

Briefing: The Health and Care of Older People in England 2015

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Introduction

The purpose of this publication is to present the most authoritative and up to date facts and figures available concerning older people's health and care needs in England and how those needs are being met.

For the last few years Age UK has produced an annual briefing of this kind focused on social care. But in this 'age of integration' – both within health and across health and care – it seems especially important to cover health as well as care. Our intention is that this will be the model for all such Age UK reports from now on.

Monitor, the health service's financial regulator, has recently said that NHS providers, predominantly hospitals, overspent by £930m in three months, putting it on course for an annual deficit in 2015/16 of at least £2 billion, in what they described in unusually frank language as its 'worst financial crisis in a generation'. Meanwhile, report after report expresses concern about the lack of social care available to older people, as well as about the fragility of the social care market and the poor quality of what is often on offer.

This publication looks beyond the headlines and tells a different side of the story, looking at issues like costs and activity through the prism of what older people need from the NHS and from social care in order to thrive.

In reviewing all the trends and statistics we have been acutely conscious that the vast majority of older people in this country are spirited and resilient and want to live life on their own terms, preferably in their own homes, for as long as they possibly can. Our health and care system has a crucial role to play in enabling this to happen and our intention is that this briefing will shed some light on how well it is performing in this respect, which matters so much to older people.

During the summer of 2015 Age UK commissioned BritainThinks to carry out some focus groups with older people about what they wanted from the NHS and social care. This exercise showed once again that the vast majority of older people greatly value the NHS and are grateful to the people who work in it for the help they receive.

The focus groups also brought home to us though how concerns about their health are often very near the surface for older people. Participants living with multiple long-term conditions were acutely aware that a minor health problem might turn into something more serious quite quickly, causing them pain and distress if it was not recognised and treated with reasonable haste. They therefore looked to the NHS to perform this role and, understandably, they wanted the NHS to be there for them, standing with them, when they needed it.

Being able to keep going if they developed what would be regarded by professionals as a social care need was important to the research participants too, even though most of them did not realise that social care provision is not part of the NHS. Those who already had some experience of the social care system, for example as a result of caring for a loved one, had some worries about the capacity of the system to help them if and when the time came when they too needed support.

On the whole the participants were happy with the health services they were receiving, but worries were expressed by some about having to wait too long to see their GP, about insufficient support in managing different medications, and about lack of continuity in staffing at primary care level. They valued having a strong relationship with the main health professionals in their lives, especially if they had long-term conditions and complex needs

which necessitated frequent discussion, but for a new health complaint that might be something to worry about what mattered most was seeing a health professional fast.

Their perspectives were a salutary reminder that it is not just what our health and care system does to help older people that matters: how it does it and the confidence that it manages to instil in them in the process also play a big part in enabling us all to keep strong and make the most of our later lives, come what may.

Summary of key facts and figures in the report

Introduction

[Our growing older population](#)

- The population is ageing, which means we are living longer and there are more older people as a proportion of us all; between 2005/06 and 2014/15 the number of people aged 65 or over in England increased by almost a fifth and the number aged 85 and over rose by approaching a third.
- The increase in the older population is projected to accelerate over the next twenty years.

[Older age groups are more likely to have health conditions, many of which are preventable and most of which are manageable](#)

- Disability-free life expectancy is rising more slowly than life expectancy – the length of time we are likely to live - meaning that people are living for more years with disabilities.
- There are big inequalities both in terms of how long we are likely to live (life expectancy) and in how well people are likely to be in older age (disability-free life expectancy), mirroring broader social and economic trends.
- Most people aged 75 and over have one or more health conditions, but 50 per cent of them do not consider themselves to be living with a 'life limiting' long-term condition, meaning that even if they have one or more health conditions they do not feel it has a significant impact on their lives.
- 1 in 10 of people age 65 and over are 'frail', rising to one in four of those aged 85 and over.
- Most long-term conditions are more prevalent among older age groups; for example, the prevalence of diabetes rises steadily among men and women until their early eighties, peaking at 22 per cent for men and 17 per cent for women.
- The rate of falls also increases with age; women are more likely to fall than men and in 2014, among those aged 85 to 89 nearly a quarter of men and a third of women had a fall in the last five years. Many falls are preventable and were osteoporosis to be identified and treated better it is estimated that a quarter of all hip fractures could be avoided.
- The prevalence of dementia is very low (0.3 per cent) for both men and women aged 60-64 and only four per cent for 75 to 79 year olds, but then rises sharply to more than one in four among women aged 95 to 99, and to one in five for men of the same age.

Social care funding and services

Less and less funding for fewer people

- £1.95 billion has come out of social care budgets because of central Government cuts over the last 10 years, mostly over the last five years.
- Government budget allocations for 2015/16 suggest that social care budgets will reduce by a further £472 million, even after taking into account the transfer from the NHS for the Better Care Fund.
- In 2005/06 15.3 per cent of people aged 65 and over received support with social care. This dropped to 9.2 per cent in 2013/14.
- By 2020/21 it will cost an extra £600 million a year to provide social care at the 2013/14 level of eligibility, due to rising numbers of older people, assuming they have the same incidence of care needs as the current older population.
- It would have cost an extra £4.2 to 4.6 billion in 2020/21 for every older person with an unmet social care need to receive a social care service, and only a little less to provide a service for those with three or more currently unmet needs.

Increasing costs, and some savings

- It has been estimated that by 2020/21 the Government's proposed new Living Wage will cost the social care sector an extra £1 billion a year.
- The Government says it will save £6 billion by deciding not to implement the Dilnot cap on social care costs until at least 2020, if at all.

Public resources increasingly focused on those with the greatest needs

- Government spending on home care for older people reduced by a fifth between 2010/11 and 2013/14, with 15 per cent fewer older people getting support.
- State spending on meals on wheels has halved in the last three years and approaching two-thirds fewer older people now receive them.
- A similar pattern can be seen as regards day care (including day centres)
- State spending on aids and adaptations has increased by 7 per cent in the last three years, but fewer people are benefitting.
- There has been a slight fall in the numbers of older people with public support in nursing homes over this period and a more significant fall in the numbers of older people in care homes. However the reduction in community and home care services and recipients is much higher.

Unmet need is rising

- More than a million older people in England now have at least one unmet need for social care, compared to 800,000 in 2010; this means they receive no help from their local authority or from family, neighbours or friends.
- The risk of having an unmet care need is greatest for the oldest and those who live alone.
- Around half of those older people who have difficulty bathing or getting dressed without help, and around a third of those older people who have difficulty going to the toilet unaided, are receiving no support.

Pressure on unpaid carers, especially older carers

- The numbers caring informally for older people have fluctuated slightly in recent years, but in 2014 about one in six of the population were doing so, a third of them for more than 20 hours a week.
- Higher numbers of older people are unpaid carers compared to the population as a whole and their numbers are rising: as a result one in five people aged 65 and over was caring in 2014, a quarter of them effectively full-time (more than 50 hours a week).

Increased financial demands on service recipients

- In 2012/13 more than a quarter of those older people who were eligible for local authority funded residential care, or their families, had to make an extra payment towards it themselves (so called 'top up' fees).
- There is clear evidence of older people who pay for their own residential care subsidising the State, since in 2012/13 local authorities paid an average £492 in real terms for a care home place a week, compared to an overall average cost of £538.

The NHS funding and demand on services

Funding increases haven't kept pace with rising demands and costs

- It has been estimated by the Kings Fund that NHS spending has to increase by between 3 per cent and 6 per cent a year to keep pace with rising demand and the cost of new technology; in fact, in real terms, since 2010/11 NHS funding has increased by an average of 0.8 per cent a year.
- NHS England says that the NHS funding gap will reach £30 billion a year by 2021. The Government has pledged to increase NHS funding by £10 billion a year by 2020/21 but this leaves at least a £20 billion gap to be bridged through increased productivity and efficiencies. This is highly ambitious.

Disparities in funding between types of health services

- In 2012/13, spending on hospitals (in 2014/15 prices) was £45.78 billion, compared to £10.09 billion for community health services, £9.10 billion for mental health services and £8.14 billion for GP services.
- Between 2009/10 and 2012/13 spending on hospitals increased by £2.7 billion, on community health services by £1.3 billion, and on mental health services by £220 million.
- Between 2009/10 and 2012/13 spending on GP services fell by £0.31 billion to £8.14 billion before rising to £8.34 billion in 2014/15.
- Additional funding packages have recently been announced for mental health, primary care and community health. However the Royal College of General Practice has observed that this will not close the gap or meet growing demand.
- In 2013 the UK spent 9.3 per cent of its GDP on health, including both public and private funding. The amount spent per capita was \$3, 289. On both measures the UK comes towards the bottom of a chart of 9 European countries, with only Italy contributing a similar percentage of GDP and amount per capita.

Increased staffing mainly going to hospitals

- Between 2009/10 and 2013/14 the numbers of (full-time equivalent) hospital and community doctors increased by 10 per cent but over the same period the numbers of GPs increased by only 2.3 per cent
- Between 2009/10 and 2013/14 the numbers of (full-time equivalent) nurses rose by 2.5 per cent with most of the increase happening in the last two years.
- Most of the growth in the numbers of nurses has benefited hospitals, where the Francis Inquiry pinpointed insufficient nursing numbers as contributing to poor care. Between 2009/10 and 2013/14 the numbers of (full-time equivalent) nurses within NHS community services (excluding health visitors and children's nurses) reduced by eight per cent. The numbers of nurses in GP practices increased slightly (from 13,500 to 15,000).

Growing demands on GP practices

- Demand on GP practices has inexorably risen over a generation: between 1995 and 2008 the numbers of consultations with GP partners per year increased by more than a third.
- In 1995 a woman aged 85-89 had an average of seven GP consultations a year; by 2008 the number had risen to 13.34.

Growing demands on hospitals

- Between 2007/08 and 2013/14 the numbers of A&E attendances by people aged 60 or over rose by two thirds, a steeper increase than is explained by demographic change alone.
- Older people tend to spend longer in A&E than younger people because their needs are often more complex: in a study older people aged 75 or over spent an average of 213 minutes in A and E, compared to 149 minutes for people below this age.
- Between 2005/06 and 2012/13 emergency hospital admissions of people aged 65 or older rose by a fifth, which is more than the increase in the numbers of older people.
- Between 2005/06 and 2013/14 the numbers of finished consultant episodes of care older people aged 60 and over received increased by 40 per cent.
- Between 2005/06 and 2013/14 the numbers of outpatient appointments for older people aged 60 and above increased by more than two thirds, a steeper increase than is explained by the rising numbers of older people in the population.

Stress in the system

Concerns about quality

- There is a growing body of qualitative research suggesting a health and care workforce under stress and with concerns about the quality of care they are sometimes able to offer.
- Between 2005/06 and 2010/11 emergency hospital re-admissions of people aged 75 or older increased by a quarter.

Increased waits for appropriate care outside hospitals

- Between 2011/12 and 2014/15 the annual numbers of delayed discharges for acute patients in hospitals increased by 40 per cent.

- In 2014/15, the main reasons for discharges being delayed were as follows, with the most prevalent first: waiting for further, non acute NHS care to be put into place; waits for completion of health and care assessments; patients' or family choice; care packages at home, nursing home placements and residential care placements.
- Between 2013/14 and 2014/15 delays due to social care increased by 15.5 per cent.
- The sharpest increases in reasons for delay between 2011/12 and 2014/15 were: waiting for a nursing home; waiting for care packages in the patient's own home; and further NHS non-acute care.

Rising admissions that might have been avoidable with appropriate care

- Ambulatory care sensitive conditions are a set of conditions for which effective treatment and management should limit the need for hospital treatment; in 2013 they accounted for an estimated 1 in 5 emergency hospital admissions:
- Between 2005/06 and 2013/14 the numbers of hospital admissions per 100,000 people aged 60 and over for pneumonia more than doubled; for suspected urinary tract infections they rose by 81 per cent, for congestive heart failure they rose by 43 per cent and for gastroenteritis they rose by a third. For chronic obstructive pulmonary disease (COPD) the rate of admissions fluctuated slightly, but still accounted for 24 per cent of all ACSC admissions relating to a long-term condition (i.e. non-acute).

Conclusion

The summary above is based on more than forty charts and graphs in the full report, and many more facts and figures contained within the text: what is the story that they collectively tell?

Really it is quite a simple one, because essentially all the data point in the same direction. The numbers of older people in England are steadily growing, and the proportion with long term conditions is growing faster still, but investment in health care overall is failing to keep pace with the impact of demographic change and other factors driving higher demand, and spending on social care has fallen quite spectacularly over the last five years.

Some areas of provision have done better than others, but on the whole it is the primary and community based services on which many older people depend in order to sustain their independence which have seen the sharpest falls or where supply is most obviously failing to meet rising demand. So, for example, GP numbers are not keeping up with a growing older population and meals on wheels provision, once a mainstay of community care, is rapidly falling away.

Our health and care system is designed so that social care and NHS provision butt up against each other and interact in many different ways to help keep older people fit and well, but there are increasing examples of how starving social care of resources is seriously undermining the operation of the NHS – our hospitals especially. This can be seen, for example, in the rapidly worsening figures for delayed discharges and emergency readmissions to hospital.

This is partly happening because as the needs of older people exceed the system's capacity to respond, decisions are often being made to focus what is available on those in greatest need.

This is a rational response by managers, but it inevitably harms our overall capacity to intervene early to prevent small problems older people have from becoming bigger ones, thus storing up difficulties for the future. In addition, it condemns hospitals to 'run hot' for increasing periods of time as the only place where the lights are always on. This places a lot of stress on professionals, which in turn risks making it harder to recruit and retain staff, thus placing more of a burden on those who remain - a destructive vicious circle.

There is a deeply interesting and constructive policy conversation underway nationally at the moment about how to make the best use of NHS and social care resources to meet the needs of our growing older population, with ideas to do with devolution, integration and personalisation very much to the fore. There are also some exciting examples of innovative practice to be seen in some local areas which, if scaled up, could make a considerable difference to the health and wellbeing of millions of older people, with some of which Age UK is heavily involved.

But in the end, one is forced back to the hard facts and figures presented in this briefing. There is a lot of ingenuity and commitment within our health and care system but even so, it is hard to see it being a match for the consequences of a steadily rising older population, combined with health spending failing to keep pace and social care spending significantly declining.

In the introduction to this briefing we referred to the importance older people attach to their health and the crucial role the NHS and social care play in helping them to keep going and be resilient as they age. Unless there is significant change to the funding of our health and care system for older people as a result of decisions taken in the Government's Spending Review, we look to the future with considerable foreboding.

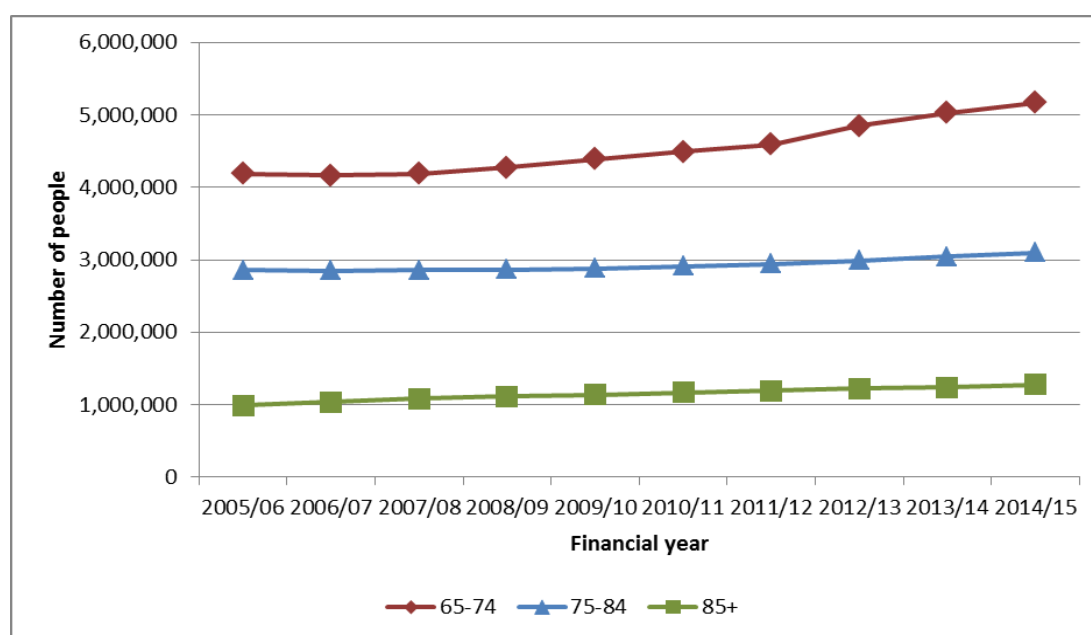
Indeed, on the basis of the trends presented in this briefing, if an older person asked us today how confident we were that their health and care needs will be met well in the future we would be whistling in the dark if we gave a wholly reassuring answer. That is something about which we should all be profoundly concerned and which the Government must change.

1. The health and care needs of our ageing population

1.1 Our growing older population

It hardly needs stating that our older population is growing rapidly. Between 2005 and 2014 the number of people aged 65 or over in England increased by 18.8 per cent, or by more than 1.5 million people. Moreover, the greatest growth in percentage terms has been amongst those aged 85 and over - this age group increased by 29.3 per cent (or 289,000 people) over that period.

Figure 1: Number of people aged 65 or over in England by age group, 2005/06¹ to 2014/15

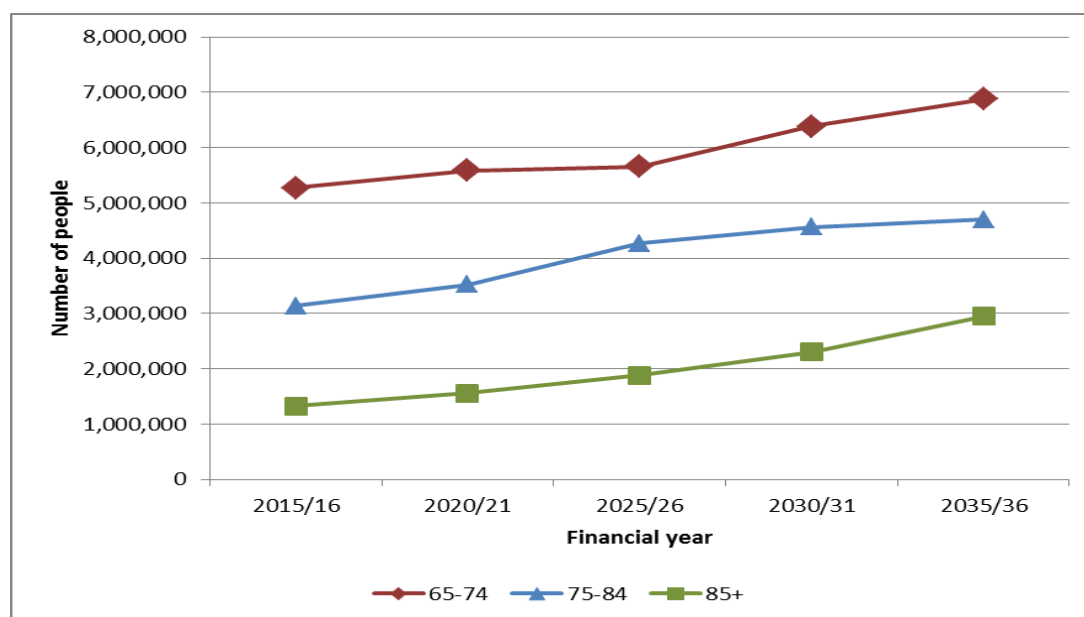


Source: Office for National Statistics (2015¹, 2015a², 2013³)

Furthermore, the pace of population ageing is set to increase in coming decades. Over the 20 years between 2015 and 2035 the 65+ population is estimated to grow by 49.2 per cent, or more than 4.7 million people. Once again, those aged 85+ will be the fastest growing group. The number of people aged 85 and over is projected to increase by 122.4 per cent from 1.3 million to 2.9 million.

¹ Throughout the report, the first mid-year population estimate for that financial year is used. For example the 2005/06 financial year describes mid-2005 population estimates.

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

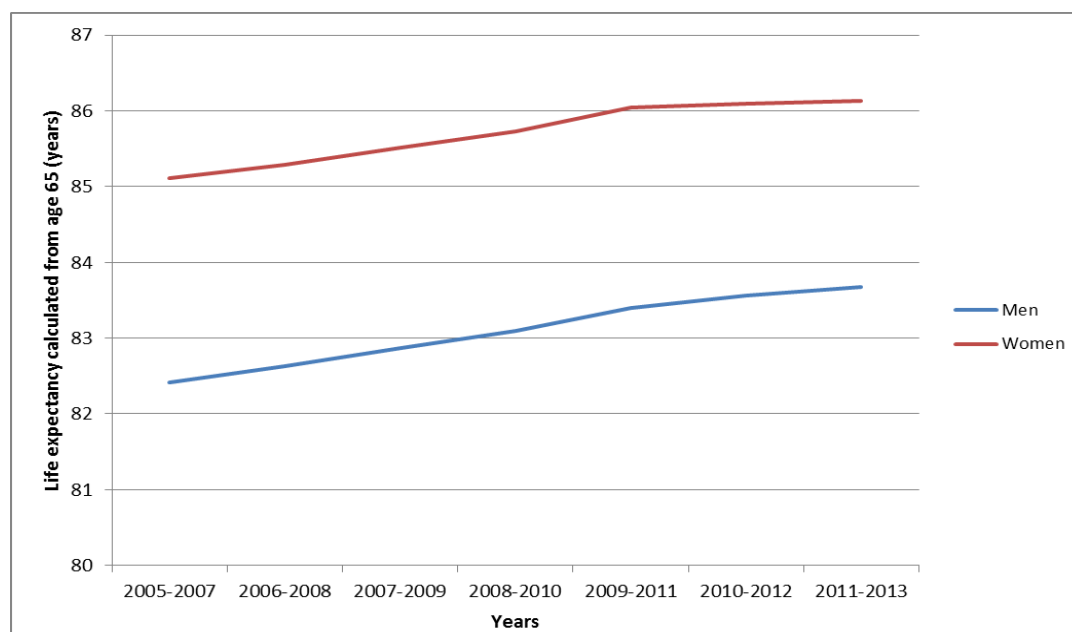


Source: Office for National Statistics (2013a⁴)

1.2 Life expectancy and disability free life expectancy (DFLE)

Over recent decades we have seen a slow but steady increase in life expectancy. Today a woman aged 65 can expect to live another 21.1 years, while a man can expect another 18.7 years. However increases in life expectancy for both sexes have slowed since 2009-11.

Figure 3: Life expectancy at age 65 for men and women in England (expressed in total number of years), 2005-07 to 2011-13



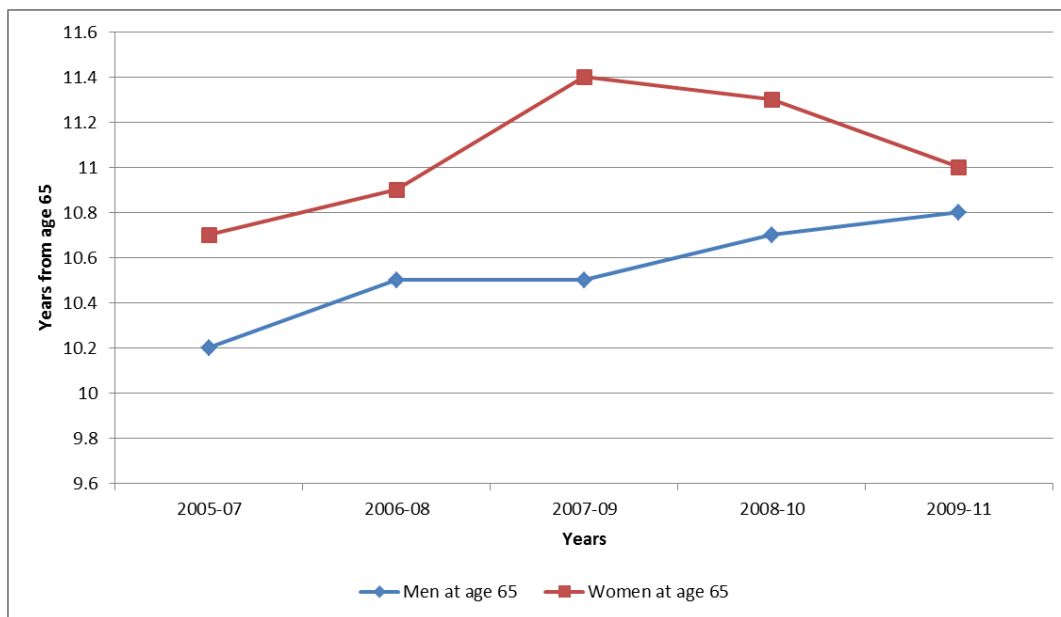
Source: Office for National Statistics (2014⁵)

Disability-free life expectancy (DFLE) at age 65 has also risen in recent decades, increasing by 0.3 years for women and 0.6 years for men overall between 2005-07 and 2009-11. By

2009-11 both men and women could expect to live approximately another 11 years in good health after the age of 65.

However overall life expectancy has risen further and faster than disability-free expectancy, meaning more of us are living into older age with multiple long-term conditions, frailty, dementia and social care needs. For men life expectancy at age 65 increased by 0.99 years between 2005-07 and 2009-11 yet over the same period DFLE only rose by 0.6 years. Similarly, for women life expectancy at age 65 rose by 0.94 years while DFLE increased by just 0.3 years. It is also concerning that DFLE for women peaked at 11.4 years in 2007-09, before falling back to 11 years by 2009-11.

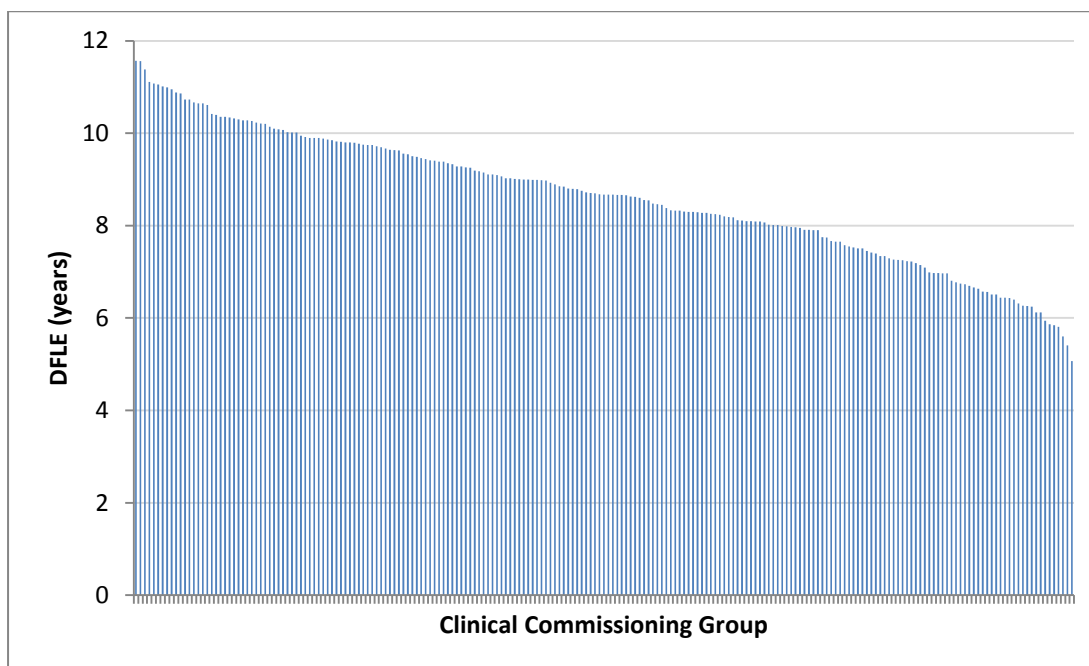
Figure 4: The average number of years that people live free of disability at age 65 in England, 2005-07 to 2009-11



Source: Office for National Statistics (2014a⁶)

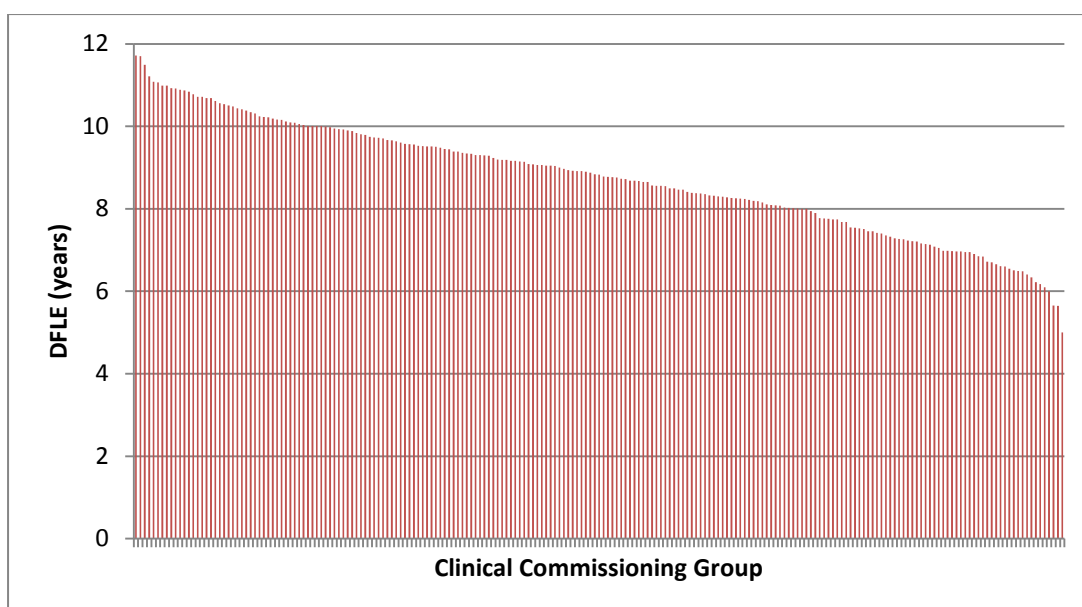
It is also important to note that there is huge inequality within the population. As **figures 5 and 6** illustrate, there is a wide gulf in DFLE at age 65 between the 211 different clinical commissioning group (CCG) areas. In the CCG areas with the lowest DFLE, men can expect 5.1 years in good health at age 65 and women just five years. In comparison, in CCG areas with the highest DFLE men can expect 11.6 years of good health and women 11.7.

Figure 5: Disability-free life expectancy (DFLE) at age 65 by Clinical Commissioning Group in England, 2010-2012, men



Source: Office for National Statistics (2014b⁷)

Figure 6: Disability-free life expectancy (DFLE) at age 65 by Clinical Commissioning Group in England, 2010-2012, women



Source: Office for National Statistics (2014b⁸)

1.3 Health and care needs amongst older people

Although in aggregate a growing older population will lead to great demand for health and care services, it is important to recognise that old age does not automatically mean poor health. The good news is that the onset of age related conditions and disabilities can be prevented or delayed, or the impact on people's lives significantly lessened, even in later life.

As shown in **figures 5 and 6** above, there are huge disparities in life expectancy and disability free life expectancy in different parts of England, strongly linked to levels of socio-economic deprivation. The gap in DFLE between CCG areas means men in the healthiest areas can expect an extra 6.5 years in good health and women an extra 6.7 years, compared to the least healthy areas.

Unfortunately unless we start to see real progress in improving disability-free life expectancy, the numbers of older people living with long-term conditions and disabilities is going to increase significantly over the next 20 years as our older population grows.

Equally, acquiring a health condition does not necessarily mean high levels of dependency on health and care services. Most people aged 75 and over have one or more health conditions, but almost 50 per cent of them do not consider themselves to be living with a 'life limiting' long-term condition⁹, meaning that even if they have one or more health conditions this is not perceived to have a significant impact on their lives.

Where older people do need support, the quality of support they receive and how well they are able to adapt is a crucial factor in their long-term prospects for living well and maintaining independence. Lack of appropriate treatment and support can have very serious consequences for the health of older people; particularly for individuals with multiple long-term conditions and/or frailty who are most in need of joined up, responsive health and care services.

Frailty is a distinctive health state relating to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10 per cent of people aged 65 and over are frail, rising to between 25 and 50 per cent of those aged 85 and over¹⁰. Older people living with frailty are at risk of adverse health events, such as a fall or infection, and will often experience dramatic changes in their physical and mental well-being even after an apparently minor incident.

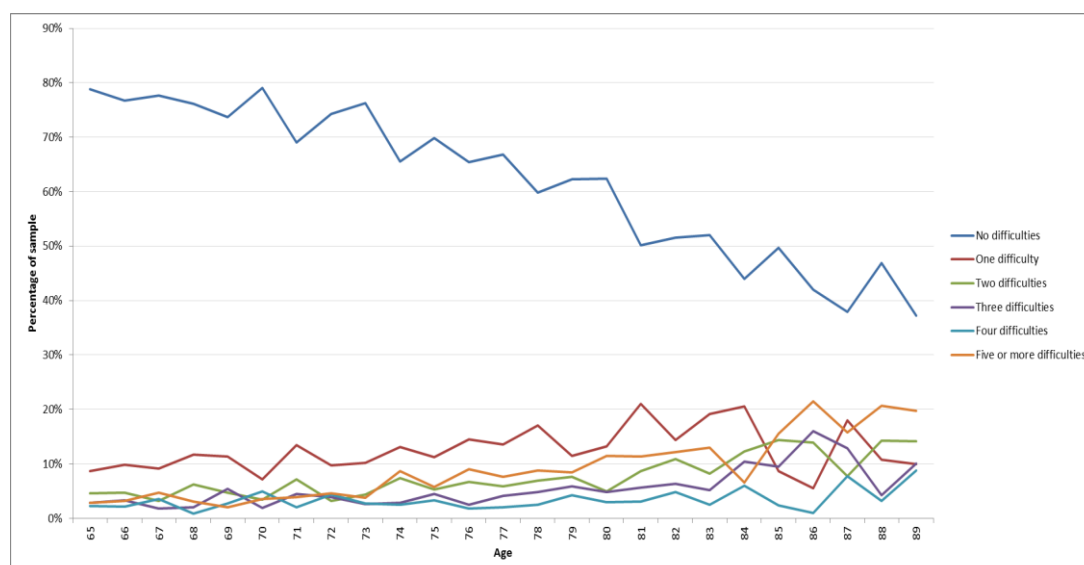
Good management and support mean many health conditions and disabilities can be effectively managed without getting worse or leading to a major health event requiring acute care. However reducing demand for more intensive or high cost services will require appropriate provision of services that support well-being and independence.

Difficulties with activities of daily living, multiple health conditions and care needs

The proportion of people who have difficulties with activities of daily living^{2,11,12} increases with age. The percentage of people with at least one difficulty increases from 21.2 per cent at age 65 to more than half aged over 85¹³. By people's late 80s (85+) around one in five people in their late 80s have difficulties undertaking five or more activities of daily living.

² An 'activity of daily living' is defined as a basic task of everyday life. These are split into *instrumental* which are less fundamental to functioning such as doing housework, taking medication and preparing meals and *basic* activities of daily living which include more fundamental tasks such as eating, toileting and washing.

Figure 7: Number of difficulties with activities of daily living by age, England, 2012/13



Source: English Longitudinal Study of Ageing (2014¹⁴)

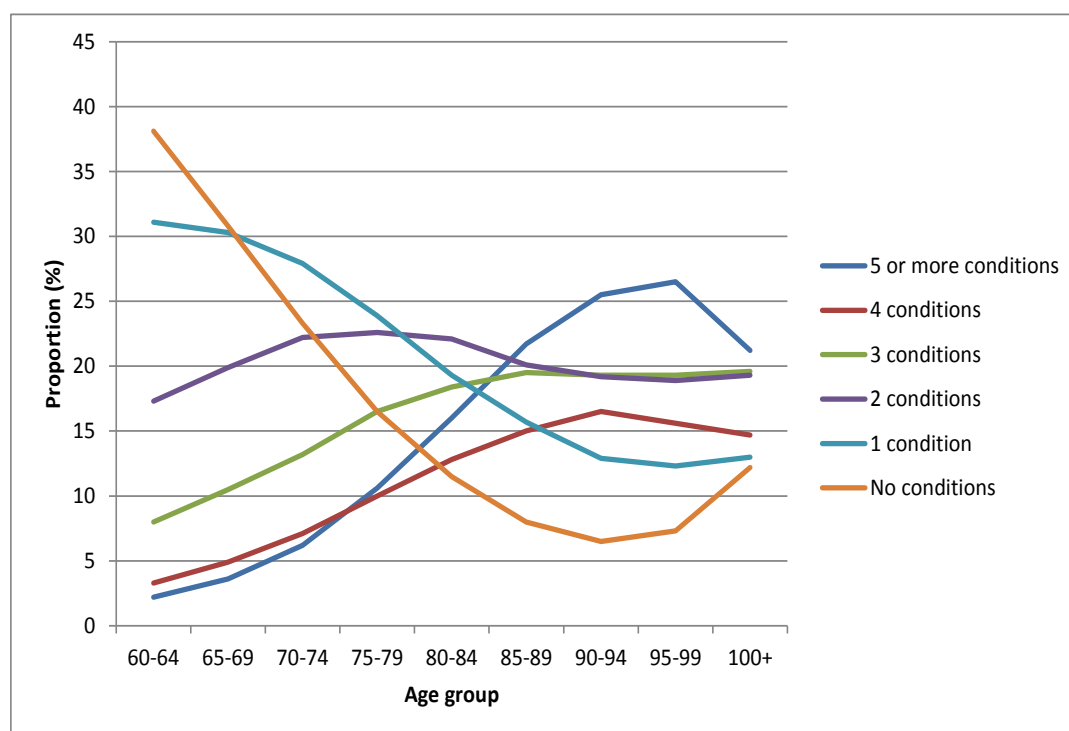
The prevalence of common long-term and chronic health conditions^{3,15} also increases significantly with age. For example, prevalence of heart disease, hypertension, stroke, diabetes and cancer all rise rapidly after the age of 60. Furthermore, although recent research suggests dementia prevalence and incidence rates are not increasing as quickly as previously predicted, and some evidence states that these are falling¹⁶, the absolute numbers of people with dementia will nonetheless increase as the older population continues to grow.

As **figure 8** below shows, the prevalence of health conditions increases with age. While having a long-term health condition does not necessarily impact upon people's quality of life, the more conditions someone has the more likely they are to need joined up health and social care. Specifically the prevalence for different age groups is:

- 38.1 per cent of people aged 60 to 64 do not have a diagnosed long-term condition, however this falls to just 6.5 per cent of people in the 90 to 94 age group.
- Amongst 60 to 64 year olds, 31.1 per cent have one condition; 17.3 per cent have two; 8 per cent have three; 3.3 per cent have four, and 2.2 per cent have five or more.
- By the 90 to 94 age group it becomes most common for people to have five conditions (25.5 per cent), three conditions (19.3 per cent), or two conditions (19.2 per cent). In total 80.5 per cent of 90 to 94 year olds have two or more conditions.

³ The Department of Health define a long-term condition as one that cannot at present be cured but can be controlled by medication and other therapies.

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



Source: Age UK and University of Exeter Medical School (2015¹⁷)

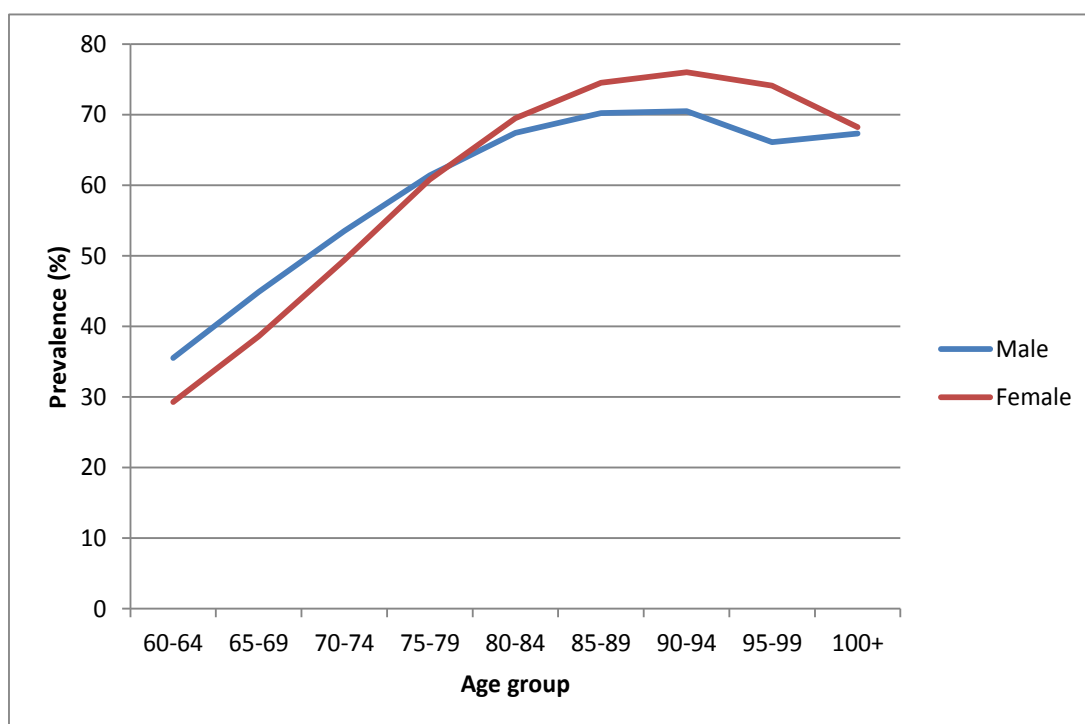
Prevalence of common age-related health conditions

The following section presents the prevalence of long-term health conditions by age. In the majority of cases, the prevalence of conditions decreases amongst nonagenarians and centenarians¹⁸ as individuals in these subgroups are more likely to have survived, delayed or escaped onset¹⁹.

Hypertension

The development of hypertension (high blood pressure) is strongly associated with age. If unmanaged, it can contribute to the risk of strokes and heart attacks as well as other cardiovascular conditions. Prevalence rates are very high for both sexes after the age of 80, with hypertension being the norm in people aged 80 and over (prevalence between 67.4 and 76 per cent).

Figure 9: Prevalence of hypertension amongst males and females in England, 2014

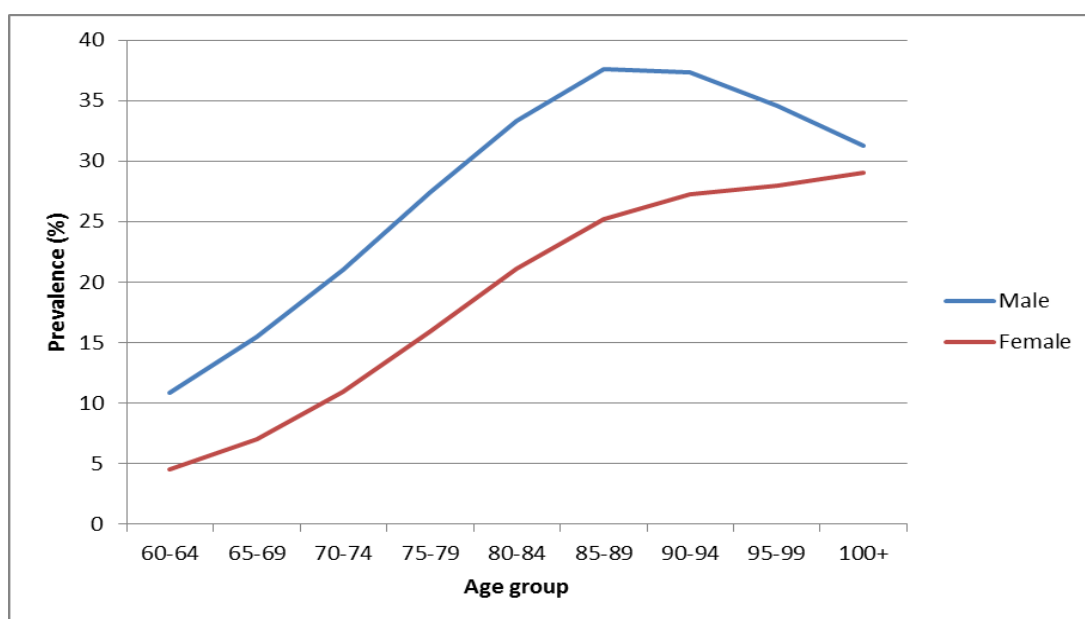


Source: Age UK and University of Exeter Medical School (2015²⁰)

Coronary heart disease

Coronary heart disease is frequently the precursor to a heart attack, although much can be done to improve quality of life and health outcomes through better management of lifestyle factors as well as medical treatments. Prevalence rates are higher in men than women across all ages groups aged 60 and over, but increase steadily for both sexes up to people's late 80s.

Figure 10: Prevalence of coronary heart disease amongst males and females in England, 2014



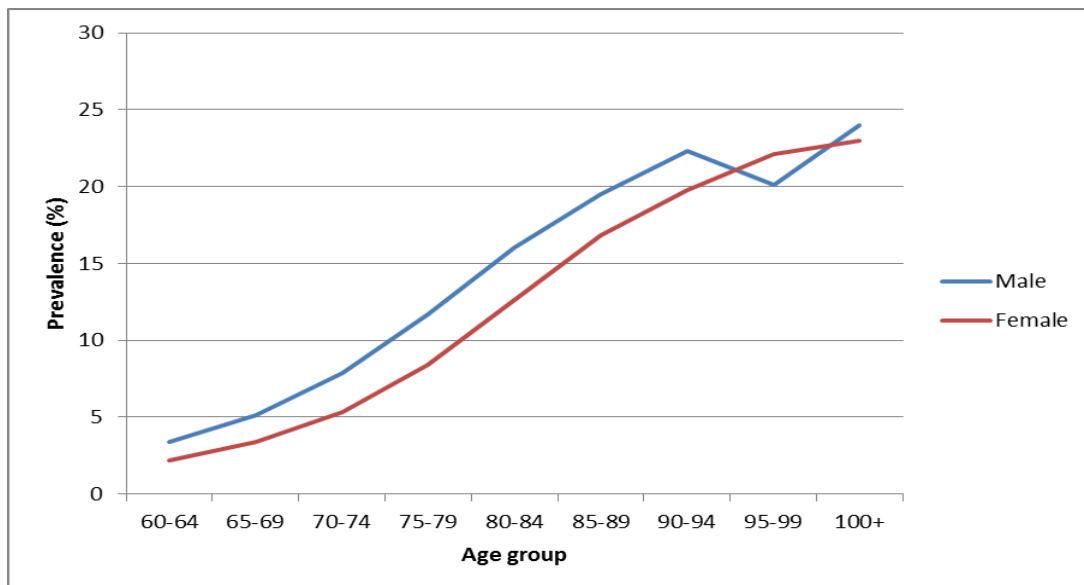
Source: Age UK and University of Exeter Medical School (2015²¹)

Stroke and transient ischaemic attack (TIA)

It is estimated that 80 per cent of strokes could be prevented²² through improvements in lifestyle and measures to prevent second and subsequent strokes.

The incidence of stroke and TIA is in general higher for men across all older ages. 3.4 per cent of men aged 60 to 64 have experienced a stroke, rising to 19.5 per cent of men aged 85 to 89. Amongst women, 2.2 per cent aged 60 to 64 have experienced a stroke rising to 16.8 per cent by ages 85 to 89.

Figure 11: Prevalence⁴ of stroke and transient ischaemic attack amongst males and females in England, 2014



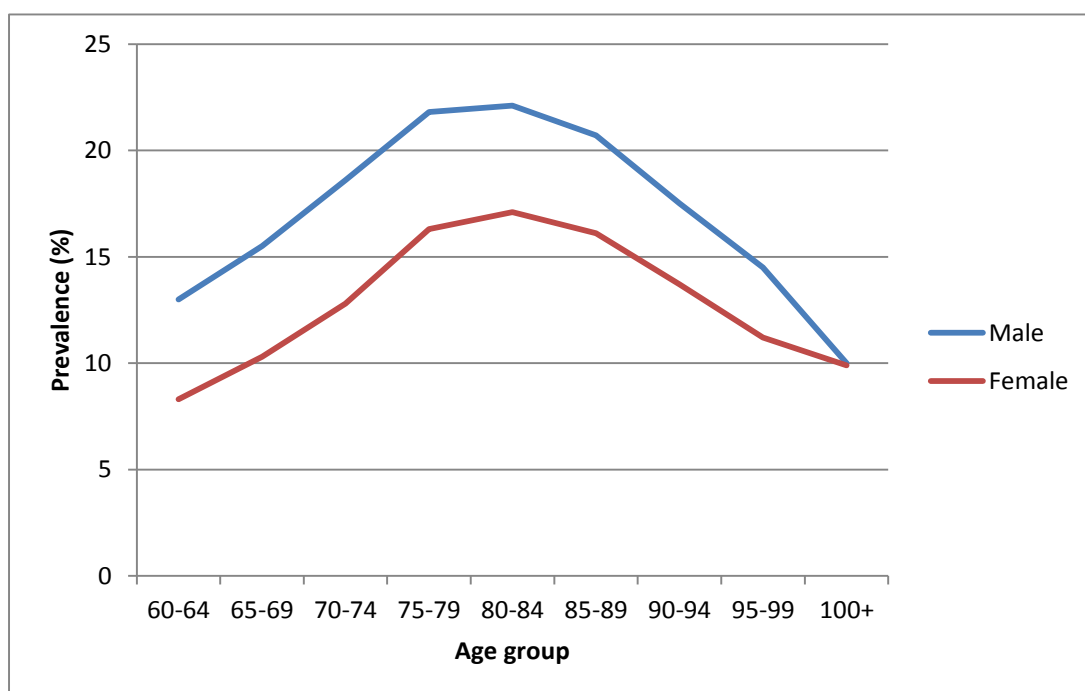
Source: Age UK and University of Exeter Medical School (2015²³)

Diabetes

One in four of the UK adult population is at high risk of type 2 diabetes, but up to 80 per cent of cases could be delayed or prevented²⁴. The prevalence of diabetes rises steadily for both men and women from the age of 60 until they are in their early eighties, peaking at 22.3 per cent amongst men and 17.2 per cent amongst women. It is also higher for men rather than women across all age groups.

⁴ The word “prevalence” refers here to the proportion of people who have experienced one or more strokes or TIAs.

Figure 12: Prevalence of diabetes amongst males and females in England, 2014

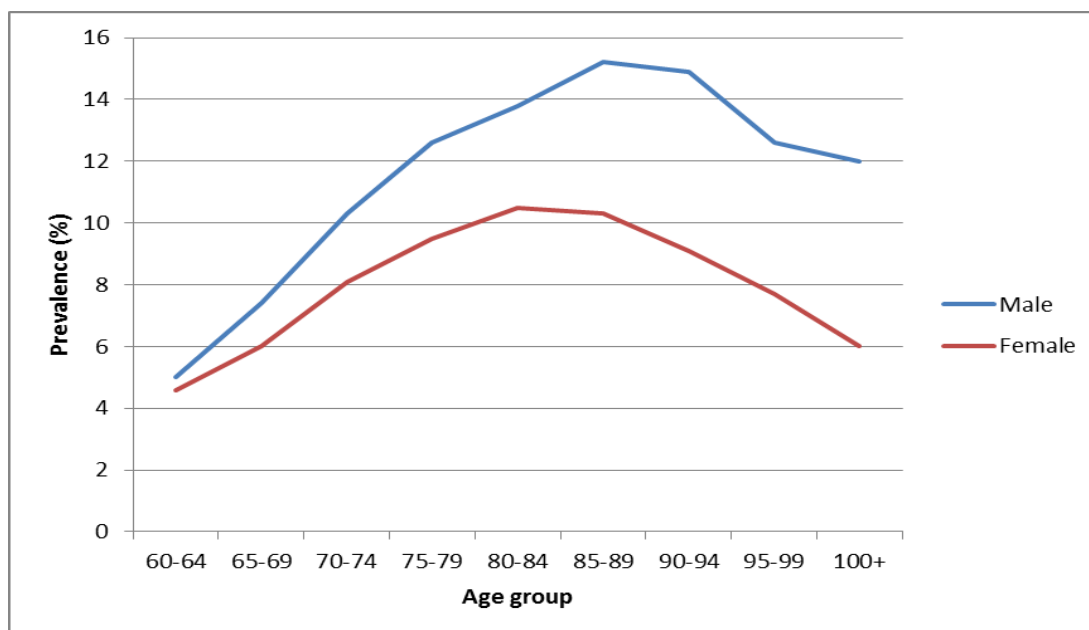


Source: Age UK and University of Exeter Medical School (2015²⁵)

Chronic obstructive pulmonary disease (COPD)

Many cases of chronic obstructive pulmonary disease are attributable to smoking. For people who have the condition there are a number of ways in which people can be supported to manage their condition well at home and reducing avoidable emergency hospital admissions. The prevalence of COPD rises steadily from age 60 to 64 to the mid-80s for both men and women. However overall prevalence rates are significantly higher for men, with 15.2 per cent of men aged 85 to 89 living with the condition.

Figure 13: Prevalence rates of COPD amongst males and females in England, 2014



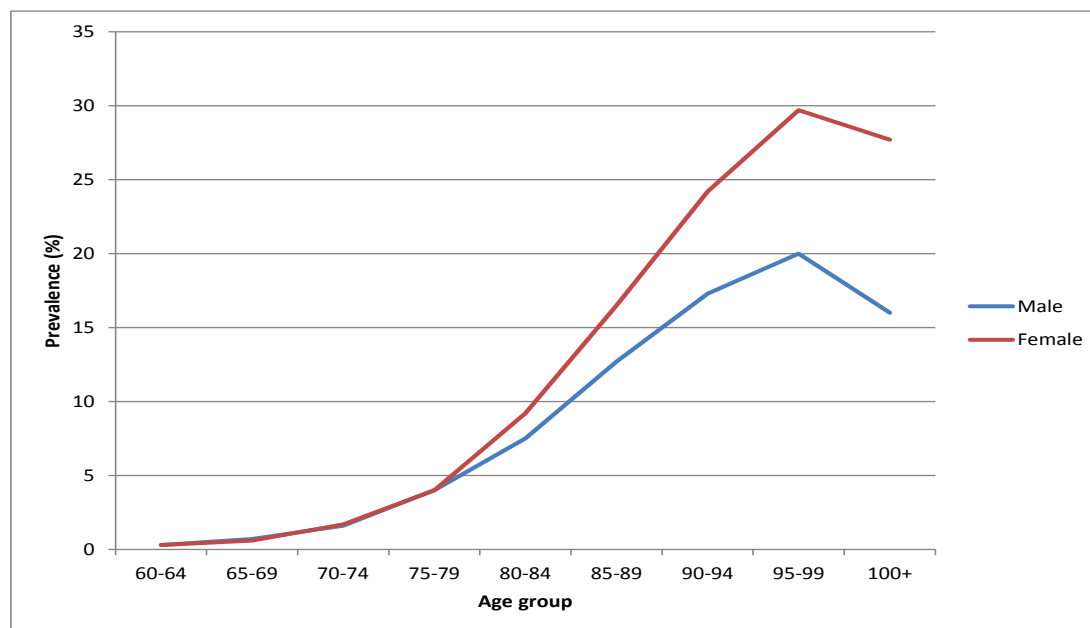
Source: Age UK and University of Exeter Medical School (2015²⁶)

Dementia

Dementia has a very strong link with ageing, although those who have dementia are a minority in all age groups. There is also a growing body of evidence that the risk of dementia can be reduced through tackling modifiable lifestyle and health factors²⁷.

The prevalence of diagnosed dementia is very low (0.3 per cent) for both men and women aged 60 to 64 and then rises slowly to four per cent for 75 to 79 year olds of both sexes. However, for women, prevalence then rises quite steeply to 29.7 per cent of 95 to 99 year olds. For men the rise is less steep, peaking at 20 per cent for 95 to 99 year olds.

Figure 14: Prevalence of dementia amongst males and females in England, 2014



Source: Age UK and University of Exeter Medical School (2015²⁸)

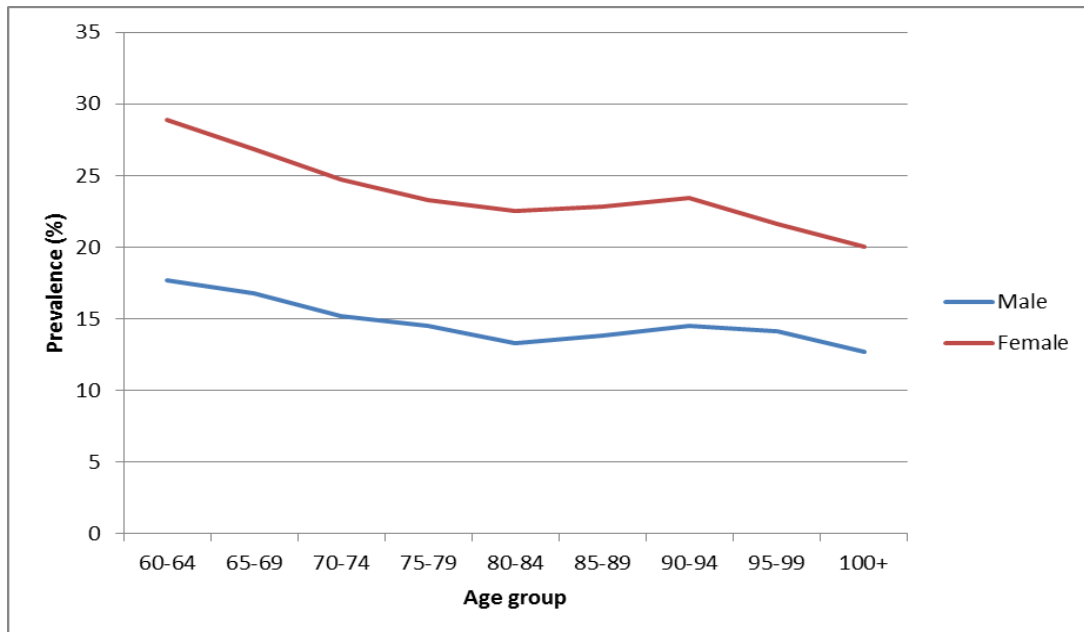
Depression and anxiety

Depression and low level mental health conditions are frequently under-recognised and under-diagnosed amongst older people. Therefore although the diagnosed rates of depression below in **figure 14** suggest incidence peaks amongst 65-74 year olds, in the GP patient survey self-reported rates of depression and anxiety on the day of the survey showed a different pattern.

In the GP patient survey 2014²⁹, respondents were asked to select one of a range of statements describing anxiety and depression on the day of the survey. There are five categories ranging from 'I am not anxious or depressed' to 'I am extremely anxious or depressed'. On this measure, anxiety and depression increased with age. 9 per cent of 65 to 74 years olds were moderately, severely or extremely anxious, rising to 10 per cent of 75 to 84 year olds and 17 per cent of those aged 85+.

In 2009 the Royal College of Psychiatrists estimated that 85% of older people with depression receive no help at all from the NHS³⁰.

Figure 14: Prevalence rates of depression amongst males and females in England, 2014



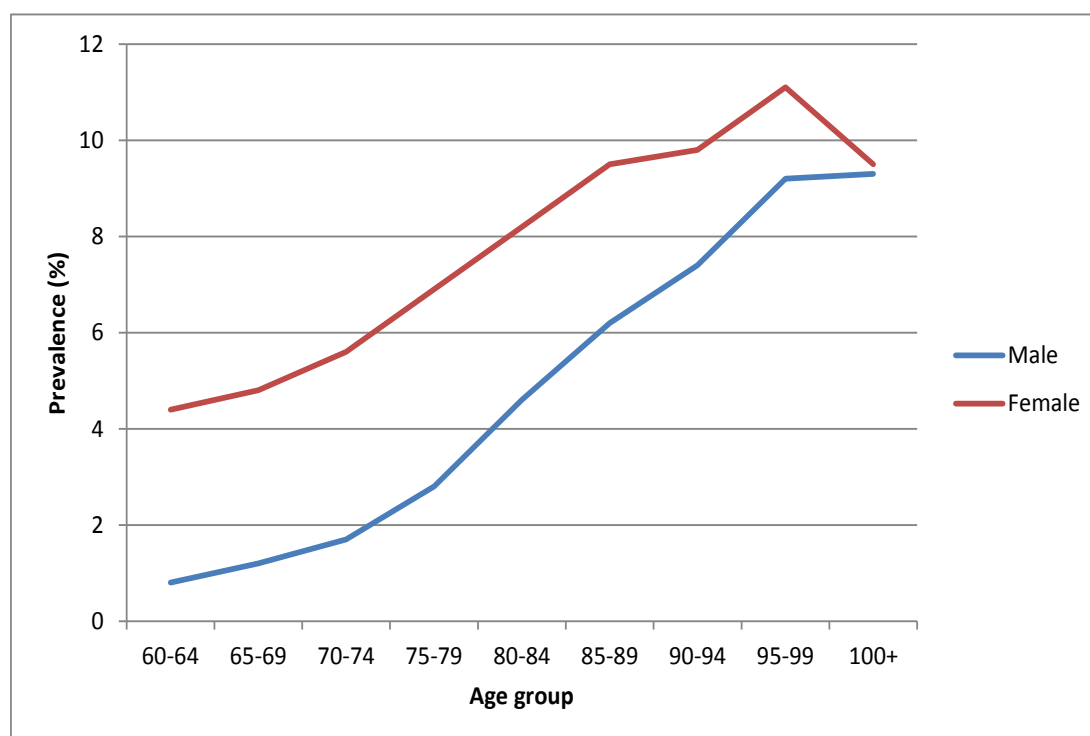
Source: Age UK and University of Exeter Medical School (2015³¹)

Incontinence

Incontinence disrupts the daily lives of millions of older people. Poor management of incontinence is associated with serious complications such as falls and fractures, anxiety and depression and pressure ulcers. We also know that incontinence is second only to dementia as a precipitating factor in care home admissions and affects nearly two in three residents in nursing homes³².

The prevalence of incontinence is very low amongst people in their 60s and early 70s although higher for females. Rates rise steeply with age, with 1 in 10 females and almost in 1 in 10 males experiencing incontinence amongst older age groups (95+).

Figure 15: Prevalence of incontinence amongst males and females in England, 2014



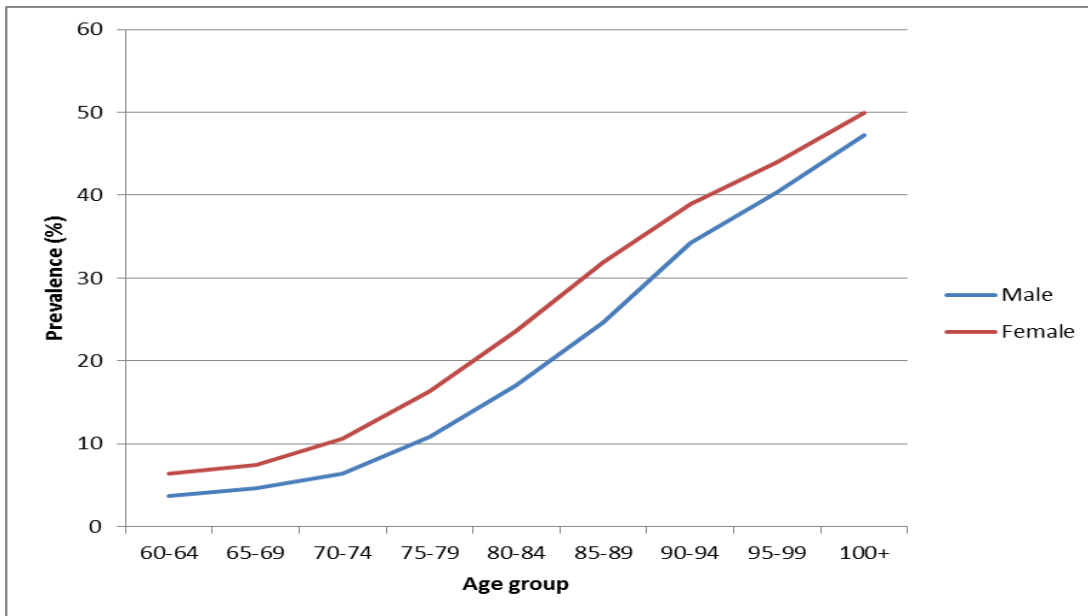
Source: Age UK and University of Exeter Medical School (2015³³)

Falls (in last five years)

Many falls are preventable through risk assessments of home environments and through fall and walking clinics to improve postural stability. The consequences of falls are compounded by osteoporosis. Indeed, were osteoporosis to be identified and treated more consistently the Falls and Fractures Alliance estimate 25 per cent of hip fractures (around 20,000 a year) could be prevented. They also estimate that, within the UK, hip fractures account for 85,000 unplanned hospital admissions, 1.8 million bed days and cost approximately £1.9 billion a year in hospital treatment³⁴. The impact of a fall when an older person is also living with frailty can be even more serious.

The rate of falls increases with age. Women are more likely to fall than men, with 6.4 per cent of women and 3.7 per cent of men in the 60 to 64 age group having had falls in the last five years. Amongst the 85 to 89 year old age group, 24.7 per cent of males and 31.9 per cent of females experienced a fall.

Figure 16: Prevalence of falls in last five years amongst males and females in England, 2014



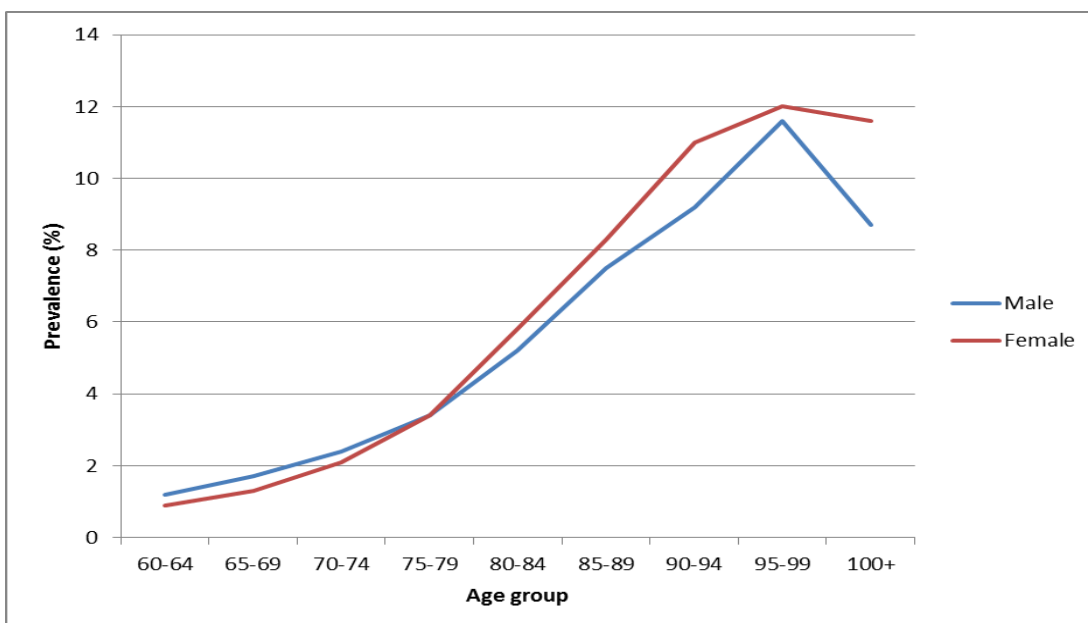
Source: Age UK and University of Exeter Medical School (2015³⁵)

Pressure sores

Pressure sores are wounds caused by continuous and/or heavy pressure to one area of the body, often exacerbated by a lack of mobility, through sitting or being in bed for long periods. Older people’s skin becomes more fragile and thus more susceptible to pressure sores. Pressure sores can often be prevented or mitigated through support and encouragement to move regularly and/or the provision of appropriate mobility aids.

The prevalence rates of pressure sores increase steadily as people age, peaking amongst people aged 95 to 99 at 12 per cent for women and 11.6 per cent for men.

Figure 17: Prevalence of pressure sores amongst males and females in England, 2014



Source: Age UK and University of Exeter Medical School (2015³⁶)

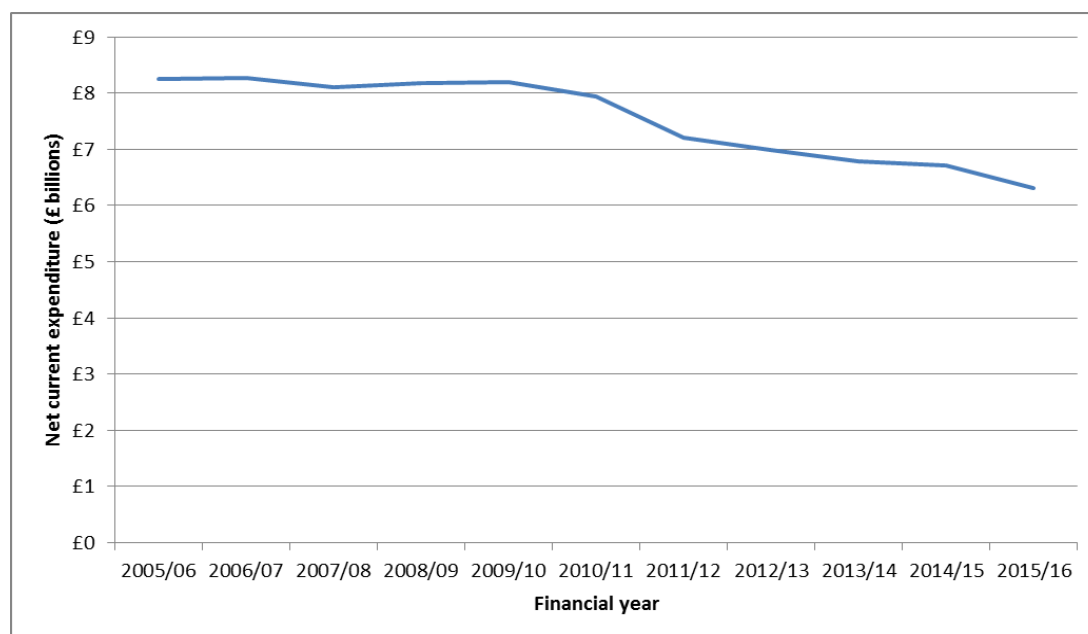
2. The state of social care

2.1 Trends in publicly funded social care services

Public spending⁵ on older people's social care has fallen significantly over the past decade. It decreased slightly between 2005/06 and 2009/10 before falling dramatically from 2010/11.

In 2005/06 local authorities were spending a total of £8.26 billion in real terms on older people's care services, however the latest local authority revenue accounts reveal that the budget for older people's social care has fallen to just £6.31 billion in 2015/16. This represents a decrease in real terms of £1.95 billion in just 10 years. Much of that reduction has been concentrated in the last five years: social care budgets declined by £1.2 billion between 2010/11 and 2013/14, and budget projections for 2015/16 show a further reduction of over £472 million⁶.

Figure 18: Net current expenditure on older people's social care, England, 2005/06 – 2015/16⁷ (in 2014/15 prices)



Source: Health and Social Care Information Centre (2014³⁷) and Department for Communities and Local Government (2014³⁸, 2015³⁹)

⁵ All spending figures throughout the report are expressed in 2014/15 prices using a GDP deflator (HM Treasury) -

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/444238/GDP_Deflators_July_Budget_2015_update.xls.

⁶ Prior to 2014/15 revenue expenditure and financing data, a large part of the budget used to be disaggregated into two components: spend for younger adults (18 to 64) and spend for people aged 65 and over. Since 2014/15 this is no longer the case. Therefore for this part of the budget in 2014/15 and 2015/16 we have used the balance of spending between younger adults (18 to 64) and older adults in the personal social services expenditure and unit cost data to apportion the amounts that are likely to be spent on older people. In 2015/16 this entailed apportioning £1.4 billion to older people's services as 44.8 per cent of £3.1 billion.

⁷ The figures for social care expenditure from 2005/06 to 2013/14 are final figures reporting actual spend as reported by HSCIC. The amounts for 2014/15 and 2015/16 are based upon DCLG allocations, pre-spend.

We assume that income from the NHS (including transfers from the NHS in 2014/15 and the portion of the Better Care Fund that will be available for social care services) is included in the DCLG figures cited above because it was included in the years up to 2013/14. The latest detailed outturn **expenditure** data for older people’s social care is available through the Health and Social Care Information Centre for 2013/14. It includes income from the NHS and other sources. The amount (£6.68 billion of spend) is consistent with the amount allocated for the same time period by the DCLG (£6.61 billion)⁸.

Funding to 2020/21

Pressure on social care budgets is set to increase significantly in the coming years.

As set out below in *table 1*, maintaining the current, wholly inadequate, level of service provision in the context of demographic change will increase the cost of care from £6.3 billion in 2015/16 to £6.9 billion by 2020/21 in today’s prices, an additional £600 million. Furthermore this is a very conservative estimate that assumes a constant health profile of the older population. As the numbers of people in the oldest age groups (85+) are increasing the most rapidly, the reality is that the growth in demand is likely to outpace increases in the older population as a whole.

Table 1 also sets out the funding required to deliver an improved system with estimates for providing care for people with one or more, two or more and three or more unmet needs. An additional £4.2 billion would ensure that all who currently have one or more unmet needs, and meet the financial eligibility criteria, have access to social care in 2015/16. An additional £4.6 billion would be required to fund this in 2020/21.

As **table 1** demonstrates, increasing funding to meet the needs of people living with 1 or more social care needs is only marginally more expensive than meeting the needs of people with 3 or more needs. Supporting people at lower levels of need could also have a major impact on helping people retain their independence and reduce demand for healthcare services.

Table 1: Funding required to maintain the current social care system and to provide an improved system in 2015/16 and in 2020/21

Year	Funding to maintain current level of service	Funding for an improved system (1+ unmet care needs)	Funding for an improved system (2+ unmet care needs)	Funding for an improved system (3+ unmet care needs)
2015/16	£6.31 billion	£10.50 billion (+£4.2 billion)	£10.18 billion (+£3.9 billion)	£10.10 billion (+£3.8 billion)
2020/21	£6.91 billion	£11.51 billion (+£4.6 billion)	£11.16 billion (+£4.2 billion)	£11.07 billion (+£4.2 billion)

Source: Age UK analysis (2015⁴⁰)

⁸ Specifically the 2013/14 net expenditure figure was £6,684,499,000^[i] (nominal price) and the corresponding proposed net expenditure figure in the 2013/14 revenue account budget from DCLG was £6,606,481,000^[ii] (nominal price).

In addition to adopting a conservative perspective on demand growth, our calculations also do not take into account wider pressures on the social care system that may have a significant impact on future funding.

The current state of the care market is of huge concern. We know from media reports and our own networks that an alarming number of domiciliary and residential care providers are failing or considering leaving the business. While we support the National Living Wage and see it as an essential long-term part of improving the quality and sustainability of the care system, it could add considerable costs to adult social care. For example, the United Kingdom Home Care Association estimates it could cost an additional £753 million in the first year of implementation alone⁴¹ and a consortium of care home providers estimate the living wage will add costs of an additional £1 billion by 2020/21⁴².

Savings through deferring the implementation of the cap on care costs

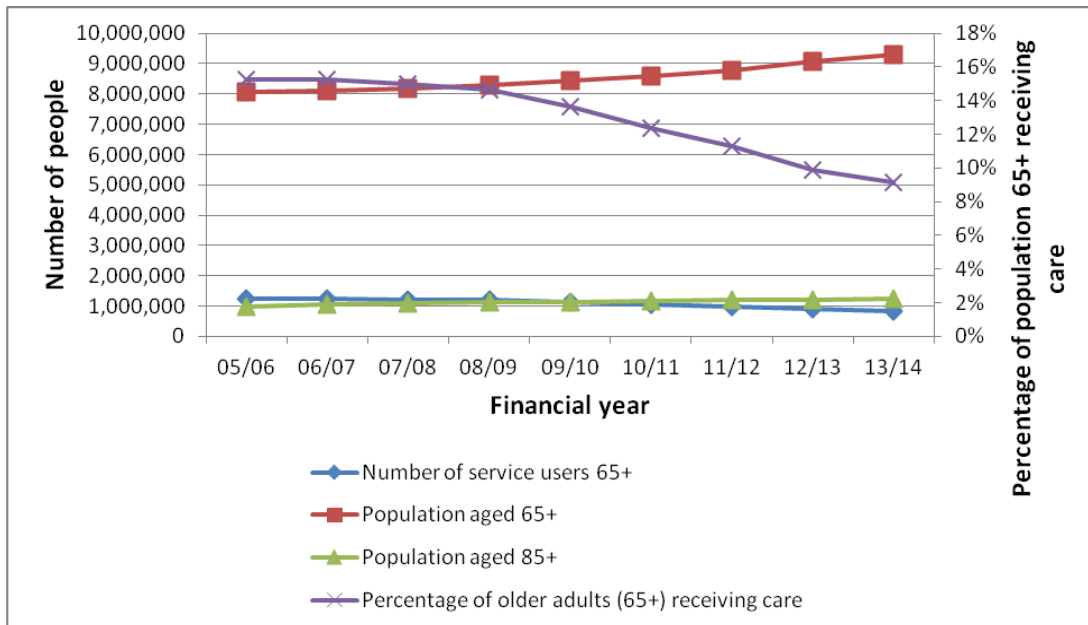
The Government has stated that delaying the implementation of the cap on care costs and related reforms until 2020 will save £6 billion. This includes delaying the costs of administrative systems, delaying the introduction of a higher capital threshold for the means test element in assessing eligibility for publicly funded social care in addition to public funding for the care needs of those who reach the cap. However there is currently no commitment to spend this money within the care system. Age UK supports the deferral as long as the savings are used to increase the amount of social care resources available to older people in need.

2.2 Implications of cuts to social care

The number of older people receiving social care support organised and/or funded by local authority social care services has been in steady decline.

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

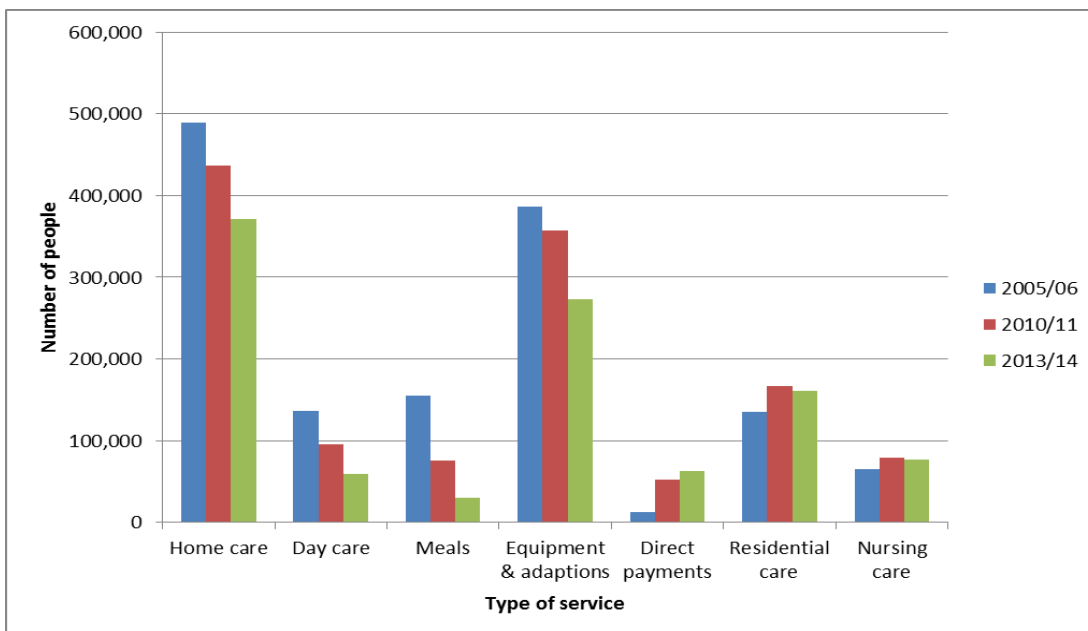
Figure 19: Number and percentage of people receiving support with social care in England, 2005/06 – 2013/14



Source: Health and Social Care Information Centre (2014⁴³) & Office for National Statistics (2014⁴⁴)

Home care (domiciliary care) and community based services have been hardest hit by the cuts as local authorities have focused limited resources on those with the highest levels of need. Services that have experienced particularly deep cuts are those most associated with prevention, support for independent living and support for informal carers.

Figure 20: Number of older people supported by social services department by type of social care support, England, 2005/06 to 2013/14



Source: Health and Social Care Information Centre (2014⁴⁵, 2012⁴⁶, 2007⁴⁷)

Home care services

Support for people to remain living independently in their own homes has been severely affected by cuts to care services. Spending on home care services has reduced by almost a fifth (19.4 per cent) between 2010/11 and 2013/14^{48,49}. This has resulted in a 15 per cent decline in the number of older people receiving local authority support with home care from 437,150 in 2010/11 to 371,770 in 2013/14^{50,51}.

The distribution of the number of hours of home care has also changed as limited resources become increasingly focused on adults with higher needs who might otherwise be at risk of entering residential care. The proportion of all adults receiving two or fewer hours per week, for example, has fallen dramatically. In 2010/11, 13.8 per cent of home care recipients received two or fewer hours per week compared with just 9.1 per cent of recipients in 2013/14^{52,53}. This trend is in real danger of undermining efforts to adopt more preventative approaches that delay or prevent the onset of more intensive care needs.

Community based services

Likewise essential community based services are also in severe decline. In the last three years spending on meals on wheels has been reduced by 47 per cent (from £42.1 million⁵⁴ to £22.3 million⁵⁵). As a result there has been a 61 per cent reduction in the numbers of people receiving this type of support, from 75,885 in 2010/11⁵⁶ to just 29,605⁵⁷ in 2013/14. Meanwhile spending on day care provision has reduced by 30 per cent^{58,59} over the same time period. The number of people now accessing day care support which is commissioned or provided by the local authority, has fallen by 35,845, from 95,145 people aged 65+ in 2010/11⁶⁰ to 59,300 in 2013/14⁶¹. Once again the reduction in community based services will only serve to undermine prevention and older people's own ability to maintain their independence.

Aids and adaptations

Although spending on aids and adaptations has increased by 7.3 per cent since 2010/11^{62,63} the number of older people benefiting from these services has fallen by 83,945^{64,65}. This is because scarce resources are being focused on people with highest needs. Many people who would have previously received help with aids and adaptations no longer doing so.

Care homes

The number of people supported in residential care has also fallen slightly between 2010/11 and 2013/14 from 166,820⁶⁶ to 160,745⁶⁷. This is a reduction of 3.6 per cent. The number of older people in nursing care has also fallen but by less than in residential care. In 2013/14, 77,300 people⁶⁸ were supported by councils compared to 79,465 in 2010/11⁶⁹. This may be partly because, as noted above, councils are maintaining levels of home care for those people who would otherwise be at risk of entering residential care. It may also be due to increasing rates of home ownership and to higher property values, both of which mean that a greater proportion of older people are considered able to pay for their own care.

Direct payments

Direct payments are an option for people who are eligible for local authority funding to meet their social care needs but who choose to organise and pay for services themselves with local authority funding provided as a cash payment for the purpose.

Older people receiving direct payments are a small minority of the total number of people eligible for publicly funded support with social care. The number of older people receiving direct payments has also increased only slightly (by less than 60,000 people) since 2005/06.

2.3 Impact of cuts to social care on older people

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

Rising levels of unmet need

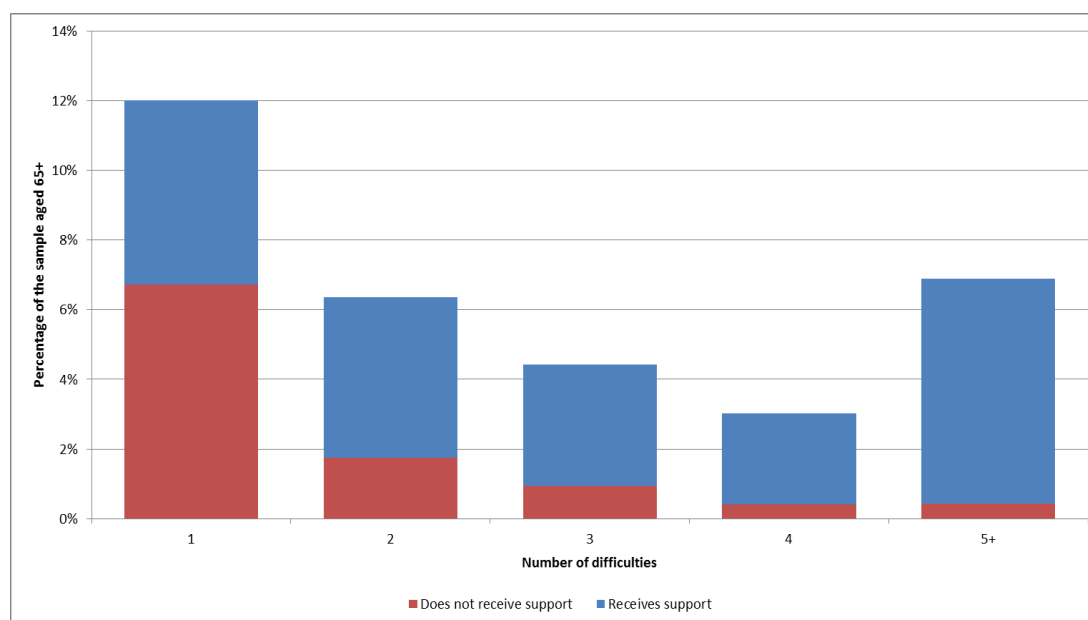
Through analysis of data from the English Longitudinal Study of Ageing, it is possible to calculate the number of older people (aged 65 to 89) living in the community who have difficulty undertaking activities of daily living (such as getting dressed, washed and eating) and instrumental activities of daily living (including managing medication, cooking or shopping for essential items) unaided⁹. An unmet need is where an individual states a difficulty with one of these activities and does not receive support from any source, either from formal (paid for) carers or informal networks of family and friends.

As **figure 21** shows:

- Over half of all those living with one difficulty do not have their need met; this equates to around 660,000 people (or seven per cent) of people aged 65 to 89
- Another 170,000 people with two difficulties do not receive any support.
- Amongst those with five or more daily difficulties, around 42,000 go without help.

Overall 10 per cent of older people have at least one unmet care need: applied to the most recent population data this equates to around 1,004,000 people. This figure has grown by 26 per cent since 2010 when PSSRU estimated that 800,000 people had some level of unmet need for social care⁷⁰.

Figure 21: Percentage of the population aged 65 to 89 in England having difficulties with activities of daily living by whether support is received, 2012/13



Source: Age UK analysis of the English Longitudinal Study of Ageing (2014⁷¹)

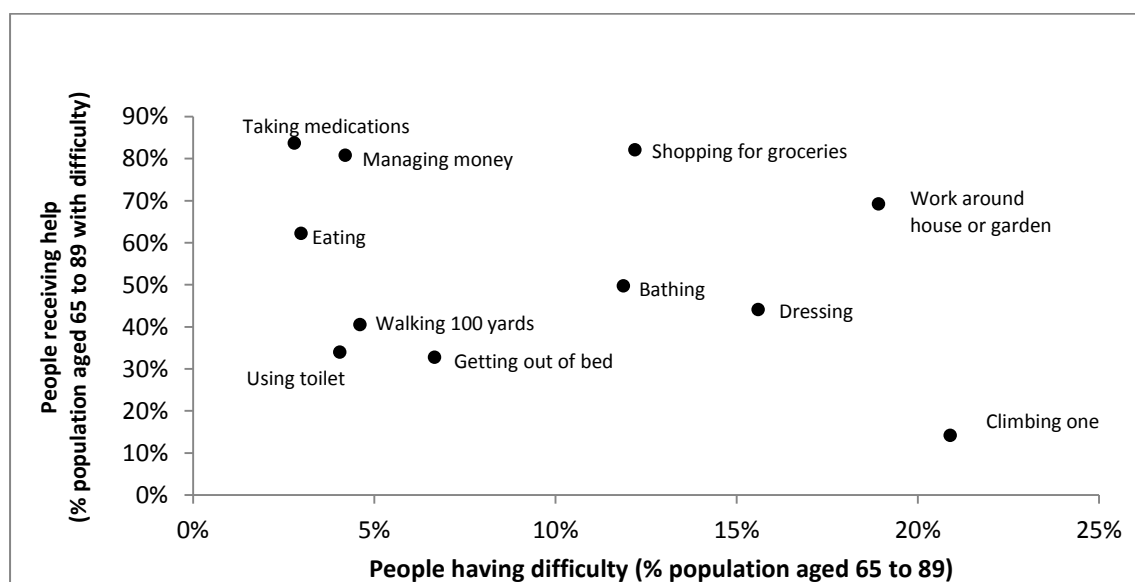
⁹ An 'activity of daily living' is defined as a basic task of everyday life. These are split into *instrumental* which are less fundamental to functioning such as doing housework, taking medication and preparing meals and *basic* activities of daily living which include more fundamental tasks such as eating, toileting and washing.

Within the older population:

- Women are more likely to have an unmet need than men. Almost 69 per cent of women have at least one unmet need compared with 56 per cent of men.
- The risk of having an unmet need increases with age. Close to 78 per cent of those aged 85 to 89 have at least one unmet need compared to 65 per cent of those aged 65 to 69.
- Marital status affects the likelihood of having unmet care needs. Over 70 per cent of those who are single or divorced have one or more unmet needs compared with 64 per cent of those who are widowed and 59 per cent of people who are married or partnered⁷².

Figure 22 demonstrates the likelihood of having unmet needs according to types of activity. Older people are less likely to receive support for difficulties with personal care activities, such as bathing or getting dressed. Around half of people who have difficulty bathing independently or difficulty getting dressed on their own do not get any help. Alarmingly, only around a third of older people who have difficulty using the toilet on their own receive any assistance with this essential activity.

Figure 22: People aged 65 to 89 having difficulty with an activity of daily living by whether help was received, England, 2012/13



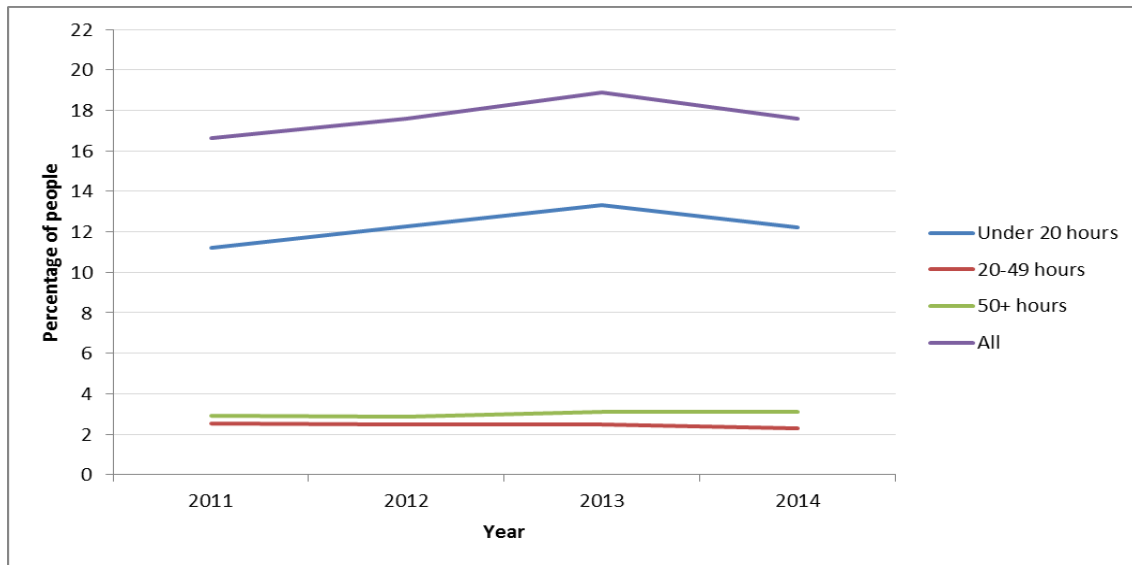
Source: Age UK analysis of the English Longitudinal Study of Ageing (2014⁷³)

Growing pressure on informal carers

Declining provision of local authority care services has also placed increasing pressure on unpaid carers, often older people themselves.

There has been an increase in the number of unpaid carers of all ages over recent years, with the numbers of people providing care rising from 16.6 per cent of the population in 2011, peaking at 18.9 per cent in 2013, before falling slightly to 17.6 per cent by 2014. In 2014, 30.6 per cent of people providing care did so for 20 or more hours a week.

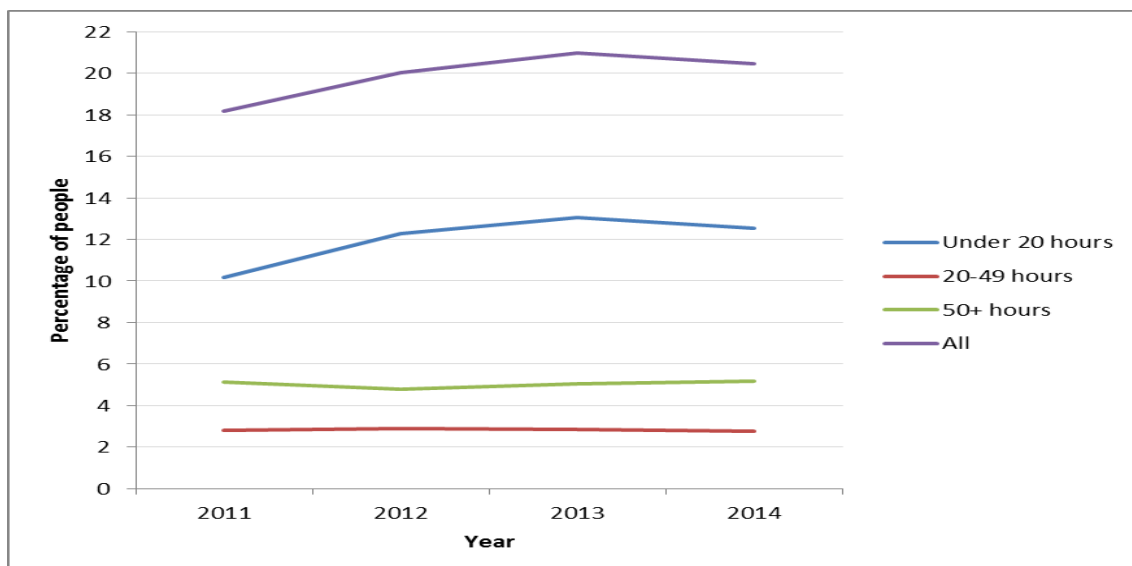
Figure 23: Hours of informal caring a week at all ages, UK, 2011-14



Source: *Understanding Society (2015⁷⁴)*

It is also vital to recognise that large numbers of unpaid carers are older people themselves, often caring for partners, family and friends. 20.5 per cent of older people provided unpaid care in 2014, up from 18.2 per cent in 2011. Furthermore older people are often caring for more hours than the population of unpaid carers as a whole, with 38.8 per cent of older carers caring for 20+ hours a week and more than 25.3 per cent of them caring for 50+ hours a week.

Figure 24: Hours of informal caring a week amongst people aged 65 and over, UK, 2011-2014



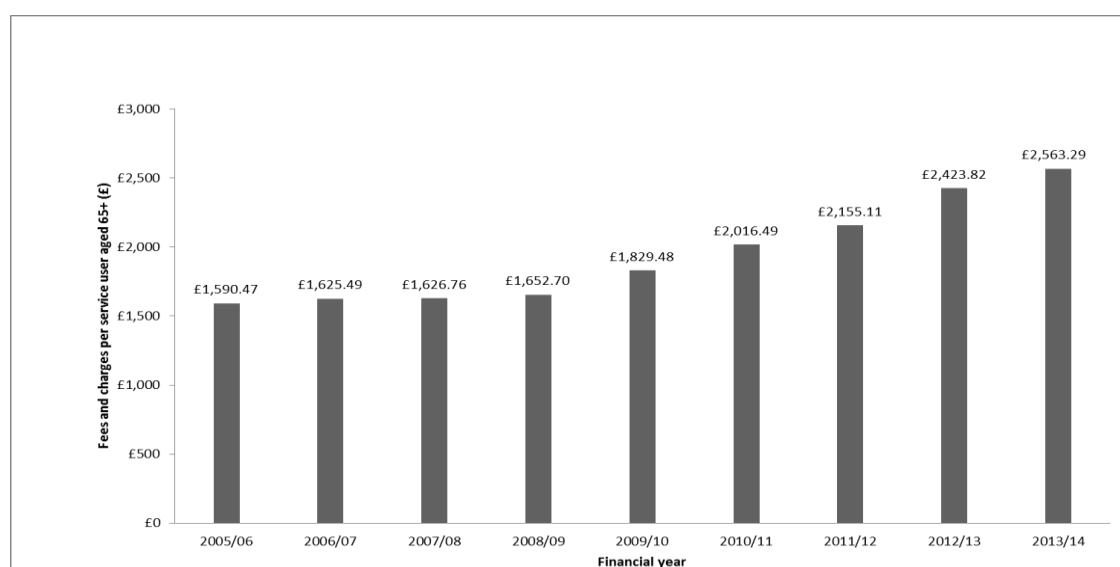
Source: *Understanding Society (2015⁷⁵)*

In 2011, Carers UK estimated the value of unpaid care to be £119 billion per year⁷⁶ based on the estimated amount that the state would have to pay to replace its contribution. Yet access to services that support carers has been cut in recent years, such as community based day services that provide essential respite and practical and emotional support.

Higher charges and individual financial contributions

Cuts to social care budgets have also had a financial impact on older people. Older people who are assessed as being able to make some contribution towards the cost of their care have seen fees and charges rise significantly over the past 10 years. In 2005/06 the average contribution was £1,590 per year. This has increased by nearly £1,000 in real terms to £2,563 in 2013/14. In addition in 2013/14, 27 per cent of older people eligible for local authority funded care home places incurred some form of top-up payments⁷⁷. Prior to April 2015 'top up' payments were only allowed to be made by a third party, usually the family, and were meant to be voluntary. However in practice many older people and families were given little option. Under the Care Act from April 2015 people will be allowed to top up their own care, so the percentage may increase.

Figure 25: Average annual fees contributed by older people for their social care, England, 2005/06 to 2013/14



Source: Department for Communities and Local Government (2015⁷⁸)

Self-funders subsidise people getting public funding

The number of older people paying for their own care services has grown significantly, particularly the number of people funding their own care home places⁷⁹, and it is now widely acknowledged that private clients are cross-subsidising the provision of local authority commissioned services. In 2012/13 the average care home fee paid by English local authorities for a home place was £492 per week compared to an industry average of £538 per week⁸⁰. As the industry average includes both local authority and private payers, this is a conservative estimate of the real difference.

3. The state of healthcare

3.1 Trends in NHS funding

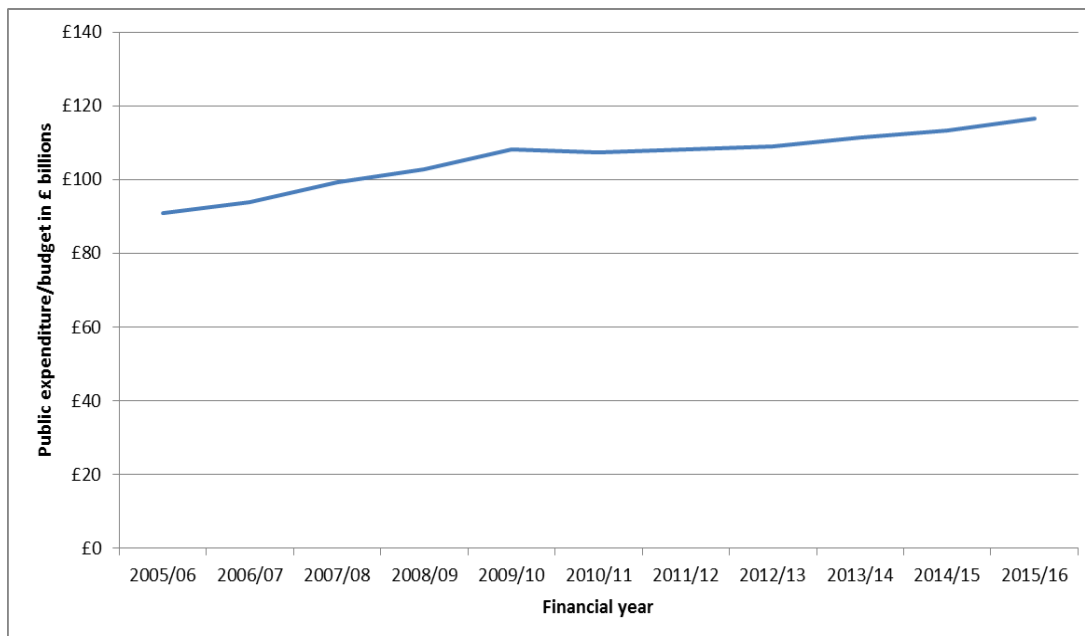
Despite experiencing a period of unprecedented financial constraint, NHS funding has fared better than social care and many other public services.

Whereas spending on social care was already drifting downwards in real terms between 2005/6 and 2009/10, over the same period public expenditure¹⁰ on health rose steadily from £90.96 billion to £108.26 billion⁸¹. However from 2009/10 onwards the effects of measures to address the financial crisis are more evident.

In real terms, spending on health services dropped slightly between 2009/10 and 2011/12 before recovering to £108.14 billion in 2011/12 and £111.3 billion by 2013/14⁸². The health budget in 2014/15 was £113.3 billion⁸³ rising to almost £116.6 billion for 2015/16⁸⁴. In real terms, since 2010/11 funding has increased by 8.46 per cent or 0.8 per cent per year. Yet these increases in spending since 2009/10 have fallen far short of the estimated three to six per cent increase required to keep pace with demand and new technology⁸⁵, meaning the NHS still has had to make significant savings.

In its Five Year Forward View NHS England estimated that on current trends the gap between NHS funding and demand will have grown to around £30 billion a year in 2020/21⁸⁶. In response in the Summer Budget 2015, the Chancellor announced an additional £8 billion a year in funding for the NHS by 2020/21; this is on top of the additional £2 billion previously announced in the 2014 Autumn Statement. However this still leaves the NHS with a challenging £20 billion gap to close through improvements in productivity and efficiency gains⁸⁷ – an average of 4 per cent year on year improvement.

Figure 26: NHS (health), total department expenditure limit expenditure, England, 2005/06 to 2015/16 (in 2014/15 prices)



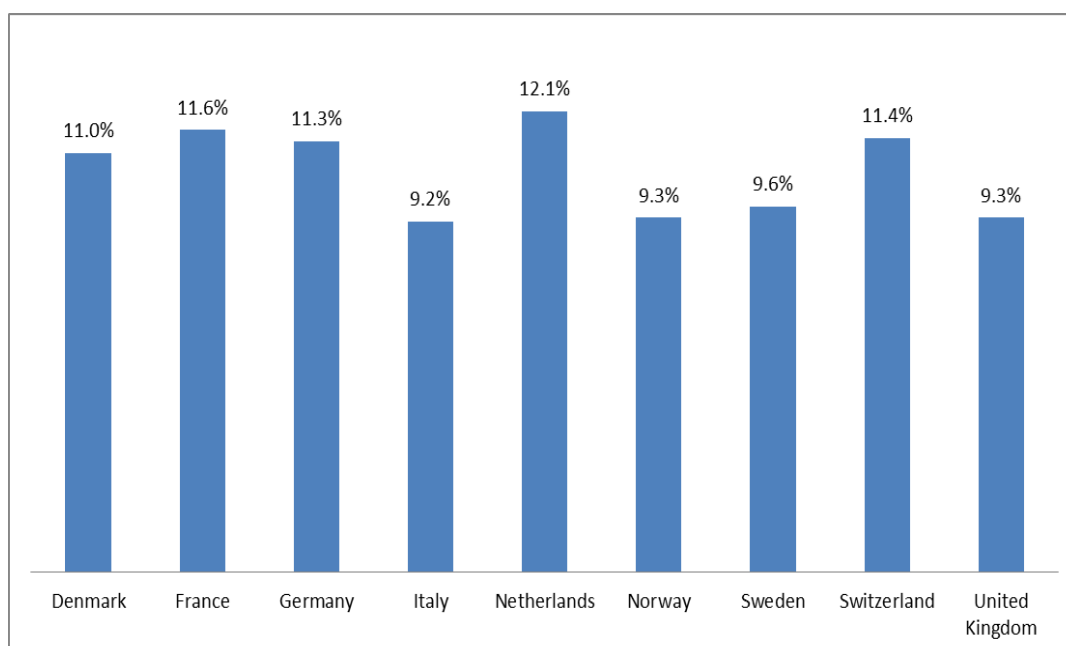
Source: HM Treasury (2015⁸⁸)

¹⁰ This includes current and capital expenditure on health expressed in 2014/15 prices using a GDP deflator (HM Treasury) -

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/444238/GDP_Deflators_July_Budget_2015_update.xls.

In 2013 the UK spent 9.3 per cent of its GDP on health, including both public and private funding. The amount spent per capita was \$3,289. On both measures the UK comes towards the bottom of a chart of nine European countries, with only Italy contributing a similar percentage of GDP and amount per capita (**figure 26a**). Each country has a different balance between state and private funding and the figures express total spending on health. Amongst the nine countries considered, the UK shares joint seventh position with Norway regarding the percentage of GDP spent on health, but spends considerably less per capita. Only Italy has a slightly lower percentage on both GDP and per capita spend.

Figure 26a: International comparison of proportion of GDP spent on health care in 2012



Source: extracted from *International Profiles of Health Care Systems, 2014*. Commonwealth Fund 2015⁸⁹

Uneven investment and growth across NHS services

Unfortunately aggregate budget data for hospital, community health and mental health services is only available up to 2012/13 from Primary Care Trust budget statements¹¹. GP data is available up to 2014/15. Despite these shortcomings with the data it is clear that investment across the NHS has not been evenly spread with hospital services seeing greater growth in resources and capacity.

Despite a long standing policy desire to move more care out of hospitals into the community, spending on hospital services¹² has increased more than any other NHS service, rising from £43.06 billion in real terms in 2009/10 to £45.78 billion in 2012/13, an increase of £2.72 billion.

Funding for community health services also increased over the same period, although by a more modest amount, with the budget for community health services increasing by £1.33 billion from £8.76 billion in 2009/10 to £10.09 in 2012/13.

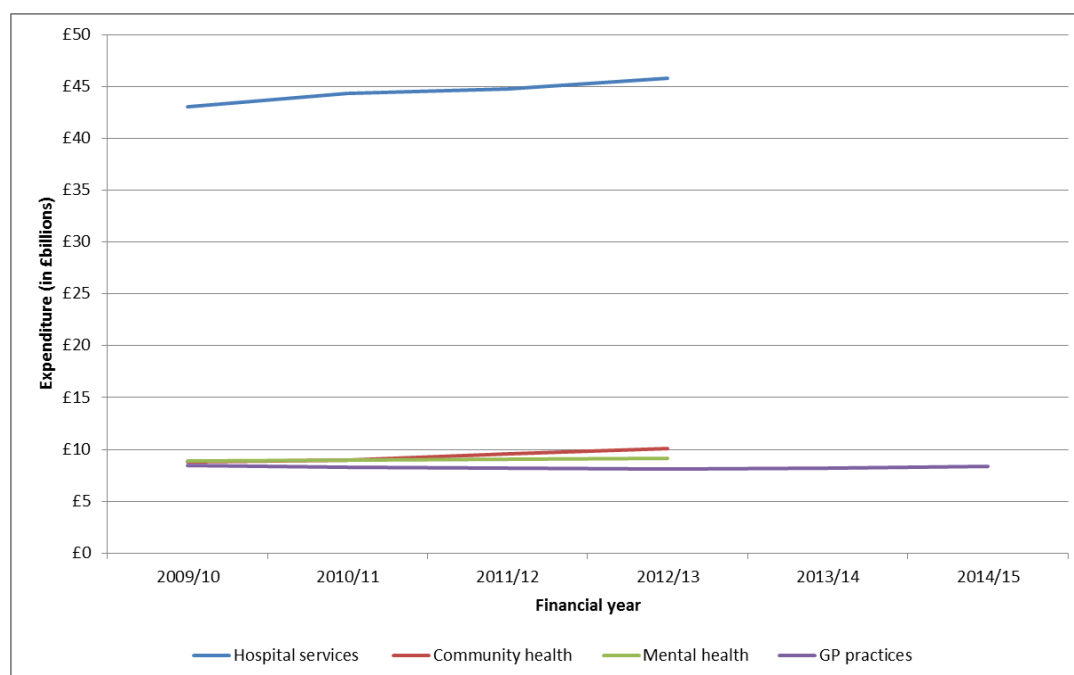
¹¹ Primary Care Trusts were abolished in April 2013 by the Health and Social Care Act 2012 and their functions transferred to NHS England and Clinical Commissioning Groups.

¹² Total spending on general and acute services and accident and emergency services.

Over the same period the primary care GP services budget¹³ fell in real terms by £0.31 billion from £8.45 billion in 2009/10 down to £8.14 billion in 2012/13, before increasing to £8.21 billion in 2013/14 and £8.34 billion in 2014/15. Meanwhile funding for mental health grew by only £0.22 billion, from £8.88 billion in 2009/10 to £9.10 billion in 2012/13.

More recently additional funding packages have been announced for mental health, primary care and community health and care services, including the Prime Minister GP Challenge Fund, the Investment and Transformation Fund and additional winter pressures funding. However, as the Royal College of General Practitioners has implied, this will not close the gap or meet growing demand⁹⁰.

Figure 27: Operating expenditure in the NHS by service sector in England, 2009/10 to 2014/15



Source: *Investment in General Practice 2009/10 to 2014/15*, Health and Social Care Information Centre & Department of Health Annual Reports and Accounts 2009/10 to 2012/13

Note: Hospital services include general and acute services and accident and emergency

3.2 Healthcare workforce

This uneven investment in services is clearly apparent in workforce trends. While we have only looked at registered doctors and nurses in this analysis the numbers nonetheless give an important indication of relative investment.

Doctors

Although there has been a substantial increase in the number of doctors (including consultants, registrars and trainees) working in the NHS between 2009 and 2014, the number of full-time equivalent (FTE) doctors working in hospital and community health has risen further and faster than GP numbers. Furthermore, the vast majority of doctors described here as working 'in hospital and community health' work in hospitals.

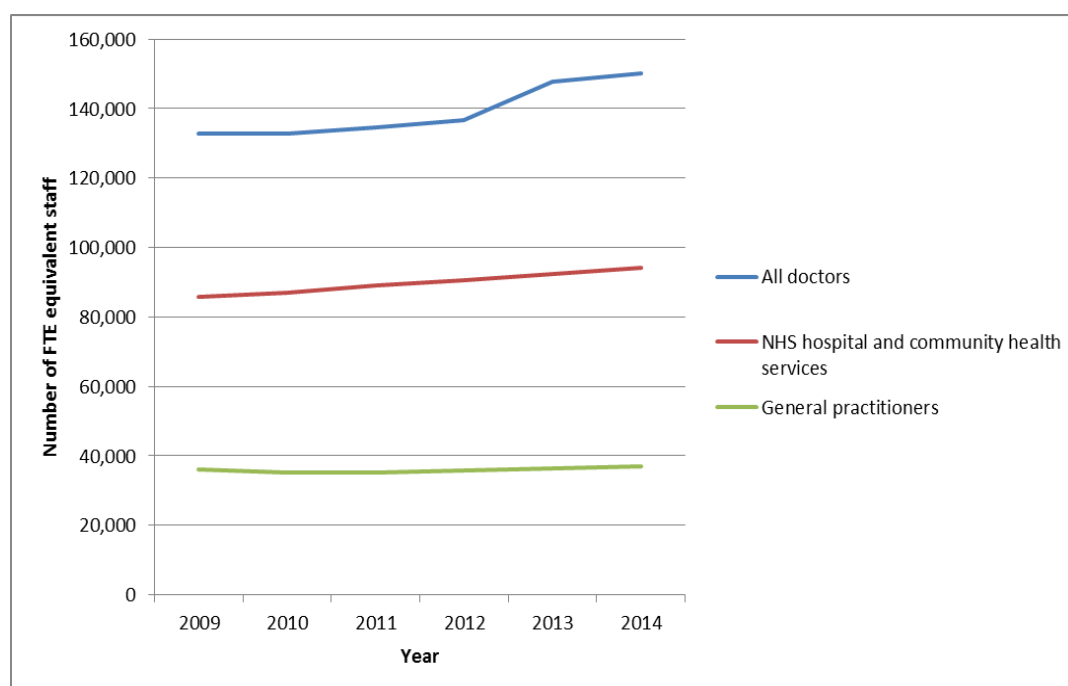
¹³ Total investment in primary care services net of dispensing and excluding reimbursement of drugs.

In 2009 there were 85,871 FTE hospital and community health doctors, compared to 36,085 FTE GPs. However, by 2014 the number of hospital and community health doctors had increased by 9.7 per cent to 94,229 FTEs, while GP numbers increased by 2.3 only per cent to 36,920 FTE GPs over the same period.

Despite a longstanding Department of Health policy to increase GP training numbers in England to 3,250 per annum by 2015, GP recruitment has remained below this target, at around 2,700 per annum between 2010/11 and 2013/14. This cumulative recruitment shortfall has been compounded by rising numbers of GPs leaving the workforce, including GPs approaching retirement as well as women in their 30s⁹¹. In April 2015 a survey undertaken by the GP magazine Pulse found that nine per cent of FTE GP positions were currently unfilled⁹².

In June 2015 the Secretary of State for Health pledged to increase the GP workforce by 5,000 by 2020⁹³ to address the shortfall. However in the current context ,achieving this pledge is likely to remain extremely challenging.

Figure 28: Number of Doctors (FTE equivalent, including registrars and trainees) in England, 2009 to 2014



Source: NHS Workforce: Summary of staff in the NHS: Results from the September 2014 census - appendix table 1b

Nurses

Nursing numbers have fared less well in recent years. Overall the number of FTE nurses employed in the NHS and by GP practices rose by 2.5 per cent between 2009 and 2014, from 320,469 to 328,577, but this growth has been relatively recent with the numbers of nurses declining between 2011 and 2013 before recovering in 2014.

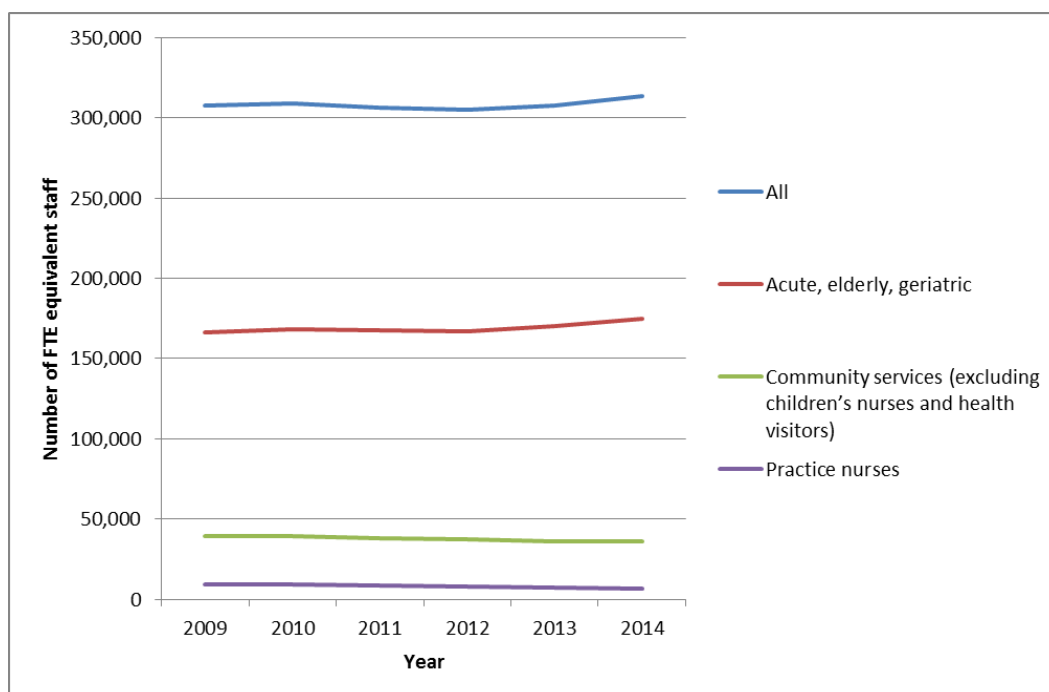
The rise in nursing numbers must be seen in the context of the 2013 Francis Inquiry recommendations on safe staffing levels in hospitals. It is therefore no surprise that the growth in numbers has been concentrated in hospitals, with the number of FTE nurses working in acute general and geriatric nursing rising 5.1 per cent, from 166,443 in 2009 to 174,994 in 2014.

Meanwhile the numbers of FTE nurses employed in NHS community services (excluding children’s nurses and health visitors) has been steadily drifting downwards, falling by eight per cent from 39,468 in 2009 to 36,296 in 2014.

Over the same period the numbers of practice nurses increased slightly from 13,582 to 15,062. However this too must be seen in the context of relatively flat growth in GP numbers and rising demand for primary care services.

It is important to note that the proportion of community based services provided by non-NHS providers has been increasing; 31 per cent of NHS spending on community services in 2012/13⁹⁴ was on non-NHS providers and there are currently no centrally collated workforce or activity statistics. However, a King’s College London study of the community nursing workforce who are members of the Royal College of Nursing found that amongst those responding to the survey 88 per cent were employed by the NHS compared to 10 per cent by social enterprises and 2 per cent by independent providers⁹⁵.

Figure 29: Numbers of FTE nurses employed by NHS providers between 2009 and 2014



Source: NHS Workforce: Summary of staff in the NHS: Results from the September 2014 census - appendix table 1b & NHS Workforce statistics - May 2015, Provisional statistics: Nurses Area and Level Tables

3.3 Trends in activity and demand within primary care and community health

Unfortunately statistics on activity in primary and community care services are not collected nationally. However, past surveys and current surveys provide important insight into the growing need for these services.

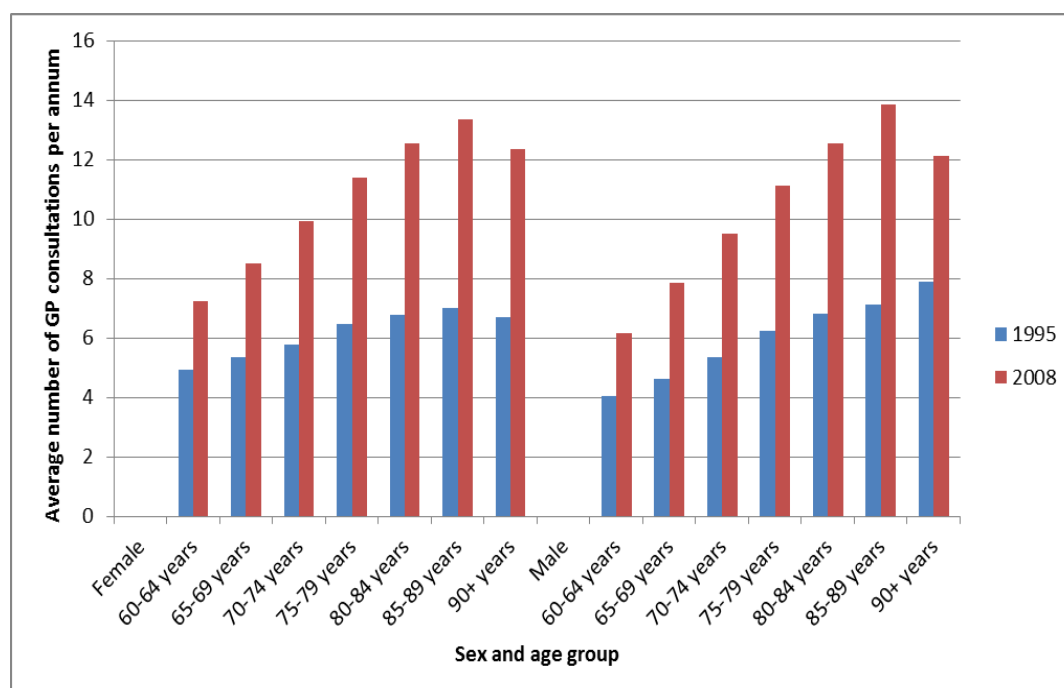
General practice: activity increasing, and increase especially marked for older people

Demand in general practice has been growing steadily. Between 1995 and 2008 a longitudinal study concluded that the number of consultations had grown by 38.3 per cent, from 217 million consultations a year to 300 million. For the average GP practice this means

the estimated number of consultations rose from 21,100 to 34,200⁹⁶. More recently NHS England estimated that consultations would have reached 340 million a year by 2013⁹⁷.

Furthermore as **figure 30** below demonstrates, the significant growth in general practice activity is attributable to more than the increasing size of the overall population. The average number of consultations per person per year amongst all age groups grew between 1995 and 2008 from an average of 3.9 consultations a year to 5.5. However, the trend is particularly marked amongst older people, particularly the oldest age groups that make up the fastest growing part of our population. In 1995 a women aged 85 to 89 would average 6.99 consultations a year: by 2008 this had nearly doubled to 13.34.

Figure 30: Average number of GP practice consultations per person per year, by sex and age group, 1995 to 2008



Source: Trends in Consultation Rates in General Practice 1995 to 2008: Analysis of the QRsearch database - table 3, total recorded consultations per person per year by age and sex

At the same time there is also evidence that patients and patient consultations are becoming more complex. In 1992/93 the average length of appointment with a GP Partner (as opposed to all GPs) was 8.4 minutes: by 2006/7 (the last year of the GP Workload Survey) that had increased to 11.7 minutes. This trend appears to have continued since. The Centre for Workforce Intelligence cited GP reports that ‘increasing case complexity had likely seen consultation length continue to increase since then’⁹⁸.

3.4 Trends in activity and demand within secondary care

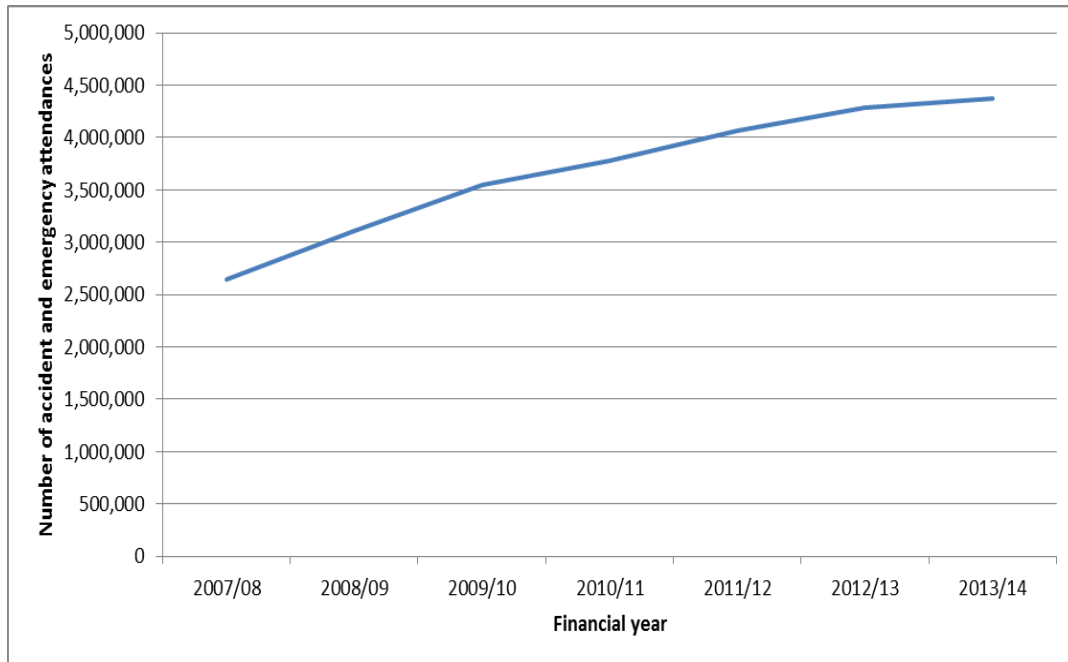
Hospital activity for older people has been increasing across the board in recent years, both routine and elective care as well as emergency care.

Accident and emergency attendances

A&E attendance rates for older people (60+) have increased significantly in recent years. Between 2007/8 and 2013/14 A&E attendance by those aged 60 and over rose by 65.6 per cent from 2.6 million attendances to 4.4 million⁹⁹. The attendance of older people in A&E is

disproportionate; in 2013/14 20 per cent of all attendances are for people aged 65 and over yet this group represents 17.3 per cent of the total population¹⁰⁰.

Figure 31: Total number of accident and emergency attendances for people aged 60 and over in England, 2007/08 to 2013/14

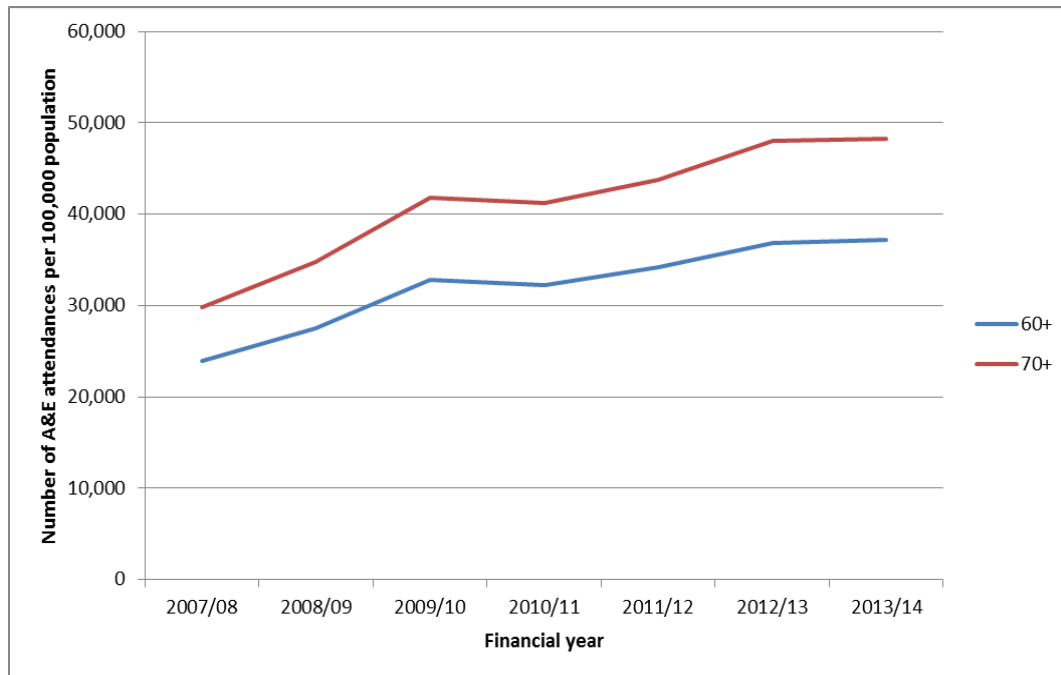


Source: Health and Social Care Information Centre (2015¹⁰¹)

As **figure 32** demonstrates, the rate of attendances per 100,000 of the population has also been increasing, particularly amongst those aged over 75.

Much of this increase is due to the introduction of type 2 and 3 units including walk-in centres and minor injury units along with specialist emergency departments such as trauma centres and hyper acute stroke units. A & E attendances account for four per cent of the total cost to the NHS¹⁰², and at an average cost of £124 (2013/14 DH reference costs), A&E attendances amongst those aged 60+ cost around £542 million per year.

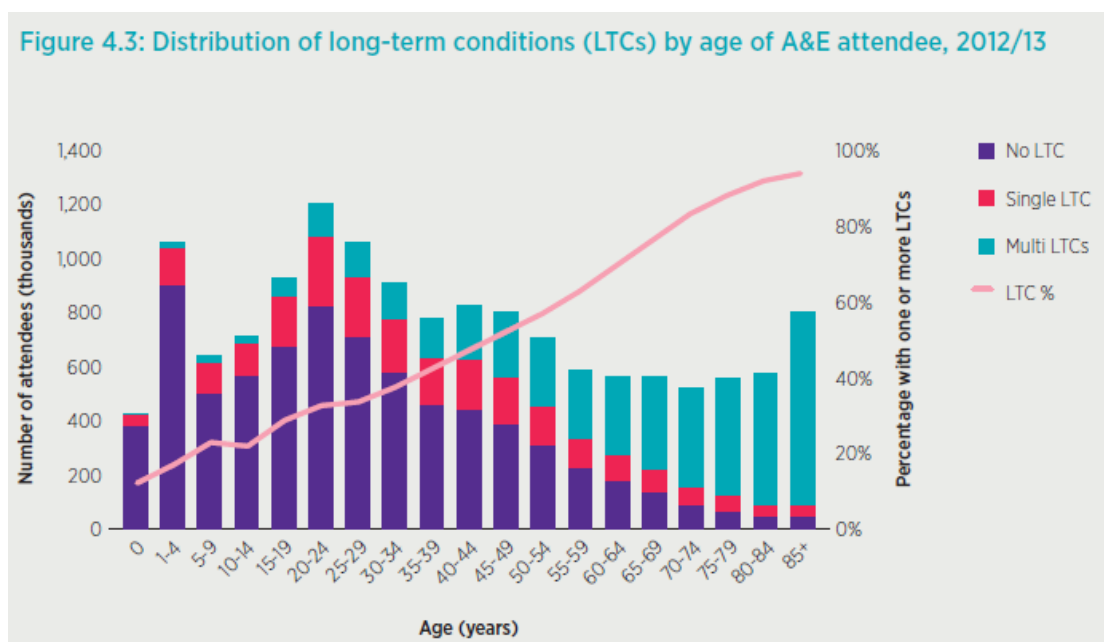
Figure 32: A&E attendances per 100,000 of the population for people aged 60+ and 70+ in England, 2007/08 to 2013/14



Source: Health and Social Care Information Centre (2015¹⁰³) and Office for National Statistics (2015¹⁰⁴)

Furthermore, according to analysis by QualityWatch for 2012/13 older people are also more likely to have complex needs that take longer to resolve. The likelihood of A&E attendees having multiple long-term conditions increases dramatically with age and people aged 75+ spend an average of 213 minutes in A&E compared to 149 minutes for people aged less than 75¹⁰⁵.

Image 1: Distribution of long-term conditions by age of A&E attendee 2012/13, Focus on A&E attendances, QualityWatch¹⁰⁶

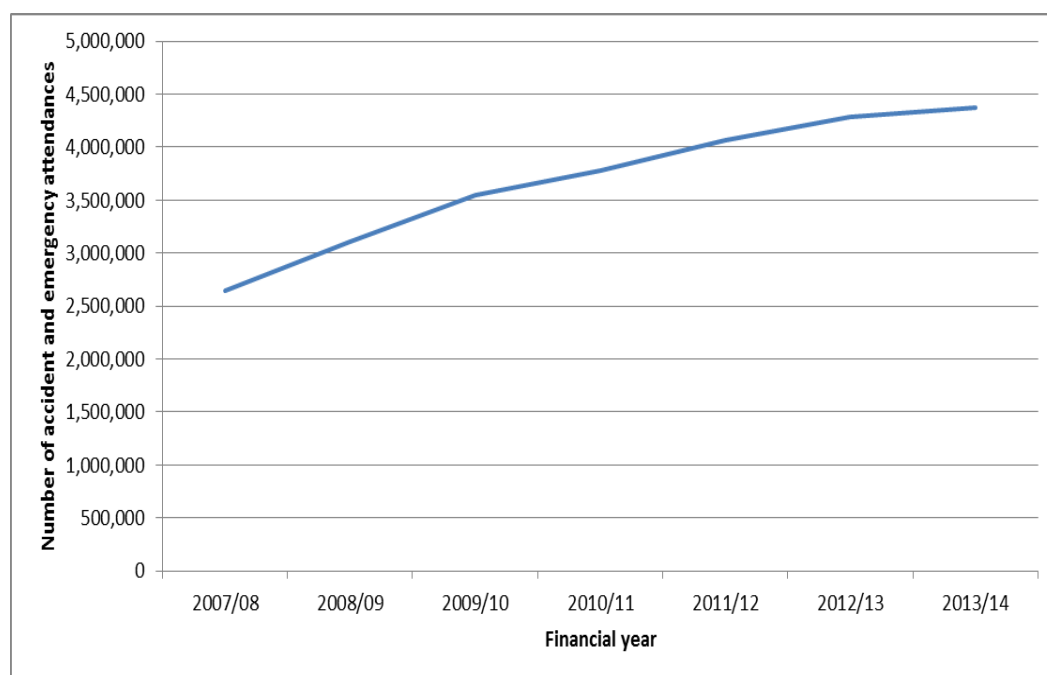


Source: Nuffield Trust and Health Foundation (2014)

Emergency admissions

As **figure 33** shows, the number of emergency admissions to hospital of people aged 65+ has also been rising steadily, increasing by around 22.1 per cent from 1,810,531 in 2005/6 to 2,211,228 in 2012/13¹⁰⁷. This increase outstrips the growth of this age group; in 2005/06 there were 22,552 emergency admission per 100,000 of people aged 65 and over, increasing to 24,415 per 100,000 by 2012/13^{108,109}.

Figure 33: Number of emergency admissions for people aged 65 and over in England, 2005/06 to 2012/13

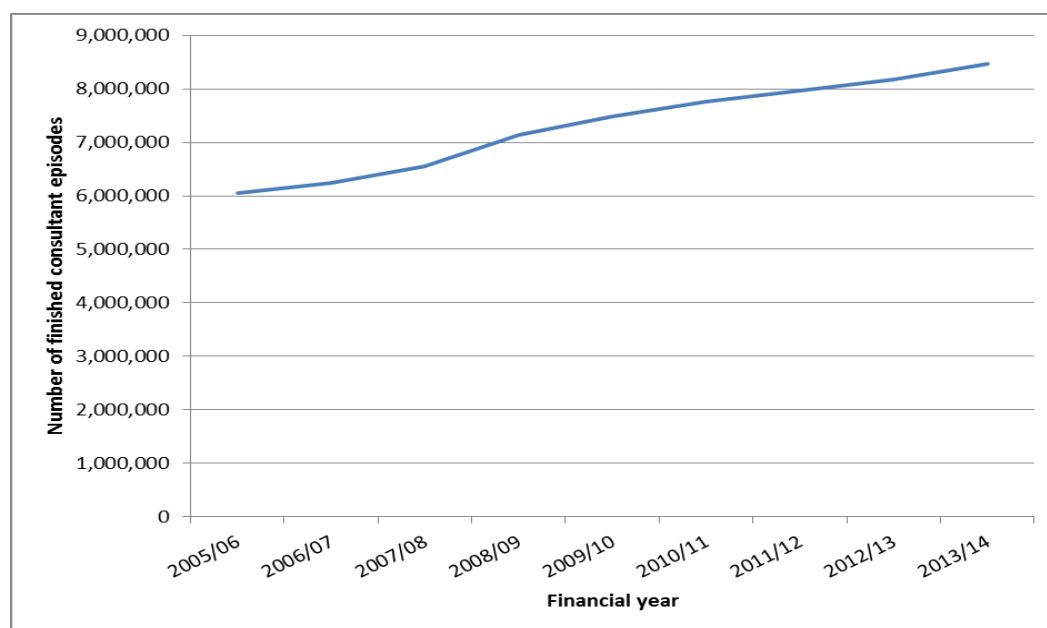


Source: Health and Social Care Information Centre (2015¹¹⁰)

Finished Consultant Episodes

The number of Finished Consultant Episodes attributed to patients of 60 and over in England rose steadily over eight years from just over six million in 2005/06 to nearly 8.5 million in 2013/14, an increase of 40 per cent.

Figure 34: Number of finished consultant episodes of people aged 60 and over in England, 2005/06 to 2013/14

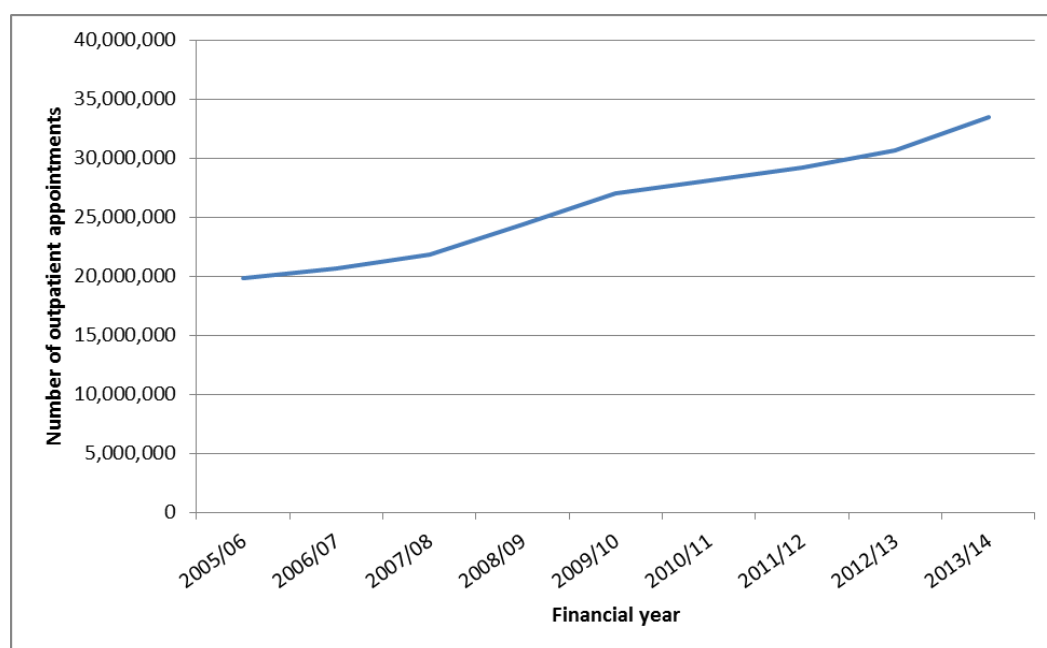


Source: Health and Social Care Information Centre (2015¹¹¹)

Outpatient activity

Outpatient activity has also increased steadily for older people. Between 2005/06 and 2013/14 the number of outpatient appointments attended by people aged 60 and over increased by 68.8 per cent from 19.8 million a year to 33.4 million, once again far above the increase in the overall numbers of people in this age group. In 2005/06, there were on average 2.5 outpatient appointments per person aged 60 and over, this increased to 2.7 in 2013/14.

Figure 35: Number of outpatient appointments amongst people aged 60 and over in England, 2005/06 to 2013/14



Source: Health and Social Care Information Centre (2015¹¹²)

4. A system under stress

It is clear that the health and care system for older people is under severe stress and failing to function as effectively as it should. The result is higher costs, lower productivity, poorer health outcomes and worse service user experience.

The social care sector has seen a catastrophic collapse in funding and service provision for older people. Likewise across the NHS we have seen a pattern of consistent under investment in primary care and community based services. Furthermore it is the very services that support people with lower levels of need to stay well and living independently that have been the hardest hit.

There is now a broad consensus across the health and social care sector that inadequate access to high quality social care is having a significant impact on NHS services. In 2015, an NHS Confederation survey¹¹³ found that 99 per cent of NHS leaders agreed or strongly agreed with the statement '*Cuts to social care funding are putting increasing pressures on the NHS as a whole*'. 92 per cent agreed or strongly agreed with the statement '*Cuts to social care funding are putting increasing pressures on my organisation and services for patients*'. When asked which NHS services were being adversely affected, responses cited all hospital, community and general practice services¹¹⁴.

At the same time the lack of effective, joined up health services out of hospital is undermining policy efforts to provide more responsive, preventative care that would enable people to manage many health conditions and illnesses effectively without recourse to acute services.

4.1 Primary and community care services under strain

Unfortunately the lack of robust national statistics makes it difficult to make an accurate assessment of how well primary and community care services are currently coping compared with previous years. However, there are indications that health professionals are struggling to manage demand.

In a 2012, a Royal College of Nursing survey of community nurses found¹¹⁵:

- 92 per cent of community nurses said they were caring for patients with more complex needs compared to a year ago, with only six per cent agreeing they had time to deliver the care the patient needed;
- 60 per cent said they were spending less time with patients than they had the year before;
- 76 per cent said that reductions in social care had resulted in increased work pressure and only 15 per cent felt their patients had adequate support from social services;

In addition, in open ended questions, many commented that unmet social care requirements were resulting in increased health care needs and avoidable re-admissions into hospitals.

In a 2013 survey of district and community nurses who were members of the Royal College of Nursing carried out by the National Nursing Research Unit at Kings College London and the Employment Research Unit it was found that:

- 20 per cent rated the quality of the care they provided as 'poor' or 'fair'. Of these 95 per cent agreed or strongly agreed with the statement 'there are not enough staff to get the work done'; and this group had on average seen 11 patients on their last shift¹¹⁶.
- 77 per cent of all the respondents reported that their workload was too heavy¹¹⁷ and 75 per cent said there were not sufficient district nurses on their team.¹¹⁸

The results also point to an impending workforce crisis.

- 38 per cent of district nurses were 50 or more years old¹¹⁹.
- 44 per cent of all the respondents said they were not satisfied with their current job and
- 40 per cent would leave their job if they could¹²⁰.

A GP Taskforce, commissioned by the Department of Health and Health Education England, reported in March 2014, agreed with the Centre for Workforce Intelligence's description of 'a workforce under considerable strain', with 'insufficient capacity to meet current and future patient need'¹²¹. They observed that 'a marginal shift from primary care to secondary care has the potential to overwhelm other parts of the NHS'¹²²

In the 2014 Q2 British Medical Association quarterly tracker, 67 per cent of GPs responding to the survey agreed their workload was 'unmanageable to unsustainable'. By Q2 2015 this had increased to 73.5 per cent¹²³.

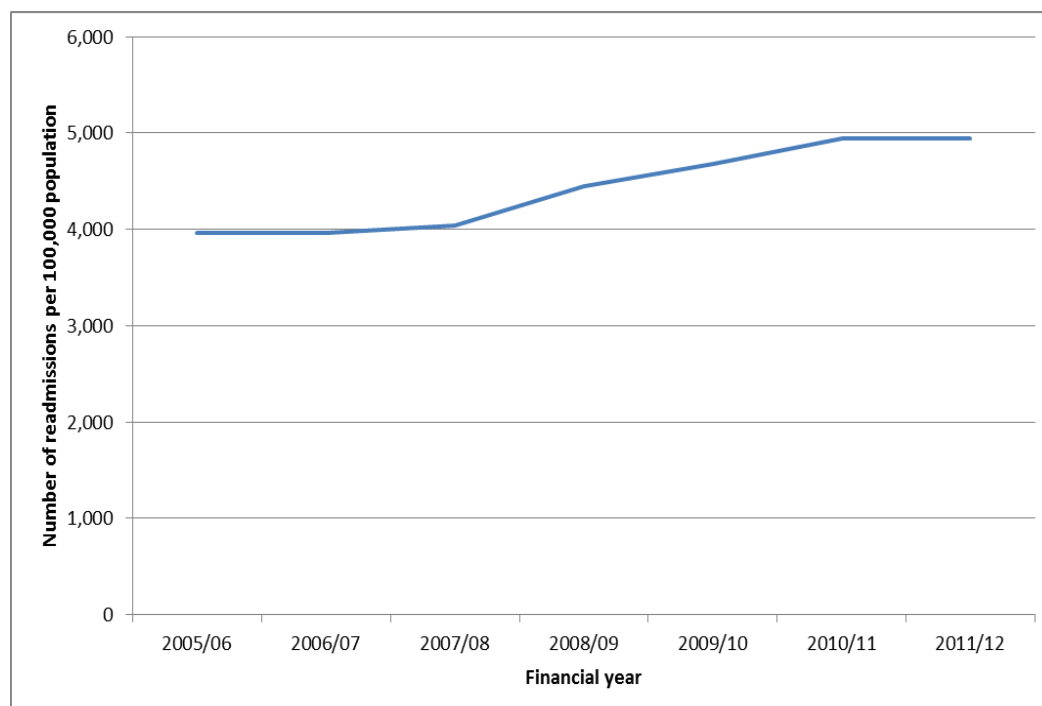
4.2 Stress in the acute sector

Evidence of stress in the system is more easily discerned in the acute sector. In recent years there has been a steady increase in the numbers of older people readmitted as an emergency, experiencing delayed transfers of care and, of even more serious concern, growing numbers admitted for illnesses and health conditions that should have been manageable in the community.

Rising emergency readmissions

The number of emergency hospital readmissions amongst older people rose significantly between 2005/06 to 2011/12. In 2005/06 3,964 per 100,000 people aged 75 and over were readmitted to hospital within 28 days of discharge. By 2011/12 this had increased by 24.8 per cent, to 4,948 per 100,000. High levels of emergency readmission within 28 days are often an indication of a lack of community based health and social care services to support people to recover or regain independence after a period of ill health.

Figure 36: Emergency readmission rate within 28 days per 100,000 people aged 75 and over in England, 2005/06 to 2011/12



Source: Health and Social Care Information Centre (2013¹²⁴) & Office for National Statistics (2013¹²⁵)

Growing numbers of bed days lost through delayed transfers of care

Bed days lost through delayed transfer of acute patients from hospitals to other more appropriate settings has increased steadily since 2011/12. Between 2011/12 and 2014/15 there has been a massive 40.3 per cent rise, from 766,253 to 1,074,686, in hospital bed days used by acute patients who have had to wait for transfer to a more appropriate place¹²⁶.

It is particularly concerning that the problem seems to be becoming more intractable. Last year the number of days lost shot up by 21.1 per cent, from 887,127 days in 2013/14 to 1,074,686 days in 2014/15.

Reasons for delayed transfer

As **figure 37** demonstrates, the most frequent cause of delay is waiting for further non-acute NHS care to be put in place, followed by waits for assessments, patient or family choice, availability of a place in a nursing home, care packages at home and availability of places in residential care.

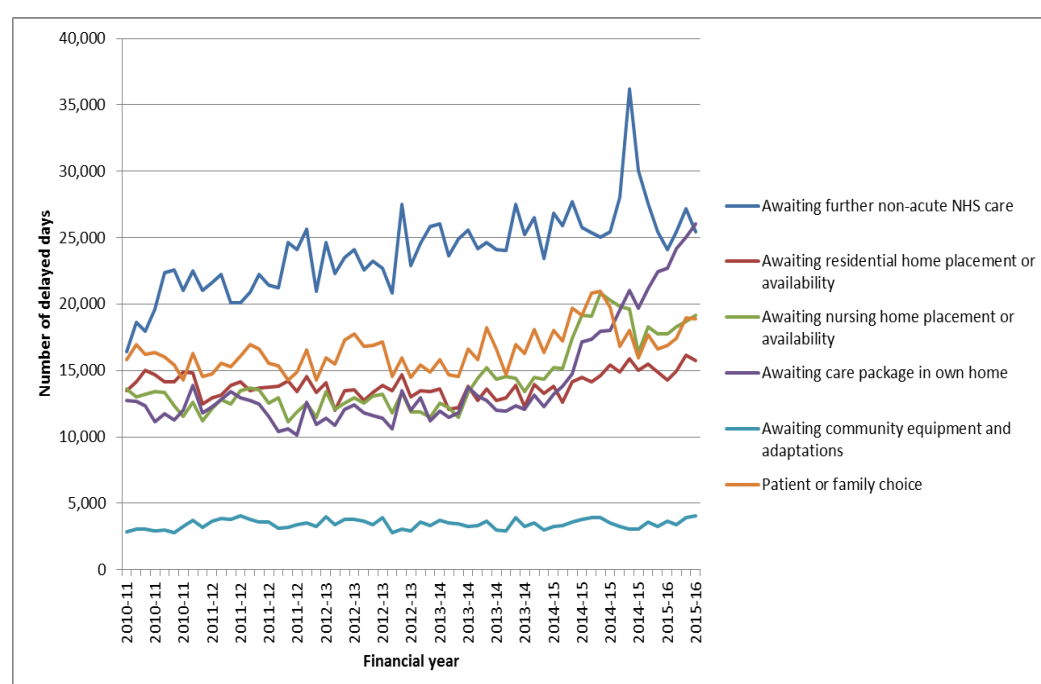
While the numbers of days lost has been rising across all the major causes, there are some key trends to note:

- Between 2011/12 and 2014/15 bed days lost due to delays in accessing non-acute NHS services, such as community nursing or intermediate care, increased by 23.5 per cent, from 265,116 to 327,419.
- The total number of bed days that were the responsibility solely of social care authorities fell by 13.6 per cent, from 422,604 to 365,061 between 2011/12 and 2013/14. This would appear to be as a result of higher eligibility thresholds, meaning fewer people qualify for

social care support, as well as efforts in many areas to prioritise resources to enable people to leave hospital as soon as possible. It is therefore especially alarming that in the last year the number of bed days lost that were solely the responsibility of social care authorities increased by 15.5 per cent, from 365,061 to 421,557. This suggests the beginning of a sharp trend upwards if public resources for social care continue to shrink.

- In addition, waits for nursing home placements and care packages in people's own homes, which may be attributable to the NHS, social care or both have shown especially sharp increases. From 2011/12 to 2014/15, the number of bed days lost due to waits for nursing home placements increased from 150,465 to 215,659 (43.3 per cent) between 2011/12 and 2014/15 and in the same period delays due to care packages in people's own homes increased from 143,916 to 206,053 (43.2 per cent).
- Delays attributable to patient and family choice increased by 18.3 per cent over this period, from 186,440 in 2011/12 to 220,597 in 2014/15. This is likely to be due to growing numbers of people who need to organise and fund their own care placements or care packages in their own homes as a result of higher eligibility criteria for support from social services.

Figure 37: Number of monthly delayed days by reason amongst people of all ages, England, August 2010 – August 2015



Source: NHS England (2015)¹²⁷

Rising admissions for ambulatory care sensitive conditions

Ambulatory care sensitive conditions (ACSCs) are conditions for which effective treatment and management in the community should limit the need for hospital treatment. Common examples amongst older people include exacerbations of COPD and congestive heart failure, urinary tract infections and pneumonia, and episodes of gastroenteritis.

In 2013, the Nuffield Trust/Health Foundation estimated that ACSCs accounted for 1 in 5 emergency admissions in England, costing the NHS £1.4 billion a year¹²⁸. People over 75 account for 40 per cent of total spend¹²⁹.

Emergency admissions for ACSCs increased by 48 per cent between 2001 and 2013¹³⁰, with the fastest growing and highest rates of admission occurring in the oldest old¹³¹. NHS England warns that some acute conditions, such as infections, may have been prevented by better management of long-term conditions in people living with frailty and/or multiple conditions¹³².

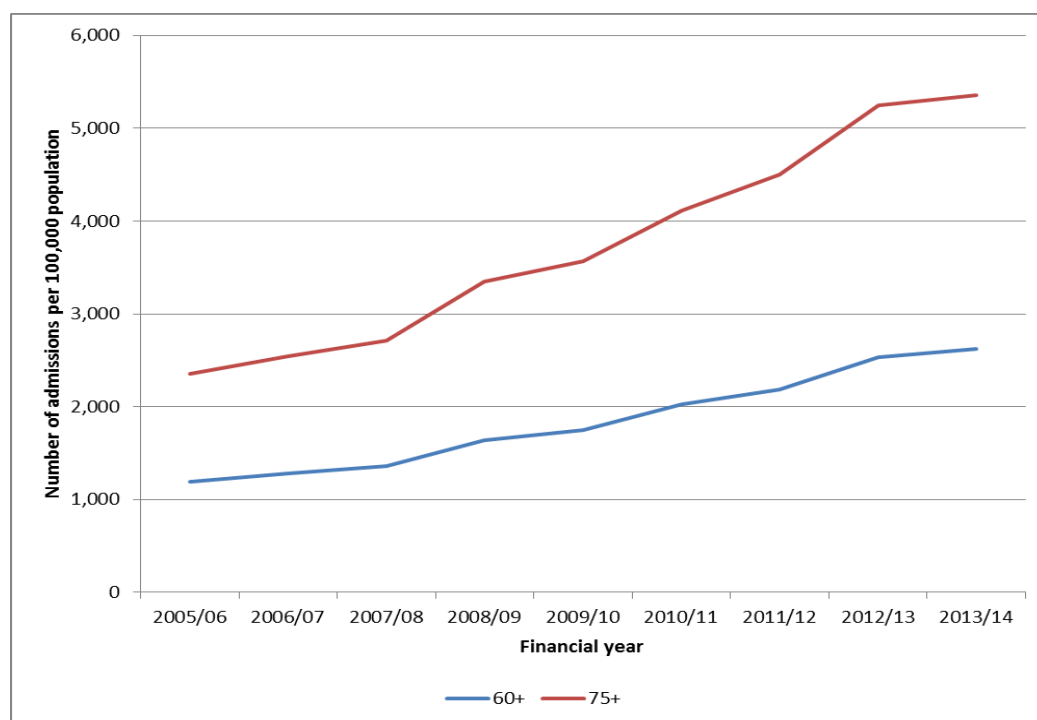
The following sections show alarming increases in hospital admissions for pneumonia, urinary tract infections and congestive heart failure for older people which indicate deterioration in community health and social care services.

Pneumonia

Pneumonia is a very dangerous condition, especially for older people living with frailty. The admission rate for pneumonia amongst older people has increased at a very alarming rate over the last eight years.

The numbers of admissions per 100,000 people aged 60 and over has more than doubled from 1,187 in 2005/06 to 2,621 in 2013/14. This is an average annual increase of 179 admissions per 100,000 each year. The increase is even more dramatic for the 75+ age group where there were 2,355 admissions per 100,000 in 2005/06 which rose to 5,359 by 2013/14, an increase of 127.6 per cent.

Figure 38: Admission rate for pneumonia per 100,000 people aged 60+ and 75+ in England, 2005/06 to 2013/14



Source: Health and Social Care Information Centre (2015¹³³)

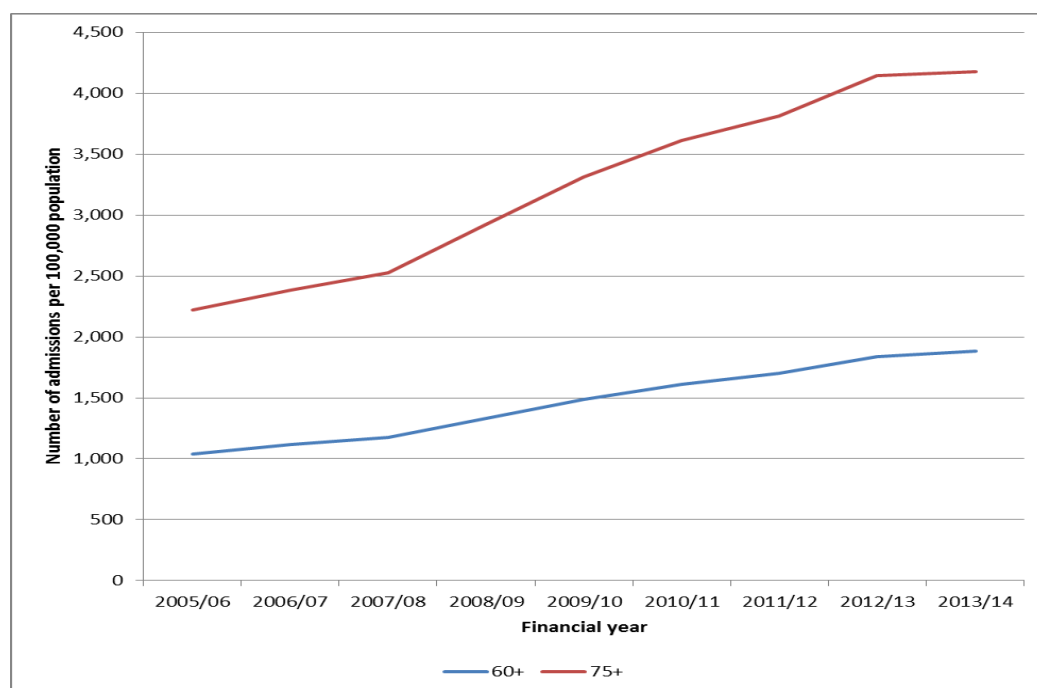
Urinary tract infections

Urinary tract infections (UTIs) cause a great deal of pain and discomfort and, without timely treatment, can lead to renal problems, fevers and delirium. They are frequently caused by catheterisation. Hospital admissions should usually be preventable with access to appropriate care in the community.

The number of admissions amongst people aged 60 and over attributed to UTIs increased by a staggering 81 per cent between 2005/6 and 2013/14, from 1,039 per 100,000 to 1,881. Amongst people aged 75+ admissions for UTIs the increase was even worse at 88.1 per cent, from 2,219 per 100,000 in 2005/06 to 4,173 in 2013/14.

It is possible that these statistics overstate the cause of the admission. Concern has been raised in the past that UTIs are over-diagnosed and over-treated¹³⁴ and the National Institute for Health and Care Excellence warns that accuracy of simple diagnostic tests can vary and that other factors should be taken into account. This would mean the real causes of the symptoms leading to admission were not being addressed.

Figure 39: Admission rate for urinary tract infections per 100,000 people aged 60+ and 75+ in England, 2005/06 to 2013/14

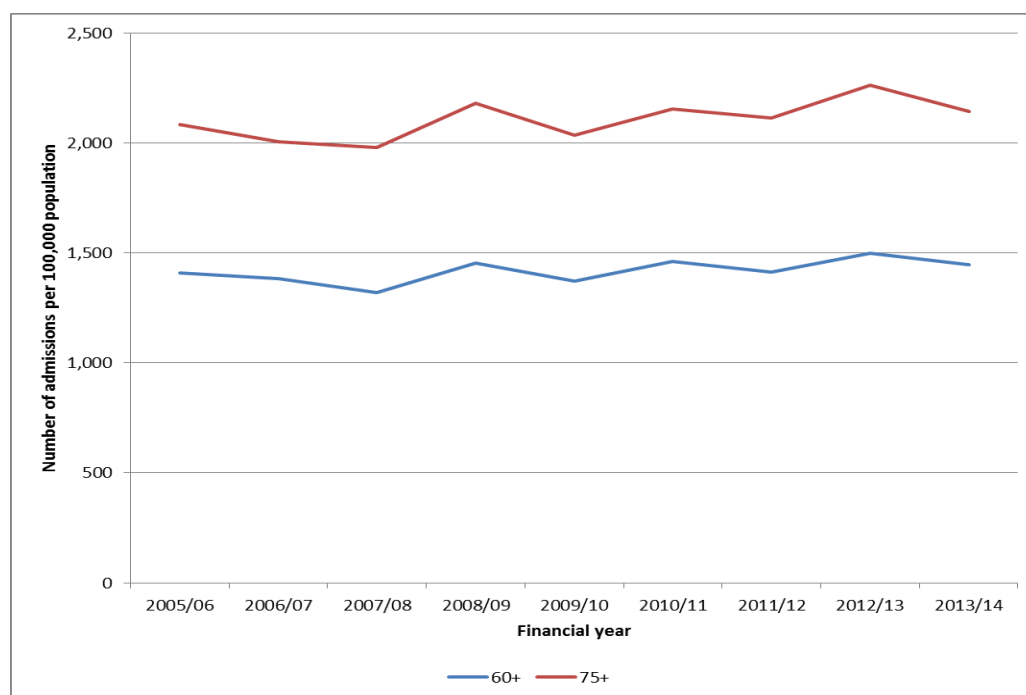


Source: Health and Social Care Information Centre (2015¹³⁵)

Chronic obstructive pulmonary disease

The trends for chronic obstructive pulmonary disease (COPD) are fortunately less alarming, with a relatively low increase for both age cohorts between 2005/06 and 2013/14. However, COPD still accounts for 24 per cent of all ACSC admissions relating to a long-term condition¹³⁶ and could be largely managed in the community with access to appropriate primary and community care and support to self-manage. Between 700,000 and 900,000 people in the UK have been diagnosed with COPD, affecting around 1 in 10 people over 75, and it has been estimated that a further 2 million remain undiagnosed¹³⁷.

Figure 40: Admission rate for chronic obstructive pulmonary disease per 100,000 people aged 60+ and 75+ in England, 2005/06 to 2013/14

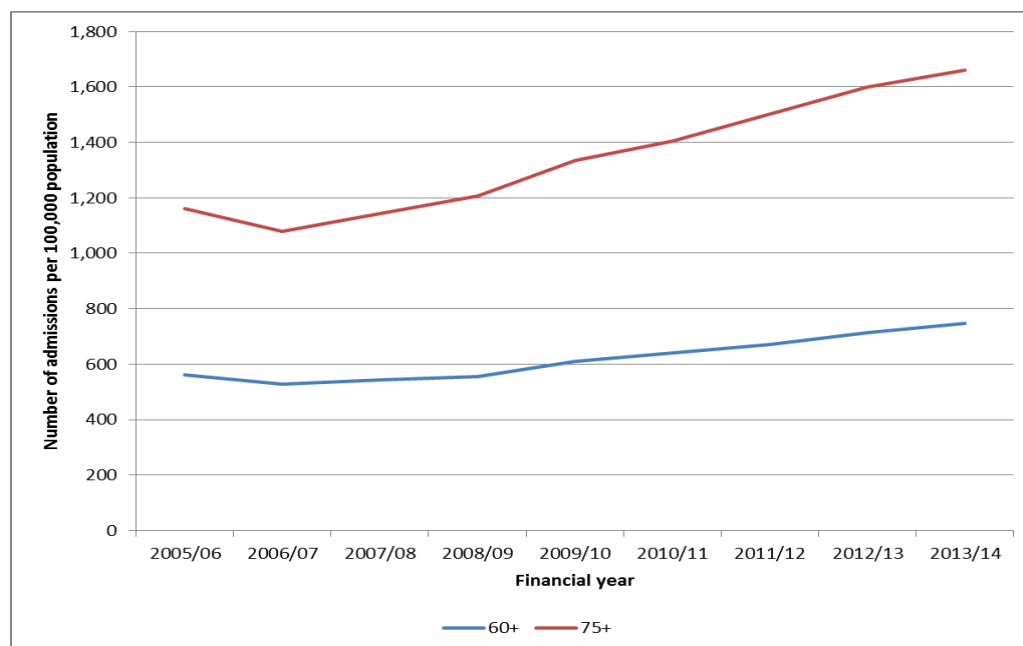


Source: Health and Social Care Information Centre (2015¹³⁸)

Congestive heart failure

Although incidences of hospital admissions for congestive heart failure are comparatively low, numbers have been rising steadily since 2005/06. Amongst people aged 60 and over, the number of admission rose by 33.1 per cent, from 562 per 100,000 in 2005/06 to 748 by 2013/14. Amongst people aged 75 and over, the number of admissions rose by 43 per cent, from 1,162 per 100,000 to 1,662.

Figure 41: Admission rate for congestive heart failure per 100,000 people aged 60+ and 75+ in England, 2005/06 to 2013/14

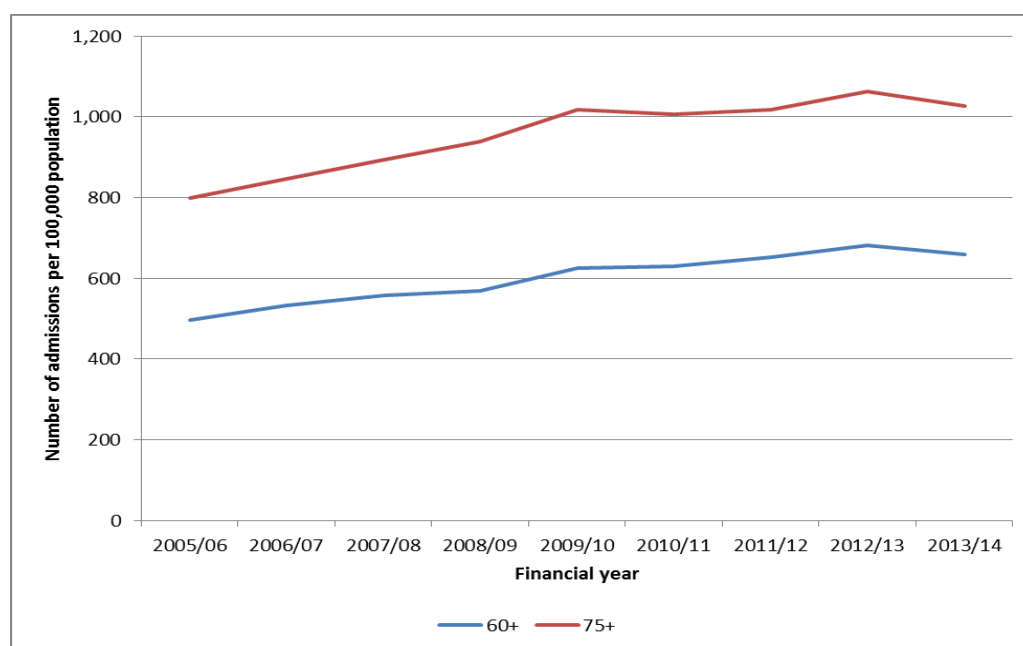


Source: Health and Social Care Information Centre (2015¹³⁹)

Gastroenteritis

The numbers of older people admitted to hospital with gastroenteritis have also been drifting upwards. Gastroenteritis can have much more serious consequences for people living with health conditions or who are frail; it can lead to dangerous dehydration and delirium without a timely response to the infection. Admissions grew by 33.1 per cent amongst people aged 60+, from 496 per 100,000 in 2005/06 to 660 in 2013/14. Amongst people aged 75+ admissions increased by 28.7 per cent over the same period, from 798 per 100,000 to 1,028.

Figure 42: Admission rate for gastroenteritis per 100,000 people aged 60+ and 75+ in England, 2005/06 to 2013/14



Source: Health and Social Care Information Centre (2015¹⁴⁰)

5. Conclusion

The summary above is based on more than forty charts and graphs in the full report, and many more facts and figures contained within the text: what is the story that they collectively tell?

Really it is quite a simple one, because essentially all the data point in the same direction. The numbers of older people in England are steadily growing, and the proportion with long term conditions is growing faster still, but investment in health care overall is failing to keep pace with the impact of demographic change and other factors driving higher demand, and spending on social care has fallen quite spectacularly over the last five years.

Some areas of provision have done better than others, but on the whole it is the primary and community based services on which many older people depend in order to sustain their independence which have seen the sharpest falls or where supply is most obviously failing to meet rising demand. So, for example, GP numbers are not keeping up with a growing older population and meals on wheels provision, once a mainstay of community care, is rapidly falling away.

Our health and care system is designed so that social care and NHS provision butt up against each other and interact in many different ways to help keep older people fit and well, but there are increasing examples of how starving social care of resources is seriously undermining the operation of the NHS – our hospitals especially. This can be seen, for example, in the rapidly worsening figures for delayed discharges and emergency readmissions to hospital.

This is partly happening because as the needs of older people exceed the system's capacity to respond, decisions are often being made to focus what is available on those in greatest need.

This is a rational response by managers, but it inevitably harms our overall capacity to intervene early to prevent small problems older people have from becoming bigger ones, thus storing up difficulties for the future. In addition, it condemns hospitals to 'run hot' for increasing periods of time as the only place where the lights are always on. This places a lot of stress on professionals, which in turn risks making it harder to recruit and retain staff, thus placing more of a burden on those who remain - a destructive vicious circle.

There is a deeply interesting and constructive policy conversation underway nationally at the moment about how to make the best use of NHS and social care resources to meet the needs of our growing older population, with ideas to do with devolution, integration and personalisation very much to the fore. There are also some exciting examples of innovative practice to be seen in some local areas which, if scaled up, could make a considerable difference to the health and wellbeing of millions of older people, with some of which Age UK is heavily involved.

But in the end, one is forced back to the hard facts and figures presented in this briefing. There is a lot of ingenuity and commitment within our health and care system but even so, it is hard to see it being a match for the consequences of a steadily rising older population, combined with health spending failing to keep pace and social care spending significantly declining.

In the introduction to this briefing we referred to the importance older people attach to their health and the crucial role the NHS and social care play in helping them to keep going and be resilient as they age. Unless there is significant change to the funding of our health and

care system for older people as a result of decisions taken in the Government's Spending Review, we look to the future with considerable foreboding.

Indeed, on the basis of the trends presented in this briefing, if an older person asked us today how confident we were that their health and care needs will be met well in the future we would be whistling in the dark if we gave a wholly reassuring answer. That is something about which we should all be profoundly concerned and which the Government must change.

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- ² Office for National Statistics; "Revised population estimates for UK, England and Wales Scotland and Northern Ireland, mid-2013," **Office for National Statistics (2015a)** - <http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/mid-2014/rft---mid-2013-uk-population-estimates.zip>
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