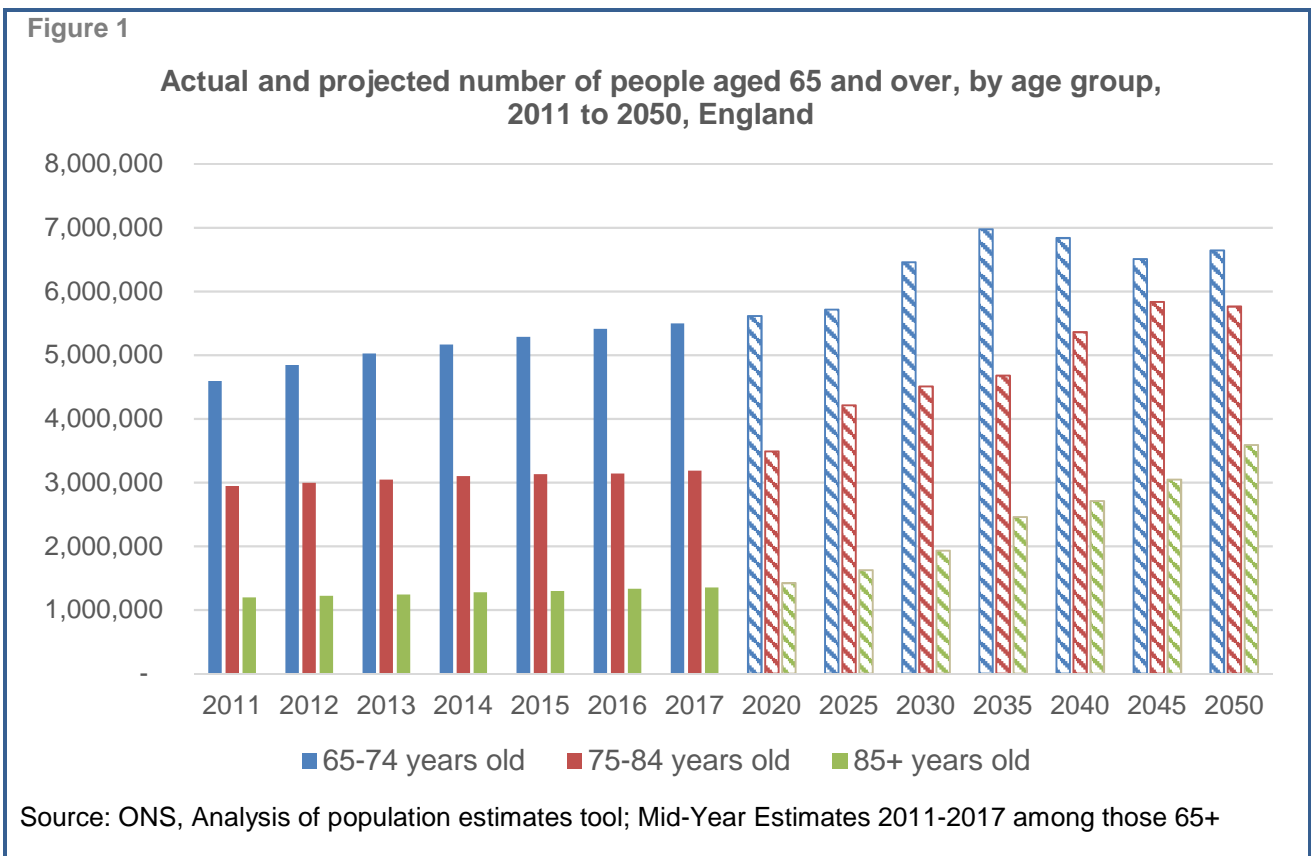
The percentage of people treated within 18 weeks also fell between 2013/14 and November 2018 across all treatment categories, with many of the specialties that routinely treat a large proportion of older people seeing some of the most significant deterioration in waiting times. Spending on private self-pay healthcare – excluding private insurance and cosmetic surgery – has more than doubled since 2010, primarily driven by procedures most usually undertaken by older people such as hip and knee replacement and cataract surgery.

# 1. THE HEALTH AND CARE NEEDS OF OUR AGEING POPULATION

It is well understood that our population is ageing rapidly. When the NHS was founded and the National Assistance Act 1948 (within which the current adult social system has its origins) was enacted 70 years ago, one-in-two people died before they reached 65. Now around 9 in 10 people will see their 65<sup>th</sup> birthdays (King’s Fund 2014). At this point a man can expect to live at least another 19 years on average, while a woman can expect to live another 21 years (ONS 2018d). Increasing longevity is a major success story, and one in which the health and care system has played an important part, however it is also a significant driver of changing health and care needs within our society.

## 1.1 Our growing older population

The population is ageing in all regions of England, with the numbers of people aged 65 and over growing considerably faster than younger age groups (ONS 2018a). As shown in *figure 1*, in total the population of people aged 65 and over in England is projected to increase by 49 per cent from 2017 to 2040 (10.0 million to 14.9 million), as members of the large cohort of people born after the Second World War continue to reach age 65. The population aged 75 and over is expected to double in total over the next 30 years. In addition, the population aged 85 and over – the group most likely to need health and care services – is projected to increase dramatically from 1.4 to 2.7 million from 2017 to 2040.



Every local authority in England will almost certainly see an increase in the number of older people over the next decade. In 2016, 36 English local authorities had a population where at least one-quarter

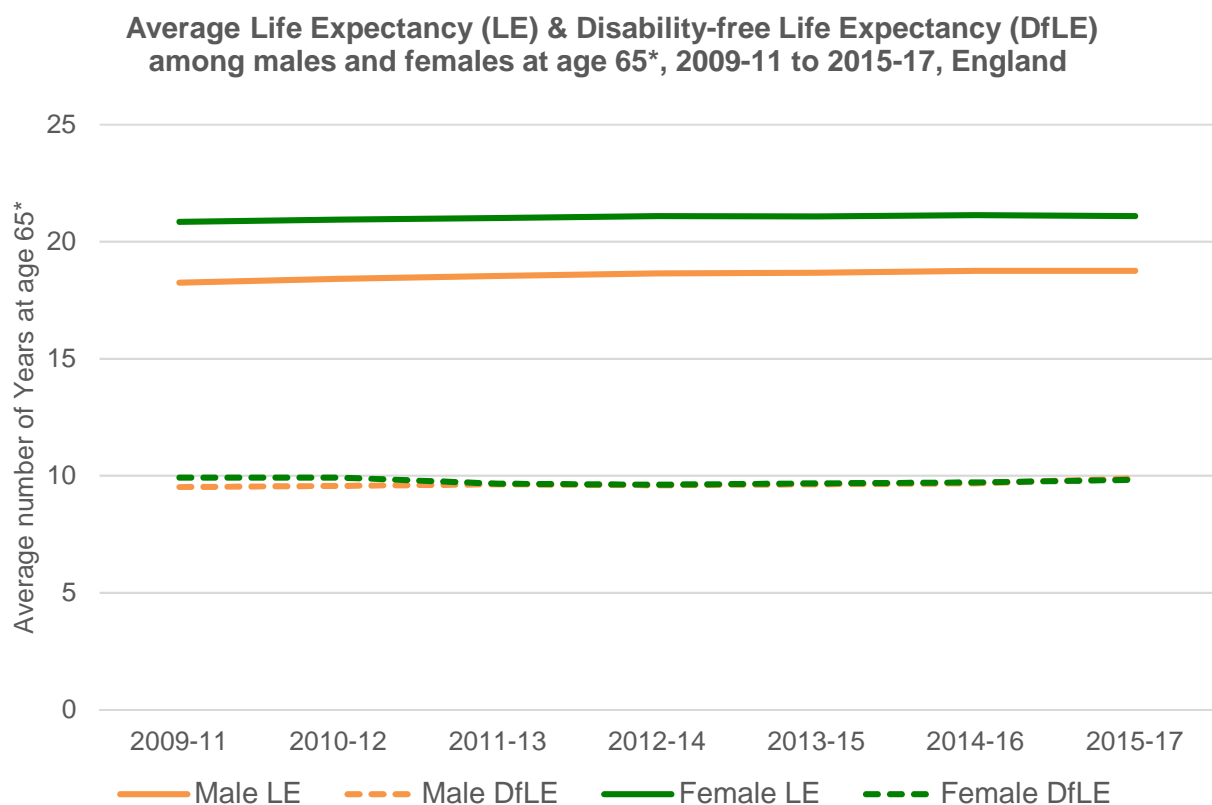
of people were estimated to be aged 65 years and over. This is projected to rise to 97 out of 343 local authorities by 2026 (ONS 2018a).

## 1.2 Life expectancy, healthy life expectancy and disability-free life expectancy

Life expectancy at birth rose steadily each year between 1945 and 2011. However, since 2011, improvements have been slowing down and remained unchanged between 2014/16 and 2015/17 for both men and women in England (ONS 2018d). On average, a woman born in England between 2015 and 2017 can expect to live until 82.9 years old and a male to 79.2, which is no change on the previous figures for 2014 to 2016 (ONS 2018d).

Life expectancy at birth can be sensitive to changes in infant mortality at the youngest ages, but it is important to note that improvements in life expectancy at older ages have also flat-lined in recent years, as shown in *figure 2*, below. For women in England average life expectancy at 65 only increased from 20.9 years in 2009/11 to 21.1 years in 2015/17; over the same period life expectancy at 65 for men increased from 18.2 years to just 18.8. While a deceleration in improvements in life expectancy at birth and age 65 is evident in a number of countries across Europe, North America and Australia over the course of this decade, the UK has seen one of the largest slowdowns (ONS 2018d).

Figure 2



Source: ONS, 2018: Health state life expectancy estimates, England

\*Note: The age group used is 65-69 years

Most people experience the majority of any years lived with poor health and disability after the age of 65, and can on average expect to spend around half of their later years living with a life-limiting health condition or disability from this age (ONS 2018f). As shown in *figure 2* above, disability-free life expectancy (DFLE) at age 65 in England is 9.9 years for men and 9.8 years for women, meaning they can expect to spend 8.9 and 11.3 years in poor health respectively.

The evidence also suggests that DFLE has plateaued over the past decade. Between 2009/11 and 2015/17, men at age 65 gained 0.5 years in life expectancy, but only 0.4 disability-free life years; while women gained 0.2 years in life expectancy, but actually lost 0.1 disability-free life years (ONS 2018f). It has long been the case that, while both on an upwards trajectory, improvements in healthy life expectancy have not kept pace with improvements in overall life expectancy, but recent trends may indicate we are starting to lose further ground.

### Geographic variation

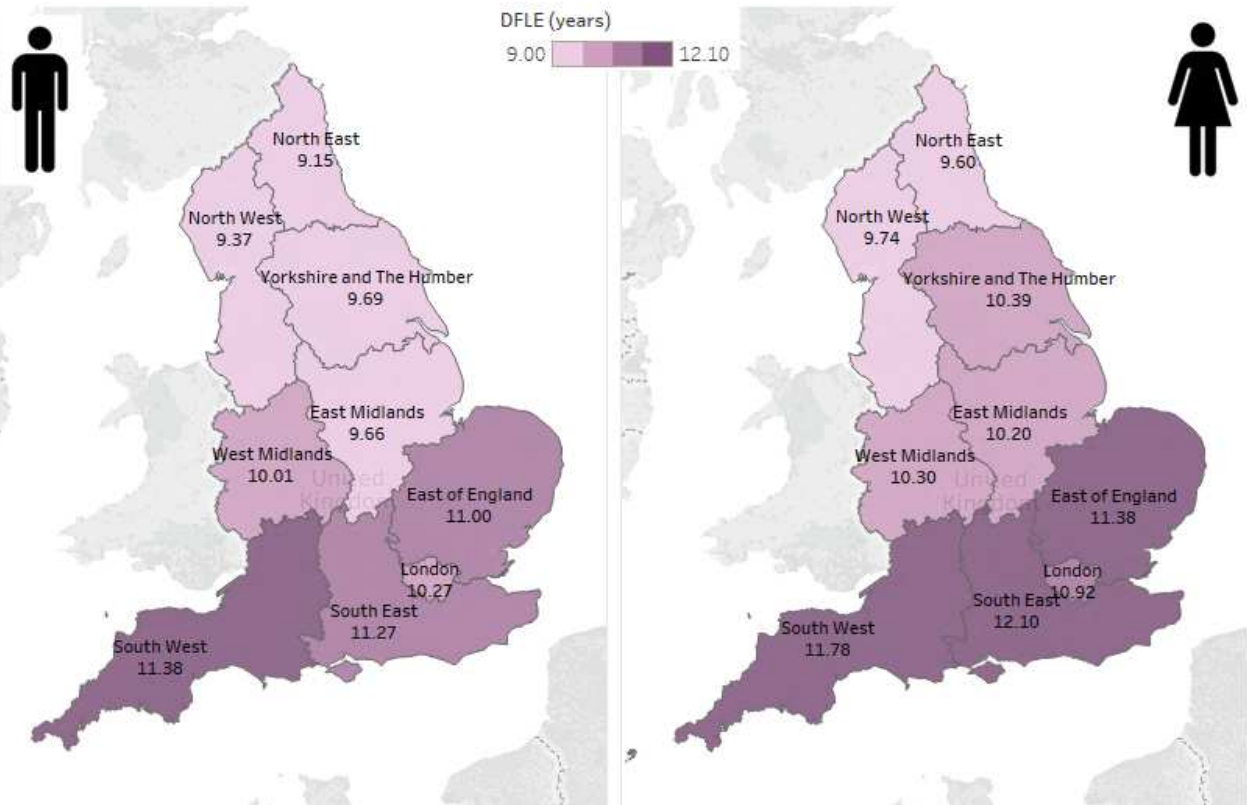
Looking ahead, the population aged 65 years and over is projected to grow by a similar amount - around 50 per cent - in both urban and rural areas between 2016 and 2039 (ONS 2018c). In comparison, the younger population (aged under 65 years) is projected to grow by 8 per cent in urban areas, but with virtually no increase in the size of the younger population projected in more rural areas (ONS 2018c). This will result in an increase in the ratio of older to younger people, particularly in rural and coastal areas - indeed the 10 local authorities with the highest percentage of the population aged 65 years and over are already on the coast (ONS 2018c). This will continue the trend of the last several decades, in which rural areas have seen larger increases in average age than urban areas (ONS 2018c).

However, it is not simply the case that the older population is unevenly distributed, as shown in *figure 3*, there is also significant variation in the burden of ill health and disability in later life. The disparity in disability-free life expectancy at age 65 years ranges from 11.38 years in the South West to 9.15 in the North East for men, and 12.10 years in the South East to 9.60 years in the North East for women.

Taken to local authority level the differences in both life expectancy and disability-free life expectancy demonstrate stark inequalities. Men in the local authority areas at the top of the scale can expect an additional 5.7 years of life and 11.2 years of disability-free life compared to those in areas at the bottom. Likewise, woman can expect an additional 5.8 years of life and 13.4 years of disability-free life (ONS 2016).

Figure 3

Disability-free Life Expectancy at age 65 by region, 2012-14, England



Source: ONS, 2016: Analysis of disability-free expectancies data, England

### 1.3 Health and care needs of older people

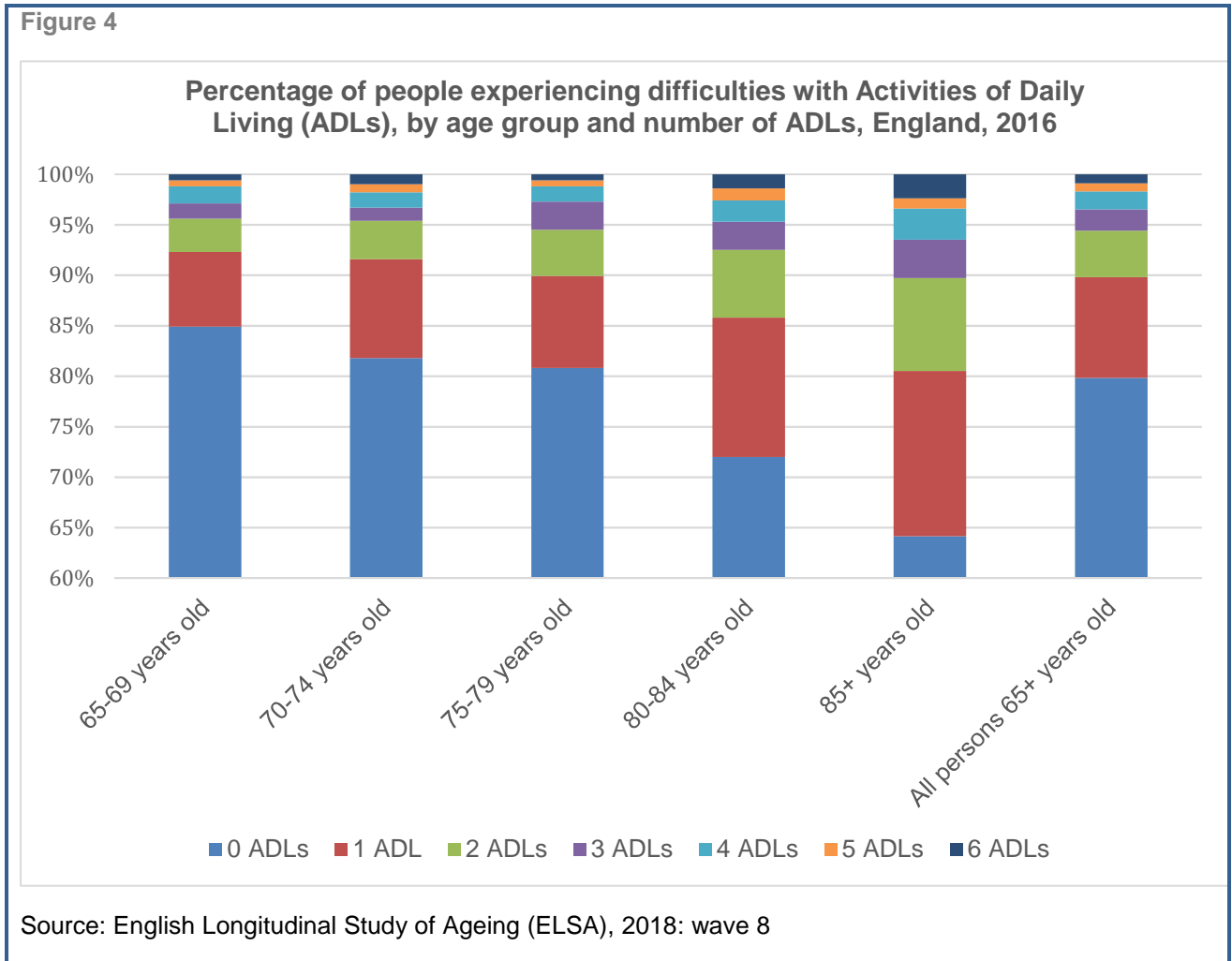
The prevalence of nearly all chronic and long-term conditions increases with age, but it is important to recognise the diversity within the older population – both within and across the 65 to 74 years, 75 to 84 years, and 85 years and over age groups. While it is indeed the case that over the next 20 years a growing older population in England will lead to an increasing number of people living with complex health and care needs, there will also be growing numbers across all older age groups living without any significant needs for support.

Furthermore, acquiring a health condition or disability does not necessarily equate to high levels of demand for health and care services. Most people aged 75 and over have one or more health condition, but only 45 per cent of people aged 75 and over consider themselves to be living with a ‘limiting’ long-term condition, meaning they may not consider their health condition/s to have a significant impact on their lives (ONS 2015).

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

## Care and support needs in later life

As shown in *figure 4*, the proportion of people experiencing difficulties with Activities of Daily Living (ADL)<sup>1</sup>, and the number of difficulties experienced, increases significantly with age. Within the 65-69 age group just 15 per cent of people live with one or more ADL. However, by the age of 85 more than 1 in 3 people live with some level of need for care and support.

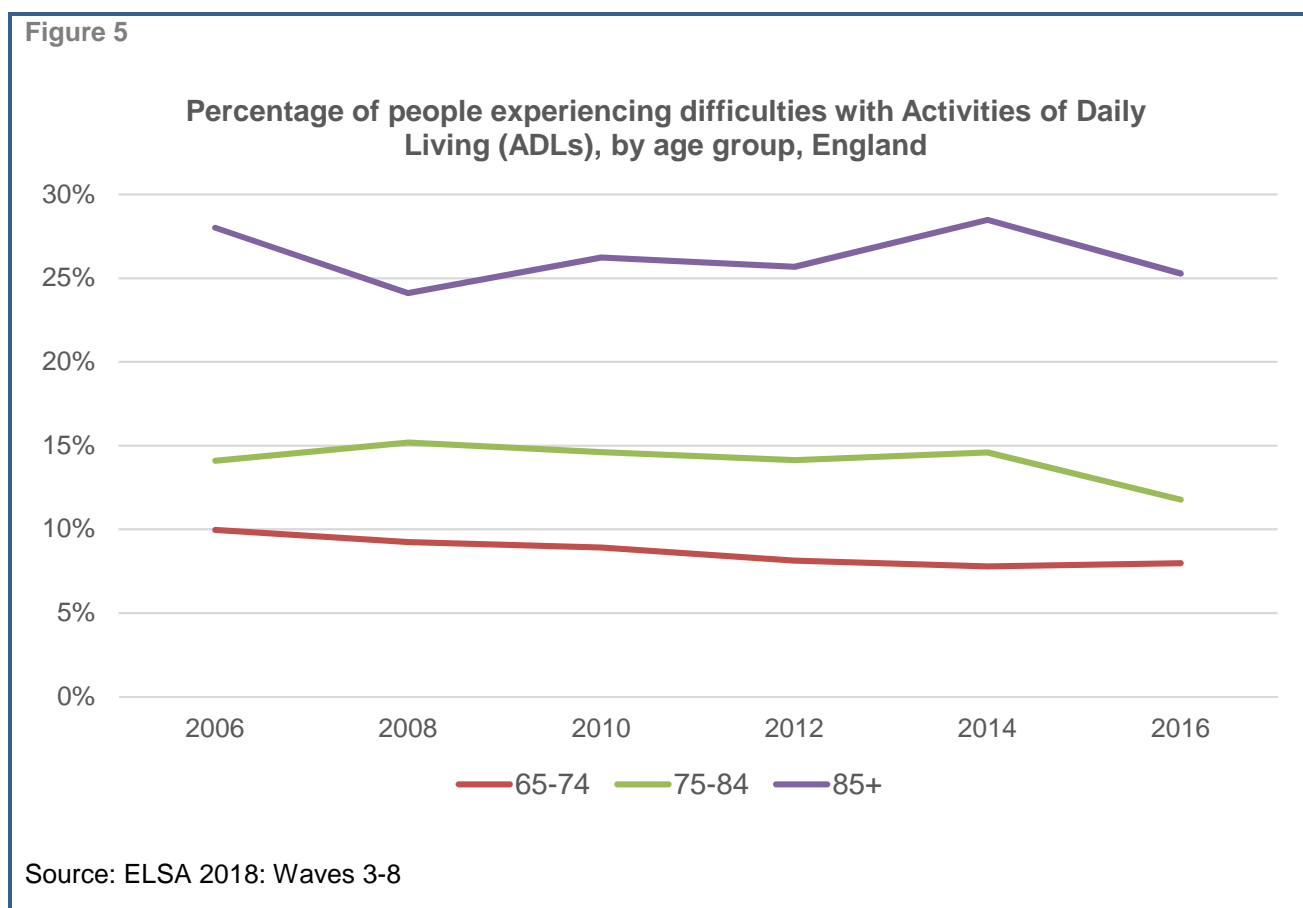


As our older population continues to grow, the number of disabled older people, defined as those experiencing difficulty with at least one IADL<sup>2</sup>, is also projected to increase; rising by 67 per cent, from 3.5 million to 5.9 million people between 2015 and 2040, and to 7.6 million by 2070. The number of older people with more severe disability, defined as those unable to perform one or more ADL without help/at all, will increase by 69 per cent between 2015 and 2040 (from 1.7 million to 3.0 million) and 124 per cent between 2015 and 2070 (from 1.7 million to 3.9 million) (Wittenberg et al 2018).

<sup>1</sup> 'Activities of daily living' are routine, everyday self-care tasks, including walking, feeding, toileting and bathing. 'Instrumental activities of daily living' require higher mental and physical capacity and functioning and include activities usually considered necessary to live independently (such as managing finances, taking medication, negotiating transport and preparing a hot meal).

<sup>2</sup> 'Instrumental activities of daily living' require higher mental and physical capacity and functioning and include activities usually considered necessary to live independently (such as managing finances, taking medication, negotiating transport and preparing a hot meal).

However, patterns are changing. As shown in *figure 5* below, the percentage of people experiencing difficulties with ADLs has shown some signs of decreasing over the last decade amongst those aged 65 to 74. Further analysis suggests that between 2015 and 2035 in England, both the percentage and the number of people with care needs are projected to fall within the 65 to 74 years age group. However, over the same time period, the percentage of people with care needs aged 85 and over will remain much the same, and given rapid growth in the size of this 'oldest old' population this will mean a significant increase in absolute numbers. The number of people aged 85 and over with low 'dependency' (less than daily care) is projected to increase by 148 per cent, while the number with high 'dependency' (24-hour care) will increase by 92 per cent (Kingston et al 2018).



### Long-term conditions and multimorbidity

As *figure 6* shows, long-term conditions are not an inevitability of ageing, but the likelihood of having one or more long-term condition does increase with age. While 53.5 per cent of people in their early 60s (60-64) do not have a diagnosed long-term condition, this falls to just 34.9 per cent of people aged 85 and over.<sup>3</sup>

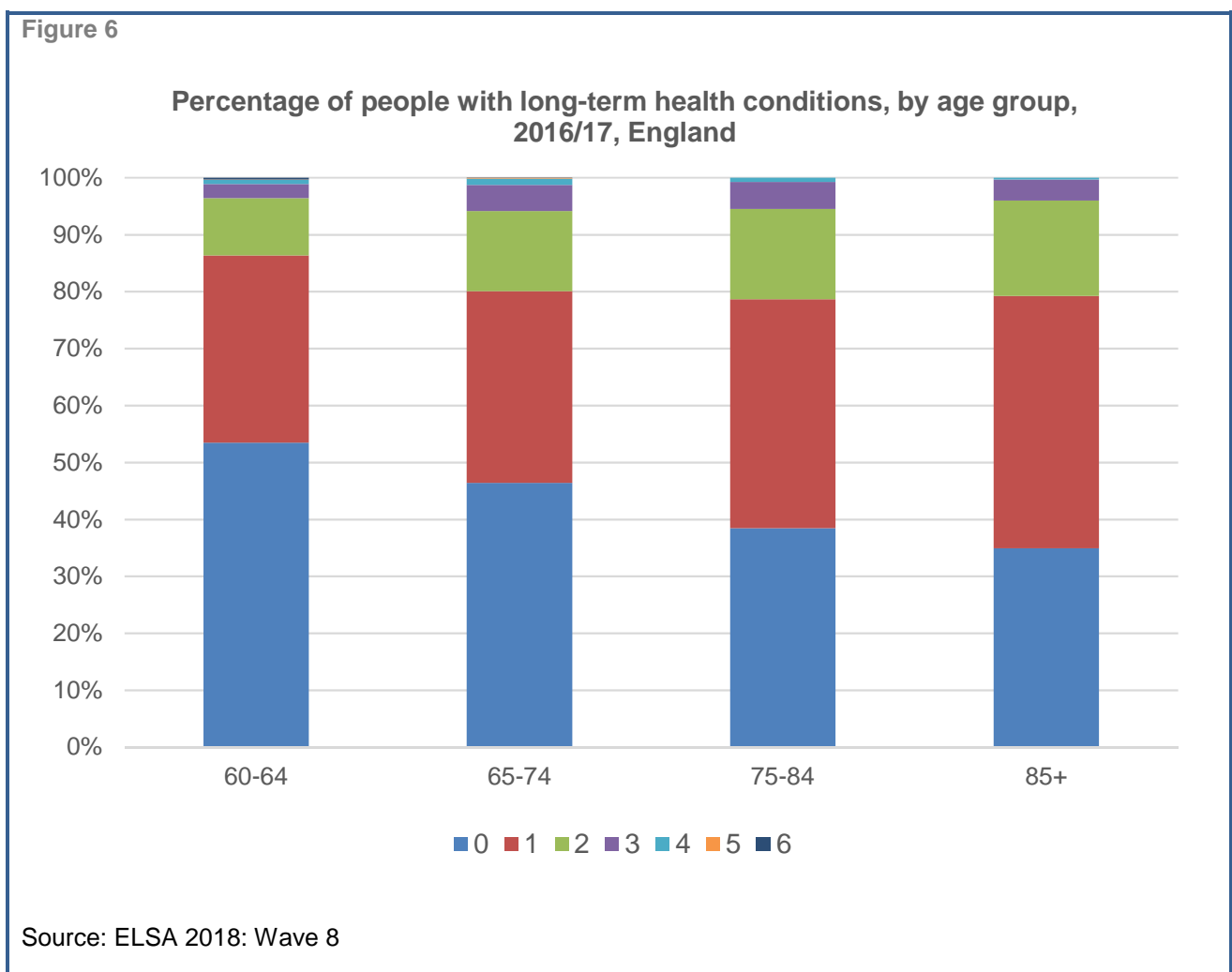
'Multimorbidity' is usually defined by the presence of two or more long-term conditions, which are those that cannot currently be cured but can be managed through medications, lifestyle or other treatments. Estimates for the percentage of people currently living with two or more long-term

<sup>3</sup> All recent studies show that multimorbidity increases with age (NICE 2016). However, the percentages range considerably, according to which conditions are counted. Hypertension makes a pronounced difference, inflating some of the figures by around 20 percentage points. We have therefore excluded hypertension from the data used in *figure 6*.



conditions in England vary according to which conditions are counted – from 15 per cent to 30 per cent according to different national and local sources (Aiden 2018). Compared to those with one or no long-term conditions, people with multimorbidity have an increased risk of functional decline, poorer quality of life, greater healthcare use and mortality (Yarnall et al 2017). As figure 6 demonstrates, multimorbidity is also more common with age.

For an important proportion of people with multimorbidity, their conditions are of discordant types, meaning conditions that have divergent treatments, aetiologies and/or affected systems<sup>4</sup>. This discordance can add an extra layer of complexity to health needs and care (Bajekal et al 2018) and may have a greater impact on overall health and wellbeing than closely related multimorbidities. Multimorbidity among people aged 85 and over is linked to particular challenges around polypharmacy<sup>5</sup>, with one study finding that 70 per cent of those aged 85 and over with multimorbidity were prescribed five or more medications and 17 per cent prescribed 10 or more (Collerton et al 2015).



<sup>4</sup> Some conditions share a common ‘aetiology’ and/or affect the same body systems– for example coronary heart disease and cerebrovascular disease (stroke) are both types of cardiovascular disease and share common causes and may be treated with the same types of interventions. ‘Discordant type’ multimorbidity in essence describes the opposite; a situation when an individual has multiple conditions at least some of which have different causes (aetiology), affect different body systems and have different, possibly conflicting, treatments.

<sup>5</sup> Polypharmacy is the concurrent use of multiple medications by an individual patient. Even when clinically justified the more medications taken the greater the risk of medication related harm, poor medications management or adverse drug reactions.

## Frailty

Frailty is defined within the NHS as “where someone is less able to cope and recover from accidents, physical illness or other stressful events” (NHS England 2018a). It is generally characterised by issues such as unintentional weight loss, reduced muscle strength and fatigue and thought to affect around 6.5 per cent of people aged 60 to 69, rising to 65 per cent of those aged over 90 (Gale et al 2015).

Frailty is distinct from multimorbidity. However, while someone living with frailty may have no other diagnosed health conditions, it is apparent that there is a large overlap between frailty and multimorbidity meaning many people will live with both (Villacampa-Fernandez et al 2017).

Since 2017/18, the GP contract requires general practice to identify all patients aged 65 and over who may be living with moderate or severe frailty. As figure 7 shows below, 34.8 per cent of people aged 65 and over in England had received some form of Frailty Assessment by September 2018. 22.0 per cent of older people were assessed as fit or with mild frailty, 8.4 per cent with a diagnosis of moderate frailty, and 4.4 per cent a diagnosis of severe frailty. A further 65.2 per cent are yet to be assessed. NHS England expects the percentage of older people with a diagnosis of moderate frailty to increase to 12.0 per cent as more people are assessed (NHS England 2018a)<sup>6</sup>.

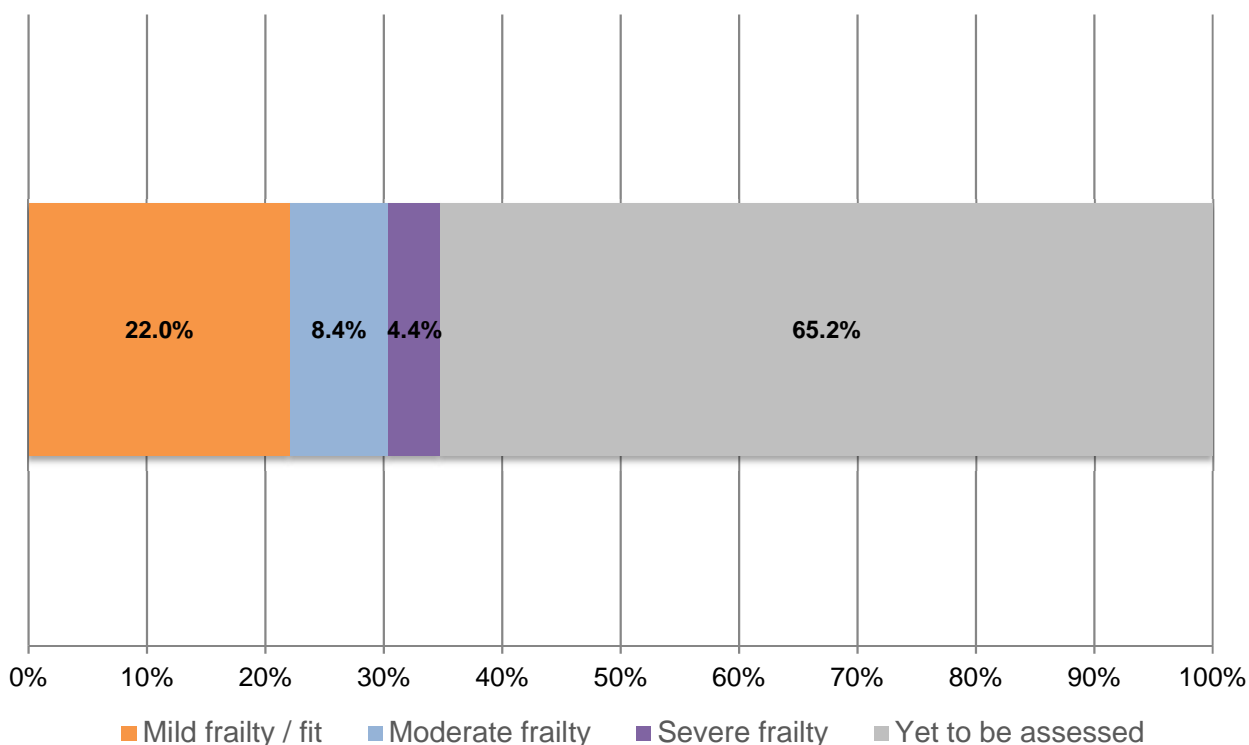
People living with frailty are at greater risk of hospitalisation, long hospital stays, unplanned readmission to hospital, care home admission or mortality. Indeed, for those living with severe frailty, the annual risk of hospitalisation, care home admission or death is over four times greater (NHS England 2018a). People living with severe frailty are in a particularly precarious situation and are likely to require significant health and social care support, while identifying people living with moderate frailty enables interventions to be put in place to prevent or delay the onset of and reduce the impacts of severe frailty.

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<sup>6</sup> There are currently some data quality issues with the figures provided by GP contract data returns on frailty. One issue is that there is currently no assurance on the method of diagnosis for frailty. The method for stratifying the population, the electronic frailty index, is a validated tool, but is not a diagnostic tool. Therefore, these figures should be used as a provisional snapshot of the proportion of people living with frailty.

Figure 7

### Outcomes of Frailty Assessments, people aged 65 and over, as at September 2018, England



Source: NHS Digital 2018: GP Contract Services

### Factors affecting health and care in later life

There is of course a wide range of factors that affect emotional and physical health and wellbeing in later life, but there is increasing evidence that living alone, loneliness and being a carer have an impact on both health and experience of care in particular. A growing older population and changing lifestyles means these factors are likely to become more prevalent.

**Living alone:** Across the UK, nearly a third of people aged 65 and over (3.6 million people) live alone, while around one in 10 (1.2 million people) are ageing without children (Age UK 2018c). The number of one-person households in England is projected to increase by 26 per cent between 2016 and 2041, primarily driven by increases in the number of people aged 65 years and over living on their own, including the 'oldest old' (ONS 2018g). The number of people aged 90 years and over living alone is projected to more than double, to 588,000 over that period (ONS 2018g).

A recent study suggests that people living alone are less well on average than those living with others. It found that one in four older people living alone have a mental health condition, compared to one in five of older people living with others; while 50 per cent of older people living alone had three or more long-term conditions, compared with 42 per cent of older people living with others (Health Foundation 2018a).

**Caring responsibilities:** We are moving towards a ‘four generation’ society meaning it is likely to become increasingly common for people in their 60s and 70s to have caring responsibilities for parents or other older relatives (Centre for Policy on Ageing 2014). The number of older people receiving care from a spouse or partner is also projected to increase between 2015 and 2040 – indeed the numbers will grow faster than those older people receiving care from an adult child (Wittenberg et al 2018).

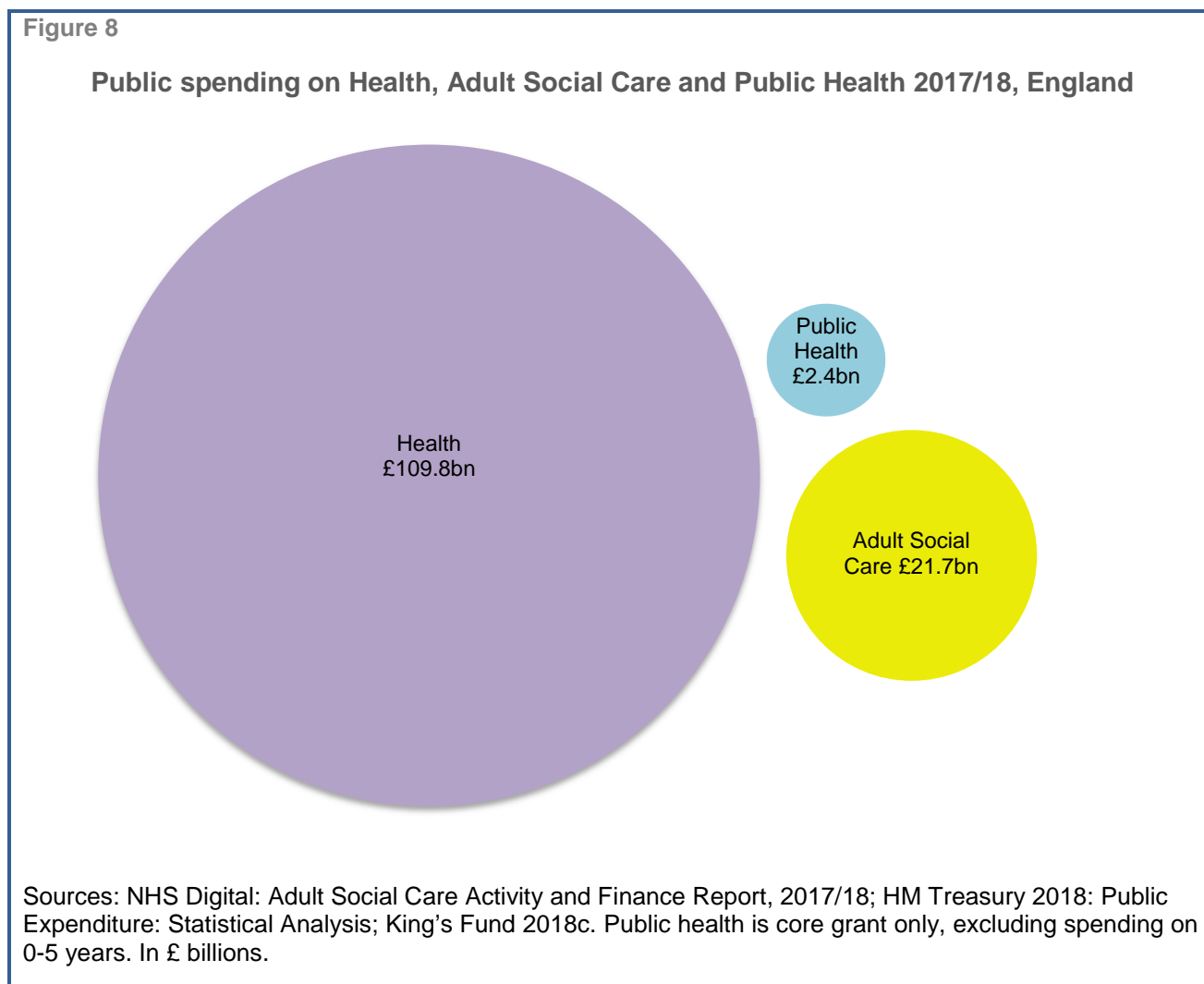
Around two thirds of older carers (aged 60 and older) have long-term health problems or disability themselves, while 69 per cent say that being a carer has had an adverse effect on their mental health (Carers Trust 2018). One third of older carers say they have cancelled treatment or an operation for themselves because of their caring responsibilities (Carers Trust 2018).

**Loneliness and isolation:** It is possible to feel lonely without being socially isolated, and vice versa, however both can have a significant impact on physical and mental health, and have similar risk factors. Where social isolation is objectively defined in terms of people’s access to interactions and their community, feelings of loneliness occur when people are unable to have the types of interactions they may desire.

1.4 million older people class themselves as often lonely, and it is estimated this will rise to 2 million people over the aged of 50 by 2025/26 (Age UK, 2018). Loneliness is associated with a range of poor health outcomes, including: low quality of sleep, increased risk of cardiovascular disease, weakened immune system and, ultimately, higher risk of mortality (Age UK, 2019).

## 2. THE STATE OF SOCIAL CARE

Public spending on local authority provided and/or arranged care in England is significantly lower than on the NHS in England, as *figure 8* shows. In 2017/18, for every pound spent on adult social care five pounds were spent on health services.



Of those receiving local authority provided or arranged adult social care in England, around two-thirds (66 per cent) are older people (aged 65 and over), and one-third are younger adults (aged 18 to 64 years). Older people account for half of public spending on adult social care (Charlesworth & Johnson 2018).

However, most care for older people is delivered outside of the publicly funded system. Over a third, 37.5 per cent, receive the majority of their help with care needs from family and friends, and 12.5 per cent from privately funded sources. In comparison, just 21 per cent of older people are estimated to receive the majority of their help from their local authority, while an estimated 30 per cent receive no help at all<sup>7</sup> (BBC 2018).

<sup>7</sup> Percentages may not total 100 due to rounding.

Adult social care services in England are facing significant funding pressures due to the combination of a growing and ageing population, increasingly complex care needs, reductions in government funding to local authorities and increases in care costs.

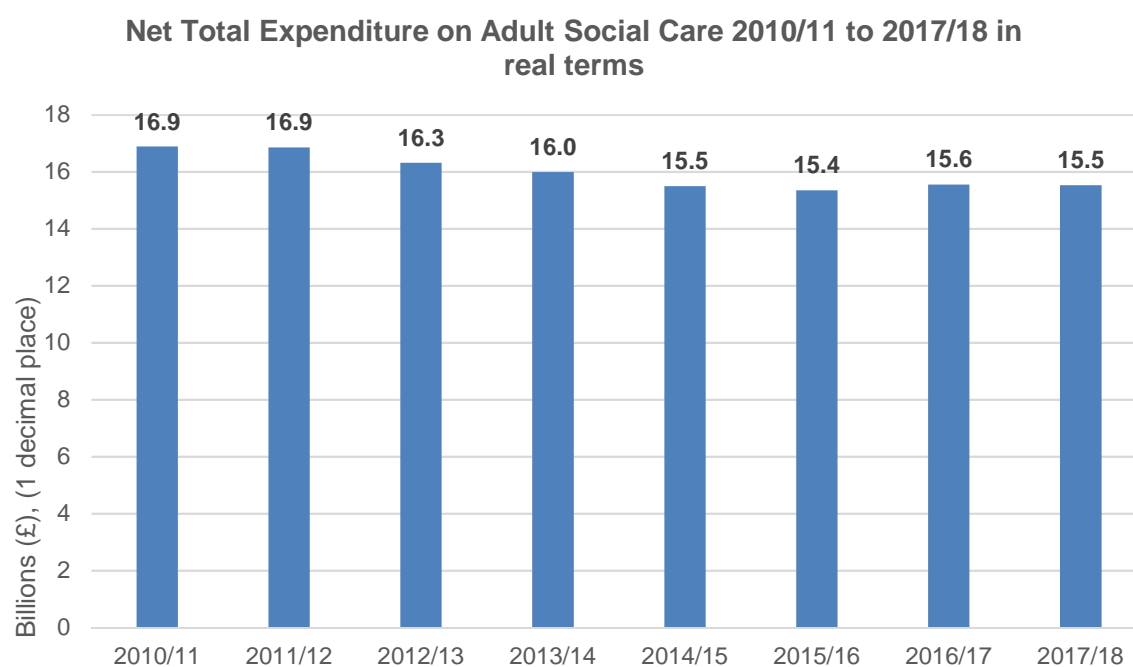
## 2.1 Trends in public funding of adult social care services

Local authorities primarily fund the care they provide and arrange through three types of income: 1) local authority funds including council tax, government grants and business rates, 2) means-tested client contributions, and 3) transfers from the NHS and other joint funding arrangements.

### Trends in expenditure from local authority funds

In 2017/18 total net expenditure on adult social care in England (which accounts for spending by local authorities from their own funds) was £15.5 billion (NHS Digital 2018a). As *figure 9* depicts, this represents an 8 per cent – or £1.4 billion – reduction in real terms in local authority spending since 2010/11, although a slight improvement on 2015/16 when spending reached a low of £15.4 billion in real terms.

Figure 9



Sources: For 2010/11 to 2015/16: NHS Digital: Personal Social Services: Expenditure and Unit Costs, England. For 2016/17 & 2017/18: NHS Digital: Adult Social Care Activity and Finance Report, England, using the May 2019 GDP deflator.

### Trends in additional income

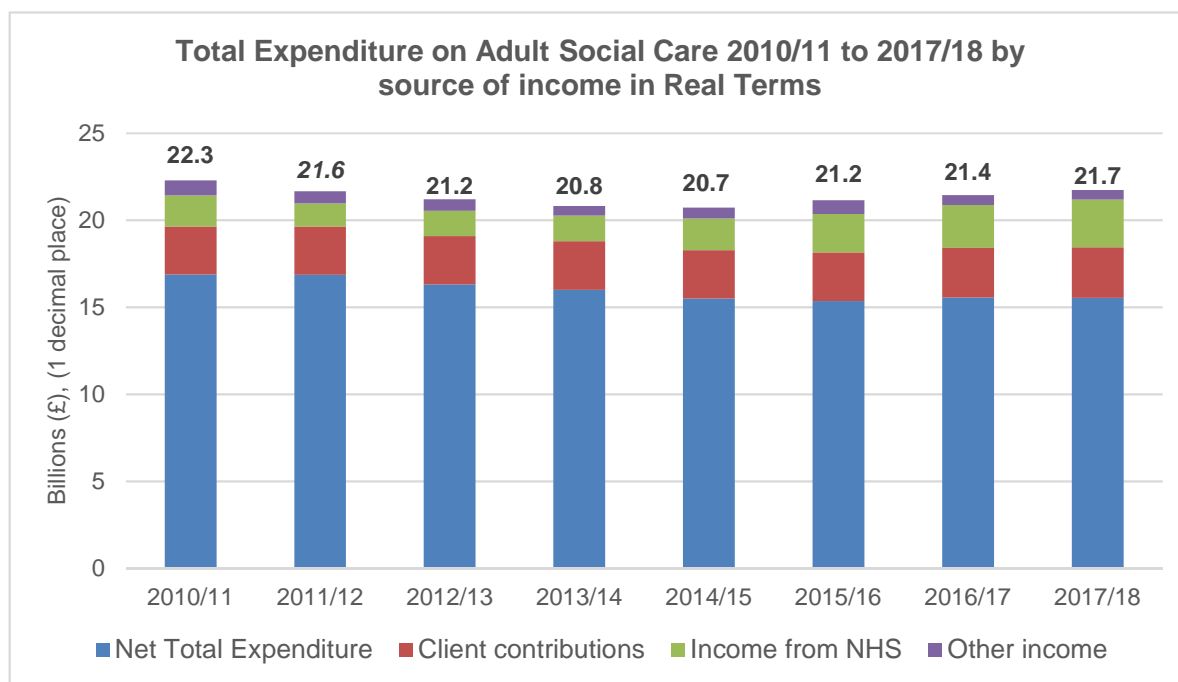
As *figure 10* demonstrates, some of the reduction in local authority funding has been compensated for through increasing client contributions and income from the NHS and other sources. In 2012/11 total spending on adult social care stood at £22.3 billion in real terms, falling by £1.6 billion to a low of £20.7 billion in 2015/16 before rising to £21.7 billion in 2017/18. Overall total spending fell by around £547 million – or 2.5 per cent – over this period. However, as a result the percentage of total spending

on adult social care that comes from sources other than local authority funds rose from 24 per cent in 2010/11 to 29 per cent in 2017/1.

Income from means-tested client contributions now stands at £2.9 billion, an increase of £156 million in real terms since 2010/11 – as set out in *figure 10*. In contrast, as explored in later chapters, the number of people aged 65 years and over receiving local authority long-term care has decreased year-on-year since 2014/15 – and numbers have only risen modestly amongst other age groups. Therefore, this inverse relationship between the total number of people receiving care and the total amount of client contributions is concerning. It suggests local authorities are increasing their charges for adult social care in order to mitigate reductions in government funding – and that service users are bearing an increasing financial burden themselves.

There has been a growing reliance on funding from the NHS alongside ‘other income’ sources and ‘joint arrangements’ as well. In 2017/18 NHS sources accounted for £2.7 billion of spending – rising by £965 million from £1.76 billion in 2010/11. The Better Care Fund provides the bulk of funding, with local authorities stating they received a combined total of £1.8 billion from the fund in 2017/18, which accounted for around 68 per cent of their income from the NHS (NHS Digital 2018a).

**Figure 10**



Sources: For 2010/11 to 2015/16: NHS Digital: Personal Social Services: Expenditure and Unit Costs, England. For 2016/17 & 2017/18: NHS Digital: Adult Social Care Activity and Finance Report, England, using the May 2019 GDP deflator.

Total expenditure is the sum of all public expenditure on adult social care including client contributions, income from the NHS and other sources or joint arrangements.

In addition to this, local authorities have been able to increase council tax levels by up to 2 per cent (over and above any increase up to the referendum threshold) for each year between 2016/17 and 2019/20, to raise extra funds through a ‘Social Care Precept’. In December 2016 the Government enabled local authorities to bring forward the Precept by raising council tax by up to 3 per cent in 2017/18 and 2018/19. 147 out of 152 local authorities with adult social care responsibilities utilised

some or all of this 3 per cent precept in 2017/18, which generated a further £552 million in total (NHS Digital 2018a).

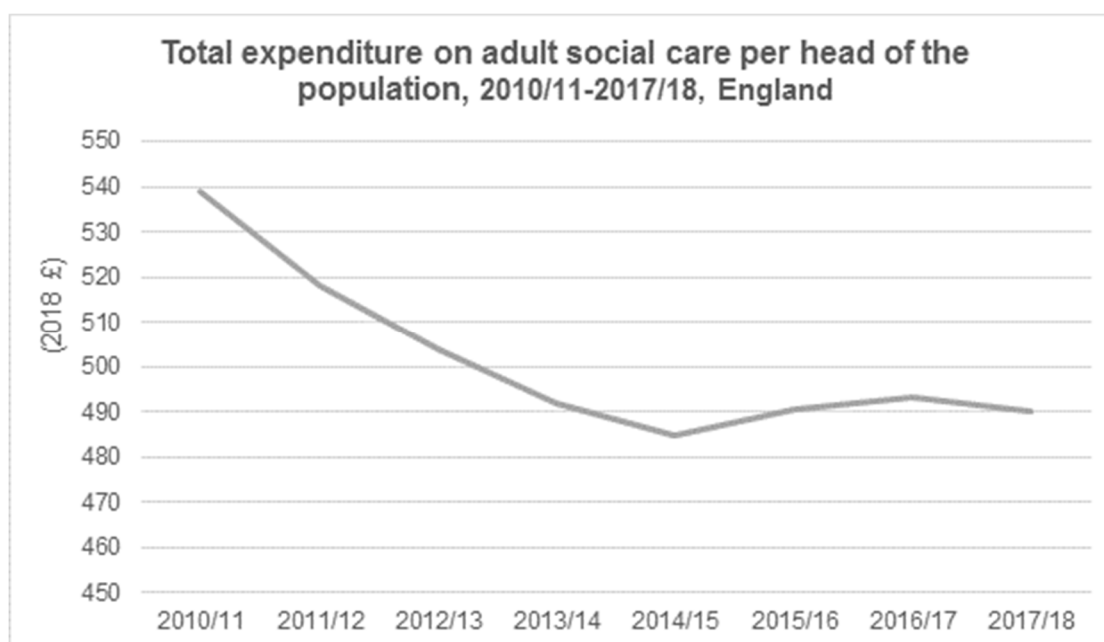
In October 2018, the Government also announced an additional £240 million for social care services in England, allocated to local authorities based on the relative needs formula to help ease winter pressures on the NHS during 2018/19 (DHSC 2018a).

### Comparative spending on social care

Although spending on social care has increased over the last three years, as set out in *figure 10*, in real terms spending has still been cut by £0.5 billion since 2010/11. Furthermore, this does not take into account how demand for social care will have changed over the course of the decade. As *figure 11* shows, spending per head of the population has fallen significantly over the same period. In 2010/11 total expenditure on social care per head of the adult population stood at £539. By 2017/18 that has fallen by £49 – or 17.5 per cent – per head.

Given that it is the older population that is growing most rapidly – particularly the oldest old who are most likely to need care – the picture for people aged over 65 is likely to be even more acute. Local authority spending on care *per person for people aged 65 and over* in England is estimated to have fallen by 24 per cent between 2010/11 and 2017/18<sup>8</sup> (BBC 2018).

Figure 11



Sources: For 2010/11 to 2015/16: NHS Digital: Personal Social Services: Expenditure and Unit Costs, England. For 2016/17 & 2017/18: NHS Digital: Adult Social Care Activity and Finance Report, England. ONS 2018: Population Estimates.

<sup>8</sup> Adjusted for inflation.



## 2.2 Growing funding pressures on social care

### Demographic changes

As the population grows and ages, rising demand for care and increasingly complex needs are putting further pressure on the social care system. Demand and cost pressures on adult social care are projected to grow at a rate of 3.7 per cent a year, increasing costs by around £12.2 billion a year by 2030/31 (Watt et al 2018). With social care spending growing at an estimated 2.1 per cent a year<sup>9</sup>, this leaves a projected funding gap of £1.5 billion a year by 2020/21 and £6.1 billion a year by 2030/31 just to stand still and maintain the existing system (Watt et al 2018).

However, over 400,000 fewer older people accessed publicly funded social care in 2013/14 than in 2009/10 – a drop of 26 per cent (Watt et al 2018). While it is not possible to directly compare more recent access figures, there is little sign that access to care has improved. Restoring levels of access to 2009/10 levels (before the care system began to experience significant spending cuts) would require an additional £8 billion a year by 2020/21 with expenditure rising to £27 billion, and to £38.7 billion by 2030/31 (Watt et al 2018).

If trends keep pace with demographic pressures, then the number of older people in receipt of publicly funded home care services or direct payments is projected to rise from 249,000 in 2015 to 466,000 in 2040 (an increase of 87 per cent) (Wittenberg et al 2018). Likewise, the number of publicly funded care home residents aged over 65 is projected to increase from 157,000 in 2015 to 280,000 by 2040 (an increase of 67 per cent) (Wittenberg et al 2018).

### Increasing unit costs

As well as the pressures associated with a growing and ageing population, increasingly complex care needs and reductions in government funding, local authorities are also seeing increases in unit costs for care. For example, the average weekly cost of local authority funded residential care for an older person was £565 in 2016/17 compared to £604 in 2017/18, an increase of 6.9 per cent in that period alone (NHS Digital 2018a). This placed local authority budgets in a precarious position.

The 2018 Association of Directors of Adult Social Care (ADASS) members survey found that 83% believe the National Living Wage (NLW) will be the biggest driver of increases in unit costs for residential, nursing and home care (ADASS 2018a). The NLW, the statutory minimum for workers aged 25 and over, increased by 4.9 per cent to £8.21 per hour on 1<sup>st</sup> April 2019. Rates for younger workers will also increase above inflation and average earnings. This is expected to cost local authorities in the region of an extra £585m (ADASS 2018a).

Altogether, net public expenditure on social care for older people (excluding service user charges) is projected to rise by 159 per cent under the current funding system, from around £7.2 billion in 2015 to £18.7 billion in 2040 (at constant 2015 prices) (Wittenberg et al 2018). Yet, these base projections assume that the unit costs of care will rise more or less in line with average earnings. There is scope for debate about whether costs and wages in the care sector will rise faster than other sectors. If the real unit costs of care were to rise by 0.5 per cent a year faster than average earnings, net public expenditure would in fact increase by 189 per cent to £20.9 billion in 2040 (Wittenberg et al 2018).

### Generating savings

The 2018 ADASS Budget Survey found that just over half (76) of all local authorities overspent against their adult social care budgets (ADASS 2018a). Of these, around half financed this overspend from reserves and a further 31 local authorities funded overspends by making savings in other departments – both approaches that are unsustainable over the longer term (ADASS 2018a).

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<sup>9</sup> Estimated using current plans to 2017/18, estimated spending powers for local authorities to 2019/20, and GDP growth to 2030/31.

In order to balance their budgets locally Directors reported plans to make savings of £700 million in 2018/19, with developing self-help approaches to reduce demand for long term care, efficiency savings and reducing services/ personal budgets the most commonly cited approaches (ADASS 2018a). Furthermore, of those who were able to provide a breakdown, 43 per cent planned savings that would directly affect older people. It should also be noted that 65 per cent of Directors are only partially confident they can meet these savings (ADASS 2018a).

Although ADASS welcomes the income from the Improved Better Care Fund, they estimate that Directors will be required to offer up further savings of approximately £500 million in 2019/20 (ADASS 2018b). Only 6 per cent of Directors are fully confident of meeting planned savings in 2019/20, with 62 per cent partially confident (ADASS 2018b).

### Ability to raise funds

As set out before, 147 out of 152 local authorities with adult social care responsibilities utilised some or all of their ability to levy a social care precept of up to 3 per cent in 2017/18, generating a further £552 million in funding for adult social care (NHS Digital 2018a). However, the shift towards a model where local authorities depend on local tax revenues (including council tax and business rates) for their funding, risks a situation where revenues from those taxes do not keep pace with rising pressures on adult social care services. Of even greater concern, it places particular risk on areas with higher levels of deprivation, which typically have higher needs and lower tax revenues. Local authorities with higher levels of deprivation tend to have a lower local tax take and therefore raise less revenue per head from the Social Care Precept which, over time, will lead to increasing levels of inequality between areas if nothing more is done (Cromarty 2018).

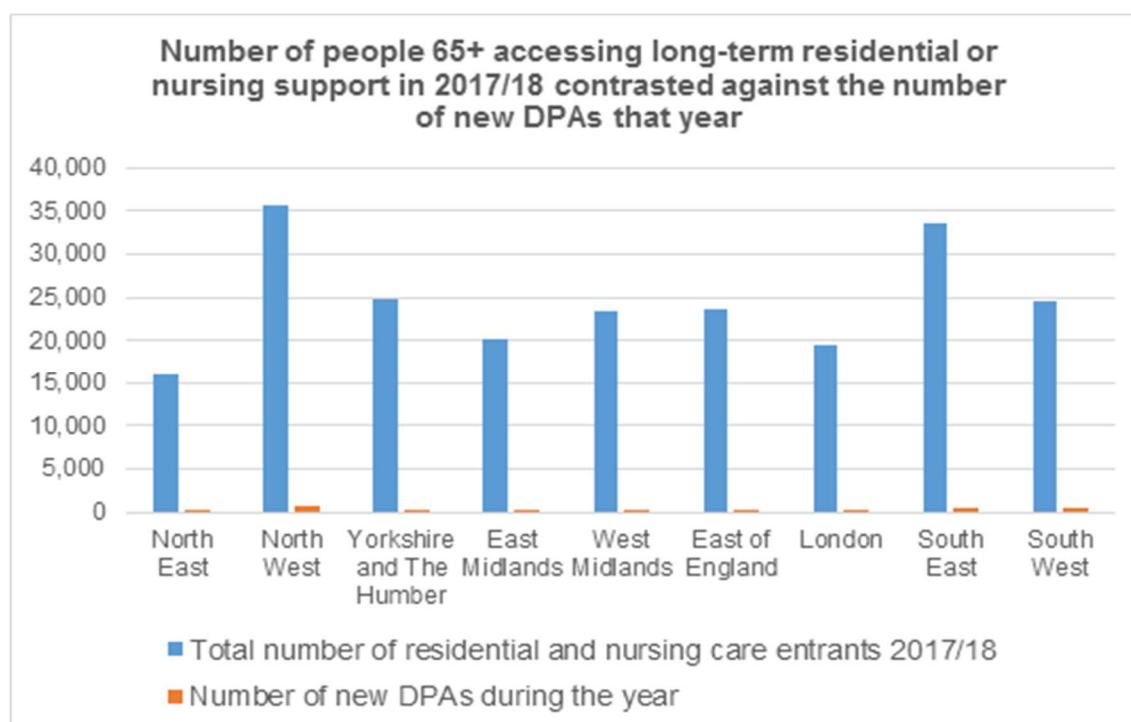
### Deferred payments

A deferred payment agreement (DPA) is an arrangement between a social care recipient and their local authority which enables people to use the value of their homes to help pay care home costs. If a person is eligible, under a DPA their local authority will help to pay the care home bills, place a legal charge on the property, and recover the spend when the person's home is sold, either at their time of choosing or after their death. Local authorities can charge interest on deferred payments to cover costs, but the Care Act 2014 assures it cannot be more than a government-approved standard rate; this currently equates to around 2 per cent.

While DPAs have been available for many years, 2017/18 is the first year for which there is a complete data set. In 2017/18 there were 3,105 new DPAs in England with a total value of £37.4 million, and 2,705 DPAs, with a total value of £63.0 million, was recovered in-year (NHS Digital 2018d). The number of outstanding DPAs at 31 March 2018 was 6,335, with a total value of £193.0 million. There were also 150 DPAs that ended in 2017/18 and were written off, with a total written-off value of £2.2 million (NHS Digital 2018d).

It is not possible, from the data available, to say what proportion of those people who would be both, eligible for, and interested in DPA actually have one. However, 98.1 per cent of live DPAs relate to people over the age of 65, and the number of DPAs issued is very low compared to the number of older people accessing long term care. As *figure 12* shows, in 2017/18 there was just one new DPA agreed for every 71 older people accessing long term residential or nursing support. Clearly, not everyone will be a property owner, and of those who are, not all will want or be eligible for a DPA. However, the comparatively low numbers are consistent with anecdotal reports which suggest that awareness of DPAs remains low. It may also reflect concern amongst local authorities about the immediate financial burden and the long-term risk of recouping the financial outlay.

Figure 12



Source: NHS Digital 2018: Deferred Payment Agreements Report, England 2017-18; NHS Digital: Adult Social Care Activity and Finance Report, England 2017-18

## Public health funding

Small variations in the projected rate of disability have a significant impact on future demand, and therefore the cost, of care. There will be an estimated 2.95 million older people living with one or more ADL by 2040, but if rates of disability amongst older people were to rise by just an additional 0.5 per cent per year (rather than remaining constant) then this figure would increase to 3.33 million, or indeed would fall to 2.62 million if the rate of disability fell by 0.5 per cent (Wittenberg et al 2018). This is a difference of tens of thousands of social care recipients a year by 2040.

This illustrates the importance of efforts to prevent and delay onset of chronic illness, disability and dependency, as well as to reduce their impact: public health and preventative services are not ‘nice to haves’. Services can directly help reduce the demand for, and therefore public expenditure on, social care for older people, both by decreasing future need for care and by supporting those already in receipt of care to stay well for longer.

Despite commitments set out in the NHS Five Year Forward View, and more recent announcements in November 2018 by Government that they would put “greater focus” on prevention, there has been a significant real terms reduction in public health spending since 2013/14 when, under the terms of the 2012 Act, responsibility was transferred to local authorities (Hancock 2018).

The public health core grant (excluding 0-5 years children’s services) rose in the first year from £2.7 billion in 2013/14 to £2.9 billion in 2014/15 in real terms. Since then there have been year on year real terms reductions, resulting in the budget falling to £2.6 billion in 2017/18 and £2.4 billion in 2018/19 (Finch, Bibby & Elwell-Sutton 2018). Between 2014/15 and 2019/20 total spending is projected to fall by 23.5 per cent per person (Finch, Bibby & Elwell-Sutton 2018). Taking into account

changes in demographics and deprivation, restoring the public health grant to 2014/15 levels would require an estimated additional £1 billion in 2020/21 (Kings Fund 2019).

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

As set out above in the previous section, if trends keep pace with demographic pressures, then under the current system the number of older people in receipt of publicly funded home care services or direct payments is projected to rise by 87 per cent between 2015 and 2040. Meanwhile the number of publicly funded care home residents aged over 65 is projected to increase by 67 per cent (Wittenberg et al 2018). This alone means public expenditure on social services for older people is projected to rise under the current funding system from around £7.2 billion (0.45 per cent of GDP) in 2015 to £18.7 billion (0.75 per cent of GDP) in 2040 at constant 2015 prices (Wittenberg et al 2018).<sup>10</sup>

However, in total the numbers of older people projected to need care and support services – whether publicly or privately funded – will grow from 657,000 in 2015 to nearly 1.2 million by 2040 (Wittenberg et al 2018). Taking account of private expenditure as well, total expenditure on care services for older people is projected to rise by 166 per cent from £15.7 billion (or 0.8 per cent of GDP) to £41.7 billion (or 1.4 per cent of GDP) by 2040 (in constant 2015 prices) (Wittenberg et al 2018). This also once again assumes there will be no significant increases in unit costs, which as discussed above, may not prove to be the case (Wittenberg et al 2018).

This raises serious questions about our existing model of social care provision. There is now widespread consensus among older and disabled people, families, policy makers and practitioners that there is urgent need for reform to deliver a sustainable system capable of providing the care people need, when they need it. The Housing, Communities and Local Government Committee and the Health and Social Care Committee June 2018 joint report on the long-term funding of adult social care concluded that *“in its present state, the system is not fit to respond to current needs, let alone predicted future needs as a result of demographic trends”* (HSCHC & CLGC 2018). This is just one of many such reports.

Since 1998, there have been 12 green papers, white papers and other consultations, as well as five independent commissions, all attempting to grapple with the problem of securing a fair and sustainable adult social care system (Humphries 2018). The current Government promised a further green paper in spring 2017 which, at the time of writing in summer 2019, is still yet to be published.

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

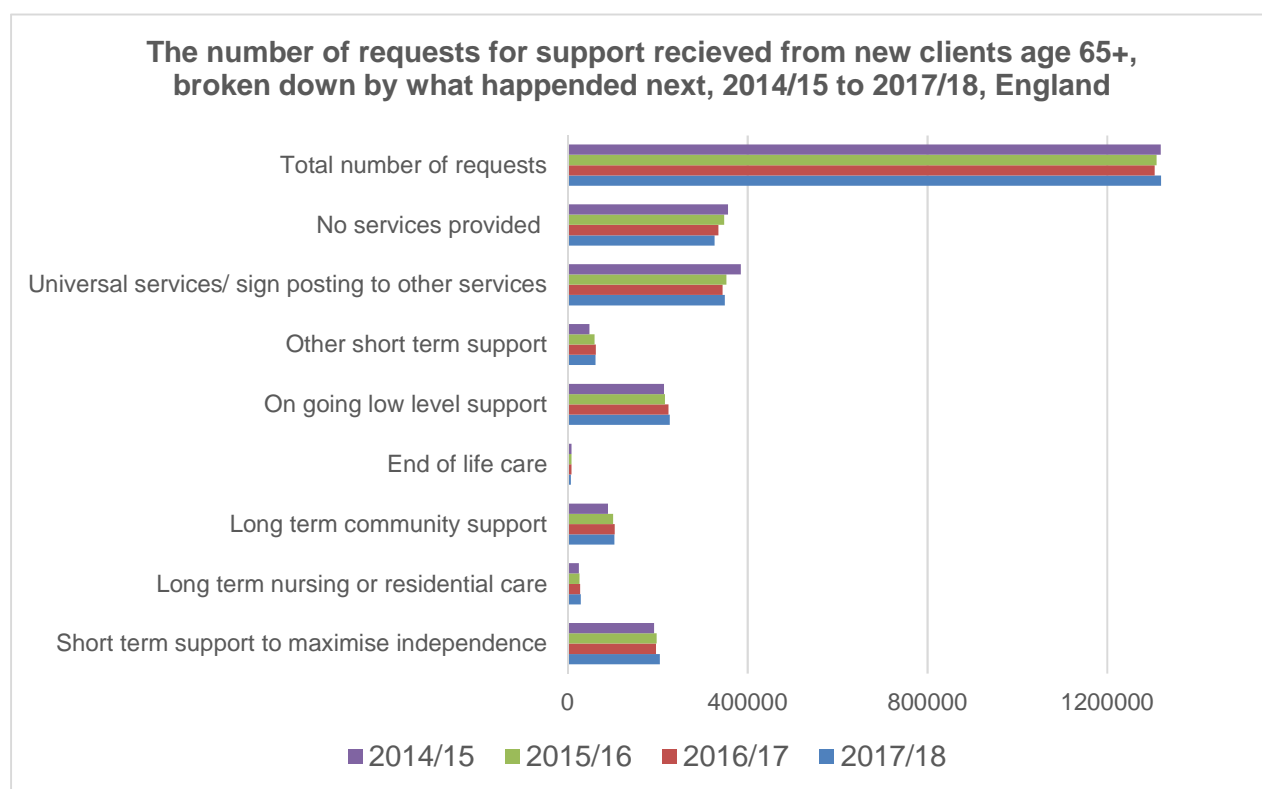
### New requests for support

There were 1.32 million new requests for support from older people in 2017/18, accounting for 71.6 per cent of all requests received by adult social services departments (NHS Digital 2018a). As *figure 13* shows, the total number of requests has remained relatively constant over the last four years. In 2017/18, 676,430 requests – or 51.2 per cent of the total – resulted in either no services being received or people being sign posted to universal services or elsewhere. A further 132,695 people were provided with long term support via nursing, residential or community-based care, 266,500 were provided with some form of short-term support and 227,175 with on-going low-level support. Again, this is broadly consistent with previous years of comparable data.

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<sup>10</sup> Under a set of base case assumptions about trends in the drivers of long-term care demand (including mortality and disability rates, current patterns of care and the current funding system) and in the unit costs of care services

Figure 13



Sources: For 2014/15 & 2015/16: NHS Digital: Community Care Statistics, Social Care Activity, England. For 2016/17 & 2017/18: NHS Digital: Adult Social Care Activity and Finance Report, England. Totals 2016/17 and 2017/18 excludes people who went on to receive fully funded NHS care as break downs are not available for previous years.

### Changing patterns of support

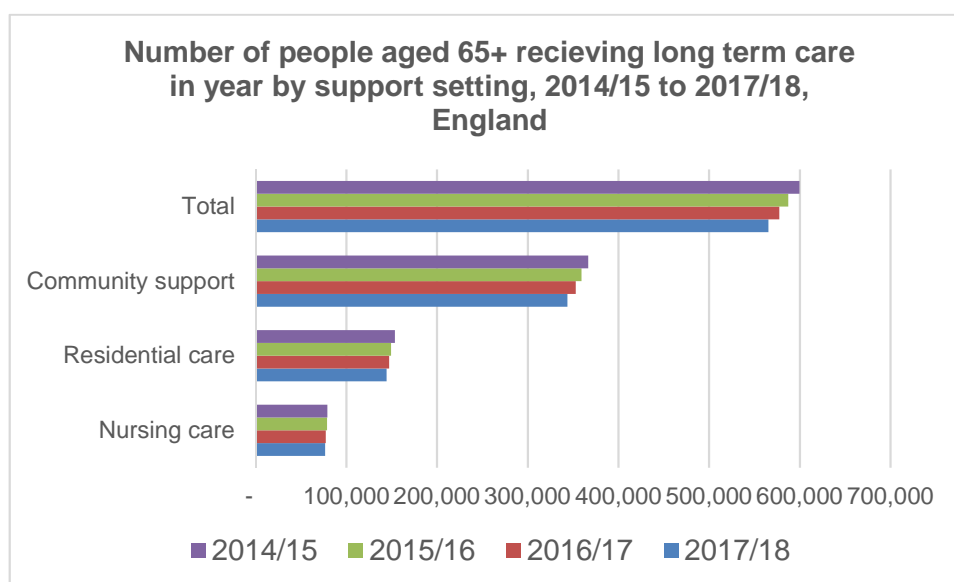
While new requests for support and provision have remained broadly stable, the size of the older population and, therefore the projected level of demand, continues to rise. Overall, as *figure 14* shows, the number of older people receiving local authority long-term care over the course of the year has decreased each year since 2014/15, from 599,680 to 565,385 in 2017/18, or by 5.7 per cent. Altogether 11,375 fewer people received nursing or residential care over the course of the year in 2017/18 compared to 2014/15 – a 4.9 per cent reduction – and 22,920 fewer people received community support – a 6.2 per cent reduction.

This could represent, in part, a shift towards more short-term packages of care. As *figure 13* demonstrates, the numbers of people provided with short term support to maximise independence (ST-max) or other short-term services after making a new request for support increased by 2 per cent over the period from 240,575 to 266,500 while numbers provided with long-term care grew at a slower rate.

However, as scope for efficiency savings reduces, there is evidence local authorities are having to manage social care funding pressures by other means, including service reductions and smaller care packages, as well as stricter eligibility criteria, and reducing the prices paid to providers (Cromarty 2018). Indeed, in ADASS's annual survey of Directors of Adult Social Services in England (100 per cent response rate), no Director reported being fully confident their local authority would be able to meet its statutory requirements in 2020/21 (ADASS 2018a).

As section 2.5 explores in more detail, levels of unmet need have risen steeply in recent years and, as set out in section 2.6, the numbers of nursing and residential care beds and hours of domiciliary care provided have all fallen as well. Therefore, we must also be concerned that these trends reflect fewer people coming forward to request support – or even being made aware of their rights in this regard – and smaller amounts of care being provided to those who do.

Figure 14



Sources: For 2014/15 & 2015/16: NHS Digital: Community Care Statistics, Social Care Activity, England. For 2016/17 & 2017/18: NHS Digital: Adult Social Care Activity and Finance Report, England.

## Ombudsman activity

The Local Government and Social Care Ombudsman’s annual review of adult social care complaints revealed the Ombudsman has become increasingly concerned about the way some local authorities are balancing the financial pressures they are under with the way they assess and charge for care. Over the 12-month period covered by the review, there was a small increase in the complaints received, including a 9 per cent increase in complaints about charging (LGSCO 2018a). The Ombudsman upheld 67 per cent of charging complaints, which is higher than the average uphold rate for adult social care of 62 per cent, and greater still than the 57 per cent uphold rate for all complaints the Ombudsman investigates (LGSCO 2018a).

In 2017/18, the Ombudsman made 1,274 recommendations to local authorities and providers, including 274 recommendations to improve procedures or undertake staff training, which was a 20 per cent increase on the previous year. They found fault in 62 per cent of adult social care cases investigated, almost a fifth more than when the Ombudsman began investigating adult social care complaints in 2010/11 (LGSCO 2018a). In total, 40 per cent of complaints remedied included service improvements to tackle systemic problems and improve services for people in the future (LGSCO 2018b).

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

The huge reduction in the provision of public funded social care has had a severe impact on older people, their families and carers in recent years. Three-quarters (75 per cent) of Directors of Adult Social Services report that reducing the number of people in receipt of care is important or very

important for them to achieve necessary savings (ADASS 2018a). If local authorities successfully develop preventative approaches that increase independence and reduce needs for care, then this is a positive ambition. However, if local authorities gate-keep resources in a way that leaves people in need without appropriate care and support, then it breaches the law, as well as being financially risky.

### High levels of unmet need

In 2016 nearly one in eight people were struggling without all the help they need to carry out activities of daily living (ADL) – essential everyday tasks, such as getting out of bed, going to the toilet or getting dressed (Age UK 2018b). In 2018 this had risen to nearly one in seven older people (Age UK 2018b). As *figure 15* shows, of the 1.4 million older people affected, nearly 300,000 of those have difficulties with three or more ADLs. More than half of these people get no help at all from paid carers, family members or friends. Taking into account instrumental activities of daily living (IADLs), such as shopping, preparing hot meals and managing finances, the number of older people with unmet needs rises to more than 1.5 million (Age UK 2018b).

Figure 15

**Numbers of people aged 65+ in need of help with 1 or more ADL and 1 or more ADL/IADL, by whether or not formal/informal help was received, 2016/17, England**

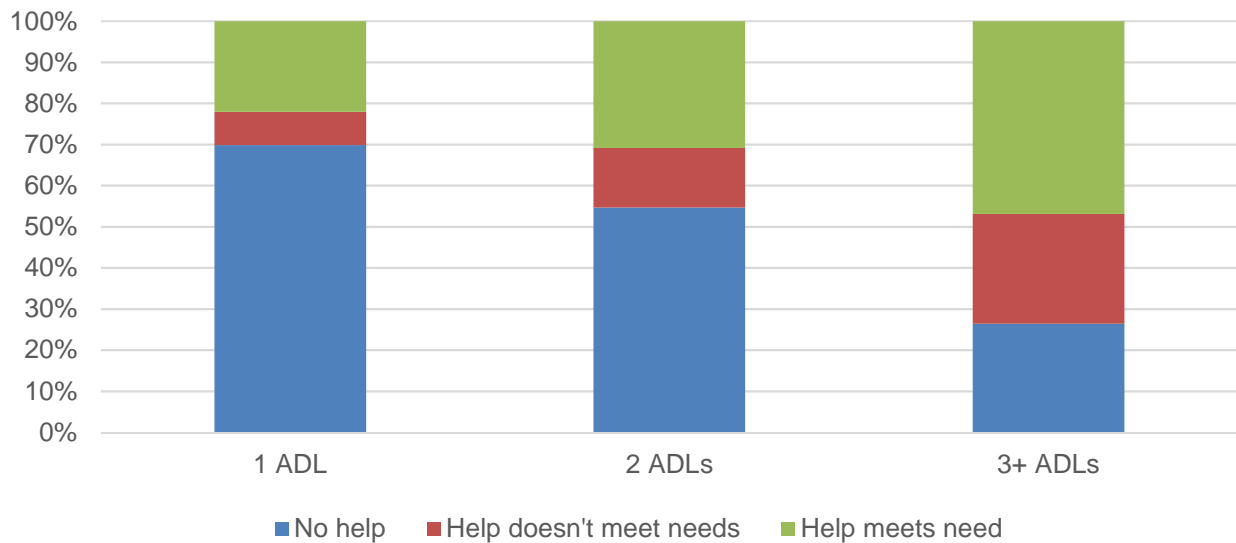
	1 or more ADL	2 or more ADLs	3 or more ADLs	1 or more ADL/IADL	2 or more ADL/IADL	3 or more ADL/IADL
Total number of people aged 65+ in need of help	1,944,585	980,287	534,858	2,767,630	1,714,424	1,129,970
Of which received <i>sufficient</i> help	942,341	579,252	376,390	1,899,261	1,393,405	990,935
Of which received <i>insufficient</i> help	262,582	196,399	138,345	672,869	512,794	374,178
Of which received no help	1,140,937	401,035	158,468	868,369	321,019	139,036
<b>Total number of people aged 65+ living with unmet needs</b>	<b>1,403,519</b>	<b>597,434</b>	<b>296,813</b>	<b>1,541,238</b>	<b>833,813</b>	<b>513,214</b>

Source: ELSA, Wave 8 (2016/17); Age UK analysis

It is widely agreed that people unable to carry out three or more ADLs would certainly be eligible for support under the Care Act 2014. It is therefore particularly shocking that, as *figure 16* below shows, an estimated 53 per cent of people aged 65 and over who are unable to complete three or more ADLs receive no help or help that does not meet their needs (Age UK 2018b).

Figure 16

**Number of Activities of Daily Living (ADLs) by whether or not formal /informal help is received or a need is met, people aged 65 and over, 2016/17, England**



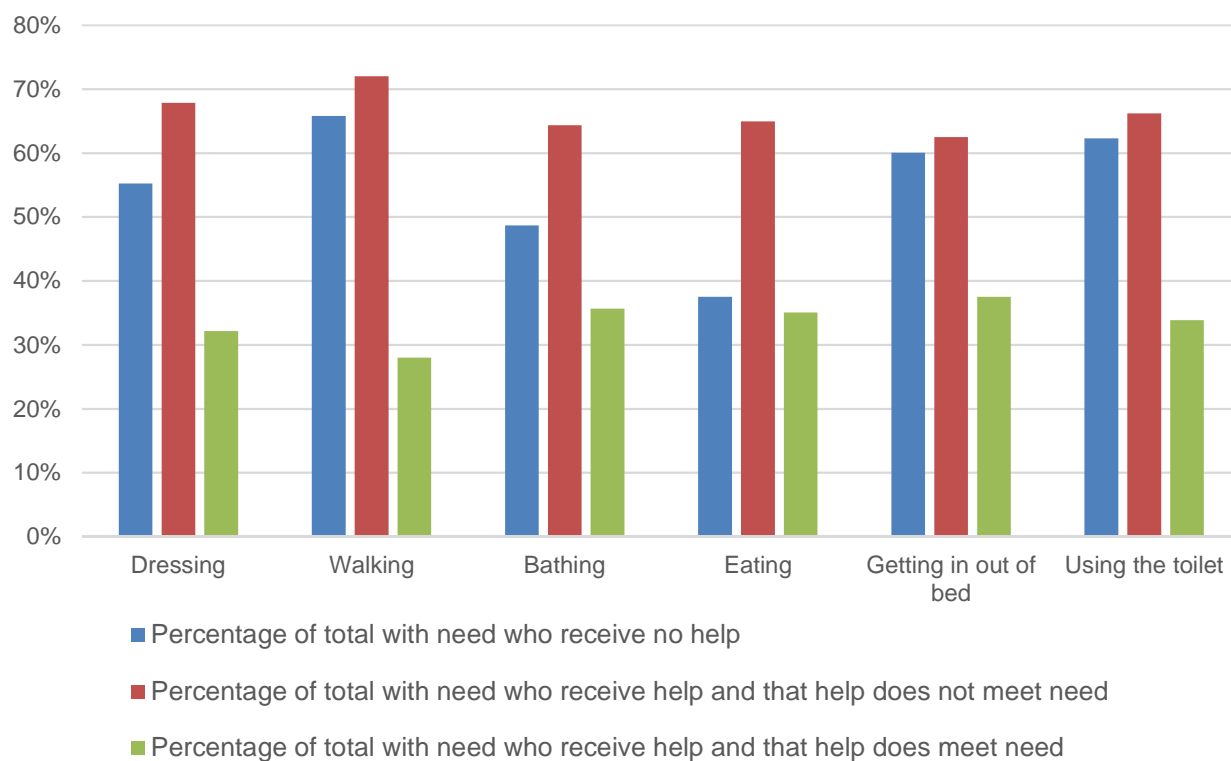
Source: ELSA, Wave 8 (2016/17); Age UK analysis

Figure 17, below, sets out the percentage of older people who report needing help with specific essential everyday tasks. It shows that an alarming percentage of people are either not receiving any help with basic tasks like getting in and out of bed, using the toilet, and eating, or they are receiving help that does not meet their needs (Age UK 2018b).



Figure 17

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 and over, 2016/17, England



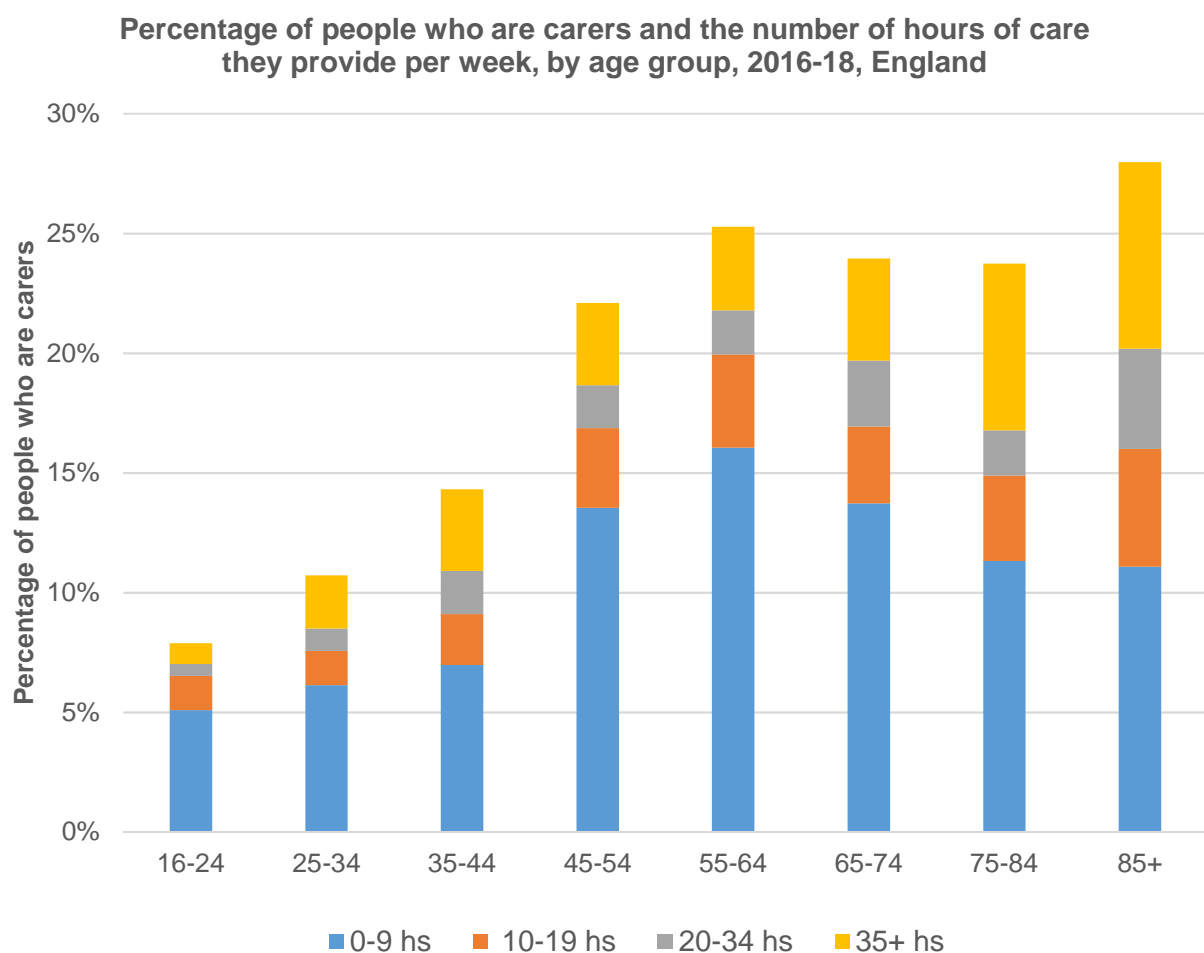
Source: ELSA, Wave 8 (2016/17); Age UK analysis

### Growing pressure on unpaid carers

The combination of a growing and ageing population, increasingly complex needs and reducing access to care services also places significant pressure on unpaid carers. Unlike healthcare, the majority of social care is provided informally by unpaid partners, family and friends, who provide personal care and practical help and coordinate formal services. Estimates of the value of informal care range from £58 billion (accounting for the value of care likely to fall within local authority eligibility criteria) to £100 billion per year (recognising the full value of all informally provided care) (NAO 2018a).

The proportion of people who provide unpaid care for family and friends has been slowly increasing in recent years, rising from 16.9 per cent of the population in 2011 to 17.8 per cent in 2015 (Age UK 2017). However, due to overall population growth, the absolute number of carers is increasing much more quickly. Many carers are older people themselves, with an estimated 2 million carers over the age of 65, of whom 417,000 are aged 80 and over (Age UK 2017). Older people are slightly more likely to be carers than the population as a whole and, as *figure 18* shows below, are also more likely to provide more intensive levels of care (Age UK 2018b). As noted in the previous chapter, the majority (65 per cent) of older carers (aged 60 and older) have long-term health problems or disability themselves, while 69 per cent say that being a carer has had an adverse effect on their mental health (Carers Trust 2018).

Figure 18



Source: ELSA, Wave 8 (2016/17); Age UK analysis

The NHS Digital 2016/17 biennial national survey of carers (55,000 total respondents, 45.4 per cent of whom were carers aged 65 and over) (NHS Digital 2017b), also found substantial reductions in the percentage of carers who reported the person they care for was in receipt of care and support, including:

- Help / care at home – fell from 41.0 per cent in 2012/13 to 34.7 per cent in 2016/17 (NHS Digital 2017b).
- Use of day centres – fell from 31.0 per cent in 2012/13 to 27.1 per cent in 2016/17 (NHS Digital 2017b).
- Aids and adaptations – fell from 61.6 per cent in 2012/13 to 56.1 per cent in 2016/17 (NHS Digital 2017b).

The survey saw a rise in the percentage of people who have had no support at all from social services in the last 12 months – from 15.1 per cent of respondents in 2012/13 to 22.4 per cent in 2016/17 (NHS Digital 2017b).

## Impact on carers and sustainability of informal care

There are also questions about the current and future sustainability of informal care.

Caring can have an adverse impact on a person's health and wellbeing, and it is important that carers are recognised and supported, both as partners in care and people with support needs in their own right. This was explicitly recognised within the Care Act 2014. Yet despite good intentions, the NHS 2016/17 biennial national survey of carers found that access to:

- Support or services allowing carers to take a break from caring at short notice or in an emergency fell from 16.7 per cent in 2012/13 to 14.5 per cent in 2016/17 (NHS Digital 2017b).
- Support or services allowing them to take a break from caring for more than 24 hours fell from 23.5 per cent in 2012/13 to 20.9 per cent in 2016/17 (NHS Digital 2017b).

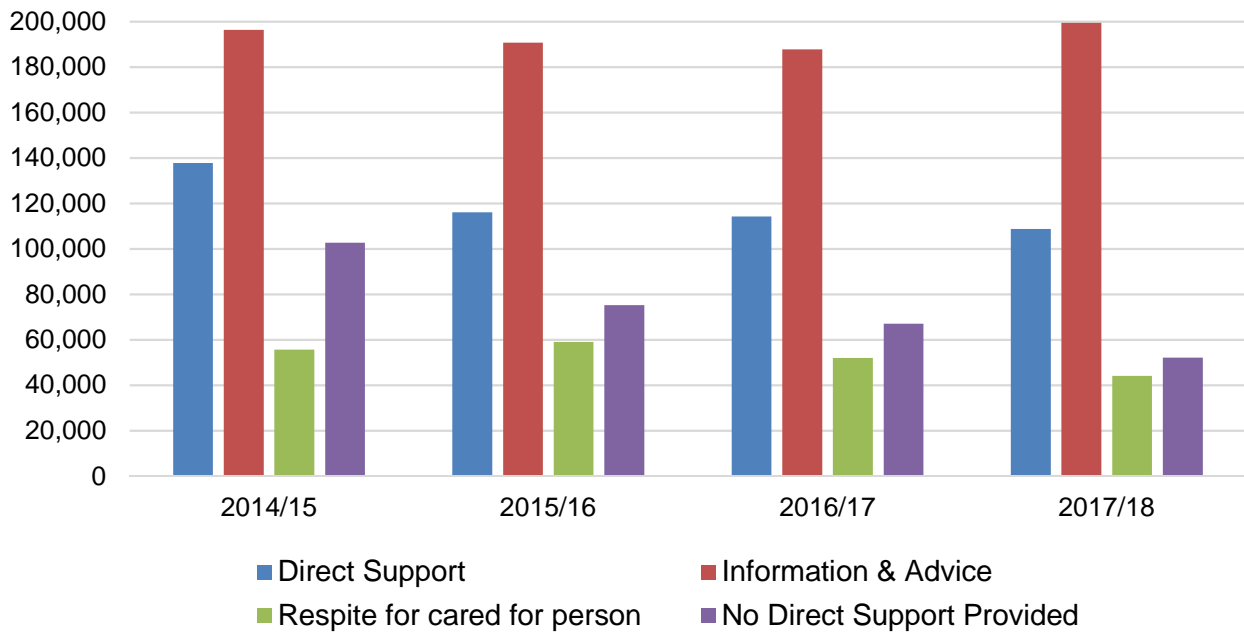
As *figure 19*, below, shows the number of carers benefiting from respite or support for the person they care for has dropped 20.7 per cent in four years, from 55,735 in 2014/15 to 44,180 in 2017/18.

The survey also found a parallel rise in concerns about carers' own health and wellbeing, with:

- More carers reporting 'I feel like I am neglecting myself' in relation to their sleeping and eating – rising from 13.7 per cent in 2012/13 to 15.8 per cent in 2016/17 (NHS Digital 2017b).
- More carers saying they feel socially isolated when talking about their social contact – rising from 13.5 per cent in 2012/13 to 16.2 per cent in 2016/17 (NHS Digital 2017b).
- More carers reporting they have a long-standing illness – rising from 24.2 per cent in 2012/13 to 28.6 per cent in 2016/17 (NHS Digital 2017b).

Figure 19

### Types of support provided or arranged by local authorities for carers, 2014/15 to 2017/18, England



Source: NHS Digital 2018: SALT, Community Care Statistics, Social Services Activity, England

There are also serious questions as to whether we are reaching the realistic and practical limit of informal care capacity. As previously set out, in recent years while the absolute number of carers has grown significantly as the population has increased, as a proportion of the population the rise is much less dramatic. At the same time the number of older people living with unmet care needs has increased significantly. Ultimately this strongly suggests that the supply of informal care has not increased sufficiently to meet growing demand for care, or fill the gap left by a social care system under acute pressure.

Furthermore, it is unrealistic to expect informal care to continue expanding indefinitely. If the probability of a disabled older person receiving care from family and friends stays the same over the next 25 years, the number of disabled older people receiving informal care and support is projected to rise by more than 75 per cent (Wittenberg et al 2018). However social and economic trends including, for example, smaller and more dispersed families, longer working lives, women's rising participation in the labour market and a growing number of people ageing without children means that it is unlikely the supply of unpaid care will increase to meet that need.

### Third-party top-up fees and charges

A third-party top-up fee is the difference between the rate a local authority is willing to pay a care home and the chosen care home's fee. In theory these should only apply when someone has chosen a more expensive care home after they have been offered suitable options within the local authority rates. This could be because a person would prefer to live in a care home that costs more than the local authority is prepared to pay for genuine extras (such as a large room, a better view, or a private balcony) or because they were previously self-funding their care home fees and want to stay in the same home now that they are eligible for local authority funding. There is no legal requirement for anybody to agree to pay a third-party top-up fee and the decision to meet this cost must be entirely voluntary. An estimated 11 per cent of care home residents pay top-up fees or have them paid on their behalf (Laing 2018).

However, there is a significant and growing gap between the rates paid by local authorities and those paid by self-funders. There is also evidence of third-party top-ups being used inappropriately where older people and their families are entering into arrangements without understanding their rights and/or being pressured into paying a top up when they are eligible for publicly funded care.

An investigation by Independent Age found some families were being asked to pay top-up fees for basic care, which should never happen (McDowell 2016). They found 43 per cent of local authorities were failing to demonstrate good practice in terms of how they introduce and oversee third-party top-up fees (McDowell 2016). The Competition and Markets Authority (CMA) also raised concerns about how third-party top-up fees were being levied and managed in their 2017 market study (CMA 2017).

In recent years the Ombudsman has also found continuing errors relating to top-up fees, with people and their families being incorrectly charged for care (Haynes 2018). This includes being given limited or poor information about top-up fees, leading them to enter into agreements they do not understand, or being led to believe the fees to be mandatory. The Ombudsman also reports some local authorities have "effectively washed their hands of control over top-up fees...they have basically said to providers, 'you levy the top-up, it's between you and the person receiving care or their relatives'... That's totally against the spirit and the letter of the guidance" (Haynes 2018).

Furthermore, growing concern about third-party top-ups sits alongside evidence that, as explored earlier on, older people are being asked to shoulder more of the cost burden through client contributions. Between 2014/15 and 2017/18 the amount raised through client contributions increased by 4.4 per cent from around £2.8 to £2.9 billion (see *figure 10*). Yet the numbers of older people accessing any form of care have remained relative constant, while the numbers of people receiving long term care – and therefore most likely to be paying charges – fell over the same period (see *figure 14*).

## 2.6 The impact of social care cuts on the sustainability of the social care market

The public sector provides very little care directly, the vast majority of services are delivered by private and third sector organisations. Local authorities have a duty under the Care Act 2014 to ensure that the market of home and residential care providers is sustainable and offers choice for local authority and privately paying service users alike. However, as local authorities – often the major purchaser in an area – have sought to manage their own budget reductions by driving down the prices they pay for services, the care market has become increasingly precarious and dysfunctional in many parts of the country. In 2018 more than three-quarters (78 per cent) of Directors of Adult Social Services reported concern about their ability to meet the statutory duty to ensure market sustainability within existing budgets (ADASS 2018a).

In 2017, CMA argued that the market-based approach to social care was unsustainable without additional public sector funding (CMA 2017). A 2019 report by Incisive Health, commissioned by Age UK, went further, concluding *'the current model has broken down in some areas of the country and is no longer capable of delivering care to people in need'* (Incisive 2019). As a result 'care deserts' are emerging in parts of the country where adequate social care provision is no longer reliably available to older people regardless of how their services are funded (Incisive 2019).

### Home care

Over 97 per cent of home care is provided by independent providers, with around 70 per cent of services commissioned by local authorities. In total an estimated 80 per cent of domiciliary care funding comes from the public sector once NHS sources are taken into account (LaingBuisson 2018a). As a result, the home care market is significantly exposed to challenges in public funding. Overall the total amount of home care delivered fell by 3 million hours between 2015 and 2018 (LaingBuisson 2019).

The data suggests that the home care market is in a state of considerable flux. In 2016/17 CQC registration data suggests 'churn' in the sector is high with around 2,000 agencies registering but 1,600 de-registering (Incisive 2019). This is consistent with the picture painted by Directors of Adult Social Services with almost a third, 31.6 per cent, reporting seeing home care providers closing or ceasing to trade in their area in the last six months of 2016/17. During the same period, 28.9 per cent of Directors had contracts handed back by home care providers (ADASS 2018a). A report from the Institute of Public Care has highlighted that the low prices being paid to home care providers by local authorities have had an impact on the sustainability of the sector and the quality of service provision (Bolton 2018).

Although local authorities have overall raised fees to providers, providers continue to report these to be unsustainable. Local authorities are concerned about this, with three-quarters of Directors reporting it to be their biggest concern about the impact of having to make and/or plan savings in 2018/19 (ADASS 2018a).

### Care homes

Over the last five years the number of care homes and care home beds have both been in decline. The number of registered locations fell by around 8.3 per cent between April 2013 and April 2018, from 17,502 to 16,037, while the number of beds available fell by 0.8 per cent from 462,624 (218,506 of these with nursing) to 458,905 (220,639 of these with nursing) (CQC 2018).

At a time of rising need and a growing older population these reductions are concerning. However, the unequal pattern of change across the country is arguably even more worrying. According to the CQC, across a two-year period, from April 2016 to 2018, changes in nursing home bed numbers ranged from a 44% rise in one local authority to a 58% reduction in another (CQC 2018). In 2018 Directors of Social Services in 58 local authorities reported having at least one care home closure in

their area, and 17 had contracts handed back (ADASS 2018a). In recent years two major providers have also collapsed – *Southern Cross* in 2012 and *Four Seasons* in 2019. Areas that have seen a significant decline in the number of beds tended to have the lowest number of self-funding service users, while those that gained beds tended to have among the highest (CQC 2018). This reflects the findings of a 2019 ‘deep dive’ report looking at the state of the care market in five areas of England which again found the most significant reductions in care home beds in areas with more publicly funded clients and greater difficulties in recruiting skilled workers (Incisive 2019).

The link between market instability and public funding is clear. An investigation<sup>11</sup> by the CMA found that the fees paid by local authorities are as much as 10 per cent below the full costs involved (CMA 2017). Care home providers have responded to this pressure on their finances by increasing prices for self-funding residents. The CMA report also found that fees for self-funders are now 41% higher on average than for local authority-funded beds in the same care homes – equivalent to an extra £236 per week (CMA 2017). As a result, the CMA concluded the sector as a *whole* is just about able to cover its operating and capital costs (CMA 2017). Yet the extent to which any *individual* care home is able to operate sustainably depends on their market mix. An estimated 25 per cent of care homes have more than 75 per cent of their residents funded by local authorities, and it is these homes that are most at risk of failure or exit from the market (CMA 2017).

## 2.7 The sustainability of the social care workforce

### Social care workforce now and in future

As demand for social care has grown, so too has the size of the workforce. There are now around 1.6 million jobs (1.13 million FTE roles), the vast majority of which are ‘frontline’ – directly providing care and support (Skills for Care 2018). 78 per cent are in the independent sector and 7 per cent are in the local authority sector (Skills for Care 2018). The remaining 15 per cent of jobs are primarily people using direct payments to employ their own care and support staff and social care jobs hosted within the NHS. A quarter of the workforce (25 per cent) is on zero-hours contracts (Skills for Care 2018).

The social care workforce is roughly equivalent in size to the NHS workforce (1.2 million FTE). Together the health and care workforce make up around 1 in 10 of the total workforce in England (Kings Fund 2018d).

Under a base case scenario, if the adult social care workforce were simply to grow at the same rate as the population of people aged 75 and older, a projected 59 per cent (950,000) more jobs would be required by 2035 (Skills for Care 2018). Despite this and the significant challenges in recruitment and retention set out next, the Department of Health and Social Care (DHSC) does not have a current workforce strategy (NAO 2018a).

### Recruitment and retention

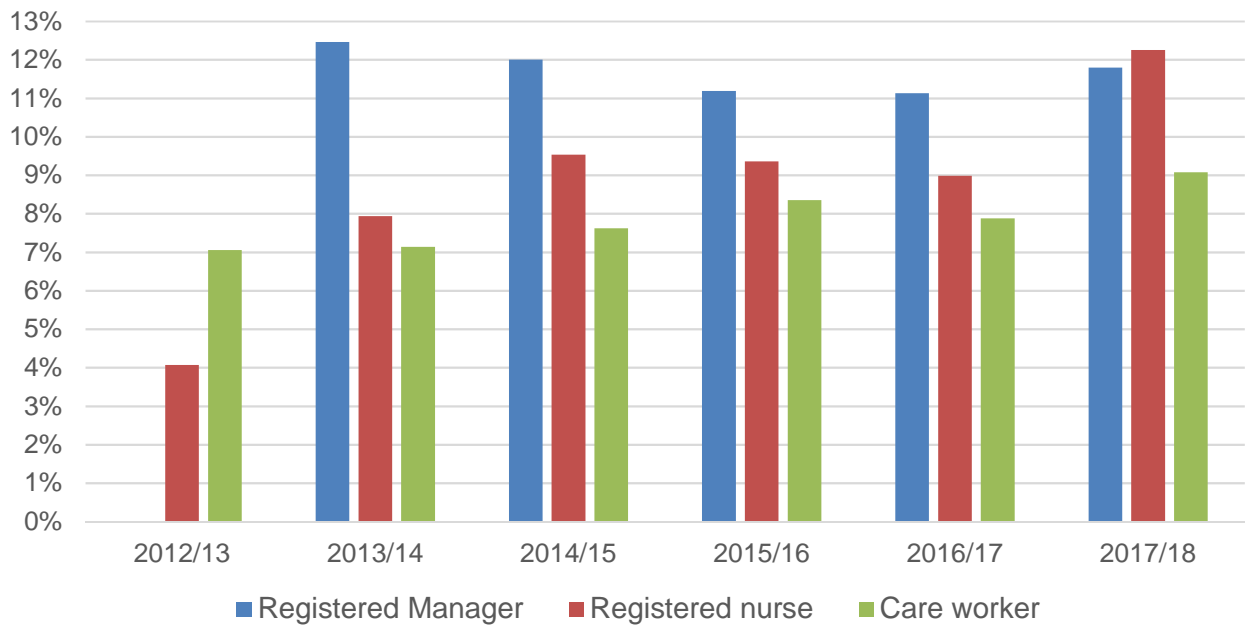
An estimated 8 per cent of roles in adult social care are vacant, meaning at any time there are approximately 110,000 vacancies (Skills for Care 2018). The vacancy rate has risen by 2.5 per cent between 2012/13 and 2017/18 (Skills for Care 2018). This rise in vacancies, especially in the context of a workforce that has grown at a slower rate in recent years, suggests that the sector is struggling to keep up with demand as the population ages (Skills for Care 2018). As *figures 20 and 21* demonstrate, the sector is particularly struggling to recruit registered nurses, and care homes have seen a sharp rise in vacancy rates.

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<sup>11</sup> A profitability analysis, understood to be the most complete in recent years, of the sector using information provided directly by care homes and taken from company accounts.

Figure 20

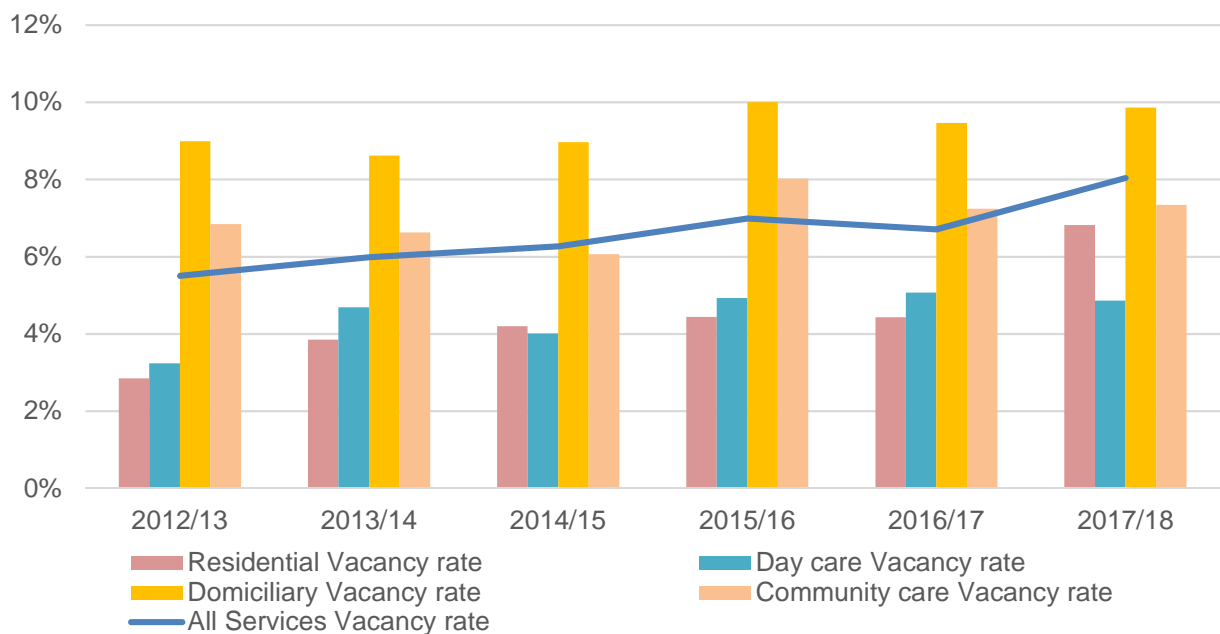
Workforce vacancy rates of key adult social care roles, 2012/13 to 2017/18, England



Source: Skills for Care 2018: Adult social care workforce estimates, England

Figure 21

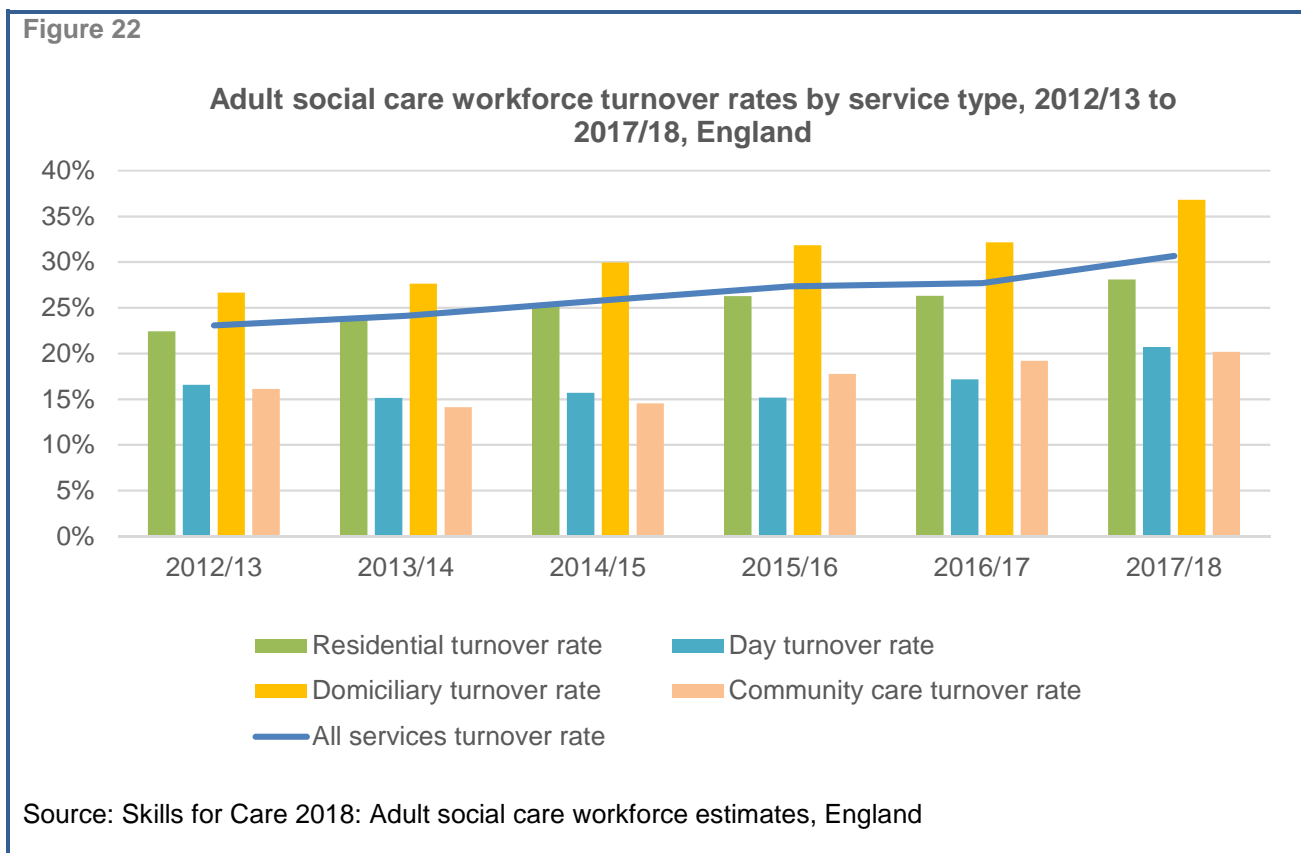
Workforce vacancy rates by adult social care service type, 2012/13 to 2017/18, England



Source: Skills for Care 2018: Adult social care workforce estimates, England

The estimated staff turnover rate of directly employed staff working in the adult social care sector is 30.7 per cent (Skills for Care 2018). As *figure 22* illustrates, turnover rates increased steadily between 2012/13 and 2017/18 by a total of 7.6 percentage points. This level of turnover and churn indicates that employers are struggling to find, recruit and retain staff to the sector. A large proportion of staff turnover is a result of people leaving jobs soon after joining.

A longitudinal analysis of turnover found workers under the age of 30 and those on the lowest pay were most likely to leave the workforce, while workers holding a relevant social care qualification had lower turnover than those without a relevant qualification (Skills for Care 2018). There is a 'core' of more experienced workers with lower rates of turnover. However, the average age of the adult social care workforce is 43 years old with 320,000 workers aged 55 years and over (Skills for Care 2018), meaning workforce planners face the challenge of significant numbers of this 'core' retiring in the next decade.



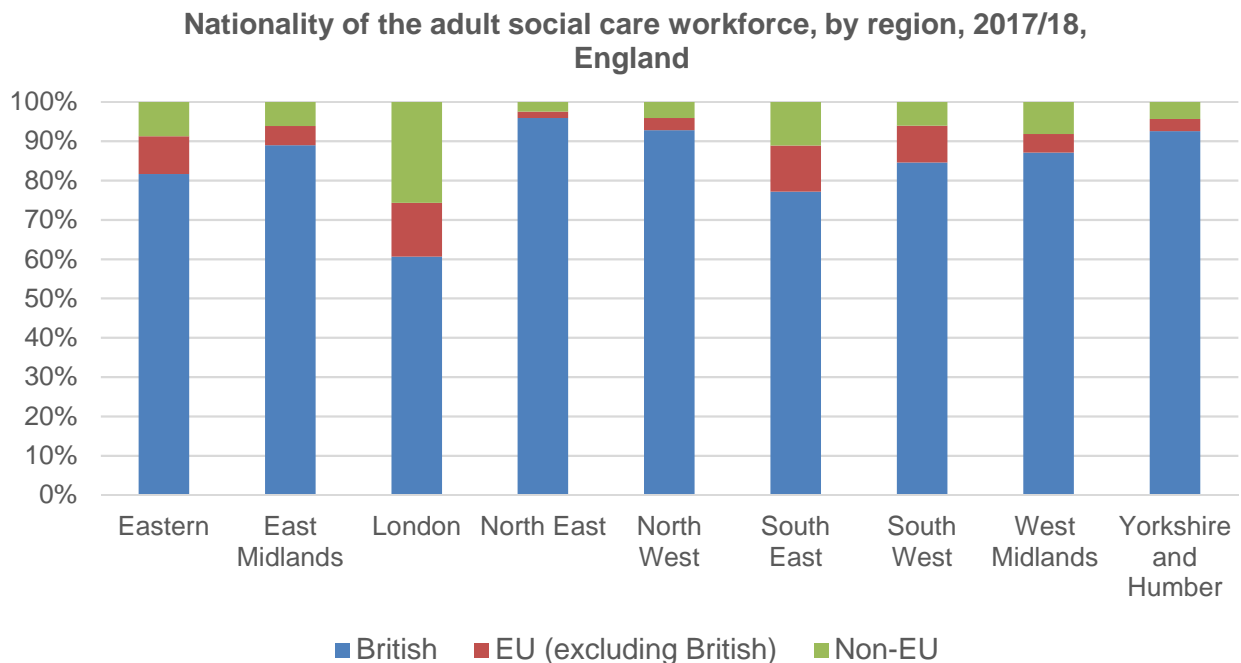
Terms and conditions are a widely acknowledge cause of concern. As set out above, turnover is highest amongst the lowest paid and least qualified. Where reasons for leaving are known, career development is one of the most commonly cited reasons (Skills for Care 2018). There is also now concern within the adult social care sector that the 2018 pay rises for the lowest paid NHS staff across England (up to 29 per cent over the next three years) will have the unintended consequence of exacerbating recruitment and retention challenges as it struggles to compete with the terms and conditions on offer to NHS employed healthcare assistants. An initial estimate of the cost of giving a similar increase to social care staff would be £3 billion a year (ADASS 2018b).



## Reliance on overseas workers

The majority (83 per cent) of the adult social care workforce is British, but 8 per cent have an EU nationality (excluding British) and 10 per cent a non-EU nationality.<sup>12</sup> According to the Government's *EU Settlement Scheme: statement of intent*, the rights of EU citizens living in the UK will not change until after 31<sup>st</sup> December 2020 (Home Office, 2018). The available data shows 21 per cent of all workers with an EU nationality (excluding British) already have British citizenship, while 50 per cent arrived in the UK either in or prior to 2015, and therefore may have gained the five years continuous residency required for 'Settled status' by the end of 2020. The remaining 29 per cent of EU workers should be eligible for 'pre-settled status' (Skills for Care 2018). However, looking ahead the majority of care workers are classified as 'low-skilled' for the purposes of preferential immigration treatment, therefore it currently looks unlikely that future workers will be offered an explicit work migration route (Migration Advisory Committee 2018).

Figure 23



Source: Skills for Care 2018: Adult social care workforce estimates, England

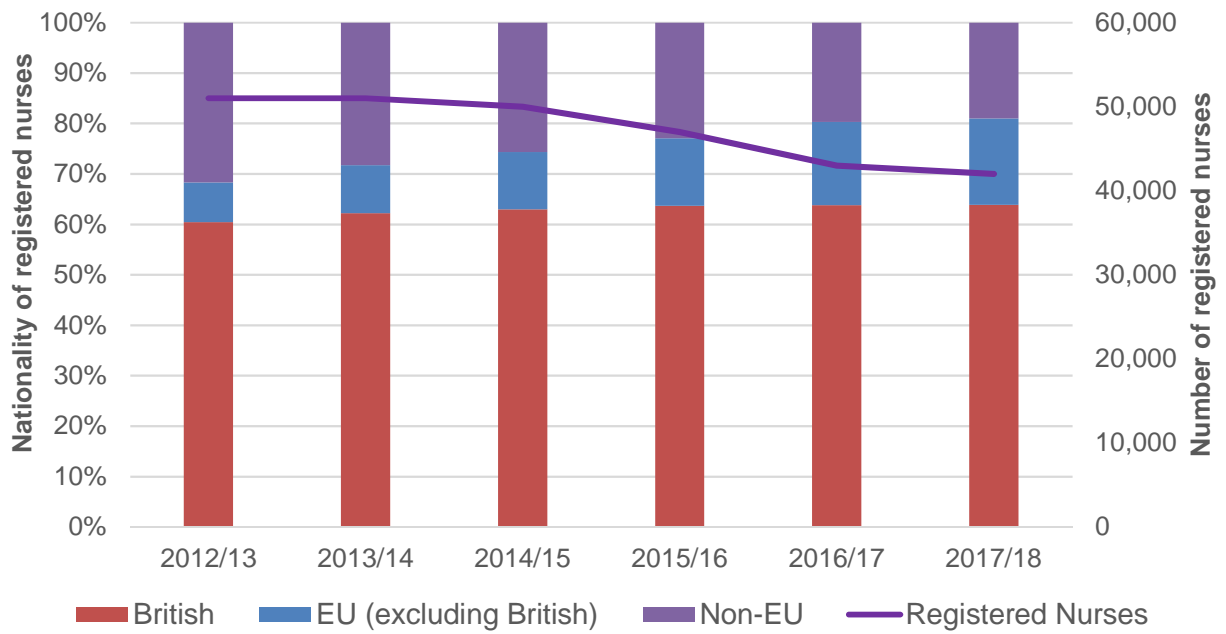
As *figure 23* shows above, there are regional variations, with some areas more affected than others (Skills for Care 2018). Care workers from other parts of the EU are often concentrated in the big cities; for example, in London EU nationals comprise a much larger proportion of the adult social care workforce than elsewhere (Skills for Care 2018).

As *figure 24* shows below, the picture is more precarious with regard to registered nurses within adult social care, of whom 17 per cent identified as having an EU nationality in 2017/18. This is especially concerning within the context of a mismatch between adult social care nursing salaries and NHS nursing salaries, which may continue to see staff drawn away from the sector and further limit the pipeline of new recruits (RCN 2018).

<sup>12</sup> Percentages may not total 100 due to rounding.

Figure 24

Number and nationality of registered nurses within adult social care, 2012/13 to 2017/18, England



Source: Skills for Care 2018: Adult social care workforce estimates, England

## 3. THE STATE OF HEALTHCARE

The NHS has fared much better than social care in terms of headline funding in recent years, though rates of growth remained well below the historical average. However, demographic changes mean the NHS serves more people and, in particular, a greater number of people with more complex needs. The service is also facing a number of significant challenges from attempts to modernise systems and redesign services to serious, and growing, workforce shortages.

### 3.1 Trends in public funding of healthcare services

Over the course of the three Parliaments between 1996/97 and 2009/10, the annual UK health care budget<sup>13</sup> benefited from a period of year-on-year growth, averaging at 5.9 per cent. Funding then fell in 2010/11 and was slow to recover over the course of the Parliament, averaging just 1.1 per cent annual growth between 2009/10 and 2014/15 (Luchinskaya, Simpson & Stoye 2017). This also coincided with the collapse in adult social care funding described in the previous chapter and substantial cuts to public health spending.

In 2013/14 the Department of Health and Social Care (DHSC) budget stood at £116.5 billion, £99.6 billion of which was directed to NHS England, the body responsible for running the NHS (HM Treasury 2018). As *figure 25* shows below, the total DHSC budget (including capital expenditure) then saw modest increases of around 2 per cent in 2014/15 (£118.8 billion) and 2.7 per cent in 2015/16 (£121.9 billion), followed by just 0.6 per cent in 2016/17 (£122.6 billion) and 1.9 per cent (£125.21 billion) in 2017/18 (HM Treasury 2018).

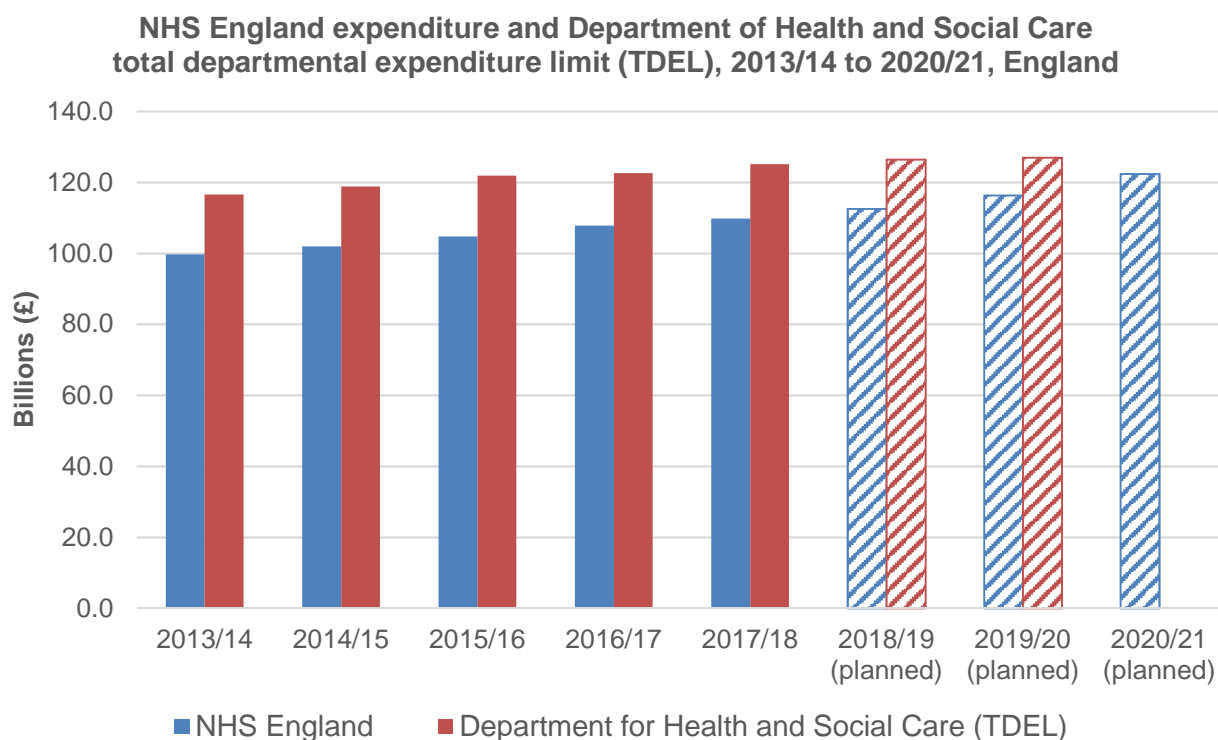
Overall UK-wide NHS spending has been falling in relation to GDP. Spending on the NHS as a percentage of GDP rose year-on-year between 1996/97 and 2009/10, from 4.7 per cent to 7.6 per cent. However, since 2010/11 it has been in decline, falling to 7.3 per cent in 2016/17 (Appleby 2018). Estimates based on planned NHS spending in England, scaled to the UK, put spending as a percentage of GDP at 7.1 per cent in 2020/21 (Appleby 2018).

It is important to note, however, that day to day spending on the NHS has generally fared better than the overall DHSC budget. As set out in *figure 25*, in 2013/14 of a total DHSC budget of £116.5 billion, £99.6 billion was allocated to NHS England leaving £16.9 billion to spend on wider DHSC responsibilities including public health, education, training, and infrastructure such as IT and building projects (HM Treasury 2018). By 2017/18 this had fallen by over a billion to £15.3 billion (HM Treasury 2018). It is projected to continue falling over the coming years. As a result, there has been significant disinvestment in public health, workforce development and capital improvements – all of which are contributing to on-going challenges facing the NHS.

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<sup>13</sup> DHSC is responsible for 99 per cent of healthcare spending in England<sup>13</sup> (HM Treasury 2017), and 99 per cent of DHSC's budget comes from general taxation and National Insurance. The rest is accounted for by the Department of Culture, Media and Sport and the Department for Business Innovation and Skills (as they were known and comprised at the time). (King's Fund 2017).

Figure 25



Source: HM Treasury 2018: Public Expenditure: Statistical Analyses

All figures are in 2017/18 prices using the October 2018 budget GDP deflator.

### Rapidly growing deficits

Rising demand and cost of care mean that, despite headline budget increases, the NHS is still facing significant financial challenges. In 2010/11, just 5 per cent of NHS providers<sup>14</sup> overspent their annual budgets, yet by 2015/16, 66 per cent were in deficit and the underlying deficit was £4.3 billion (King's Fund 2018a; Gainsbury 2017a). Providers account for over two-thirds of DHSC's total spending (DHSC 2018c).

The headline deficit for 2016/17 was £791 million (Gainsbury 2017a). However, that sum is achieved only after taking into account billions of pounds' worth of one-off savings, temporary extra funding and accountancy changes that did not improve the underlying state of provider finances. Once they are removed, the 'underlying deficit' for 2016/17 is £3.7 billion – only a marginal improvement on the previous year (Gainsbury 2017a).

In 2015 Government provided additional funding for the NHS in the form of a £1.8 billion annual 'Sustainability and Transformation Fund' (DHSC 2015). This funding contributed to a fall in deficits, but 44 per cent of providers still overspent their budgets in 2017/18, with acute hospitals accounting for almost 90 per cent of all providers in deficit (King's Fund 2018a).

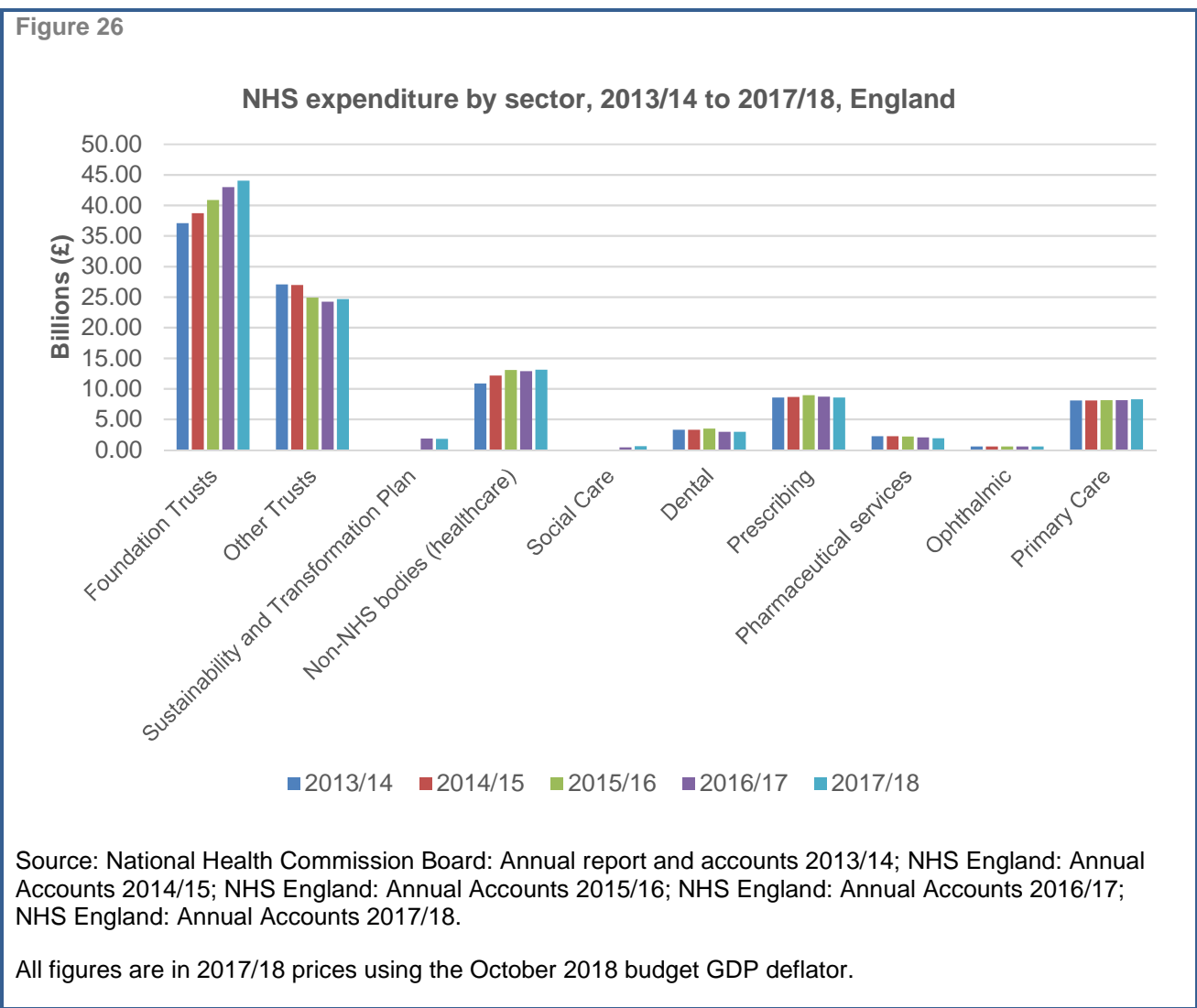
The Sustainability and Transformation Fund was replaced by a 'Provider Sustainability Fund' in 2018/19, primarily focused on supporting the delivery of emergency care. The aim of this fund was to financially balance the NHS provider sector in 2018/19, but as at September 2018 the sector forecast a year-end deficit of £558 million, with 48 per cent of providers in deficit (King's Fund 2018a). The

<sup>14</sup> NHS trusts and foundation trusts providing ambulance, hospital, community and mental health services in England.

sector’s underlying deficit is reported to be £4.3 billion, which reduces to £1.6 billion if the Provider Sustainability Fund is treated as recurrent (NHS Improvement 2018a).

### Uneven investment across NHS services

As *figure 26* shows below, the NHS spends the vast majority of its budget on secondary care – mostly hospital – services. Despite the 2014 NHS Five Year Forward View setting out a vision of shifting care away from hospitals and closer to people’s homes, as *figure 26* also shows, spending on hospitals has increased, while spending on primary care has only very risen modestly over the period. Furthermore the proportion of centrally allocated funding for general practice has fallen from 7.3 per cent in 2015/16 to 7.1 per cent of the NHS budget in England in 2018/19 (Praities 2018). The British Medical Association (BMA) has a target to spend 11 per cent of the overall NHS budget on primary care; by this measure the current shortfall is £3.7 billion (Praities 2018).



### 3.2 Future funding and expenditure

The Government announced a new multi-year settlement for the NHS in England in June 2018 which adds progressively greater amounts to public spending, reaching £23.2 billion in 2023/24 (OBR 2018). This equates to a year-on-year increase of around 3.4 per cent, which is an improvement on recent years, but nonetheless falls short of the 4.0 per cent identified as the minimum required to redress

the pressures caused by eight years of stalled growth (Health Foundation 2018b). Announced increases in the NHS England budget also exclude significant areas of spend including staff training, capital investment and public health which remain the responsibility of DHSC and other DHSC funded bodies.

As shown in Health Foundation analysis depicted in *figure 27*, as things stand, the NHS England resource budget is to increase by £5.1 billion in real terms in 2019/20 (Health Foundation 2018b). Almost one quarter, £1.25 billion, of this is required to cover additional pension costs (Health Foundation 2018b). Meanwhile, the DHSC resource budget (which includes NHS England as well as wider health spending) is only increasing by £4 billion. Therefore DHSC spending on key services outside the NHS will see a further £1 billion reduction in 2019/20 unless further funds are added to the published DHSC resource budget (DHSC RDEL) (Health Foundation 2018b). This will mean further reductions to spending across public health, workforce training and capital investment in buildings and equipment.

Figure 27

**Changes in Department of Health and Social Care and NHS England  
budgets, 2018/19 to 2019/20**

	2018/19	2019/20 (cash terms)	2019/20 (real terms)	Real £ change
<b>DHSC capital departmental expenditure limit (CDEL)</b>	£5.9bn	£6.7bn	£6.6bn	£0.7bn
<b>DHSC revenue departmental expenditure limit (RDEL)</b>	£123.3bn	£129.6bn	£127.3bn	£4.0bn
<b>DHSC total departmental expenditure limit (TDEL)</b>	£129.2bn	£136.3bn	£133.9bn	£4.7bn
<b>NHS England (NHSE) RDEL</b>	£114.6bn	£121.8bn	£119.7bn	£5.1bn
Difference between DHSC and NHSE RDEL	<b>£8.7bn</b>	<b>£7.8bn</b>	<b>£7.7bn</b>	<b>-£1.0bn</b>

Source: Health Foundation analysis of the Government's Budget, figures in 2018/19 prices using the OBR's October deflators (Health Foundation 2018b).

While improving productivity may once have been seen as a realistic option, activity across the NHS has been rising steadily since 2010 despite tight spending settlements. In response NHS productivity

has grown at an average rate of 1.4 per cent, faster than productivity across the economy as a whole over this period (Charlesworth & Johnson 2018, ONS analysis).

Furthermore, over the next 15 years investment will need to continue at pace. The IFS, working with The Health Foundation, project that NHS spending in England will need to increase by an average of 3.3 per cent a year to £210 billion by 2033/34 in order to maintain the status quo with regard to quality and access – even allowing for £29 billion to be offset in productivity gains (Charlesworth & Johnson 2018). This includes £59 billion in response to demographic pressures, £49 billion in response to input cost pressures, and £3 billion capital growth. Delivering a ‘modernised’ healthcare system would require spending to increase by an average of 4.1 per cent a year to £234 billion over the same period (Charlesworth & Johnson 2018).

Altogether, particularly in light of the serious constraints on spending on public health, social care, workforce and capital investment, recent investment in the NHS cannot be considered ‘job done’, particularly if the NHS is to deliver the commitments set out in the NHS Long Term Plan.

### 3.3 Healthcare workforce

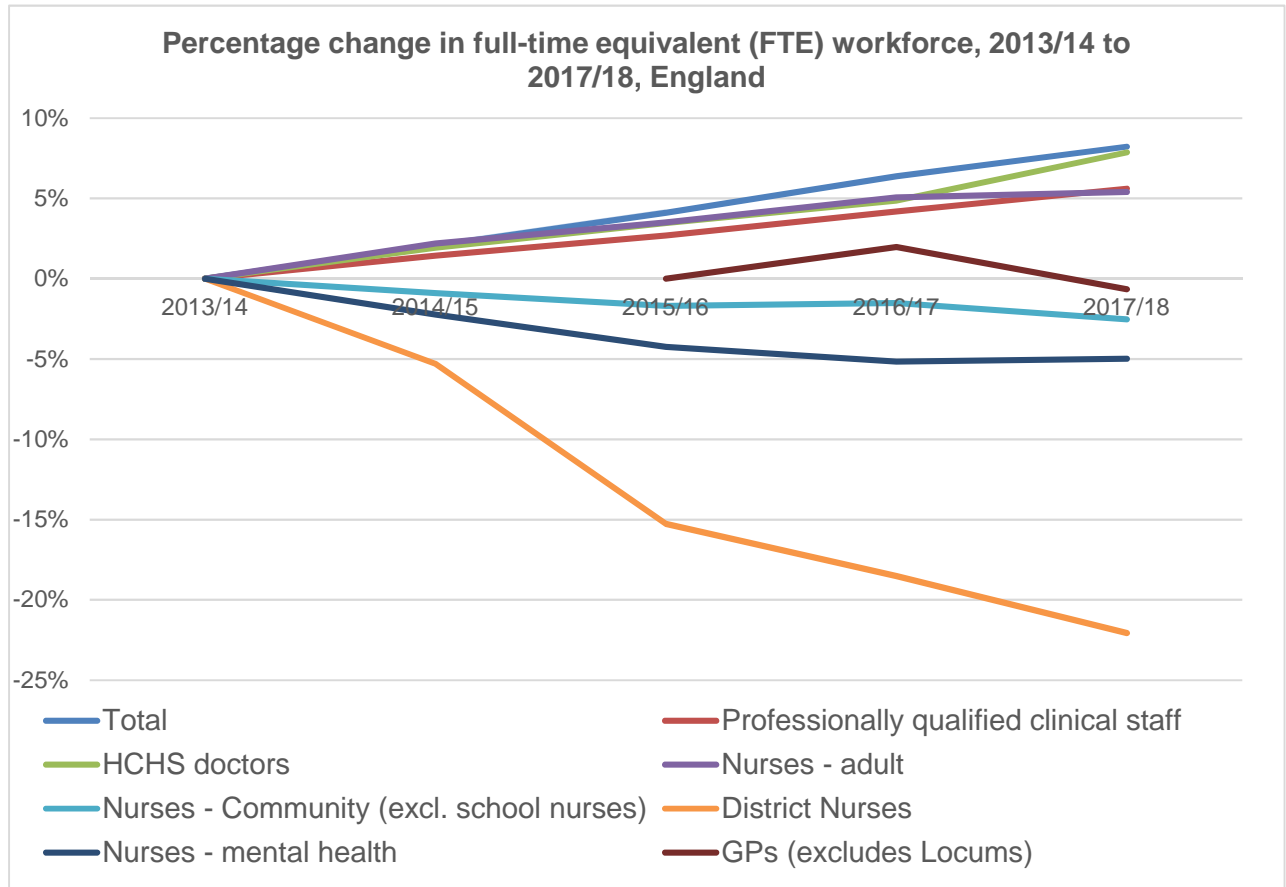
In 2016/17, £52 billion was spent on staff costs in the hospital and community health services sector in England (Charlesworth & Johnson 2018). The sector has over one million full-time equivalent employees, including 110,000 (non-GP) doctors, 310,000 nurses, midwives and health visitors, and 630,000 other staff (Charlesworth & Johnson 2018).

The workforce, however, is showing signs of severe strain. One in 11 NHS posts in England was vacant at the beginning of 2019 (NHS Improvement 2018b) and the UK has a low number of doctors and nurses per head of population compared with other countries (King’s Fund et al 2018). As *figure 28* shows below, the number of district, community and mental health nurses has fallen since 2013/14, while the number of GPs (excluding locums) can be described as ‘flat’ at best. This is despite a long standing policy objective of shifting NHS care away from hospitals and closer to people’s homes. Central investment in education and training has fallen from 5 per cent of health spending in 2006/07 to 3 per cent in 2018/19. As a result, spending is £2 billion lower in 2018/19 than it would have been that level of investment had been maintained (King’s Fund et al 2018). And 38 per cent of staff have felt unwell during the previous 12 months due to work-related stress, up 1.6 per cent on the previous year (NHS Survey Coordination Centre 2018).

Many experts, including Health Foundation, King’s Fund and Nuffield Trust, now consider the precarious state of the workforce to present a greater threat to the NHS than underfunding (King’s Fund et al 2018). If these challenges continue, they not only pose a threat to improving services and delivering the commitments set out in the NHS Long Term Plan, but there is a risk current waiting times and quality of care will be adversely affected and services will start to deteriorate.

There is a shortage of more than 100,000 staff across NHS trusts in England, which will increase to 250,000 by 2030 if current trends continue (King’s Fund et al 2018). If staff continue to leave the workforce early and the pipeline of newly trained staff and international recruits does not rise sufficiently, this number could be more than 350,000 by 2030 (King’s Fund et al 2018).

Figure 28



Source: NHS Digital 2019: NHS Workforce Statistics: June 2019; NHS Digital 2018: General Practice Work, Final September 2018, Experimental Statistics.

Staff count, full time equivalent, averages by financial year, except GP (excluding locums) which is as at September of the respective financial year. HCHS = Health and Community Health Service Doctors

## Nursing

As *figure 28* sets out, the overall number of nurses working in adult services has increased since 2013/14, but growth has been largely concentrated in acute hospitals (NHS Digital 2019). The number of community nurses has dropped, and the number of district nurses has fallen dramatically, which affects key services relied upon by older people. District nurses play an essential role in not only acute, complex and end-of-life care, but also in preventative care that supports older people to maintain independence and manage long-term conditions. If there are insufficient numbers of district and community nurses, then hospitals may not only need to delay discharging patients, but will also see increases in admissions and readmissions. This has been described as a “vicious cycle” in terms of recruitment and retention, with understaffing increasing the pressure on the district nursing workforce, which in turn causes more nurses to leave and thus increases the demand-capacity gap (Maybin et al 2016).

The pipeline of future nurses is also concerning, with the number of applicants for nursing courses declining by 17.6 per cent (11,750) between 2016 and 2017 – the biggest fall in nursing applicants on record – and 7.6 per cent between 2017 and 2018 (UCAS 2018). This means the number of applicants has reached its lowest point, having declined by more than a quarter over the last two years (UCAS 2018). Yet the NHS is projected to have a shortfall of 108,000 FTE nurses by 2029/30. Closing this



gap would require 5,000 more nurses a year to start training by 2021, reducing the drop-out rate by a third and ensuring more graduating nurses join the NHS (King’s Fund 2019b).

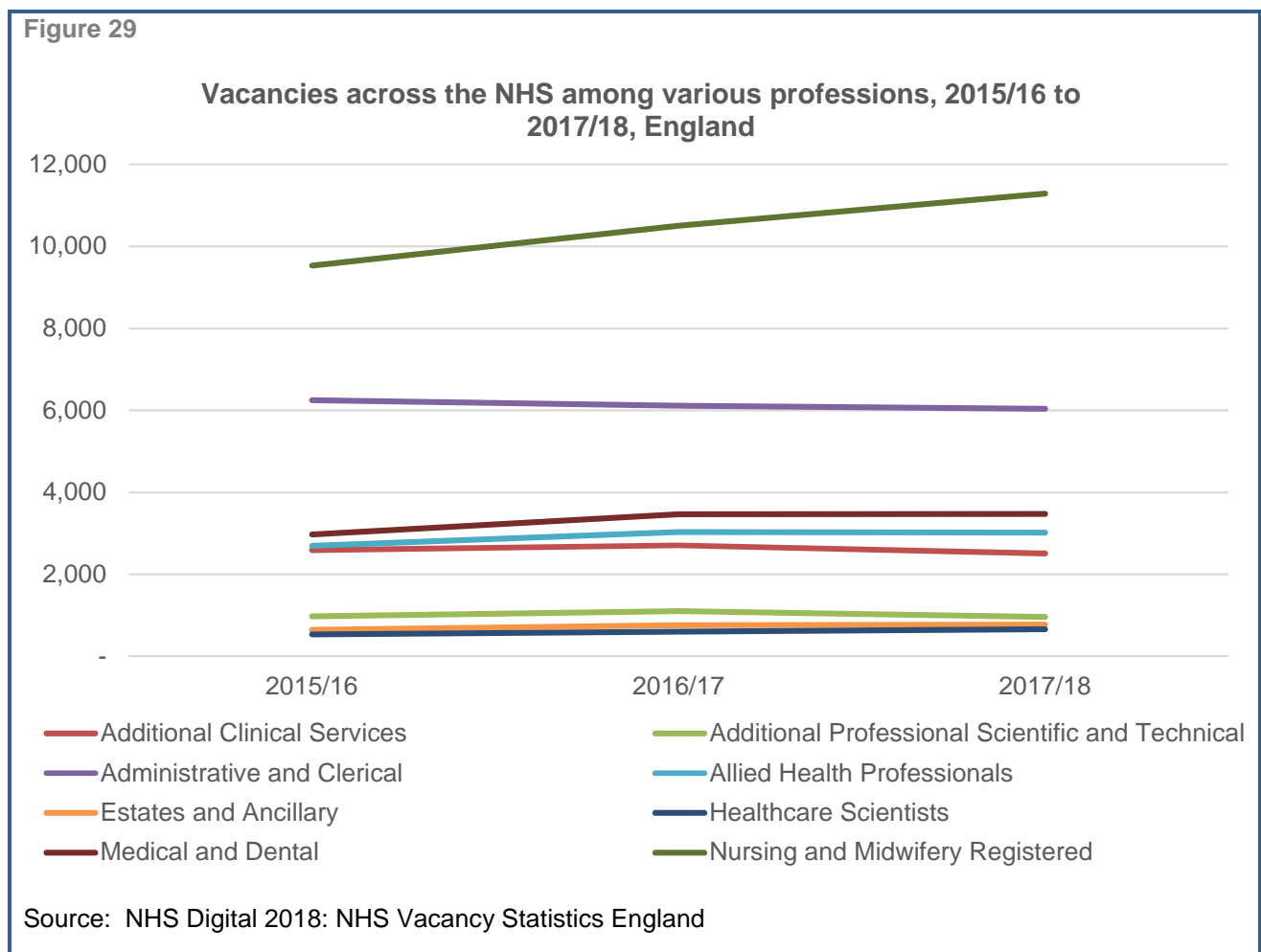
### Doctors

Over the past 20 years the number of hospital doctors has increased considerably faster than the population, while increases in the number of GPs has more or less tracked population growth (Charlesworth & Johnson 2018). Despite these increases, the UK still employs fewer doctors per head (2.8 per 1,000 people) than any other EU country (Charlesworth & Johnson 2018).

Demand for primary care has been rising rapidly over the past decade, reflecting both increases in the overall size of the population and in the numbers of people with more complex health needs. As we explore in more detail in section 3.4, general practice workloads have increased by 16 per cent in the past 7 years, and patients are finding it increasingly difficult to access services. Therefore, low growth in the number of GPs is a cause for real concern.

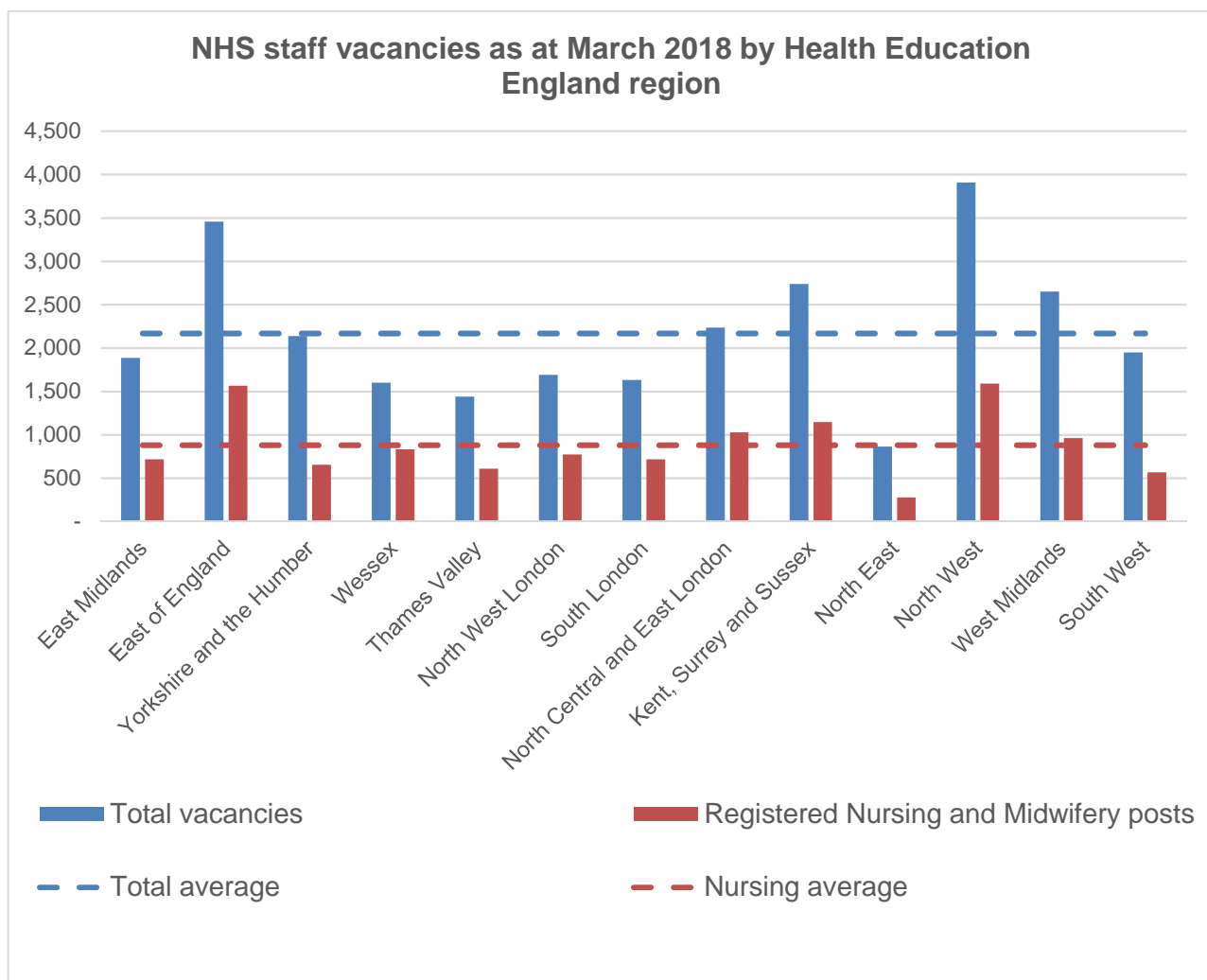
### Vacancies

In 2017/18, NHS trusts spent £5.5 billion on temporary staff to cover vacancies and other short-term absences, accounting for over 10 per cent of total pay costs (King’s Fund et al 2018). As shown in *figure 29*, nursing vacancies remain particularly high with around one in eight posts vacant, which accounts for almost 40 per cent of unfilled NHS posts (NHS Digital 2018f). With on-going uncertainty around the UK’s relationship with the EU, the number of EU nurses registering to practice here has fallen dramatically, and for the first time in 20 years we have a net exit from the NHS by EU trained clinicians (Oliver 2019).



As shown in *figure 30*, there is regional variation in terms of the extent of NHS vacancies, with the East of England, Kent, Surrey and Sussex, the North West and West Midlands especially affected. The East of England and North West have particularly pronounced numbers of registered nursing and midwifery vacancies (NHS Digital 2018f).

Figure 30



Source: NHS Digital 2018: NHS Vacancy Statistics England

### 3.4 Trends in primary and community-based care

Around 90 per cent of patient interaction with the NHS is with primary and community care, including GP practices, dental services and community pharmacies (Parkin 2018). However, as set out in previous sections, it is clear that these services have not benefited from increased financial investment and face some of the most profound workforce challenges.

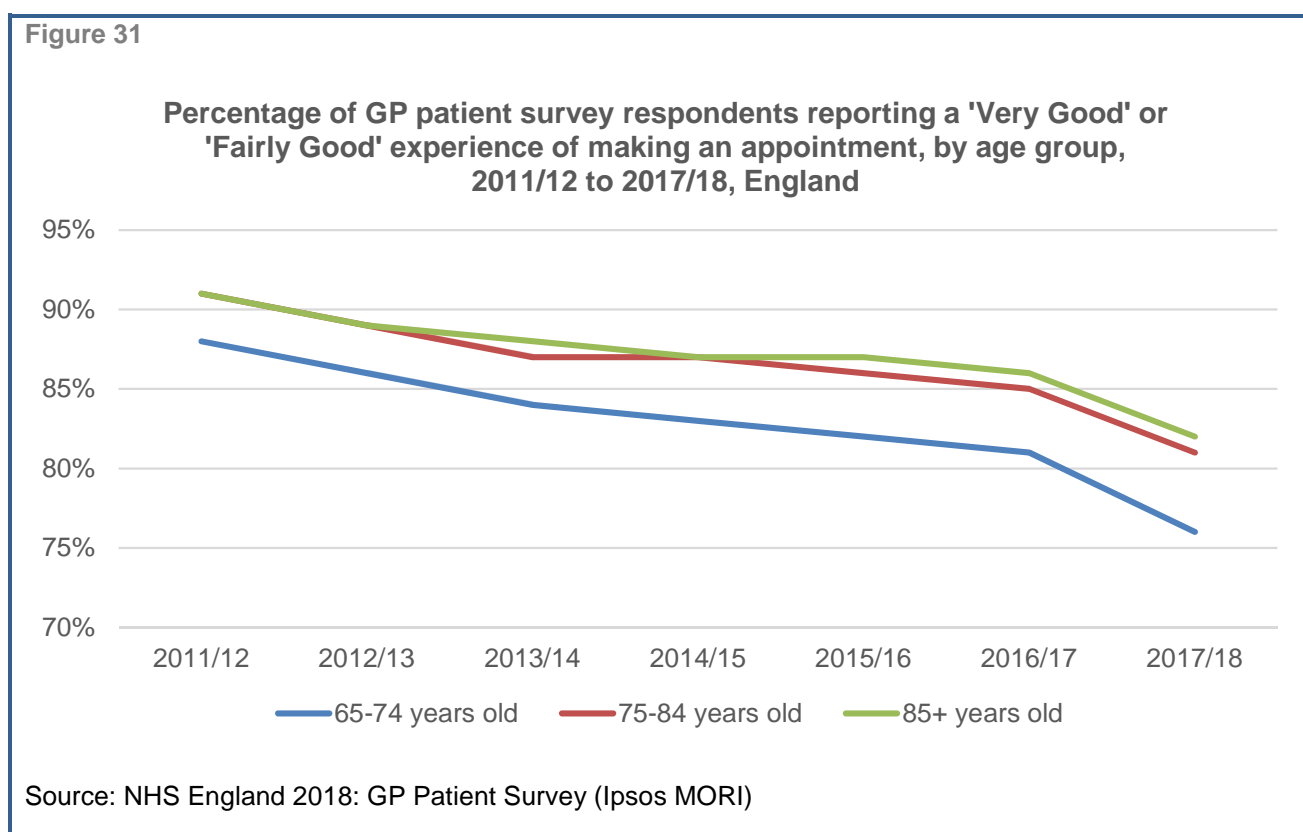
#### Primary care

Demand for primary care is increasing, with GP and nurse workloads found to have increased by 16 per cent over seven years (Hobbs et al 2016), and also growing in complexity (Baird et al 2016).

Given the number of people living with multiple conditions and frailty is only set to increase over the coming years, demand too will only continue to grow.

Indeed, a recent study of primary, secondary and community care use by people aged 85 to 90 years found that people within this age group are much more likely to consult their GP than any other primary healthcare team members. Furthermore, while use of secondary care services remains broadly unchanged, the number of primary care consultations rose significantly as people aged over the course of the study. The research also found that average consultation times increased for people over the age of 65 and were longer still for those over 85 and living with more complex health and care needs (Yadegarfar et al 2018).

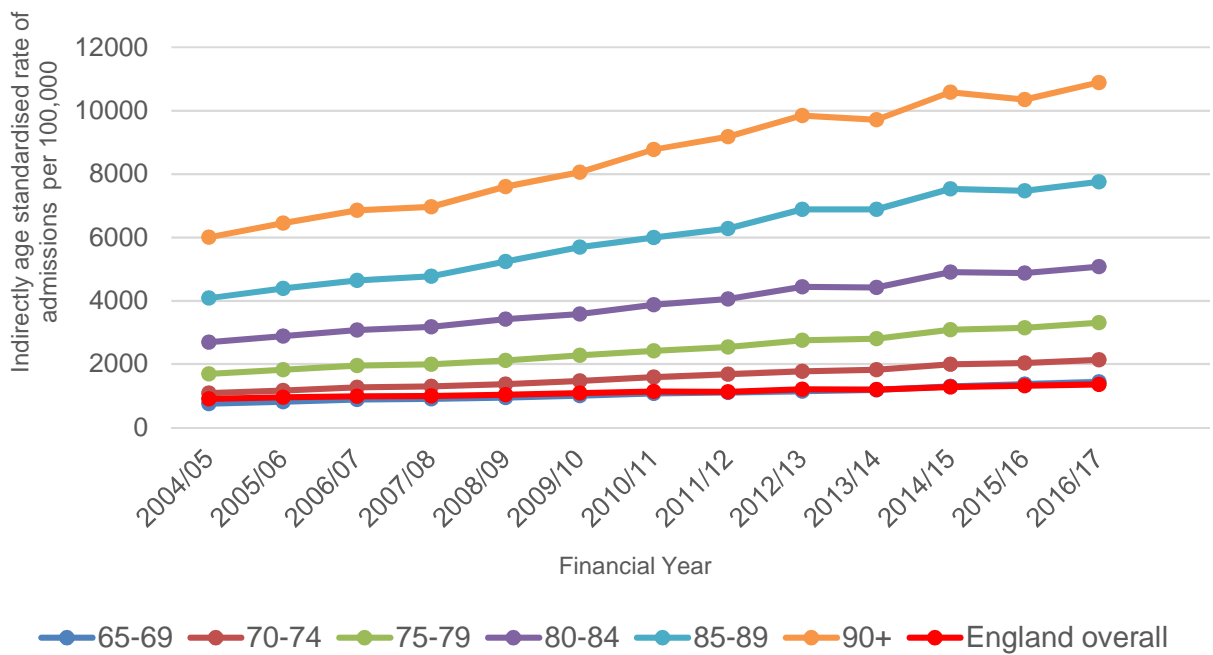
The fact that investment in primary care has not kept pace with the changing needs of increasing numbers of people living with frailty and/ or multimorbidity is increasingly evident in the experiences and concerns of patients. As *figure 31* below shows, older people are becoming less satisfied with their experience of making an appointment to see their GP (albeit from a high baseline) (NHS England 2018d). In 2017/18, public satisfaction with general practice as a whole dropped to the lowest level since the survey began in 1983 (Robertson 2018).



### Ambulatory care

Ambulatory care sensitive conditions are conditions for which effective treatment and management by primary and community-based care services should limit the need for hospital treatment. These include urinary tract infections (UTIs), pneumonia and exacerbations of chronic obstructive pulmonary disease (COPD). As shown in *figure 32*, emergency admission rates for ambulatory care sensitive conditions are unfortunately rising, particularly among the oldest age groups, suggesting primary and community-based care services are struggling to manage demand and meet their needs.

**Emergency admissions for acute conditions that should not usually require hospital admission, 2004/05 to 2016/17, England**

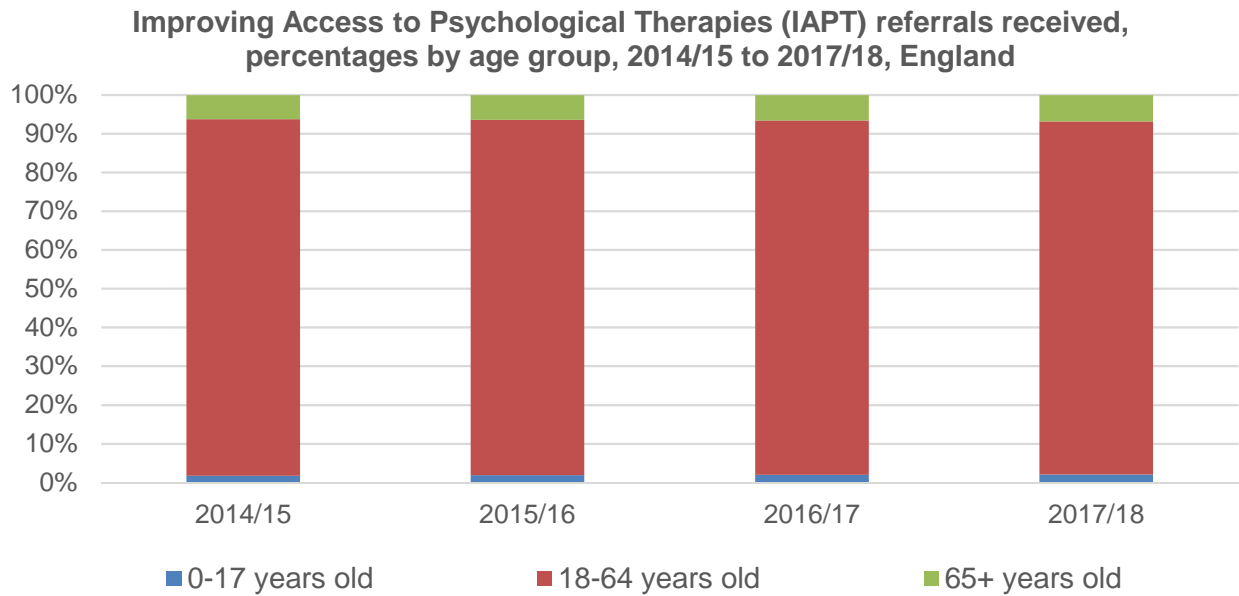


Source: NHS Digital 2018: Emergency admissions for acute conditions that should not usually require hospital admission [NHS Outcomes Framework Indicators]

### Access to psychological Therapies

In 2011 the Department of Health and Social Care set a target that 12 per cent of referrals through the Improving Access to Psychological Therapies (IAPT) programme would be of people aged 65 and over. Seven years later (2018), as shown in *figure 33*, this is still not close to being reached, with 6.8 per cent of referrals being for people aged 65 and over in 2017/18 (NHS Digital 2018h).

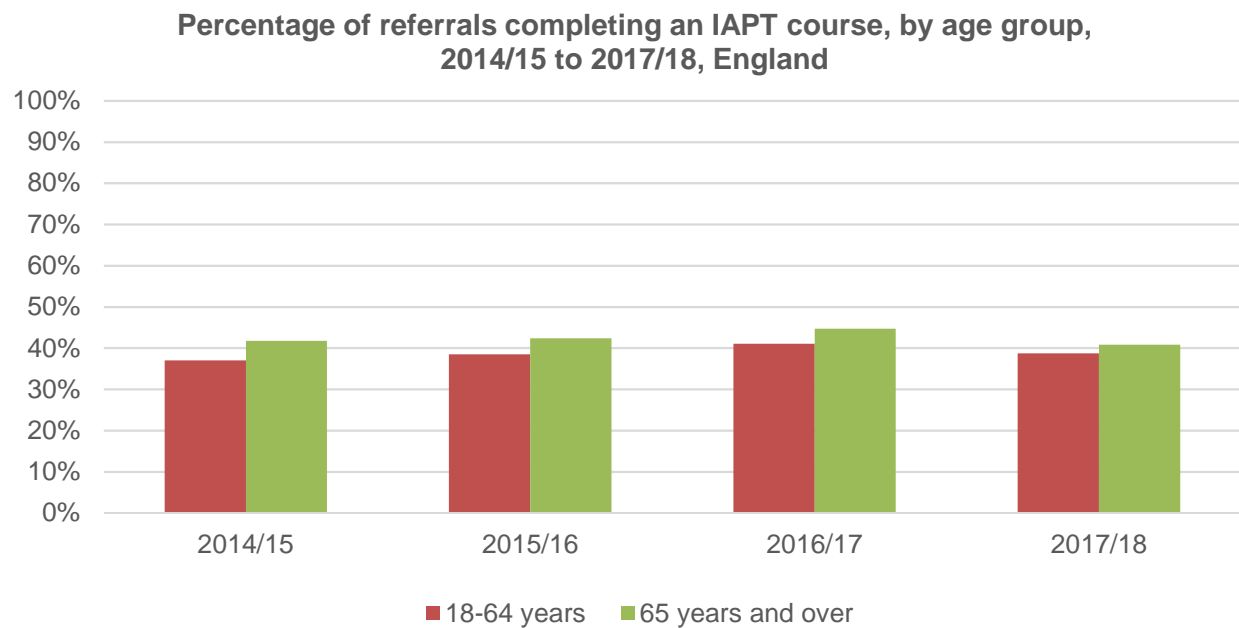
Figure 33



Source: NHS Digital 2018: Psychological Therapies, Annual Reports on the use of IAPT Services, England [PAS]

Although a low percentage of older people are being referred for IAPT services, those who are referred are relatively successful at finishing a course of treatment than younger adults, as shown in *figure 34* – something which ought to challenge outdated assumptions about how best to treat common mental health conditions in later life (NHS Digital 2018h).

Figure 34

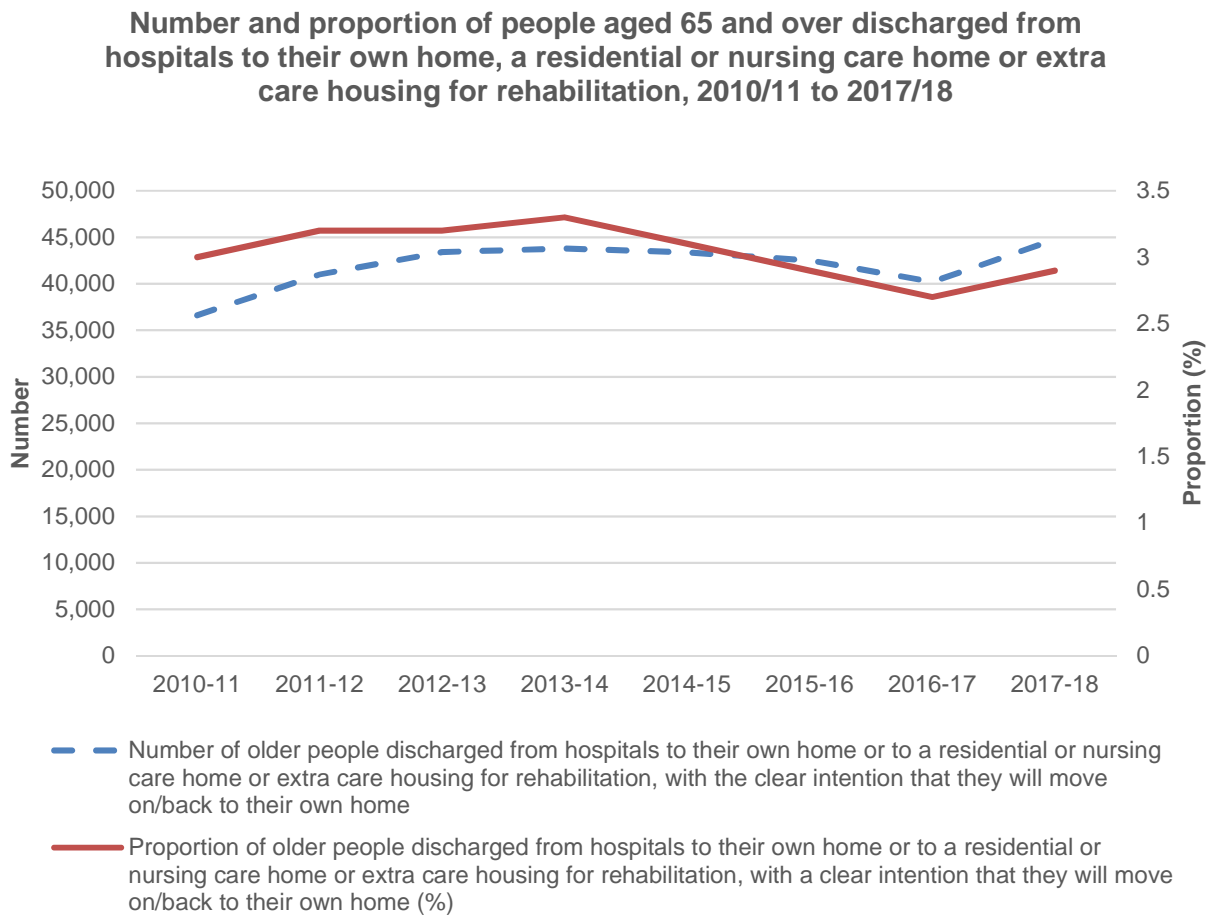


Source: NHS Digital 2018: Psychological Therapies, Annual Reports on the use of IAPT Services, England [PAS]

## Reablement and rehabilitation

As shown in *figure 35*, despite the intentions of the Better Care Fund, the proportion of older people receiving reablement/rehabilitation after discharge from hospital fell from a high of 3.3 per cent in 2013/14 to just 2.7 per cent in 2016/17 (NHS Digital 2018c). Since then, both the number and proportion of older people receiving reablement/rehabilitation has increased, but at 2.9 per cent the proportion is still below its peak of 2013/14 (NHS Digital 2018b). This suggests that while more reablement/rehabilitation packages are being made available, investment is failing to keep pace with rapidly rising demand.

Figure 35



Source: NHS Digital 2018: Adult Social Care Outcomes Framework (ASCOF): Time series of aggregated measures 2010/11- 2017/18.

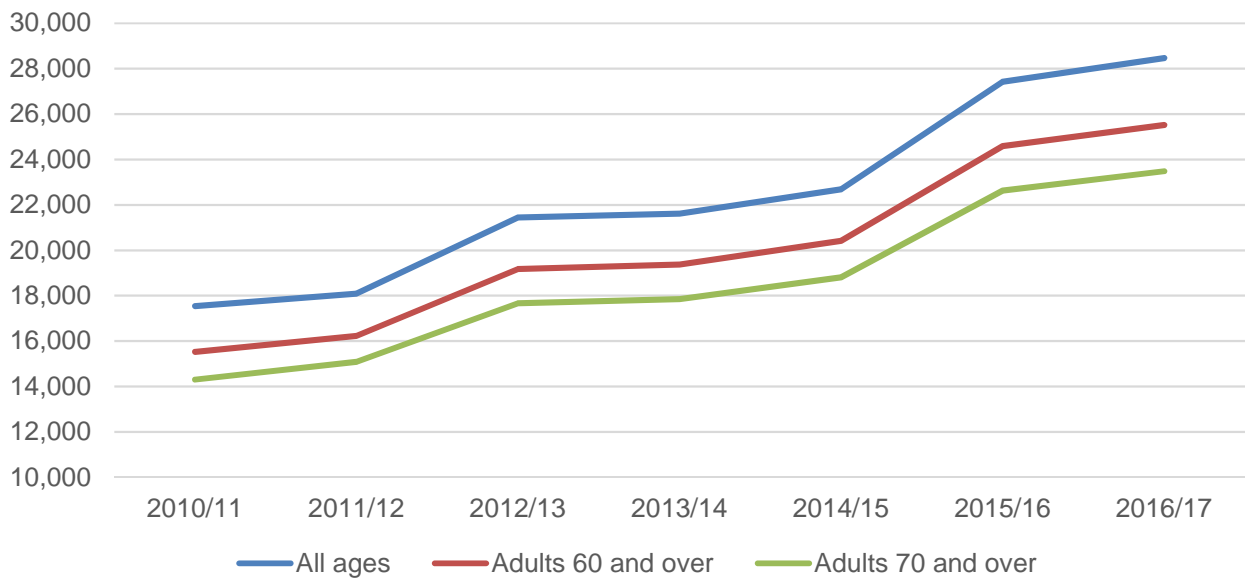
The evidence also suggests that there is significant regional variation in access to reablement/rehabilitation. For example, spending on services known as ‘ST-Max’ – or short-term services intended to maximise a person’s independence and minimise their need for ongoing support – ranges from £322,614 per 100,000 adults in the East of England to £963,419 per 100,000 adults in the East Midlands (NHS Digital 2018a).

### Emergency admissions from care homes

As shown in *figure 36* below, there were around 28,000 emergency admissions made to hospitals from care homes in 2016/17, compared to around 18,000 in 2010/11 – an increase of 62 per cent (Full Fact 2018). Throughout this period the large majority of these admissions, around 90 per cent, were for people aged 60 and over (Full Fact 2018). The number of emergency admissions from care homes has increased much more quickly than the number of emergency admissions overall, with the latter rising 11 per cent during the same period (Full Fact 2018). This suggests that even within settings intended to be tailored to the needs of older people, pressures within primary and community care provision and with the workforce are adversely impacting on timely access to key services, and leading to the increased hospitalisation of older people.

Figure 36

The number of finished hospital admission episodes with an emergency admission from a care home, 2010/11 to 2016/17, England



Source: NHS Digital Secondary Care Analysis 2017: Counts of finished admission episodes with an emergency admission by source of admission and age band from 2010-11 to 2016-17. Data provided in response to media request by Full Fact original analysed in 2018. (Full Fact 2018: Analysis of emergency admissions to care homes)

### 3.5 Trends in secondary care

Despite multiple and on-going policy commitments to shift care away from acute hospitals and into community settings, hospital activity has increased in England (Charlesworth & Johnson 2018). This means that even with secondary care services receiving the lion share of additional investment in recent years, the sector remains under severe, and growing, pressure.

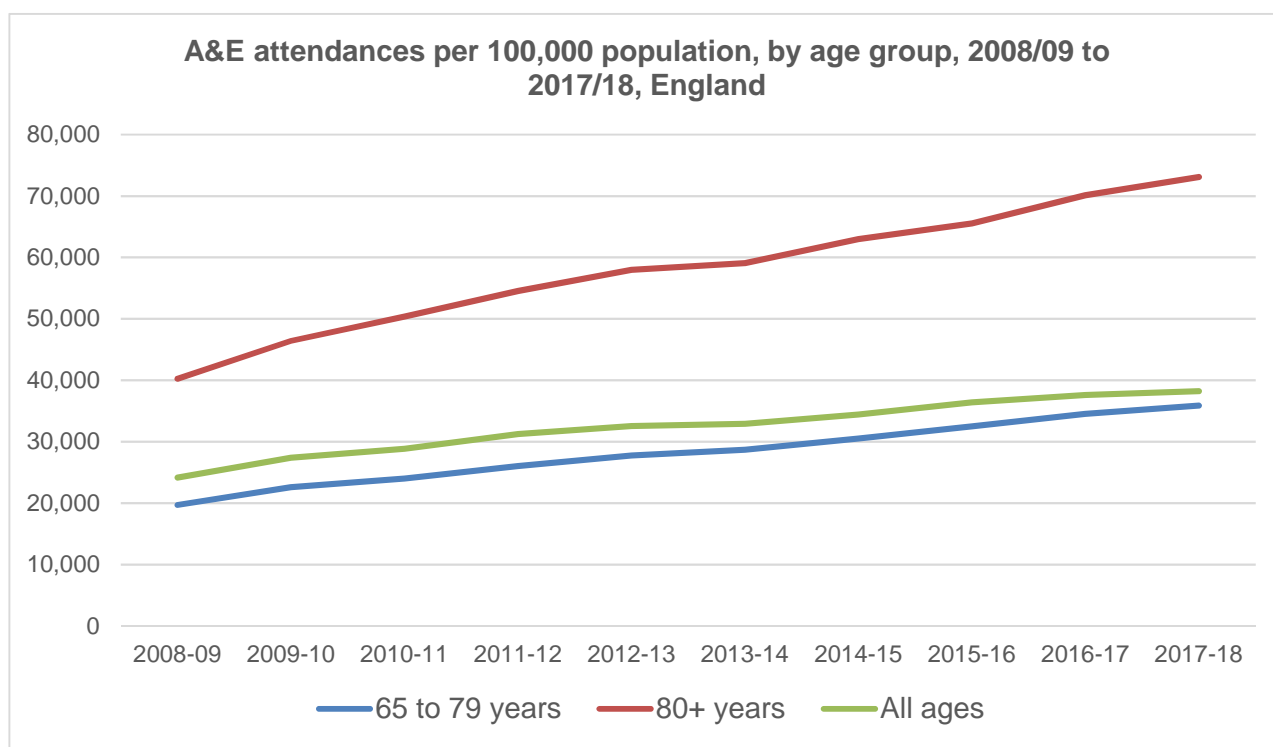
#### A&E attendance

As *figure 37* shows, almost every year since 2009/10 A&E attendances have increased across all age groups (NHS Digital 2018i; ONS 2018e). In the first eight months of 2018, an average of 67,000 people a day attended A&E departments in England, which is 3.9 per cent higher than the same period in 2017 (Baker 2018).

A&E performance also remains significantly below the NHS Constitution standard of 95 per cent of people being seen within four hours. In the period July to September 2018 just 89.3 per cent of people were seen within four hours; a deterioration on both the previous quarter of April to June 2018 (89.9 per cent) and the same period (July to September) in 2017 period (91.1 per cent) (NHS Improvement 2018a). Overall, one in six A&E attendees waited longer than four hours in 2017/18, compared with one in sixteen in 2012/13 (Baker 2018).

Furthermore, waits often do not end when a patient has been admitted. In 2017/18, in about 10 per cent of admissions (around 600,000 people), people waited four hours or more from the decision to admit them to hospital to them getting a bed (Baker 2018). A record high was reached in January 2018, when 2,646 people a day were waiting four hours or more (Baker 2018). Of the c.600,000 people who waited four hours or more in 2017/18, 3,440 waited 12 hours or more (Baker 2018). This was very marginally lower than the previous year (3,502 people) but still a marked increase on 2015/16 when 1,014 people waited for 12 hours or more (Baker 2018).

Figure 37



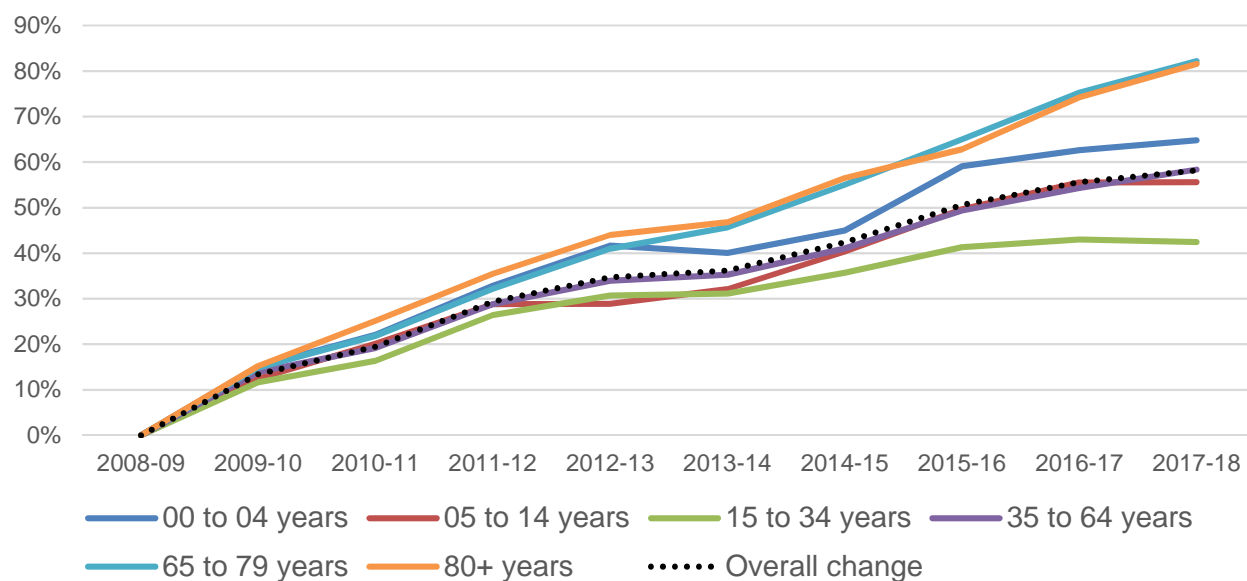
Source: NHS Digital 2018: Hospital Accident and Emergency Activity; ONS 2018: Population estimates

A&E attendance has also been rising faster among older people than other age groups, as shown by figure 38 (NHS Digital 2018i). Since 2010/11 there has been a 50 per cent increase in attendances among those aged 65 to 79 and a 45 per cent increase among those aged over 80 (NHS Digital 2018i). This compares to a 33 per cent increase among 35 to 64 year olds (NHS Digital 2018i). Older people, particularly the oldest old and those living with multiple long term conditions, are also more likely to be admitted to hospital as a result.



Figure 38

Percentage growth in A&E Attendances since 2008/09 across subsequent years, by age groups, England



Source: NHS Digital 2018: Hospital Accident and Emergency Activity

### Emergency admissions, readmissions and bed days

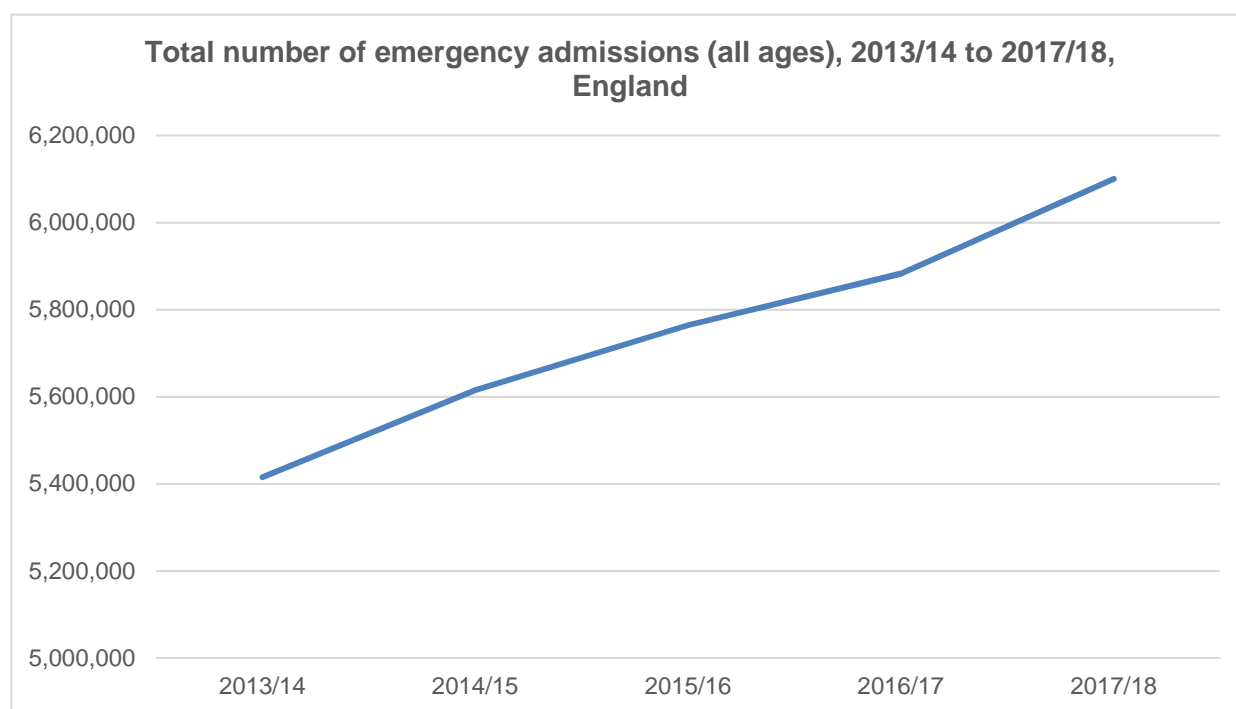
The number of emergency admissions to hospital have risen substantially over the past decade – between 2007/09 and 2016/17 emergency admissions increased by an average of 2.4 per cent a year (NAO 2018b).

This trend has continued in recent years. As *figure 39* shows below, in 2017/18 there were over 6.1 million emergency admissions, a 3.5 per cent increase on the previous year alone (NHS Digital 2018j). There is little indication of more recent changes, with emergency admissions in July to September 2018 seen to have increased by an average of more than 940 cases per day compared to the same period the previous year (NHS Improvement 2018a).

The increase in emergency admissions is mostly made up of older people, with those aged 65 and over making up more than half (53 per cent) of the growth in emergency admissions between 2013/14 and 2016/17 (NAO 2018b). Some, but not all, of this is down to demographic change. The number of people aged 65 and over grew by 6.2 per cent between 2013/14 and 2016/17, but emergency admissions for people aged 65 and over grew by almost twice the rate (12 per cent) during the same period (NAO 2018b). Furthermore, 65 per cent of hospital emergency bed days were occupied by people aged 65 and over in 2016/17 (NAO 2018b). Continuing demographic changes, including increasingly complex needs, will only increase the pressure on emergency departments in coming years.

The demand for beds can lead to cancellations of elective surgery and treatment. In winter 2017/18 there were planned reductions in elective treatment activity to free up capacity for urgent and emergency care.

Figure 39



Source: NHS Digital 2018: Hospital Episode Statistics (HES) for admitted patient care, outpatient and accident and emergency data.

Some emergency admissions are clinically appropriate and unavoidable, but others could be avoided by providing alternative forms of urgent care, or appropriate care and support earlier to prevent a person becoming unwell enough to require an emergency admission. NHS England estimates that 24 per cent of emergency admissions in 2016/17 were admissions that could have been avoided (NAO 2018b).

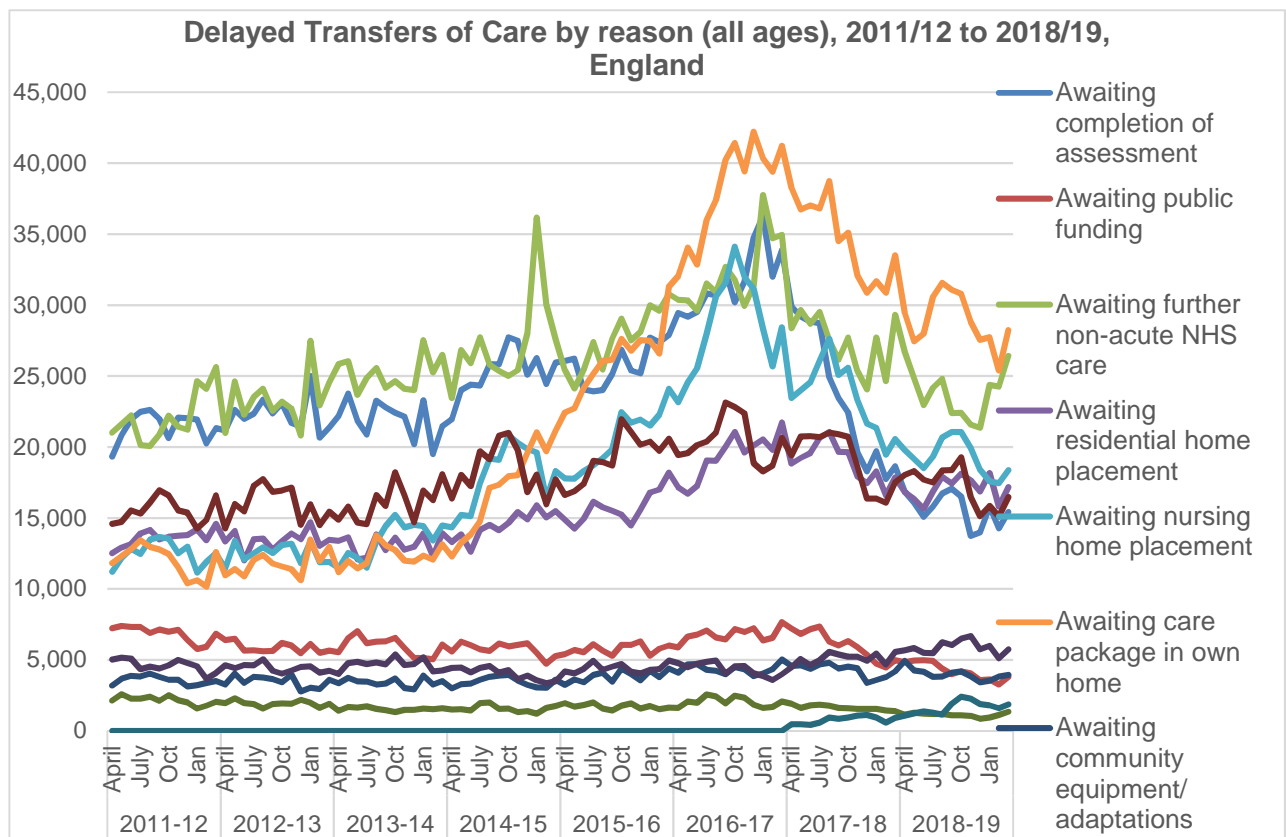
While the impact on hospitals of rising emergency admissions poses a serious challenge to the NHS, the cost of emergency admissions has not increased in line with the growth in numbers. The real-terms cost of emergency admissions is estimated to have increased by 2.2 per cent between 2013/14 and 2015/16, while the increase in emergency admissions over the same period was 7 per cent (NAO 2018b). This *may* suggest the NHS has become more cost-effective in managing emergency admissions, though caution is needed with this assumption. Reported increases in readmissions could equally be a warning indicator that some people admitted as an emergency are being discharged too soon or without appropriate support.

A recent investigation by Healthwatch England found emergency readmissions (within 30 days of discharge) rose 22 per cent between 2013/14 and 2017/18, with the number of emergency readmissions within 24 hours and 48 hours of being discharged increasing by 33 and 31 per cent respectively over the same period (Healthwatch England 2018). Readmissions within 48 hours actually account for more than one in five (22 per cent) of the total number of readmissions (Healthwatch England 2018). It is unclear why readmissions are increasing so dramatically; DHSC and NHS England have committed to develop better data to explore the issue.

## Delayed transfers of care

The fact that some people are delayed in hospital while waiting for access to appropriate support or services to enable their discharge is not new, but it has been the topic of considerable concern in recent years. Around one-fifth of beds are occupied by people who have already been in hospital for three weeks (NHS Improvement 2018c). As *figure 40* shows, delayed transfers of care rose rapidly between 2011/12 and 2016/17, with access to social care services in the community, residential and nursing care placements and, largely, community-based NHS services being particular sources of delay (NHS England 2019). Since 2017 there have been significant improvements, but there is still a long way to go. In 2011/12 there were an average of 3763 delayed transfers per day, average delays peaked at 6178 in 2016/17, but still stood at 4564 in 2018/19 (NHS England 2019).

Figure 40



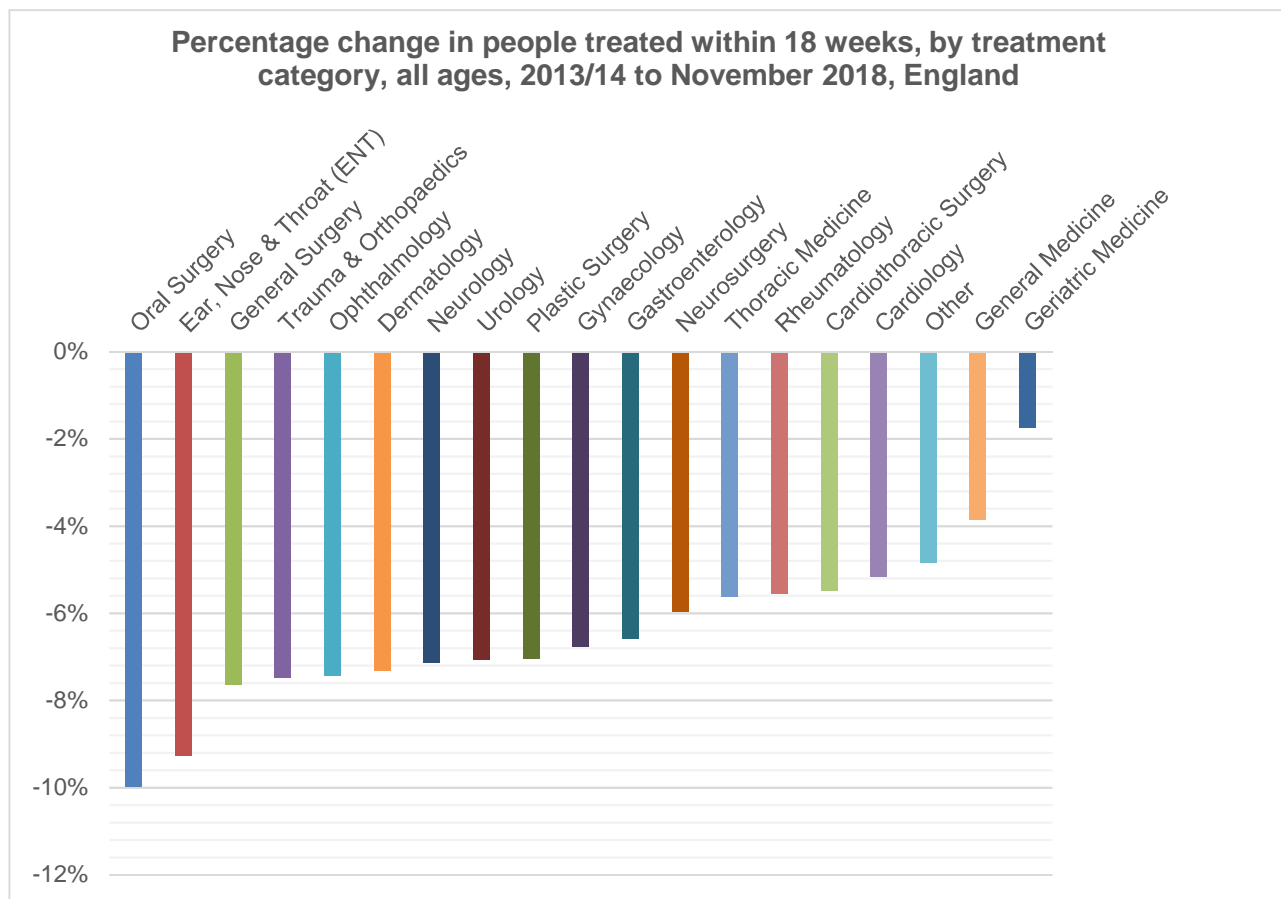
Source: NHS England, March 2019: Delayed Transfer of Care, Monthly Reports 2011/12 to 2018/19, NHS Organisations, England

## Waiting times for treatment

The number of people referred by their GP for consultant-led treatment has risen year-on-year since 2012 (Baker 2018). NHS standards state that treatment should start within 18 weeks of referral. This is underpinned by a waiting time target that stipulates 92 per cent of those on the waiting list at any given time should have been waiting for less than 18 weeks, and no patient should be waiting longer than 52 weeks. The target of 92 per cent was breached in December 2015, which was the first time since December 2011. The target was met in the following two months but was missed once more in March 2016 and in each month up to and including November 2018. In October 2018 there were also nearly 3,500 people waiting 52 weeks or more, the highest level since April 2012 (Baker 2018).

As shown in *figure 41*, below, the percentage of people treated within 18 weeks fell between 2013/14 and November 2018 across all treatment categories (NHS Digital 2018k). Geriatric medicine itself has seen the smallest percentage change, but it is important to note that many of the specialties that have seen some of the most significant deterioration in waiting times are those that routinely treat a large proportion of older people – particularly, for example, ophthalmology and orthopedics (NHS Digital 2018k).

Figure 41

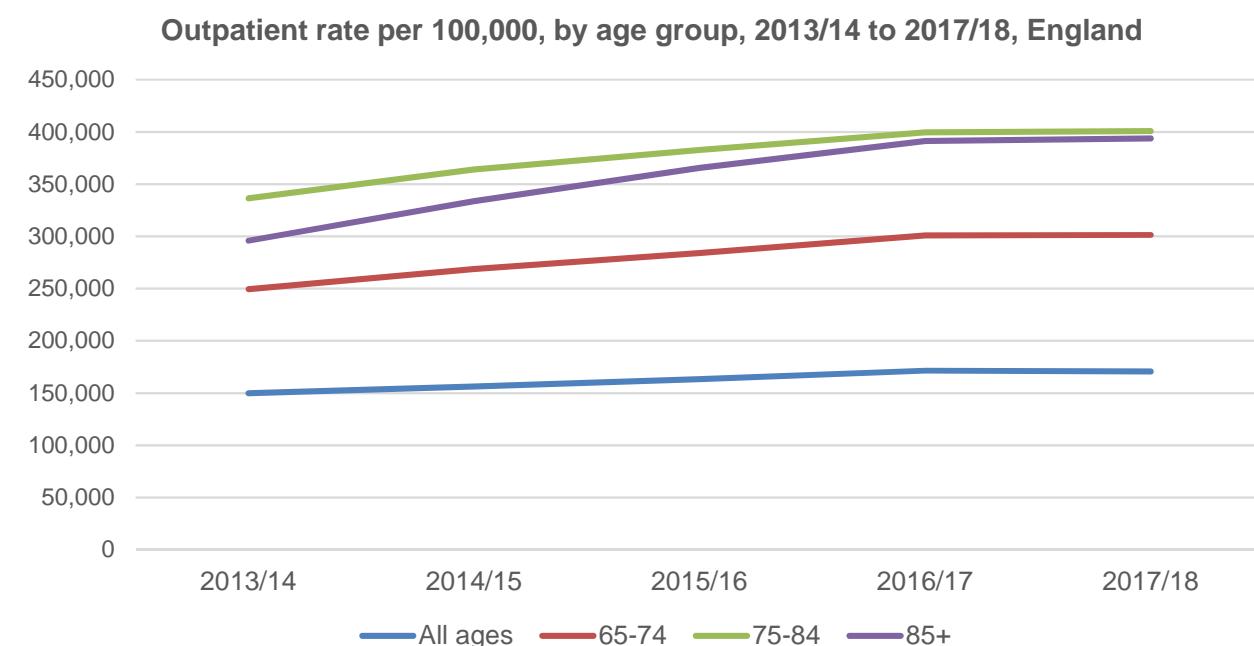


Source: NHS Digital 2018: Consultant-led Referral to Treatment Waiting Times (April 2007 to October 2018).

### Outpatient activity

The number of outpatient appointments has nearly doubled since 2007/08, up from 66.6 million appointments to 119.4 million in 2017/18, with older patients – those aged 60 to 79 years – accounting for over 30 per cent (29.6 million) of all attendances (NHS Digital 2018l). While, as shown in *figure 42*, the number of outpatient appointments appears to have stabilised between 2016/17 and 2017/18, this is more likely to be an indication of an overstretched system operating at full capacity, combined with the pause in elective surgery in response to winter pressures (NHS Digital 2014b; NHS Digital 2015b; NHS Digital 2016b; NHS Digital 2017d; NHS Digital 2018l).

Figure 42



Source: NHS Digital: Hospital Outpatient Activity 2013/14 to 2017/18

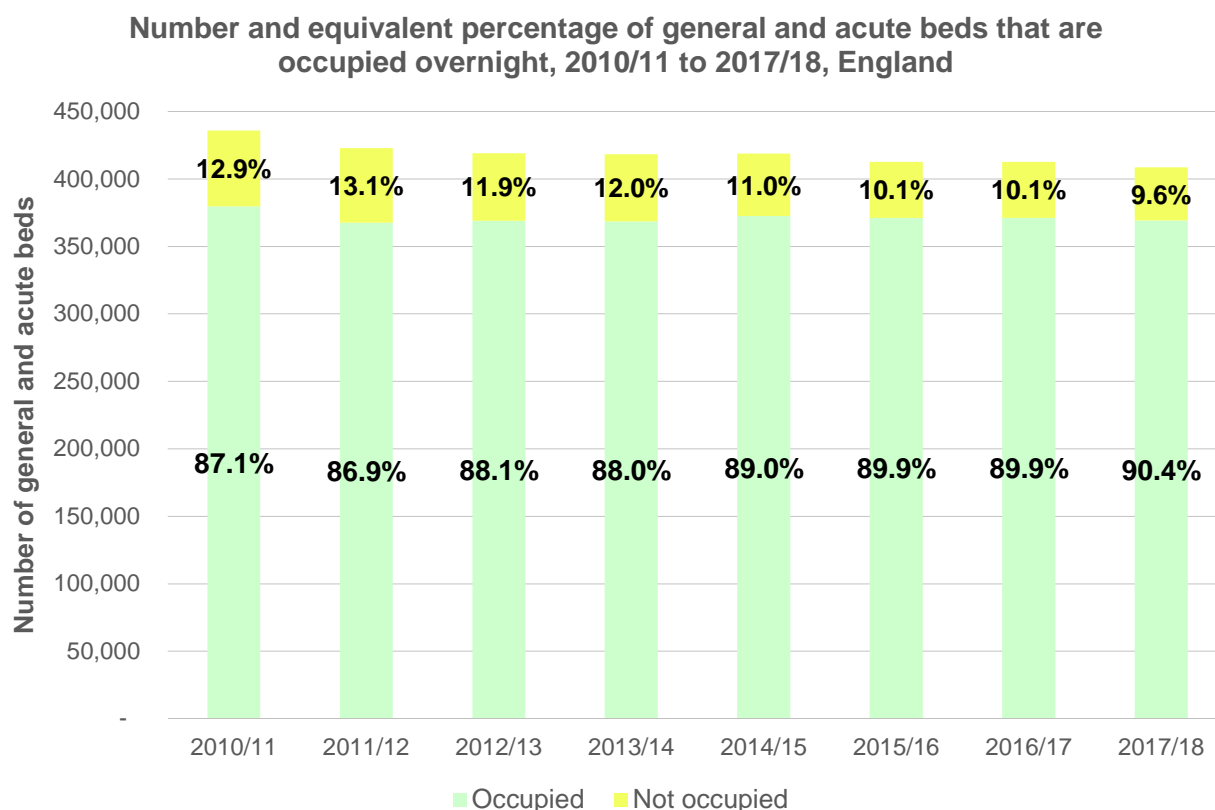
### 3.6 Pinch points within the system

#### Reducing bed numbers and bed capacity

The NHS has been reducing the number of beds for decades: over the last 30 years the total number has been reduced by more than half, from around 299,000 to 142,000 (Ewbank et al 2017). Several changes in the way that healthcare is provided have made this possible, notably improvements in treatment and surgery that have led to a rise in day-only appointments, shorter recovery times and hospital stays, as well as the gradual shift from long-term care in institutional settings to care in the community. However, while the average length of stay may have reduced, demographic changes and increasing demand for secondary care suggests that demand for beds is likely to increase in the years to come.

As shown in *figure 43*, between 2010/11 and 2017/18, the average number of *available* general and acute beds fell by 30 per cent (17,020 beds) as total bed numbers have continued to drift downwards and occupancy rates increase (NHS Digital 2018m). Over this period occupancy levels for overnight general and acute beds increased from 87.1 per cent to 90.4 per cent. The National Audit Office has noted that bed occupancy above 85 per cent can lead to regular bed shortages, periodic bed crises and increased numbers of hospital-acquired infections (NAO 2018b). In January 2018, NHS England and NHS Improvement's National Emergency Pressures Panel recommended trusts defer their elective activity for January, in light of pressures on emergency care (NHS England 2018c).

Figure 43



Source: NHS England 2018: Bed Availability and Occupancy Data – Overnight – 2010/11 to 2017/18 time series.

### The NHS tariff

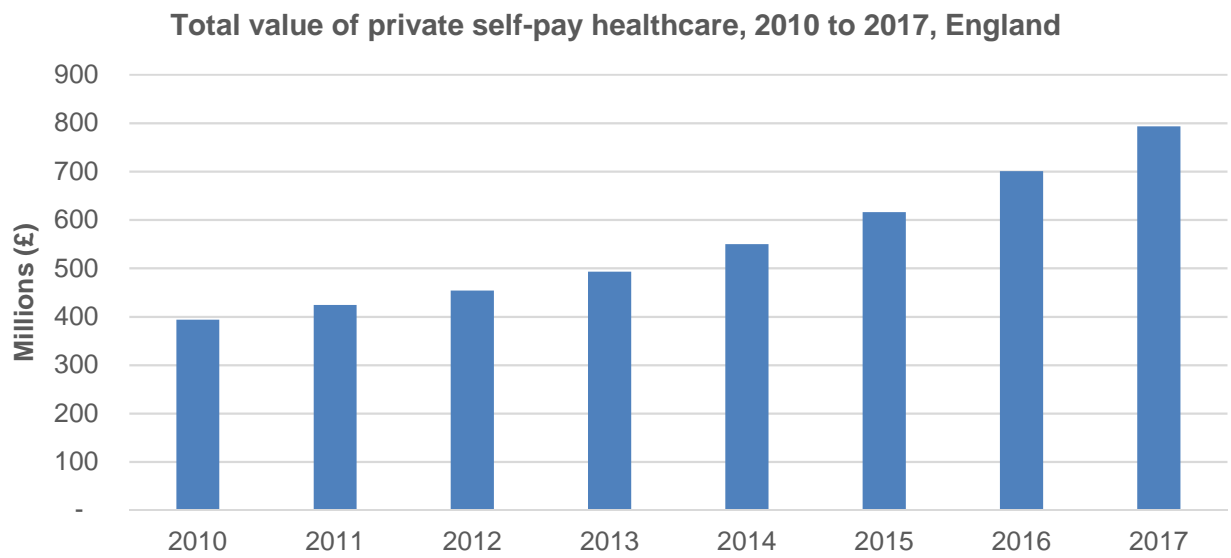
The NHS tariff is the price list of thousands of procedures that determines how much hospitals and other services are paid for each patient they treat. This was cut in cash terms every year from 2011/12 to 2015/16, during which time, as we set out earlier on, provider deficits became increasingly pronounced and problematic (Gainsbury 2017b). The tariff has not seen a real-terms increase this decade, which now results in around a 5 per cent gap between how much providers are paid to treat each patient and the actual costs of doing so, even without taking account of inflation (Gainsbury 2017b). If inflation is factored in, then the gap between how much providers are paid and what that payment is worth in real terms is much wider, and is projected to continue widening (Gainsbury 2017b).

### Private healthcare

Another key trend to note is rising private expenditure on healthcare. As shown in *figure 44*, spend on private self-pay healthcare – excluding private insurance and cosmetic surgery – has increased year-on-year, and has more than doubled since 2010 (LaingBuisson 2018b). This is primarily driven by procedures most usually undertaken by older people, such as cataract surgery and hip replacement. Indeed, orthopaedic surgery and eye surgery are the most frequently requested one-off self-pay non-cosmetic procedures (LaingBuisson 2018b). Growth in this sector is happening in parallel with increasing NHS waiting times and, more recently, national health policy directives to defer elective activity in ‘peak periods’ in order to manage demand. Taken together, these trends may

well suggest patients increasingly feel they have no option but to pay to receive timely treatment for essential care.

Figure 44



Source: LaingBuisson 2018: Private Acute Healthcare, fifth edition

## REFERENCES

[All accessed 18-01-2019]

- Aiden, H. (2018). *Multimorbidity: Understanding the challenge*. The Richmond Group of Charities. [https://richmondgroupofcharities.org.uk/sites/default/files/multimorbidity\\_-\\_understanding\\_the\\_challenge.pdf](https://richmondgroupofcharities.org.uk/sites/default/files/multimorbidity_-_understanding_the_challenge.pdf)
- Appleby, J. (2018). *70 years of NHS spending*. Nuffield Trust. <https://www.nuffieldtrust.org.uk/news-item/70-years-of-nhs-spending#then-and-now>
- Association of Directors of Adult Social Services (ADASS) (2018a). *ADASS Budget Survey*. [www.adass.org.uk/media/6434/adass-budget-survey-report-2018.pdf](http://www.adass.org.uk/media/6434/adass-budget-survey-report-2018.pdf)
- ADASS (2018b). *Autumn Budget 2018 – Representation by the Association of Directors of Adult Social Services*. [www.adass.org.uk/media/6662/autumn-budget-2018\\_adass\\_sept18\\_final.pdf](http://www.adass.org.uk/media/6662/autumn-budget-2018_adass_sept18_final.pdf)
- Adcock, A., Powell, T., Kennedy, S., Harker, R., Bolton, P., Roberts, N., Abreu, L., McGuinness, F., Jarrett, T., Cromarty, H., Powell, A (2017). *Carers: Briefing paper Number 7756*. House of Commons Library. <https://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7756>
- Age UK (2017). *Briefing: Health and Care of Older People in England 2017*. [https://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/The\\_Health\\_and\\_Care\\_of\\_Older\\_People\\_in\\_England\\_2016.pdf?dtrk=true](https://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/The_Health_and_Care_of_Older_People_in_England_2016.pdf?dtrk=true)
- Age UK (2018a). *All the lonely people: Loneliness in Later Life*. <https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/loneliness/loneliness-report.pdf>
- Age UK (2018b). *1.4 million older people aren't getting the care and support they need – a staggering increase of almost 20% in just two years*. [www.ageuk.org.uk/latest-news/articles/2018/july/1.4-million-older-people-arent-getting-the-care-and-support-they-need-a-staggering-increase-of-almost-20-in-just-two-years/](http://www.ageuk.org.uk/latest-news/articles/2018/july/1.4-million-older-people-arent-getting-the-care-and-support-they-need-a-staggering-increase-of-almost-20-in-just-two-years/)
- Age UK (2018c). *The Failing Safety Net*. [www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/care--support/rb\\_2018\\_sept18\\_failing\\_safety\\_net\\_for\\_older\\_people.pdf](http://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/care--support/rb_2018_sept18_failing_safety_net_for_older_people.pdf)
- Age UK (2019). *Later Life in the United Kingdom*. [https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/late\\_life\\_uk\\_factsheet.pdf](https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/late_life_uk_factsheet.pdf)
- Baird, B., Charles, A., Honeyman, M., Maguire, D., Das, P. (2016). *Understanding pressures in general practice*. King's Fund. [www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/Understanding-GP-pressures-Kings-Fund-May-2016.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Understanding-GP-pressures-Kings-Fund-May-2016.pdf)
- Baker, C. (2018). *NHS Key Statistics – October 2018*. House of Commons Library. <https://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7281>
- Personal communication. Bajekal M et al. (2018). *Trajectories of complex disease accumulation and impact on socioeconomic inequalities in life expectancy*. NIHR CLAHRC (part-funded) project.
- BBC News (2018). *'The NHS turned its back on mum – and it cost us £250,000'*. [www.bbc.co.uk/news/health-46378353](http://www.bbc.co.uk/news/health-46378353)
- British Geriatric Society (2014). *Fit for Frailty: Consensus Best Practice Guidance for the care old older people living with frailty*. [https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-05-14/fff2\\_short.pdf](https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-05-14/fff2_short.pdf)
- Bunn, J. (2018). *Hancock refutes reports of 'shelved' social care green paper*. Local Government Chronicle. [www.lgcplus.com/services/health-and-care/hancock-refutes-reports-of-shelved-social-care-green-paper/7027168.article](http://www.lgcplus.com/services/health-and-care/hancock-refutes-reports-of-shelved-social-care-green-paper/7027168.article)
- Bolton, J. Townson, J., (2018). *Messages on the future of domiciliary care services*. Institute of Public Care.
- Care Quality Commission (2018). *The State of Health and Adult Social Care 2018*. [https://www.cqc.org.uk/sites/default/files/20171011\\_stateofcare1718\\_report.pdf](https://www.cqc.org.uk/sites/default/files/20171011_stateofcare1718_report.pdf)
- Carers Trust (2018). *Key facts about carers and the people they care for*. <https://carers.org/key-facts-about-carers-and-people-they-care>
- Charlesworth, A. & Johnson, P. (eds.) (2018). *Securing the future: funding health and social care to the 2030s*. Institute for Fiscal Studies; The Health Foundation. [www.ifs.org.uk/uploads/publications/comms/R143.pdf](http://www.ifs.org.uk/uploads/publications/comms/R143.pdf)
- Centre for Policy on Ageing (2014). *Changing family structures and their impact on the care of older people*. [https://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/CPA-Changing\\_family\\_structures.pdf?dtrk=true](https://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/CPA-Changing_family_structures.pdf?dtrk=true)



Collerton, J. et al (2015). Deconstructing Complex Multimorbidity in the Very Old: Findings from the Newcastle 85+ Study. *BioMed Research International*. 2016, article no: 8745670. [eprint.ncl.ac.uk/file\\_store/production/219428/D9FC9A3D-D505-43EB-9849-98A4D63FF04B.pdf](https://eprint.ncl.ac.uk/file_store/production/219428/D9FC9A3D-D505-43EB-9849-98A4D63FF04B.pdf)

Competition & Markets Authority (CMA) (2017). *Care homes market study: Final report*. <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf>

Cromarty, H. (2018). *Adult Social Care Funding (England): Briefing paper CBP07903*. House of Commons Library. <https://researchbriefings.files.parliament.uk/documents/CBP-7903/CBP-7903.pdf>

Department of Health and Social Care (DHSC 2015). *Hospitals get £1.8 billion for sustainability and transformation*. <https://www.gov.uk/government/news/hospitals-get-18-billion-for-sustainability-and-transformation>

DHSC (2018a). *£240 million social care investment to ease NHS winter pressures*. [www.gov.uk/government/news/240-million-social-care-investment-to-ease-nhs-winter-pressures](http://www.gov.uk/government/news/240-million-social-care-investment-to-ease-nhs-winter-pressures)

DHSC (2018b). *Public health grants to local authorities: 2019 to 2020*. [www.gov.uk/government/publications/public-health-grants-to-local-authorities-2019-to-2020](http://www.gov.uk/government/publications/public-health-grants-to-local-authorities-2019-to-2020)

DHSC (2018c). *Annual Report and Accounts 2017-18*. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/728780/Department\\_of\\_Health\\_Annual\\_Report\\_Accounts\\_Web\\_Accessible\\_NEW.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/728780/Department_of_Health_Annual_Report_Accounts_Web_Accessible_NEW.pdf)

Ewbank, L., Thompson, J., McKenna, H., (2017). *NHS Hospital bed numbers: past, present and future*, King's Fund. <https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers>

Finch, D., Bibby, J. & Elwell-Sutton, T. (2018). *Briefing: Taking our health for granted. Plugging the public health funding gap*. (Health Foundation). <http://reader.health.org.uk/taking-our-health-for-granted>

Full Fact (2018). *Emergency admissions to hospitals from care homes are up 62%*. [https://fullfact.org/health/emergency-admissions-care-homes/?gclid=EAlaIqobChMktOw7bX33wIVTbftCh37QQwrEAAYASAAEgLiUPD\\_BwE](https://fullfact.org/health/emergency-admissions-care-homes/?gclid=EAlaIqobChMktOw7bX33wIVTbftCh37QQwrEAAYASAAEgLiUPD_BwE)

Gale, C. R., Cooper, C., & Sayer, A. A. (2015). *Prevalence of frailty and disability: findings from the English Longitudinal Study of Ageing*. <https://www.ifs.org.uk/publications/7910>

Gainsbury, S. (2017a). *The bottom line: Understanding the NHS deficit and why it won't go away*. Nuffield Trust. [www.nuffieldtrust.org.uk/research/the-bottom-line-understanding-the-nhs-deficit-and-why-it-won-t-go-away](http://www.nuffieldtrust.org.uk/research/the-bottom-line-understanding-the-nhs-deficit-and-why-it-won-t-go-away)

Gainsbury, S. (2017b). *When the price isn't right: How cuts in hospital payments added to the NHS deficit*. Nuffield Trust. [www.nuffieldtrust.org.uk/news-item/when-the-price-isn-t-right-how-cuts-in-hospital-payments-added-up-to-the-nhs-deficit](http://www.nuffieldtrust.org.uk/news-item/when-the-price-isn-t-right-how-cuts-in-hospital-payments-added-up-to-the-nhs-deficit)

Gainsbury, S. (2018). *With strings attached: Taking a closer look at the new NHS money*. Nuffield Trust. [www.nuffieldtrust.org.uk/news-item/with-strings-attached-taking-a-closer-look-at-the-new-nhs-money#provider-deficits](http://www.nuffieldtrust.org.uk/news-item/with-strings-attached-taking-a-closer-look-at-the-new-nhs-money#provider-deficits)

Hancock, M. (2018). *Prevention is better than cure [speech to the International Association of Public Health Institutes]*. Transcript available: [www.gov.uk/government/speeches/prevention-is-better-than-cure-matt-hancocks-speech-to-ianphi](http://www.gov.uk/government/speeches/prevention-is-better-than-cure-matt-hancocks-speech-to-ianphi)

Harker, R. (2018). *NHS Funding and Expenditure*. House of Commons Library. <https://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN00724>

Haynes, L. (2018). *Some councils 'washing their hands' of top-up fee control*. [www.communitycare.co.uk/2018/05/02/councils-washing-hands-top-fee-control/](http://www.communitycare.co.uk/2018/05/02/councils-washing-hands-top-fee-control/)

Health and Social Care Committee and Housing, Communities and Local Government Committees (HSCHC & CLGC) (2018). *Long-term funding of adult social care*, HC768 (2017–19), 27 June 2018, p3. <https://publications.parliament.uk/pa/cm201719/cmselect/cmcomloc/768/76802.htm>

Health Foundation (2018a). *Health and health care use of older people living alone*. [www.health.org.uk/chart/health-and-health-care-use-of-older-people-living-alone](http://www.health.org.uk/chart/health-and-health-care-use-of-older-people-living-alone)

Health Foundation (2018b). *Budget 2018: £1bn real terms cut to wider health budget*. [www.health.org.uk/news-and-comment/news/budget-2018-1bn-real-terms-cut-to-wider-health-budget](http://www.health.org.uk/news-and-comment/news/budget-2018-1bn-real-terms-cut-to-wider-health-budget)

Healthwatch England (2018). *Emergency readmissions: What's changed one year on?* [www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20181114%20Emergency%20readmissions\\_0.pdf](http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20181114%20Emergency%20readmissions_0.pdf)

HM Treasury (2018). *HM Treasury: Public Expenditure: Statistical Analyses*. <https://www.gov.uk/government/statistics/public-expenditure-statistical-analyses-2018>

- Hobbs, R., Bankhead, C., Mukhtar, T., Stevens, S., Perera-Salazar, R., Holt, T. (2016). *Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007–14*. The Lancet. [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(16\)00620-6/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)00620-6/abstract)
- Home Office (2018). *EU Settlement Scheme: Statement of intent*. [www.gov.uk/government/publications/eu-settlement-scheme-statement-of-intent](http://www.gov.uk/government/publications/eu-settlement-scheme-statement-of-intent)
- Humphries, R., Thorlby, R., Holder, H., Hall, P. and Charles, A., (2016). *Social Care for Older People: Home truths*. The King's Fund. [www.kingsfund.org.uk/sites/default/files/field/field\\_publication\\_file/Social\\_care\\_older\\_people\\_Kings\\_Fund\\_Sep\\_2016.pdf](http://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Social_care_older_people_Kings_Fund_Sep_2016.pdf)
- Humphries, R. (2018). *What are the stages to reform?* Local Government Association. [www.local.gov.uk/about/campaigns/towards-sustainable-adult-social-care-and-support-system/5-what-are-stages-reform-1](http://www.local.gov.uk/about/campaigns/towards-sustainable-adult-social-care-and-support-system/5-what-are-stages-reform-1)
- Incisive Health (2019). *Care deserts: the impact of a dysfunctional market in adult social care provision*. <https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/care--support/care-deserts---age-uk-report.pdf>
- King's Fund (2014). *Making our health and care system fit for an ageing population*. [https://www.kingsfund.org.uk/sites/default/files/field/field\\_publication\\_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf](https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf)
- King's Fund (2017). *How the NHS is funded*. [www.kingsfund.org.uk/projects/nhs-in-a-nutshell/how-nhs-funded](http://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/how-nhs-funded)
- King's Fund (2018a). *Trusts in deficit*. [www.kingsfund.org.uk/projects/nhs-in-a-nutshell/trusts-deficit](http://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/trusts-deficit)
- King's Fund (2018b). *The NHS budget and how it has changed*. [www.kingsfund.org.uk/projects/nhs-in-a-nutshell/nhs-budget](http://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/nhs-budget)
- King's Fund (2018c). *Spending on public health*. [www.kingsfund.org.uk/projects/nhs-in-a-nutshell/spending-public-health](http://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/spending-public-health)
- King's Fund, Health Foundation, Nuffield Trust (2018). *The health care workforce in England: make or break?* [www.kingsfund.org.uk/publications/health-care-workforce-england](http://www.kingsfund.org.uk/publications/health-care-workforce-england)
- King's Fund, Health Foundation (2019a). <https://www.kingsfund.org.uk/press/press-releases/reverse-cuts-public-health-funding>
- King's Fund (2019b). *Closing the Gap: Key areas for action on the health and care workforce*. <https://www.kingsfund.org.uk/publications/closing-gap-health-care-workforce>
- Kingston, A., Comas-Herrera, A. & Jagger, C. (2018). Forecasting the care needs of the older population in England over the next 20 years: estimates from the Population Ageing and Care Simulation (PACSim) modelling study. *The Lancet: Public Health*. 3(9). [www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(18\)30118-X/fulltext](http://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(18)30118-X/fulltext)
- (£) Laing, W. (2018). *Care of Older People: UK Market Report, twenty-ninth edition*. LaingBuisson
- (£) LaingBuisson (2018a). *Homecare and Supported Living Report, April 2018*.
- (£) LaingBuisson (2018b). *Private Acute Healthcare, fifth edition*.
- (£) Local Government Chronicle (LGC) (2018). *Councils' delayed transfers of care reductions 'saved NHS £60 million'*. [www.lgcplus.com/services/health-and-care/councils-delayed-transfers-of-care-reductions-saved-nhs-60m/7025691.article](http://www.lgcplus.com/services/health-and-care/councils-delayed-transfers-of-care-reductions-saved-nhs-60m/7025691.article)
- Local Government & Social Care Ombudsman (LGSCO) (2018a). *Social care pressures reflected in Ombudsman's annual review of complaints*. [www.lgo.org.uk/information-centre/news/2018/nov/social-care-pressure-reflected-in-ombudsman-s-annual-review-of-complaints](http://www.lgo.org.uk/information-centre/news/2018/nov/social-care-pressure-reflected-in-ombudsman-s-annual-review-of-complaints)
- LGSCO (2018b). *Review of Adult Social Care Complaints 2017-2018*. [www.lgo.org.uk/assets/attach/4467/ASC%20Review%20FINAL.pdf](http://www.lgo.org.uk/assets/attach/4467/ASC%20Review%20FINAL.pdf)
- Luchinskaya, D., Simpson, P., Stoye, G., (2017). *The IFS Green Budget 2017: UK health and care spending*. Institute for Fiscal Studies. <https://www.ifs.org.uk/uploads/publications/budgets/gb2017/gb2017ch5.pdf>
- Maybin, J., Charles, A. & Honeyman, M. (2016). *Understanding quality in district nursing services*. King's Fund. [www.kingsfund.org.uk/sites/default/files/field/field\\_publication\\_file/quality\\_district\\_nursing\\_aug\\_2016.pdf](http://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/quality_district_nursing_aug_2016.pdf)
- Migration Advisory Committee (2018). *EEA Migration in the UK: Final report*. [www.gov.uk/government/publications/migration-advisory-committee-mac-report-eea-migration](http://www.gov.uk/government/publications/migration-advisory-committee-mac-report-eea-migration)

National Audit Office (NAO) (2018a). *Adult Social Care at a Glance*. [www.nao.org.uk/wp-content/uploads/2018/07/Adult-social-care-at-a-glance.pdf](http://www.nao.org.uk/wp-content/uploads/2018/07/Adult-social-care-at-a-glance.pdf)

NAO (2018b). *Reducing emergency admissions*. [www.nao.org.uk/wp-content/uploads/2018/02/Reducing-emergency-admissions.pdf](http://www.nao.org.uk/wp-content/uploads/2018/02/Reducing-emergency-admissions.pdf)

NHS Digital (2011). *Personal Social Services Survey of Adult Carers in England 2010-11*. <https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-expenditure-and-unit-costs>

NHS Digital (2012). *Personal Social Services Survey of Adult Carers in England 2011-12*. <https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-expenditure-and-unit-costs>

NHS Digital (2013). *Personal Social Services Survey of Adult Carers in England 2012-13*. <https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-expenditure-and-unit-costs>

NHS Digital (2014a). *Personal Social Services Survey of Adult Carers in England 2013-14*. <https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-expenditure-and-unit-costs>

NHS Digital (2014b). *Hospital Outpatient Activity 2013/14*. <https://digital.nhs.uk/data-and-information/publications/statistical/hospital-outpatient-activity/2017-18>

NHS Digital (2015a). *Personal Social Services Survey of Adult Carers in England 2014-15*. <https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-expenditure-and-unit-costs>

NHS Digital (2015b). *Hospital Outpatient Activity 2014/15*. <https://digital.nhs.uk/data-and-information/publications/statistical/hospital-outpatient-activity/hospital-outpatient-activity-2014-15>

NHS Digital (2016a). *Personal Social Services Survey of Adult Carers in England 2015-16*. <https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-expenditure-and-unit-costs>

NHS Digital (2016b). *Hospital Outpatient Activity 2015/16*. <https://digital.nhs.uk/data-and-information/publications/statistical/hospital-outpatient-activity/hospital-outpatient-activity-2015-16>

NHS Digital (2017a). *Adult Social Care Activity and Finance Report, England – 2016-17: Detailed Analysis*. <https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/adult-social-care-activity-and-finance-report-england-2016-17>

NHS Digital (2017b). *Personal Social Services Survey of Adult Carers in England, 2016-17*. <https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-survey-of-adult-carers/personal-social-services-survey-of-adult-carers-in-england-2016-17>

NHS Digital (2017c). *NHS Digital Secondary Care Analysis 2017: Counts of finished admission episodes with an emergency admission by source of admission and age band from 2010-11 to 2016-17*. [https://digital.nhs.uk/binaries/content/assets/legacy/excel/t/5/10250\\_carehome\\_admissions.xlsx](https://digital.nhs.uk/binaries/content/assets/legacy/excel/t/5/10250_carehome_admissions.xlsx)

NHS Digital (2017d). *Hospital Outpatient Activity 2016/17*. <https://digital.nhs.uk/data-and-information/publications/statistical/hospital-outpatient-activity/hospital-outpatient-activity-2016-17>

NHS Digital (2018a). *Adult Social Care Activity and Finance Report, England – 2017-18: Detailed Analysis*. <https://files.digital.nhs.uk/35/6A192B/Activity%20and%20Finance%20Report%20201718.pdf>

NHS Digital (2018b). *Measures from the Adult Social Care Outcomes Framework (ASCOF), England 2017-18: Supplementary tables*. <https://files.digital.nhs.uk/14/1F117F/meas-from-ascof-2017-18-tab-supp-annex.pdf>

NHS Digital (2018c). *Measures from the Adult Social Care Outcomes Framework (ASCOF), England 2017-18: Time-series of aggregated outcome measures*. <https://files.digital.nhs.uk/34/3A8D74/meas-from-asc-of-eng-1718-time-sers-anx.xlsx>

NHS Digital (2018d). *Deferred Payments Agreement Report, England – 2017/18*. <https://digital.nhs.uk/data-and-information/publications/statistical/deferred-payment-agreements/2017-18>

NHS Digital (2018e). *General Practice Workforce, Final September 2018, Experimental Statistics*. <https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/final-30-september-2018-experimental-statistics>

NHS Digital (2018f). *NHS Vacancy Statistics, England – February 2015 – March 2018, Provisional Experimental Statistics*. <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/nhs-vacancy-statistics-england---february-2015---march-2018-provisional-experimental-statistics>

NHS Digital (2018g). *Emergency admissions for acute conditions that should not normally require hospital admission – February 2018*. <https://digital.nhs.uk/data-and-information/publications/clinical-indicators/ccg-outcomes-indicator-set/current/domain-3-helping-people-to-recover-from-episodes-of-ill-health-or-following-injury-ccg/3-1-emergency-admissions-for-acute-conditions-that-should-not-usually-require-hospital-admission>

NHS Digital (2018h). *Psychological Therapies, Annual Reports on the use of IAPT Services versions 2013/14 to 2017/18, England*. <https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services>

NHS Digital (2018i). *Hospital Accident and Emergency Activity 2017/18*. <https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity/2017-18>

NHS Digital (2018j). *Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatients and Accident and Emergency – April 2018 – June 2018*. <https://digital.nhs.uk/data-and-information/publications/statistical/hospital-episode-statistics-for-admitted-patient-care-outpatient-and-accident-and-emergency-data/april-2018---june-2018>

NHS Digital (2018k). *Consultant-led Referral to Treatment Waiting Times Data 2018-19 (time series)*. <https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2018-19/>

NHS Digital (2018l). *Hospital Outpatient Activity 2017/18*. <https://digital.nhs.uk/data-and-information/publications/statistical/hospital-outpatient-activity/2017-18>

NHS Digital (2018m). *Bed Availability and Occupancy Data – time series 2010/11 onwards*. <https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/>

NHS Digital (2019). *NHS Workforce Statistics: March 2019* <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/nhs-workforce-statistics---march-2019-provisional-statistics>

National Health Services Commissioning Board (2014). *Annual report and accounts 2013/14*. <https://www.england.nhs.uk/wp-content/uploads/2014/07/nhs-comm-board-ann-rep-1314.pdf>

NHS England (2015). *NHS England: Annual Report 2014/15*. <https://www.england.nhs.uk/wp-content/uploads/2015/07/nhse-annual-report-2014-15.pdf>

NHS England (2016). *NHS England: Annual Report 2015/16*. <https://www.england.nhs.uk/publication/nhs-england-annual-report-201516/>

NHS England (2017). *NHS England: Annual Report 2016/17*. [https://www.england.nhs.uk/wp-content/uploads/2017/07/Annual-Report-Full\\_201617.pdf](https://www.england.nhs.uk/wp-content/uploads/2017/07/Annual-Report-Full_201617.pdf)

NHS England (2018a). *Ageing well and supporting people living with frailty*. [www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/](http://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/)

NHS England (2018b). *NHS England: Annual Report 2017/18*. <https://www.england.nhs.uk/publications/annual-report/>

NHS England (2018c). *Bed Availability and Occupancy Data*. [www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/](http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/)

NHS England (2018d). *GP Patient Survey 2018*. <https://www.england.nhs.uk/statistics/statistical-work-areas/gp-patient-survey/>

NHS England (2019). *Delayed Transfer of Care – monthly reports – 2011/12 to 2018/19*. <https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/statistical-work-areas-delayed-transfers-of-care-delayed-transfers-of-care-data-2018-19/>

NHS Improvement (2018a). *Performance of the NHS provider sector for the quarter ended 30 September 2018*. [https://improvement.nhs.uk/documents/3520/Performance\\_of\\_the\\_NHS\\_provider\\_sector\\_for\\_the\\_month\\_ended\\_30\\_Sept\\_18\\_FINAL.pdf](https://improvement.nhs.uk/documents/3520/Performance_of_the_NHS_provider_sector_for_the_month_ended_30_Sept_18_FINAL.pdf)

NHS Improvement (2018b). *Quarterly performance of the NHS provider sector: quarter 3, 2017/18*. <https://improvement.nhs.uk/resources/quarterly-performance-nhs-provider-sector-quarter-3-201718/>

NHS Improvement (2018c). *Guide to reducing hospital stays*. [https://improvement.nhs.uk/documents/2898/Guide\\_to\\_reducing\\_long\\_hospital\\_stays\\_FINAL\\_v2.pdf](https://improvement.nhs.uk/documents/2898/Guide_to_reducing_long_hospital_stays_FINAL_v2.pdf)

NHS Survey Coordination Centre (2018) *Results from the 2017 staff survey*. [www.nhsstaffsurveys.com/Page/1064/Latest-Results/2017-Results/](http://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2017-Results/)

- NICE (2017). *Multimorbidity: Clinical assessment and management – Context*. [www.nice.org.uk/guidance/ng56/chapter/Context](http://www.nice.org.uk/guidance/ng56/chapter/Context)
- Office for Budget Responsibility (OBR) (2018). *Economic and fiscal outlook*. [https://cdn.obr.uk/EFO\\_October-2018.pdf](https://cdn.obr.uk/EFO_October-2018.pdf)
- Office for National Statistics (ONS) (2015). *Opinions and Lifestyle Survey: 2013 reference tables*. [www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/compendium/opinionsandlifestylesurvey/2015-03-19/opinionsandlifestylesurvey2013referencetables](http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/compendium/opinionsandlifestylesurvey/2015-03-19/opinionsandlifestylesurvey2013referencetables)
- Oliver, D. (2019). Falling immigration could destroy the NHS. *BMJ*. 2019(364). Article no. k5308. <https://doi.org/10.1136/bmj.k5308>
- ONS (2016). Disability-free life expectancy (DFLE) and life expectancy (LE) at age 65, men and women, by upper tier local authority, England: 2012 to 2014 <http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies>
- ONS (2018a). *Subnational population projections for England: 2016-based*. [www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/subnationalpopulationprojectionsforengland/2016based](http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/subnationalpopulationprojectionsforengland/2016based)
- ONS (2018b). *Estimates of the very old, including centenarians, UK: 2002 to 2017*. [www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/bulletins/estimatesoftheveryoldincludingcentenarians/2002to2017](http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/bulletins/estimatesoftheveryoldincludingcentenarians/2002to2017)
- ONS (2018c). *Living longer – how our population is changing and why it matters*. [www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/livinglongerhowourpopulationischangingandwhyitmatters/2018-08-13](http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/livinglongerhowourpopulationischangingandwhyitmatters/2018-08-13)
- ONS (2018d). *National life tables, UK: 2015 to 2017*. [www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/nationallifetablesunitedkingdom/2015to2017](http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/nationallifetablesunitedkingdom/2015to2017)
- ONS (2018e). *Population estimates for the UK, England and Wales, Scotland and Northern Ireland: mid-2017*. [www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2017](http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2017)
- ONS (2018f). *Health state life expectancies, UK: 2015 to 2017*. [www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/2015to2017](http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/2015to2017)
- ONS (2018g). *Household projections for England – household type projections: 2016-based*. [www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/2016basedhouseholdprojectionsinengland/2016based](http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/2016basedhouseholdprojectionsinengland/2016based)
- ONS (2018h). *Overview of the UK population: November 2018*. [www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/november2018](http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/november2018)
- Parkin, E. (2018). *General Practice in England*. House of Commons Library. <http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7194>
- Phillips, D., Simpson, P. (2018). *Changes in Councils' adult social care and overall service spending in England, 2009-10 to 2017-18*. Institute for Fiscal Studies. <https://www.ifs.org.uk/uploads/BN240.pdf>
- Praities, N (2018). *GP funding allocation to fall 7.1% this year*. [www.pulsetoday.co.uk/your-practice/practice-topics/practice-income/gp-funding-allocation-to-fall-to-7-1-this-year/20036121.article](http://www.pulsetoday.co.uk/your-practice/practice-topics/practice-income/gp-funding-allocation-to-fall-to-7-1-this-year/20036121.article) Pulse Today
- Public Health England (PHE) (2018). *Health Profile for England: 2018*. [www.gov.uk/government/publications/health-profile-for-england-2018/chapter-1-population-change-and-trends-in-life-expectancy#healthy-life-expectancy-at-birth](http://www.gov.uk/government/publications/health-profile-for-england-2018/chapter-1-population-change-and-trends-in-life-expectancy#healthy-life-expectancy-at-birth)
- Robertson, R. (2018). *Public satisfaction with GP services drops to lowest level in 35 years*. King's Fund. [www.kingsfund.org.uk/blog/2018/02/public-satisfaction-gp-services](http://www.kingsfund.org.uk/blog/2018/02/public-satisfaction-gp-services)
- Rosser, E. (2018). *Majority of GPs intend to retire before the age of 60*. Pulse. [www.pulsetoday.co.uk/news/gp-topics/employment/majority-of-gps-intend-to-retire-before-the-age-of-60/20037119.article](http://www.pulsetoday.co.uk/news/gp-topics/employment/majority-of-gps-intend-to-retire-before-the-age-of-60/20037119.article)
- Royal College of Nursing (RCN) (2018a). *NHS pay deal must be extended to social care*. [www.rcn.org.uk/news-and-events/news/nhs-pay-deal-social-care](http://www.rcn.org.uk/news-and-events/news/nhs-pay-deal-social-care)

RCN (2018b). *Falls Resources for nursing professionals on the prevention, treatment and management of falls in older people*. [www.rcn.org.uk/clinical-topics/older-people/falls](http://www.rcn.org.uk/clinical-topics/older-people/falls)

Skills for Care (2018). *The state of the adult social care sector and workforce in England*. [www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2018.pdf](http://www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2018.pdf)

UCAS (2018). *End of cycle report: Patterns by subject*. [www.ucas.com/file/196141/download?token=7YGpHk71](http://www.ucas.com/file/196141/download?token=7YGpHk71)

Villacampa-Fernandez, P., Navarro-Pardo, E., Tarin, J.J., Cano, A. (2017). Frailty and multimorbidity: two related yet different concepts. *Maturitas*. **95**. pp. 31-35.

Watt, T., Varrow, M., Roberts, A. Charlesworth, A. (2018). *Social care funding options: How much and where from?* The King's Fund and The Health Foundation. [www.health.org.uk/sites/default/files/Social-care-funding-options-May-2018.pdf](http://www.health.org.uk/sites/default/files/Social-care-funding-options-May-2018.pdf)

Wittenberg, R. et al (2018). *Projections of Demand and Expenditure on Adult Social Care 2015 to 2040*. Personal Social Services Research Unit, London School of Economics. <https://www.pssru.ac.uk/pub/5421.pdf>

Yadegarfar, M.E., Jagger, C., Duncan, R., Fouweather, T., Hanratty, B., Parker, S., Robinson, L. (2018). Use of primary care and other healthcare services between age 85 and 90 years: longitudinal analysis of a single-year birth cohort, the Newcastle 85+ study. *BMJ Open*. **8**, article no: 019218. [bmjopen.bmj.com/content/8/1/e019218](http://bmjopen.bmj.com/content/8/1/e019218)

Yarnall, A., Sayer, A., Clegg, A., Rockwood, K., Parker, S., Hindle, J. (2017). New horizons in multimorbidity in older adults. *Age and Ageing*, **46**(6). pp. 882–888. <https://oi.org/10.1093/ageing/afx150>