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The State of Health and Care of Older People in England 2025

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Let's change how we age

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Foreword

Foreword

Welcome to the tenth annual edition of Age UK's State of Health and Care of Older People report. The story it tells begins with the fundamental demographic fact that the numbers of older people in our country are rising quite quickly. However, at the same time, over the last couple of years healthy life expectancy has fallen at ages 50 and 65. This overall decline in older people's health masks massive inequalities in terms of income and geography, with advantaged older people often ageing well while their less fortunate peers struggle. Many of those who do need support from NHS services and social care can't access it speedily or sometimes at all. Services are under huge pressure and levels of public satisfaction have gone down. As both the NHS and the local authorities that oversee the delivery of social care battle to meet high demand with static or reduced resources in real terms, the burdens on unpaid carers are increasing. The pressures on staff in health and social care are intense too, undermining essential efforts to improve recruitment and retention and fill substantial workforce gaps.

Within healthcare, there is a growing trend towards more older people who can afford it choosing to 'go private' for some procedures, sharpening inequalities. Within social care, increasing numbers of older people are being forced to fund their own support as the State funded system lags between growing demand from older and disabled people. This means that increasingly, it is only the very poorest older people with the most severe needs whose care is being paid for by the Government, with everyone else left to fund their own. Such is the cost that some older people are unable to afford to pay for enough, or sometimes any care, so if they lack friends or relatives who can help them for free then they have to cope alone. This in turn makes them more likely to become unwell and so a damaging cycle continues.

How have we reached this depressing position? Part of the answer is that as the years go by it is becoming clearer that the experience of living through the pandemic significantly weakened many older people's health and resilience, leading to some becoming sicker more quickly, increasing their demand for health and care support. The pandemic also halted most routine NHS procedures so waiting lists that were already lengthening increased exponentially. They remain stubbornly long today, despite energetic attempts by the NHS and the Government to bring them back down again.

However, where we are now is to an even greater extent the product of more than a decade of State underinvestment in the NHS and social care, plus a lack of workforce planning and future proofing to make our system fit for an ageing population. The upshot is that we haven't got enough GPs, hospital beds or social care professionals, among other key deficits. By any measure this is a big strategic failure on the part of predecessor governments and as the biggest users of both the NHS and social care, older people are inevitably impacted the most.

But not all is lost: we can escape this 'doom loop' and we must. A few months ago the incoming Government published a 10 Year Health Plan, which sets out the transformational change it believes is needed to put the NHS on an even keel and make it fit for the future. Age UK strongly supports its main thrust, the aim of shifting the emphasis in healthcare 'from hospital to home' through the development of a Neighbourhood Health Service. We were pleased and honoured to be able to contribute to the development of this part of the Plan. As the initiative is rolled out it is essential that older people living with frailty and other long-term health conditions are among the top priorities for help, and that the essential contributions from social care and from VCSFE organisations like Age UK are properly factored in. An effective Neighbourhood Health Service wouldn't just be good for older people, it would benefit us all and be a corrective for an approach to healthcare which leans too heavily on hospital in-patient care and underinvests in working in the community to sustain people's health.

Earlier in the year the in-coming Government announced that it was establishing an independent Commission into the future of social care, under the leadership of Baroness Louise Casey. After a delayed start the Commission is now getting into gear. Given the litany of failed government social care initiatives in recent years and against the context of the current system failing to meet current, let alone future needs, it is imperative for older people that the Commission succeeds. The biggest concern for it is the slow timetable the Government set – it is not due to report until 2028 – and we can only hope that Baroness Casey decides to speed things up. Much of the policy groundwork for an initiative of this kind is already there but the Commission has a crucial role to play in articulating the trade-offs involved in reforming and refinancing social care and helping policy makers and the public to make decisions.

Before the Election the Labour Party had pledged to introduce a Fair Pay Agreement (FPA) to benefit our underpaid care professionals quite quickly after entering office. Recently however it announced that the FPA will not come into force before 2028 – into the next Spending Review period and before ameliorative efforts are in place to compensate for new immigration rules curtailing care workers coming here from abroad. This unfortunate sequencing poses a threat to the sustainability of social care services in the next few years as they are so highly dependent on having enough staff to deliver them. It also reinforces the impression that the Government is 'long-grassing' social care reform.

The Government is keen to press ahead with improving the NHS but it remains to be seen how much progress is possible in one part of our health and social care system for as long as the other part limps behind. Ideally reforms to both sets of services would have proceeded hand-in-hand, and the fact that they are not means that in the shorter term it is the development of a Neighbourhood Health Service that has the greatest potential for improving older people's health, wellbeing and quality of life – but only if it is truly integrated in its approach so they get the joined up help they need. Age UK is committed to doing everything we can to help ensure this happens.

Recommendations

1. Make older people an explicit priority cohort for Neighbourhood Health right from the start and throughout.
2. By the end of this Parliament:
    a. Reduce the number of emergency admissions for acute and chronic conditions that could and should be managed in the community to under 100,000 a year.
    b. Guarantee that all older people diagnosed with severe frailty in the community receive a structured medication review and falls risk assessment, as a minimum.
    c. Bring down the numbers of people delayed in hospital when fit for discharge back to pre-pandemic levels (approx. 4,500 on a typical day vs 12,000+ now).
3. In order to achieve this, develop and put in place in every area shared community assessments involving NHS and social care services and minimum service requirements for rapid access to care such as physio and occupational therapy, community mental health and other rehabilitation services where needed.
4. As part of the upcoming NHS workforce strategy, the Government must:
    a. Assess and standardise maximum GP list size, taking into account the size of the older population.
    b. Make funded commitments to grow the community workforce, including District Nurses.
    c. Increase and standardise core skills and capabilities across the workforce relating to older people's care and frailty.
5. Request the Casey Commission produces its final report in 2027 at the latest, rather than 2028.
6. Develop measures to support the care workforce and mitigate the impact of the new Immigration Rules, including bringing the Fair Pay Agreement into force sooner than 2028 if at all possible.
7. Develop a funded strategy to increase the proportion of unpaid carers who are able to take a break for 24 hours to at least 1 in 4 by the end of this Parliament.

1. Health and care needs of the older population

1 HEALTH AND CARE NEEDS OF THE OLDER POPULATION

1.1 England's population is ageing

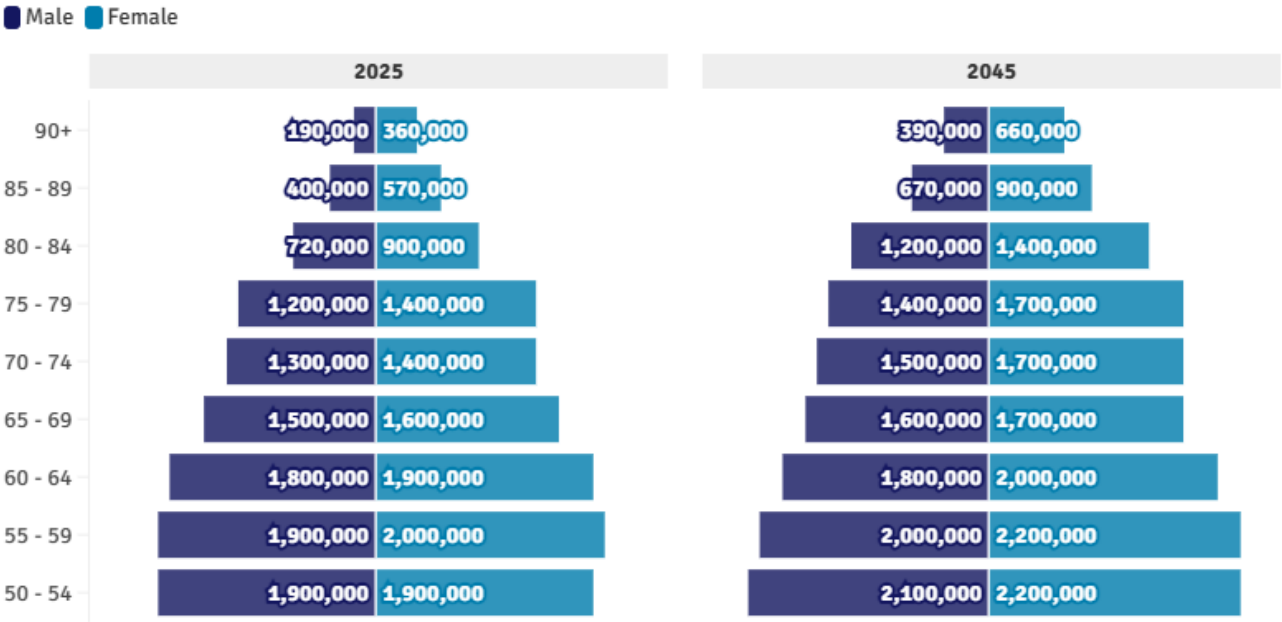
Ageing is not a linear or consistent process; trajectories are diverse and there is no typical older person. Healthy ageing is defined as "the process of developing and maintaining the functional ability that enables wellbeing in older age".[1] Physiological changes in older adults can be a consequence of the normal ageing process, disease and multimorbidity, or frailty, but is often a combination of these.[2] A recent study led by University College London found that while our organs function as an integrated system, they can age at different rates.[3] While some people will maintain their health and independence into their 80s and beyond, others will experience diseases, conditions and disabilities usually associated with later life in their 50s. A large proportion of this diversity is the result of the cumulative impact of advantage and disadvantage across people's lives. Impacts of factors such as sex, ethnicity, childhood nutrition, access to education, financial income, and caring responsibilities all contribute to diverse experiences of ageing.[4]

'Older' is not a fixed age. Data pertaining to 'older people' in England has historically been collected from the age of 65+. However, we have been struck by how much some members of the 50-64 age group are struggling, and on many different fronts. Over the past few years, Age UK has conducted seven waves of research into older people's health and care. We expanded our recent research to include people aged 50+ and found some people in their fifties and early sixties have been very severely impacted by the cost-of-living crisis. This is exacerbated by low pay or not working because of caring responsibilities, ill health, disability and/or unemployment. We also know ethnic inequalities exist (see below). As a result, it is clear to us that less advantaged people in their fifties and early sixties need more policy attention and support to help them make the most of their lives now and to help them to flourish as they age. We have therefore sought to include this age group in our considerations of the state of health and care of older people in England.[5]

The age structure of England's population is shifting toward older ages, and the older population is increasing.[6] In 2025, there are an estimated 22.3 million people aged over 50 in England, equivalent to 38% of the total population. By 2045, this is projected to increase by 4.2 million to 26.6 million (42% of England's population) (Figure 1.1).[6]

Fig 1.1 By 2045, England's population of people aged 50+ is projected to increase by 4.2 million

Population projections in five-year age groups by sex, England.



Source: Age UK analysis of ONS (2025). Population projections for regions by five-year age groups and sex, England 2022-based.

1.2 Healthy life expectancy is falling at older ages

Life expectancy gains at older ages stalled in the 2010s.[7] Life expectancy at birth is sensitive to changes in infant mortality at the youngest ages*, so to understand the experiences of older people we must focus on life expectancy at older ages. As shown in Figure 1.2, period life expectancy at older ages plateaued in the 2010s after a long period of year-on-year improvement. It fell during the COVID-19 pandemic but saw modest increases in 2021-23. These are likely, in part, to be accounted for by mortality displacement during the pandemic and a return to pre-pandemic levels (which has been modelled in other countries[8]). In 2021-23, life expectancy at age 50 stood at 34.5 years for females and 31.3 years for males. At age 65, life expectancy was 21.1 years for females and 18.6 years for males.[7]

*High infant mortality results in lower values of life expectancy at birth than at other ages. In populations with high infant mortality, those surviving the hazards of early childhood have a higher life expectancy than infants and the maximum life expectancy occurs not at birth but at a later age (usually expected to be at age one year). Thus, changes in mortality in the first year of life significantly affect life expectancy at birth. See: Miladinov, G. (2020). Socioeconomic development and life expectancy relationship: evidence from the EU accession candidate countries. *Genus Journal of Population Science* 76:2.

Fig 1.2 Life expectancy gains have slowed

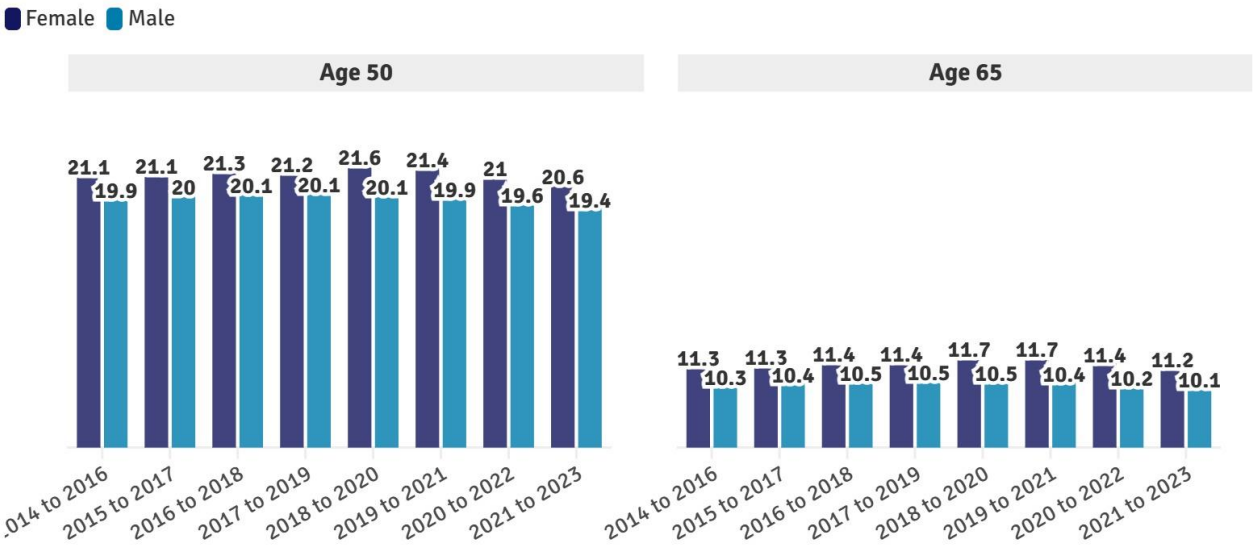
Period life expectancy (LE) at age 50 and 65, by sex, England, 1980-82 to 2021-23

Source: Age UK analysis of ONS (2024). National Life Tables – life expectancy in the UK: 1980 to 2023.

Healthy life expectancy at age 50 in England has continued to fall. Figure 1.3 shows healthy life expectancy at age 50 has dropped to 20.6 years for females and 19.4 years for males. At age 65, healthy life expectancy has dropped to 11.2 years for females, and to 10.1 years for males.[9]

Fig 1.3 Healthy life expectancy over age 50 is declining

Healthy life expectancy in years at age 50-54 and 65-69, by sex, England, 2014-16 to 2021-2023



Source: Age UK analysis of ONS (2024). Healthy life expectancy in England and Wales: between 2011 to 2013 and 2021 to 2023.

1.3 Geographic variation and health inequalities

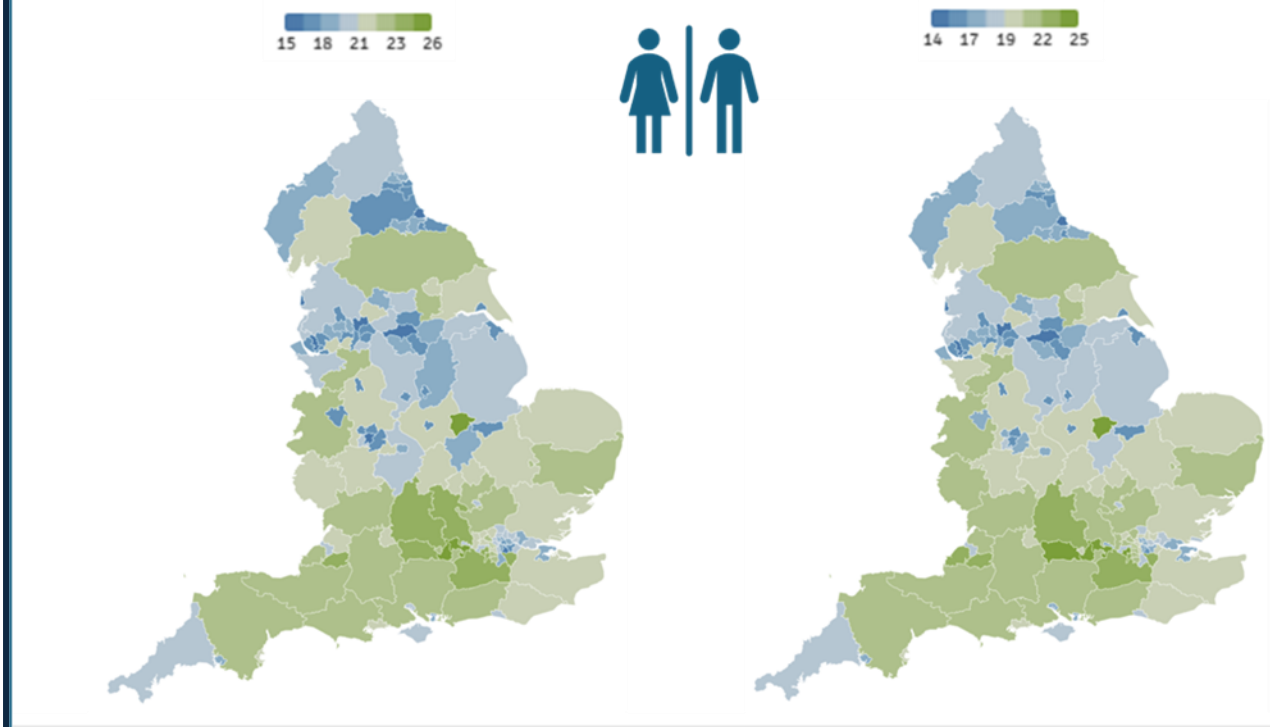
There is a 25-year age gap between the median age in the oldest local authority and the youngest. The Resolution Foundation[10] report the median age in local authorities ranged from 55.3 years in North Norfolk to 30.6 years in Tower Hamlets. The oldest parts of the country are often rural and coastal areas, while cities, particularly those with large universities, are significantly younger. This demographic divergence is expected to continue; coastal and rural areas are projected to continue ageing, as younger populations move towards cities.

The more deprived an area, the lower the proportion of life spent in good health. In 2020-22, females age 50 living in the most deprived areas of England were expected to live 44% of their lives in good health, compared to 70% for females age 50 living in the least deprived areas of England. For males, proportions were 47% and 72%, respectively.[11]

There is an 11-year gap in healthy life expectancy at age 50 between Blackpool and Wokingham, areas in the most and least deprived areas of England.[9] At age 50, people living in Blackpool, which is one of the most deprived areas of England, have the lowest healthy life expectancy; 15.1 years for females, and 14 years for males (Figure 1.4). This contrasts with people living in Wokingham, one of the least deprived areas of England, with healthy life expectancy at 26.3 years for females and 24.6 years for males at age 50.[9]

Fig 1.4 At age 50, there is an 11-year gap in healthy life expectancy between Blackpool and Wokingham

Healthy life expectancy at age 50 in England, by sex, 2021 to 2023.



Source: Age UK analysis of ONS (2024). Healthy life expectancy in England and Wales: between 2011 to 2013 and 2021 to 2023.

1.4 Health and care needs of older people

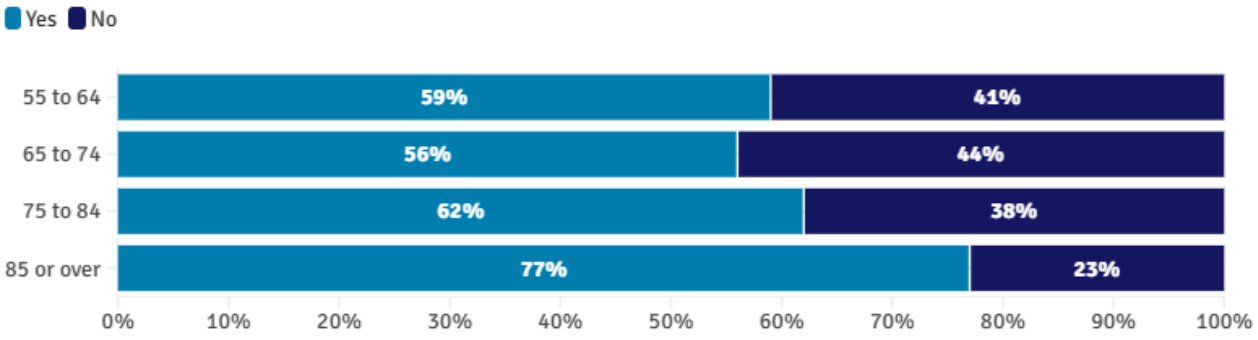
Fewer older people report good general health than younger people. ONS Opinions & Lifestyle Survey report in April 2025, 82% of people aged 16-29 reported their general health to be 'good' or 'very good', compared to 61% of people aged 50-69, and just 54% of people aged 70+.[12]

Many older people experience difficulties with day-to-day activities due to their health.* The GP Patient Survey 2025 found 59% of people aged 55-64 felt their long-term condition or illness reduced their ability to carry out day-to-day activities (Figure 1.5).[13] For those aged 65-74, 56% agreed, increasing to 62% and 77% for those aged 75-84 and 85+, respectively.[13]

* 'Activities of daily living' are routine, everyday tasks related to personal care and mobility about the home. They tend to be tasks we learn as young children, including walking (including getting up and down stairs), eating, toileting, bathing, and dressing.

Fig 1.5 Many older people are finding it difficult to carry out daily activities due to their health

Percentage of people that responded to whether or not their conditions or illnesses reduce their ability to carry out day-to-day activities



Source: Age UK analysis of NHS England (2025). GP Patient Survey 2025.

Over the past year, people aged 50–59 were the most likely older age group to report difficulties with self-care, processing information, increased anxiety, and poor sleep. Age UK polling data from September 2024 showed that in the previous 12 months, older people aged 50-59 were the most likely older age group to find it difficult to look after themselves; to process new information; to feel more anxious than the previous year; and to have not been sleeping well than any other age group over 60[14].

The likelihood of being out of work for older workers (aged 55-64) with health limitations is much higher than for younger workers with health limitations. While the employment rate for people aged 55-64 with health limitations improved in most European comparator countries between 2018 and 2022, it got worse in the UK.[15] In 2022, older workers with health limitations were 20% more likely to be out of work than their peers without health limitations. It is not fully understood if this difference reflects a greater severity of health limitations appearing with age; an imbalance in how labour market interventions are targeted at different age groups; or differing employment choices across the age groups (or a combination of these).

People's experience of poor health does not appear to have improved since the COVID-19 pandemic. The proportion of adults in Britain reporting good or very good health has declined slowly but steadily since March 2020. The ONS Lifestyle and Opinions Survey found that while 77% of people surveyed reported good or very good health at the beginning of the first lockdown, this figure had dropped to 63% at the end of March 2025.[12]

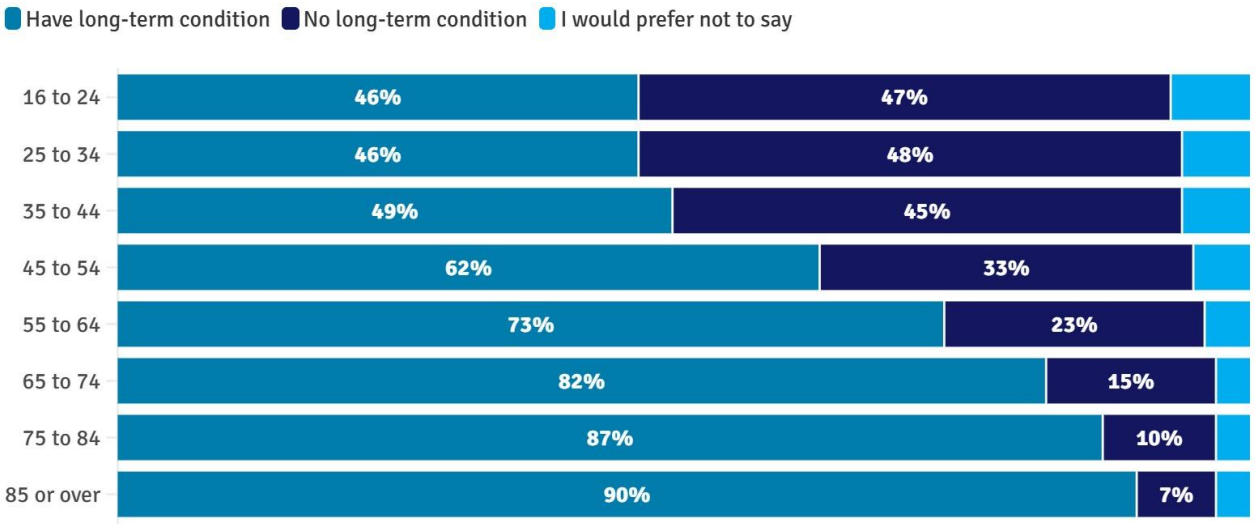
1.4.1 Long-term conditions and multiple long-term conditions

The number of older people living with long-term conditions is rising.[16] In England, 41% of people aged 16+ report having at least one long-term health condition.[17] The most common conditions were: conditions of the musculoskeletal system (14.3%); mental, behavioural and neurodevelopmental conditions (10.6%); conditions of the heart and circulatory system (9.4%); diabetes and other endocrine and metabolic conditions (8%); and conditions of the respiratory system (6.8%).[17]

People aged 55+ are more likely to report having a long-term condition or illness than people aged 16-54.[13] Figure 1.6 shows 3 in 4 people (73%) aged 55-64 self-report having a mental or physical health condition or illnesses lasting, or expected to last, 12 months or more. This rises to 82% for those aged 65 to 74, and to 87% and 90% for those aged 75 to 84 and 85+, respectively.[13]

Fig 1.6 People aged 55+ are more likely to self report having a long-term condition or illness

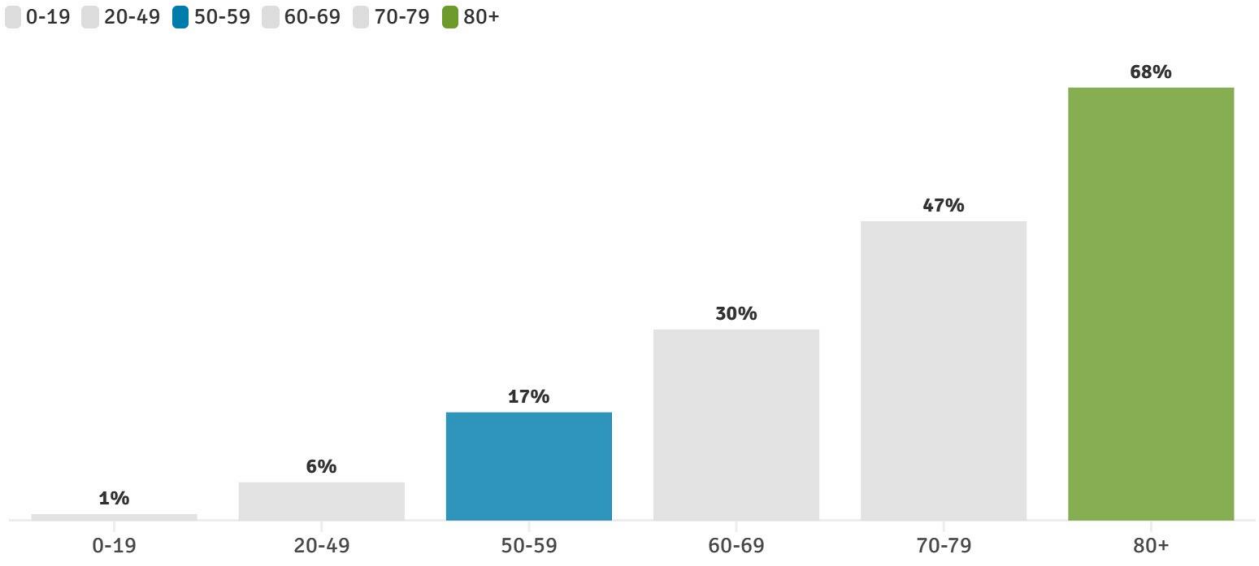
Percentage of people that self-report having a mental or physical health condition or illnesses lasting, or expected to last, 12 months or more



Source: Age UK analysis of NHS England (2025). GP Patient Survey 2025.

The likelihood of living with multiple health conditions significantly increases with age.[18] As shown in Figure 1.7, in the 50-59 age group, almost one in five (17%) people have multiple long-term conditions. By 80+, this rises to two in three (68%) people.

Fig 1.7 Multimorbidity increases significantly with age - 1 in 5 people in their 50s have multiple long-term conditions, rising to 2 in 3 people by age 80+



Source: Valabhji J et al. (2023). Prevalence of multiple long-term conditions (multimorbidity) in England: a whole population study of over 60 million people.

There are ethnic inequalities in the prevalence of multiple long-term conditions.[19] A study of both patient records and large-scale social survey data led by King's College London found that ethnic inequalities in the prevalence of multiple long-term conditions emerge from mid-life. By later life, older Pakistani, Indian, Black Caribbean and Other ethnic people have an increased risk of multiple long-term conditions compared to White British people, even after adjusting for area-level deprivation.

People tend to experience different combinations of long-term conditions across the life course. A recent study led by Imperial College London[20] found that specific combinations of long-term conditions have a distinct and significant impact on health-related quality of life. While asthma and autism were the most common combination in children aged up to 19 years, depression and asthma dominated for those aged 20-49 years, hypertension and diabetes for 50-59 years, and cardiometabolic conditions (including heart attack, stroke, diabetes and fatty liver disease) and osteoarthritis for the older age groups.

The combinations of long-term conditions experienced in later life are strongly associated with the greatest declines in health-related quality of life. A further study, led by the University of Glasgow[21], found certain combinations of chronic conditions – especially those involving pain (such as arthritis) and cardiometabolic diseases – were linked to greater long-term reductions in health-related quality of life than the total number of conditions alone. In older adults, these clusters had a stronger negative effect on daily functioning and well-being, underscoring the importance of treating the interplay and cumulative effect of conditions rather than focusing only on disease count.

1.4.2 Frailty

Frailty is a term widely used but often misunderstood. It is a health state associated with low energy, slow walking speed and poor strength,[22] but living with frailty does not mean you are incapable of living a full and independent life. When used appropriately, it describes someone being less able to recover from accidents, physical illness or other stressor events.[23] In practice, being frail means a relatively 'minor' health problem, such as a urinary tract infection, can have a severe long-term impact on someone's health and wellbeing. In practice, this means identifying frailty and mitigating those risks is critical to effective care and wellbeing.

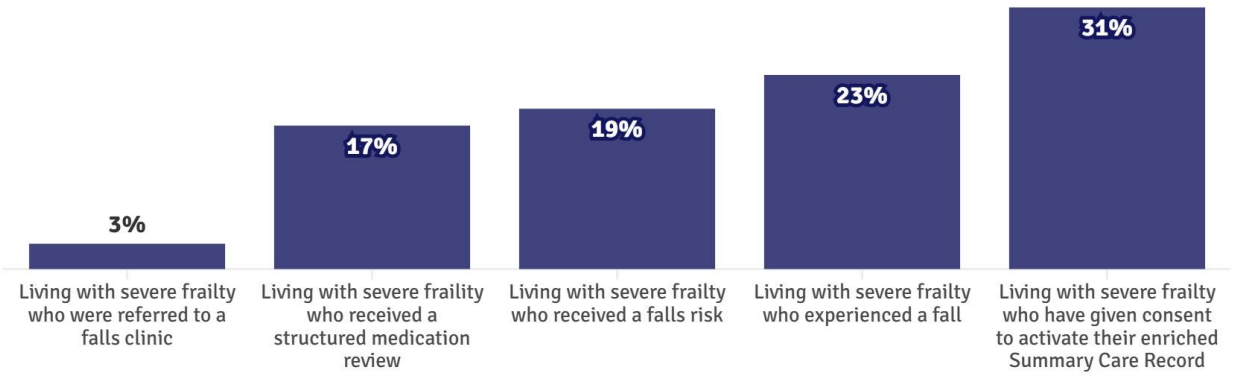
One-third of older people who received a frailty assessment in primary care were diagnosed with moderate or severe frailty in 2024/25.[24] Of the older people in England who received a frailty assessment in 2024/25, 21% were diagnosed with 'moderate' frailty and 12% with 'severe' frailty. Alongside the additional level of health risk associated with frailty, people with moderate to severe frailty may need some help with outside activities and maintaining their home and may often have problems with stairs, bathing and dressing.

Older people diagnosed with severe frailty are not always getting follow-up care. GP practices are incentivised to identify and assess people over 65 that may be living with frailty. Through this process, someone should be offered a care and support plan to optimise their care and reduce the risk of crisis and emergency care.

Following good practice, they should also receive preventative measures such as a medication review and falls risk assessment. As shown in Figure 1.8, only one in five (19%) received a falls risk assessment; 3% were referred to a falls clinic; and less than one in five (17%) received a structured medication review.[24] More than one in four (23%) went on to experience a fall.[24]

Fig 1.8 Older people diagnosed with severe frailty are not getting sufficient follow-up care

Percentage of patients aged 65 years and over diagnosed with severe frailty and referred to evidence-based preventative care or who experienced a fall.



Source: Age UK analysis of NHS England (2025). GP Contract Services - England, 2024/25.

Someone living with frailty may have no other diagnosed health conditions. However, there is an overlap with long-term conditions, and many people live with both.[25] Frailty is generally characterised by issues such as unintentional weight loss, reduced muscle strength and fatigue. The National Institute for Health and Care Excellence (NICE) recommends healthcare professionals consider assessing frailty in adults with multimorbidity.[26]

Older people with frailty are more likely to experience recurrent falls than older people without frailty.[27] Frailty-induced falls are associated with a greater risk of fractures, hospitalisation, and a permanent move to a care home.[28] Frailty assessment and diagnosis can be a gateway to support and services, including support to prevent falls.

Falls and fractures are a common and serious health issue faced by older people. Around one in three people aged 65+ and half of people aged 80+ will have at least one fall a year.[29] In 2023/24, 220,000 people aged 65+ in England had an emergency hospital admission due to a fall.[30] Falls are a significant cause of both emergency admission to hospital and admission to long-term residential care.[31] A fall (whether resulting in a fracture or not) indicates a high risk of fracture within the following year.[32] After a fall, older people are significantly more likely to have a fear of falling[33] , and older people with a fear of falling are at significantly greater risk of falls.[34]

1.4.3 Mental health

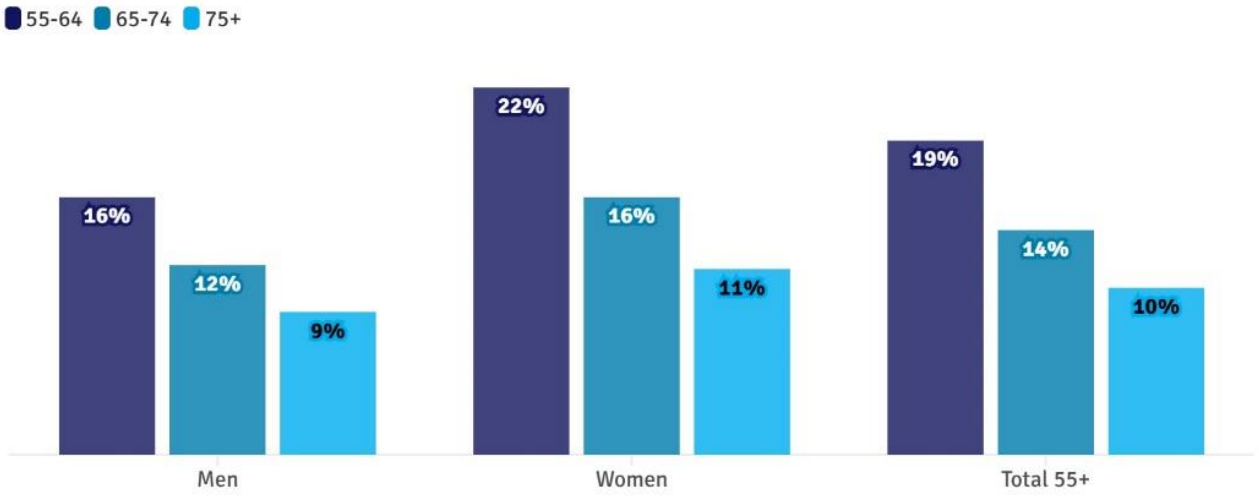
One in seven (14%) older people have symptoms of mental health problems.[17] Across all age groups, women are more likely to have higher scores than men for the General Health Questionnaire* (GHQ-12) mental health screening instrument. Adults living in the most deprived areas are more likely to have higher scores than adults living in the least deprived areas.[17]

One in five (19%) people aged 55-64 have a common mental health condition, including generalised anxiety disorder, depressive episodes and panic disorders.[35] As shown in Figure 1.9, women are more likely than men to have a common mental health condition in all age groups above 55.

*The 12-item General Health Questionnaire (GHQ-12) is a widely used mental health screening instrument that measures 12 symptoms including general levels of happiness, depression, anxiety, sleep disturbance and self-confidence. A score of four or more indicates probable psychological disturbance or mental ill health.

Fig 1.9 One in five people age 55-64 have a common mental heath condition

Percentage of people with common mental health conditions (CMHCs), by age and gender, 2023/24.



Source: Age UK analysis of NHS England (2025). Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/24.

Of new claimants of health-related benefits aged 55-64 between 2019 and 2024 in England and Wales, 22% were primarily for mental health reasons.[36] In England and Wales, 4 million people aged 16-64 (1 in 10) now claim either disability or incapacity benefits, up from 2.8 million in 2019 (1 in 13). An investigation by the IFS found "compelling evidence that mental health has worsened since the pandemic".[37]

Older people may feel it is more difficult to discuss mental health issues than it is for younger people.[38] International Longevity Centre UK found older people could be more likely to feel shame when disclosing their mental health symptoms to a healthcare professional than younger adults. Some mental healthcare facilities are also perceived to not be age-friendly.[38] A study of UK workplace mental health trends published in 2025 found that 51% of people aged 55 to 64 felt that stigma around mental health and seeking help was a barrier to accessing employee assistance programmes, with only 29% of people aged 18 to 24 feeling the same way.[39]

1.5 Factors impacting health and care needs in later life

Several interconnected factors shape health and care needs as people age. These include factors pertaining to support networks, which play a role in older people's experiences of and responses to their health and care needs.

Older people are over-represented in rural and coastal areas compared to urban regions.[40] Even though more older people live in urban areas in absolute numbers due to larger populations, the proportion of older residents is higher in rural settings, with coastal towns and remote

villages having especially high proportions of older residents. The 2025 Statistical Digest for Rural England notes the proportion of the population aged 65+ in rural settlements to be 26%, while in urban areas outside of London the proportion is 18%, and in London it's 12%.[40]

There were 4.3 million people aged 65+ living alone in the UK in 2023.[41] The number of people aged 65+ living alone in the UK increased 16% between 2013 and 2023, with older women more likely to live alone than older men (2.7 million women and 1.5 million men). Living alone increases older people's mortality risk**.**[42] A systematic review published in 2025 found that people living alone had a 21% higher chance of dying during the follow-up time of the study than those not living alone. Living alone involves structural risk (like reduced support or emergency care) that worsen over time with age and frailty. Living alone poses challenges in accessing healthcare provisions, including transportation for medical consultations, and managing healthcare logistics, but the stress associated with living alone can also exert detrimental impacts on both mental and physical health. A study by researchers at University College London found that older people who move to living alone after divorce or bereavement have a particularly significant increase in their mortality risk compared to their peers.[43]

The number of people ageing without children is significantly increasing. In 2025, 19% of women in England and Wales aged 65 have never had children, compared with 14% of women aged 75, and 11% of women aged 85.[44] The number of single and childless older people needing care in the UK is projected to increase by 80% by 2032.

One in 12 older people (8.0%) report often feeling lonely.[45] Loneliness is associated with an average 14% increased likelihood of mortality in older people, and social isolation with an average 35% increased risk.[46] Longitudinal research[47] has found higher levels of loneliness to be associated with poorer cognitive function, a worsening memory and declining verbal fluency over a decade.[*] Loneliness has also been shown to be associated with a range of poor physical health outcomes[†], including high blood pressure, heart disease, obesity, and a weakened immune system.[48] There is an increased or high risk of loneliness linked to health inequalities. Age UK research[49] found enduring loneliness to be weighted heavily towards groups of people including those on lower incomes. Life transitions – and particularly role transitions, including through retirement, divorce or bereavement – are also known to increase the risk of a person becoming or remaining lonely.[50]

Around 16% of people aged 65+ in England are unpaid carers, equivalent to 1.8 million.[51] Some 7.5 million people in England aged 16+ provide unpaid care. One in five (20%) of people aged 50% in England are unpaid carers, equivalent to 4.3 million. **'**Sandwich generation carers' are becoming increasingly common.[52] Sandwich carers provide unpaid care for one or more older person while simultaneously looking after one or more child. They are predominantly women. The ONS estimate there are 1.4 million sandwich carers aged 16-64 in the UK.[52] The ONS analysis also found sandwich carers to be more likely to find it difficult to manage financially, to have run out of food in the past 12 months, and to be diagnosed with depression than their peers.[52]

Caring has a significant impact on carers' physical and mental health. Carers are more likely than non-carers to report that they are 'not in good health'.[53] Carers UK research[54] found 80% of carers surveyed in the summer of 2024 felt the impact of caring on their physical and mental health

[*] However, there is a bidirectional relationship between these factors, as baseline memory and its rate of decline also contribute to an increase in loneliness.

[†] This may in-part be reverse causality (people with worsening health are less able to engage with society, become lonely, and go on to be diagnosed with a health condition).

would be a challenge over the coming year. Over a third (35%) of respondents said they had bad or very bad mental health, compared with 27% in 2023. Research by Age UK found 74% of older carers (aged 65+ in the UK) feel under strain, 66% have lost sleep due to worry, and 62% felt unhappy or depressed. More than half (55%) live with a long-term illness or disability themselves. [55]

2. Neighbourhood treatment, care and support

2 NEIGHBOURHOOD TREATMENT, CARE AND SUPPORT

The 10 Year Health Plan and Neighbourhood Health Guidelines reiterate repeated policy commitments in recent decades to shift care away from acute hospitals and into community settings, including the NHS Long Term Plan (2019) and its predecessor the NHS Five Year Forward View (2014), along with the Care Act 2014 and its associated Regulations and statutory guidance.

2.1 Accessing treatment, care and support

2.1.1 Primary care

The largest volume of NHS activity is in primary care – people receiving services from their local GP practice. This includes services with a GP or another member of the practice staff, such as a nurse or physiotherapist. In 2024/25, there were an estimated 370 million appointments in general practice, of which two-thirds (65%) were conducted face-to-face.[56]

The increase in full-time equivalent GPs is struggling to keep pace with increasing demand for appointments. The number of total appointments in general practice (excluding COVID-19 vaccination appointments) increased by 2.7% between 2023/24 and 2024/25.[56] Meanwhile, the number of full-time equivalent (FTE) GPs (including trainees) increased by 2.5% between March 2024 and March 2025.[57]

Satisfaction with the time it takes to get a GP appointment is the top NHS priority for older people. In 2025, 28% of people aged 65+ felt the length of time they waited for an appointment was too long.[13] Respondents to the British Social Attitudes Survey conducted between September and October 2024[58] felt the most important priority for the NHS should be making it easier to get a GP appointment (51%). This concurs with polling undertaken by Ipsos for the Health Foundation in November 2024 that found participants aged 65+ were significantly more likely to prioritise making it easier to get appointments at GP practices, with 44% citing this to be their top priority compared with 38% of all participants (aged 16+).[59]

Many adults are unable to access NHS dental treatment, with the 'oldest-old' seen least by dental services. In June 2023 (the latest data available), 43% of adults living in England reported having seen a dentist in the previous 24 months, but – despite older people being at increased risk of dental disease[60] – this proportion was only 37% of adults aged 85+, the lowest of all adult age groups.[61] In 2025, 16% of respondents to the GP Patient Survey aged 65+ said they had been unable to get a dentist appointment in the last two years.[13]

The Public Accounts Committee (PAC) reported in April 2025 that "the most vulnerable [dental] patients continue to suffer the most from long–standing failures in the system".[62] Echoing a finding by the National Audit Office that plans to increase access to NHS dentistry are "not on track"[63], a PAC inquiry into NHS dentistry found a smaller proportion of adults in England were seeing an NHS dentist than prior to the COVID-19 pandemic. It concluded "more fundamental reform to the dental contract…is necessary to mend NHS dentistry", but noted NHS England and the Department of Health and Social Care "do not yet know what that reform might look like or to what timescales it can be delivered". The Government's 10 Year Health Plan has prioritised children and young people for urgent dentistry reforms and promised major changes to the sector by 2035.

2.1.2 Adult social care

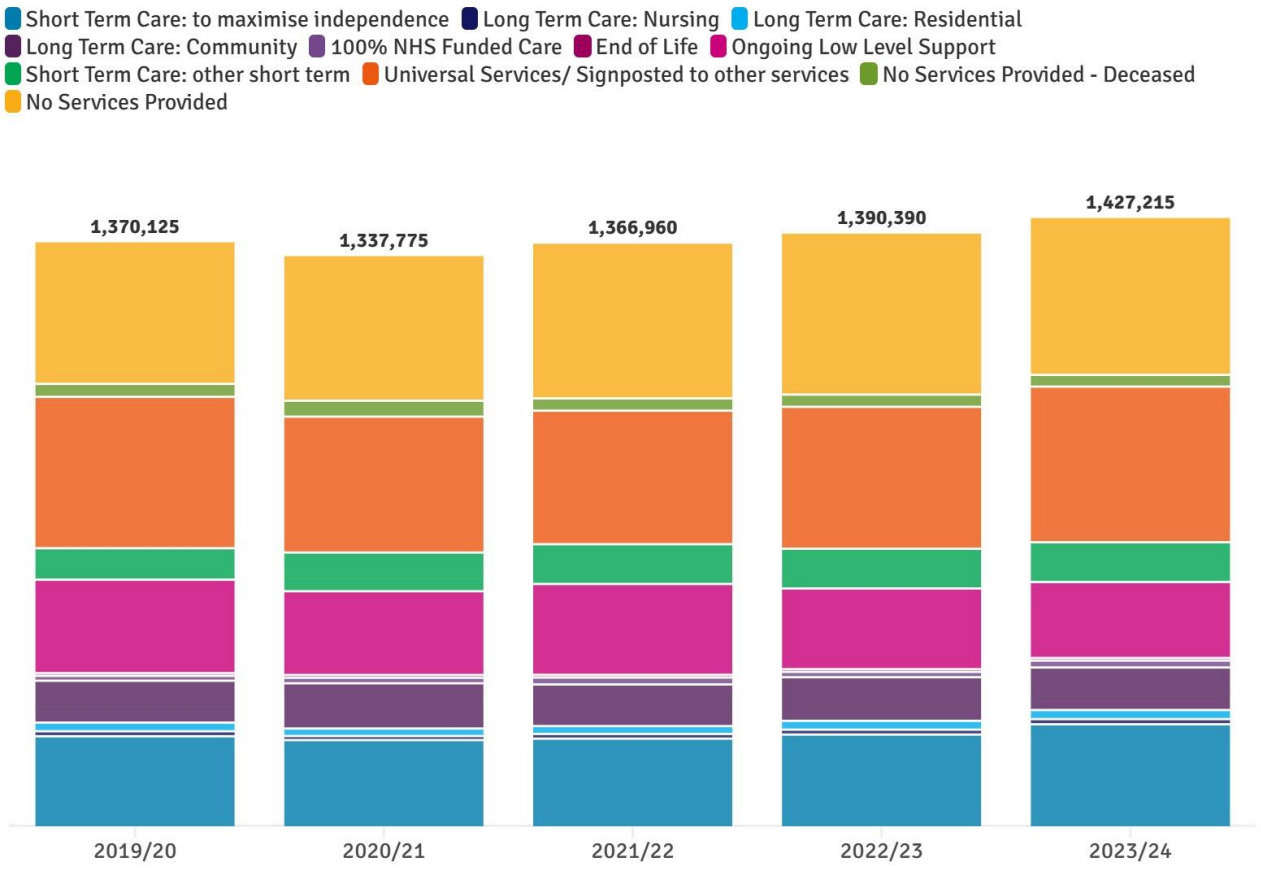
Adult social care usually refers to a variety of extra support and professional help to carry out essential daily tasks and live comfortably. For many older people, 'social care' means personal care, which can include help with washing, dressing, getting out of bed in the morning, help taking medicine and help with housework. It can also refer to support that does need meet the eligibility threshold for state-funded support under the Care Act 2014 but is nonetheless important to maintain a person's independence and their home. This includes support with household tasks, shopping or gardening, plus broader activities that are essential to a person's wellbeing, such as being active in their community and maintaining contact with family and friends. Social care also seeks to protect and safeguard people from harm and neglect.

There were 1.4 million new requests for support from older people to English local authorities in 2023/24, accounting for 68% of all requests received by Adult Social Services Departments (Figure 2.1).[64] The total number of requests for support from people aged 65+ has increased by 2.7% to 1.4 million in 2023/24[64], from 1.39 million in 2022/23[65]. In 2023/24, 368,175 requests resulted in no services provided and 365,145 were provided with universal services[*] or signposted elsewhere. This accounts for more than half (51%) of requests for support from older people in 2023/24.[64]

[*]Universal services are those that are available to everyone living in the council's area — not just to people who have been assessed as needing targeted or specialist help.

2.1 There were over 1.4 million new requests for support from older people to English local authorities in 2023/24

Number of new requests for support received from people aged 65+, and what happened next, 2019/20 to 2023/24, England.



Source: Age UK analysis of NHS Digital (2024). Adult Social Care Activity and Finance Report, England, 2023-24 • *Excluding Long Term Care: Prison*

Hundreds of thousands of adults are waiting for councils to action their care.[66] The Association of Directors of Adult Social Services (ADASS) reports that as of 31 March 2025, there were 372,113 adults waiting for an assessment, care or direct payments to begin or a review of their care plan. This is an 11% reduction on 31 March 2024, though ADASS advises caution in drawing a direct year-on-year comparison because they have made slight alterations to their methodology. Of the people waiting, 195,788 were waiting for an assessment, of which 78,641 had waited for six months or more. ADASS has previously noted that the high number of people waiting for councils to action their care "means that people have unmet or under met needs".[66]

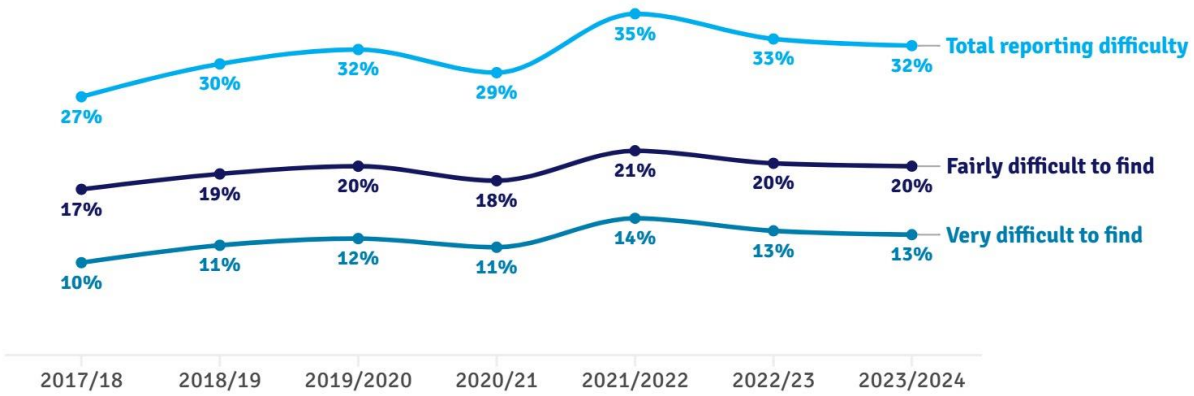
Unpaid carers are "selflessly picking up the pieces of a health and social care system that is not realising its full potential".[66] ADASS reports that 76% of Directors of Adult Social Services reported an increase in the number of unpaid carers requiring support in 2024/25. For the third year in a row, Directors ranked burnout as the number one contributing factor to increases in carer breakdown over the past 12 months. This has wide-ranging implications, with ADASS noting "Carer

breakdown is deeply upsetting and potentially damaging for the person providing care, and the person receiving care. It also accelerates the need for more expensive council-provided care".

One third of people using Adult Social Care services find it difficult to seek information and advice about support, services and benefits.[67] Under the Care Act 2014, local authorities have a duty to provide comprehensive information and advice about care and support services in their area to help people understand how care and support services work locally, what care and funding options are available, and how they can access care and support services.[68] All information and advice must be provided in formats that help people understand, regardless of their needs. Despite this, Figure 2.2 shows 32% of people using Adult Social Care services have reported finding it 'difficult' (including 'Fairly difficult and 'Very difficult') to find information and advice about support, services or benefits.[67]

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

Number of people using Adult Social Care services who report finding it difficult to find information, 2018/19 to 2023/24, England.



Source: Age UK analysis of NHS England (2024). Personal Social Services Adult Social Care Survey, England, 2023-24.

2.1.3 Home adaptations

Most older people wish to stay in their home for as long as possible, yet the vast majority will age in general mainstream housing that is not accessible or adaptable. Only 19% of homes have step-free access and less than 10% of homes have the four features that would allow a wheelchair user to visit.[69] IFS research suggests 40% of homeowners and more than 60% of renters aged 70 have moved into their property since the age of 50. More than two-thirds (70%) of over 55-year-olds say that a strong motivation behind considering a move is wanting a home better designed to meet their needs as they age.[70]

Home adaptations can enable older people to remain in their homes for longer.[71] Home adaptations – changes made to the fabric and fixtures of a home to make it safer and easier to get around and to use for everyday tasks – have an important role to play in ensuring the homes of older people can accommodate changing needs and are comfortable, healthy and safe. Local authorities administer funding for adaptations, which generally fall into two categories. 'Minor' adaptations are those with a value of less than £1,000, and include grab rails, lever taps in kitchens and bathrooms, small ramps, and raising or lowering plug sockets, light switches, and key holes. 'Major' adaptations are those with a value of £1,000 or more, and include level access showers, walk-in baths, and installing ceiling track hoists, stairlifts and 'through the floor' lifts.

The majority of Disabled Facilities Grants (DFGs) are awarded to older people. Disabled Facilities Grants (DFGs) are capital grants available to people of all ages and in all housing tenures to contribute to the cost of major adaptations that make homes more accessible. They can provide funding for a wide range of adaptations to support people in and around their homes, such as lifts, stairlifts, wash and dry toilets, grab rails, and level access showers. More than half (57%) of DFGs were awarded to people aged 65+ in 2023/24.[72]

However, people are waiting months for DFGs to be awarded and their home adaptations to be completed. In 2023/24, the total average time for completing a DFG was 247 working days (an 11% increase on 2022/23).[72] Allowing for weekends (but assuming no public holidays as it is not possible to know which fell within the period of each DFG), this equates to 346 days*, or more than 11 months.

Only 1 in 10 councils are meeting the target that all stages of the DFG application process should be completed within 6 months (for all but the most complex or non-urgent cases).[72] By law, councils must approve valid applications within 6 months, but they can defer payment for up to 12 months if their DFG budget is already fully committed. In 2023/24, 17 English councils deferred a total of 778 grants.[72] Long waiting times mean some older people are confined to the downstairs part of their homes, are unable to go to the toilet in private, or are required to use their kitchen sink to strip wash.[73]

2.1.4 Mental health

The percentage of referrals to NHS Talking Therapies for older people is still far short of the national expectation. In 2011, the Department of Health said that, based on estimated need at the time, 12% of referrals through the Improving Access to Psychological Therapies (now known as NHS Talking Therapies) programme would be people aged 65+.[74] Fourteen years later, this is still not close to being reached, with 6.7% of referrals being for people aged 65+ in 2023/24.[75]

2.1.5 Dementia

The 'Challenge on Dementia 2020' target, consistently met prior to the COVID-19 pandemic, has not been met since. The target was for 66% of people with dementia in England to receive a formal diagnosis with appropriate post-diagnostic support.[76] It had been met consistently at the

* (247 working days / 5 weekdays = 49.4 weeks) * 7 days in a week = 345.8 days

national level from July 2016 until end of March 2020, then dropped below the national ambition in April 2020 as the COVID-19 pandemic began to impact health services.[77] The percentage of people aged 65+ who are estimated to have dementia with a recorded diagnosis had incrementally increased since and had been more or less achieved in May 2025, when it stood at 65.6%.[78]

The 'Challenge on Dementia 2020' target has now been scrapped, despite concerns about NHS diagnostic capacity. In January 2025, the NHS removed the target from its annual Operational Planning Guidance for 2025/26.[79] This move was criticised by leading dementia charities who noted having dementia but no recorded diagnosis leaves people without access to care, support and treatment, and puts them at greater risk of crisis.[79] A number of MPs also criticised the move, noting England to be the only UK nation without a dementia plan[80], despite research finding the NHS in England to have "large gaps in diagnostic capacity", including the second-lowest number of specialists needed to diagnose dementia (such as neurologists, old age psychiatrists and geriatricians) among the G7 countries.[81]

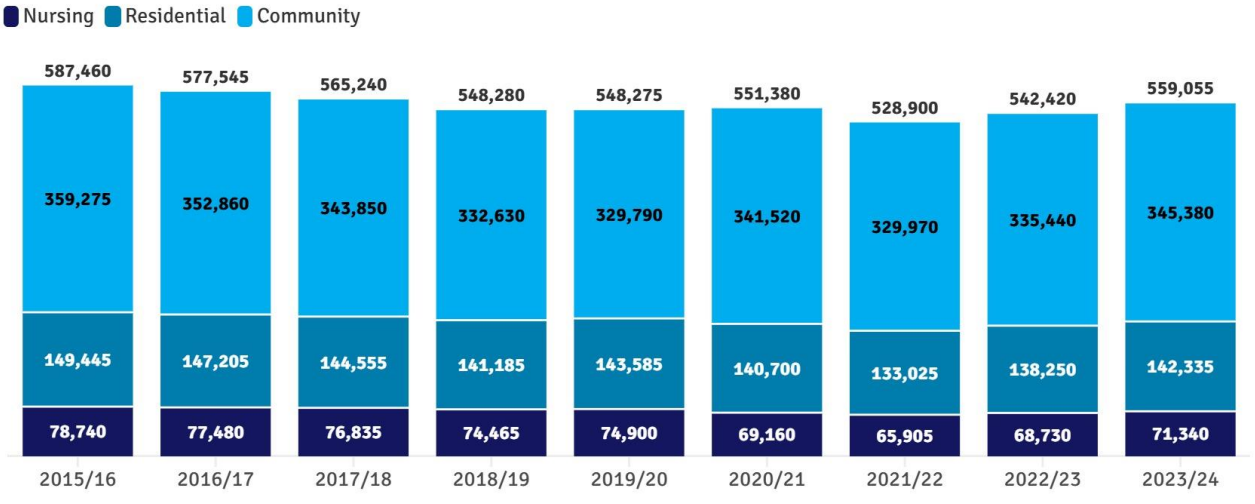
2.2 Receiving treatment, care and support

2.2.1 Adult social care

The growth in the number of older people receiving local authority long-term care is not keeping pace with the increasing older population and rise in need. The number of older people receiving local authority long-term care increased by 2% to 559,055 in the five years from 2019/20 to 2023/24 (Figure 2.3).[64] This is despite a 7% increase in the English population aged 65+, and a 16% increase in the population aged 75+ over the same period.[82]

Fig 2.3 The number of older people receiving local authority long-term care is not keeping pace with rising need

Number of people aged 65+ accessing long term support during the year, 2015/16 to 2023/24



Source: Age UK analysis of NHS Digital. Adult Social Care Activity and Finance Report, England - 2015/16 to 2023/24 • *Excluding Prison CASSR.*

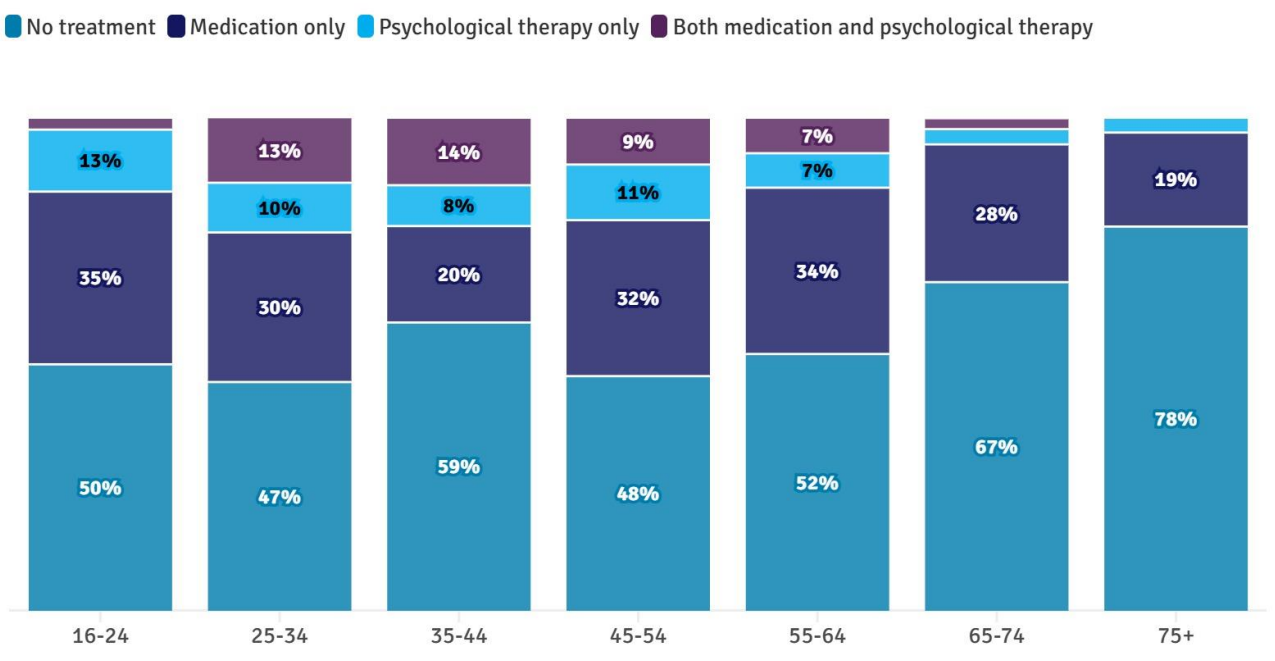
Directors of Adult Social Services are concerned about their ability to meet the increasing complexity of older people's needs.[66] ADASS reports that only 24% of Directors of Adult Social Services are fully confident their budgets will enable them to meet the care and support needs of people aged 65+ in 2025/26.

2.2.2 Mental health

The percentage of people aged 65+ receiving no treatment for common mental health conditions is higher than every other age group (Figure 2.4).[35] In the 65-74 group, two-thirds (67%) with clinically significant symptoms did not receive any treatment, with this proportion rising to 78% for the 75+ group. Similarly, these age groups were the least likely to receive psychological therapy (5% and 3%, respectively) compared to nearly 1 in 4 (23%) for people 25-34.[35]

Fig 2.4 People aged over 65 are most likely to receive no treatment for common mental health conditions

Percentage of people with common mental health conditions receiving treatment, by age, 2023/24.



Source: Age UK analysis of NHS England (2025). Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4 • CIS-R score ≥ 12: A score of 12 indicates a level of common mental health symptoms that is likely to benefit from clinical recognition.

Despite low numbers of referrals for older people, they are more likely to achieve reliable recovery/improvement through NHS Talking Therapies than younger adults.[75] As noted in Section 2.1.4 above, too few older people are being referred for NHS talking therapies services. However, those who are referred are relatively more successful at showing reliable improvement. In

2023/24, 37% of both adults aged 18-64 and adults aged 65+ finished a course of Talking Therapies treatment, however, 20% of adults aged 65+ achieved reliable recovery/improvement, compared with 16% of adults aged 18-64.[75] This ought to challenge outdated assumptions about how best to treat common mental health conditions such as depression and anxiety in later life.

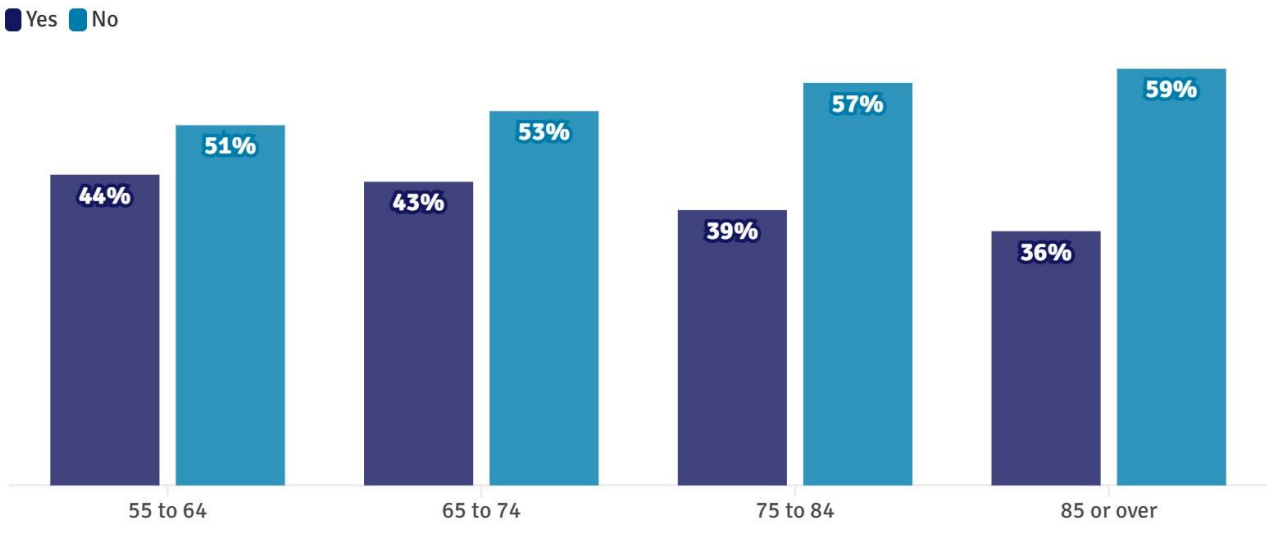
2.3 Experiences of treatment, care and support

2.3.1 Primary care

Older people report generally positive experiences of appointments with their GP practice, but older age groups are less likely to discuss what is important to them when managing their conditions or illnesses.[13] In 2025, 84% of older people aged 65+ reported a 'good' overall experience of their GP practice. However, less than half (44%) of people aged 55-64 report having a conversation with a healthcare professional from their GP practice to discuss what is important to them when managing their conditions or illnesses (Figure 2.5). This drops to 36% in the oldest age group of 85+.[13]

Fig 2.5 Older age groups are less likely to discuss what is important to them at the GP when managing their conditions or illnesses

Percentage of patients who report having a conversation with a healthcare professional from their GP.



Source: Age UK analysis of NHS England (2025). GP Patient Survey (2025).

2.3.2 Adult social care

Public satisfaction with social care remains at an all-time low.[83] The British Social Attitudes survey, carried out by the National Centre for Social Care Research (NatCen) in September and October 2024, shows public satisfaction with social care services remained at 13% in 2024 – the same as in 2023, which was the lowest level ever recorded. Only 2% said they were 'very satisfied'. More than half (53%) of people reported dissatisfaction with social care. A slightly larger proportion of older people aged 65+ (55%) report dissatisfaction than people aged 18-64 (53%).

Few members of the public think the standard of social care improved over the last 12 months.[84] Polling undertaken by Ipsos for the Health Foundation in November 2024 found only 3% of UK participants (aged 16+) thought the standard of social care had improved in the last 12 months, whereas 44% thought it had deteriorated. Participants aged 55+ (54%) and those with a health problem or disability (51%) were significantly more likely to think the general standard of social care had deteriorated over the last 12 months.[84]

2.4 Pinch points within neighbourhood treatment, care and support

2.4.1 Capacity in primary care

Capacity in primary care is not keeping pace with growing need. As noted in Section 2.1.1, the gradual increase in FTE GPs is not keeping pace with the increase in demand for appointments and satisfaction with the time it takes to get a GP appointment remains low.

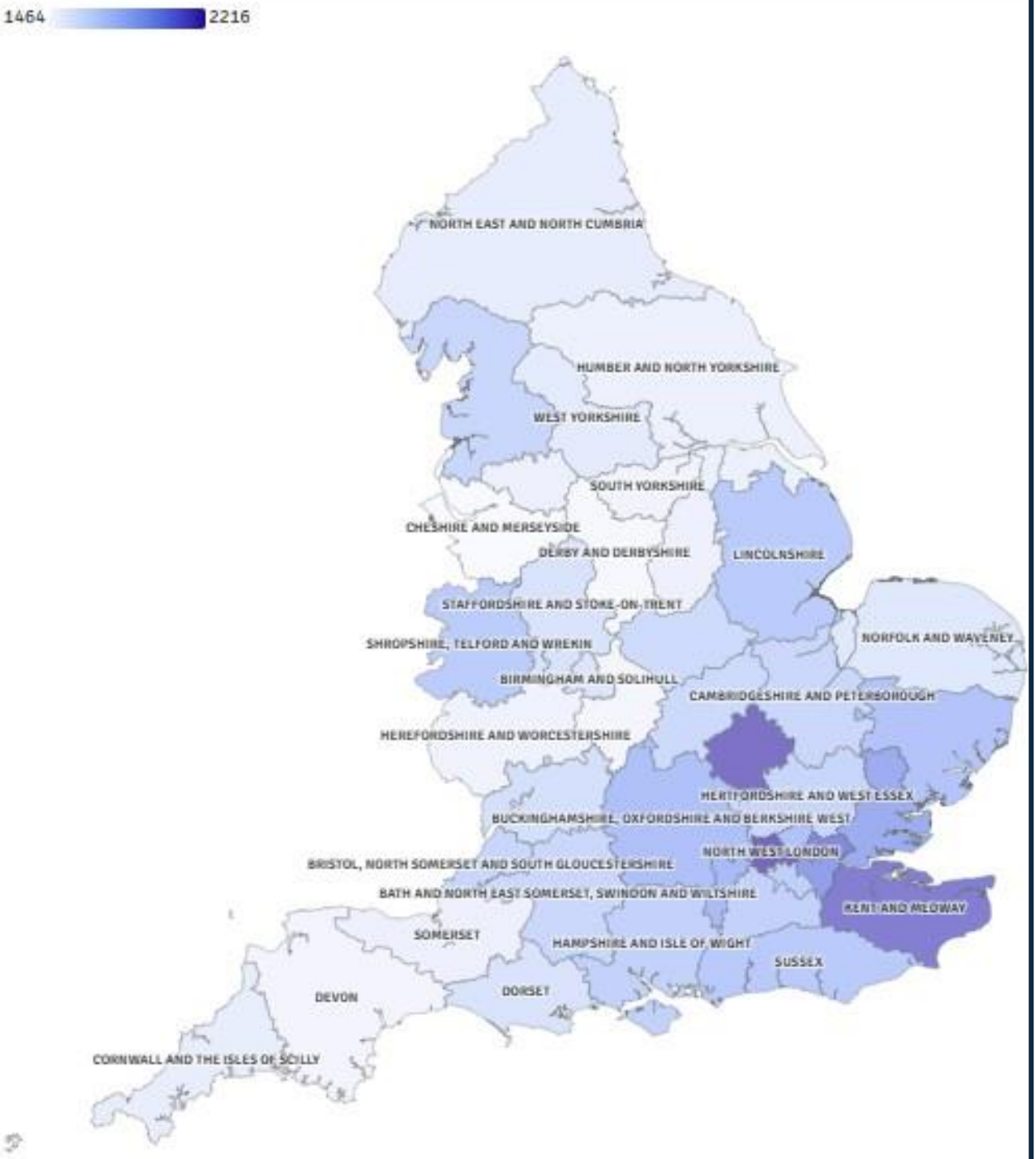
GPs are operating beyond 'safe' working practice. British Medical Association (BMA) guidance[85] on safe working recommends a safe level of GP-patient contacts of 25 consultations a day, though this would likely need to be adjusted down for doctor-patient contacts for long-term, complex, mental health, or multiple conditions due to the more demanding nature of the consultations. The BMA reports: "Currently patient contacts per day by GPs in England are significantly in excess of this", [85]with a 2024 survey of GPs by Pulse magazine finding GPs are seeing an average of 31 patient contacts each day.[86]

The number of registered patients per fully qualified FTE GP exceeds the 'limit of effective care' and continues to grow. The Family Doctor Charter of 1965 recognised the need for effective workload management as a basis for the delivery of safe, high-quality patient care, including adequate time for each appointment. It introduced a limit of 2,000 patients per GP.[85] This limit has been subject to discussion since, with arguments made that it should be lowered to recognise the increased complexity of need,[85] but it has not been formally reviewed.

It many parts of the country, the number of patients over 65 alone exceed this figure. As shown in Figure 2.6, there are also large variations depending on where you live. In NHS Northwest London ICB, there are 2,216 registered patients over 65 per GP, the most in England.[57] This is followed by NHS Bedfordshire, Luton and Milton Keynes ICB at 2,182 65+ patients per GP, and NHS Kent and Medway ICB with 2,141. The ICB with the lowest number is NHS Chesire and Merseyside with 1,464 65+ patients per GP.[57]

Fig 2.6 There is up to a 1.5 fold difference in the number of patients aged 65+ per GP depending on where you live

Number of patients over 65 years per GP, by integrated care board (ICB), England, March 2025.



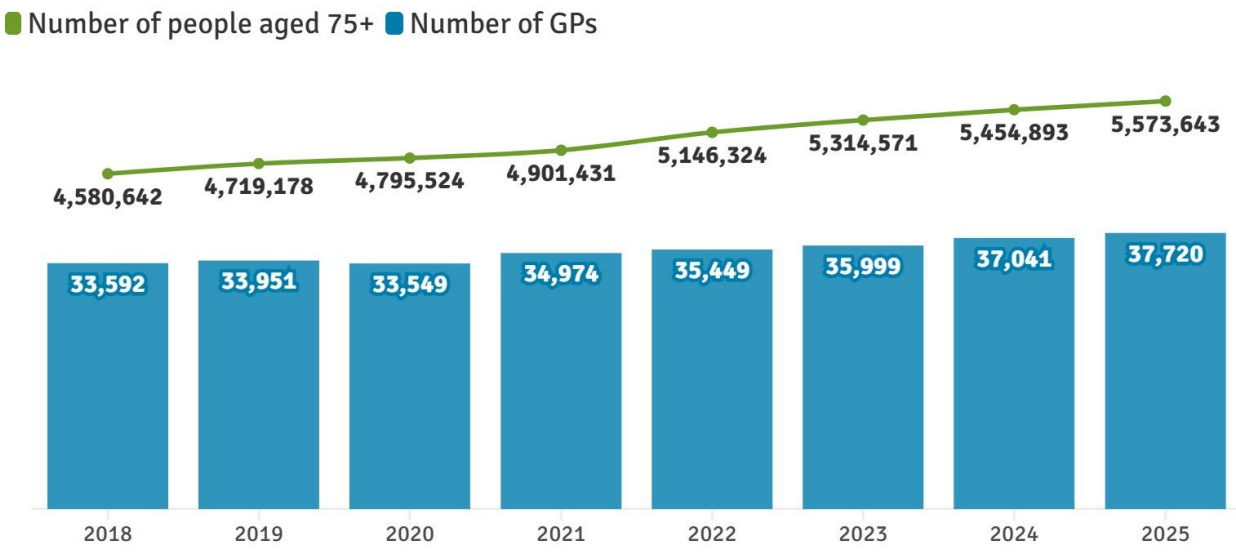
Age UK analysis of NHS England (2025). General Practice Workforce, 31 March 2025.

There are fewer GPs per patient in more deprived parts of the country.[87] Analysis by the Institute for Government found there to be substantial variation in the number of GPs per 100,000 patients when grouping practices by the deprivation of their patient lists. There were 38 fully qualified permanent GPs per 100,000 patients in the practices with the most deprived decile of patients in March 2024, compared with 49 in the least deprived. The analysis found a parallel between the variation in the number of GPs per 100,000 patients by deprivation and variation in patient satisfaction by decile of deprivation: the least deprived areas have more GPs per 100,000 patients and better patient experience.

Growth in the number of full-time equivalent GPs is not keeping pace with population growth of older people. The number of FTE GPs (including trainees) increased by 12% from June 2018 to June 2025 – from 33,592 to 37,720.[88] However, this has not kept pace with population growth as between 2018 and 2025, there was a 22% increase in those aged 75+ (Figure 2.7), the age group most likely to be living with multiple long-term conditions and frailty. The overall population of over 65s increased by 11% in the same period.

Fig 2.7 Although the number of GPs is growing, it is not keeping pace with population growth of older people aged 75+

Number of full-time equivalent GPs, June 2018 to June 2025, England, against population estimates and projections of over 75's, 2018 to 2025.



Age UK analysis of NHS England (2025). General Practice Workforce Statistics, June 2025 - Fully qualified GPs, ONS (2025). Estimates of the population for England and Wales • Number of GPs represents June of each year.

Some GPs feel unable to take time off work for mental wellbeing issues, despite recognising that working while not feeling mentally well enough may contribute to a lower standard of patient care.[89] More than a quarter (27%) of GPs surveyed by the Medical Protection Society (MPS) said taking time off for mental wellbeing issues is not 'acceptable' where they work. Of the GPs who reported working while not feeling mentally well enough, 70% said they did so because they felt guilty adding to colleagues' workloads, 51% because of staff shortages, and 46% because their patients

rely on them. However, the GPs who reported working while not feeling mentally well enough also reported adverse impacts on patient care: 68% said it has contributed to a lack of empathy with patients, 57% said it has contributed to a loss of concentration, and 15% said it may have contributed to a missed or incorrect diagnosis.

2.4.2 Sustainability of adult social care provision

The public sector provides very little social care directly, with most services being delivered by private and third sector organisations. Local authorities have a duty under the Care Act 2014 to ensure that the market of home and residential care providers is sustainable and offers choice for people drawing on local authority and privately funded services alike. However, as noted in last year's edition of this report, local authorities – often the major purchaser in an area – have sought to manage their own budget reductions by driving down the prices they pay for services. At the same time, the costs for those same providers have increased, particularly over the past year with inflationary pressures. As a result, the care market is increasingly precarious and dysfunctional in many parts of the country.

The care provider market "is in distress, struggling to cover existing costs via fees and facing underfunded increases in the National Living Wage (NLW) and National Insurance".[90] This was a key finding of the Health and Social Care Committee's inquiry into adult social care reform and the cost of inaction. The NLW rose by 6.7%, from £11.44 to £12.21 in April 2025.[91] As at December 2024, 58% of private and third sector workers were paid less than this rate, equating to around 575,000 filled posts being directly affected by the 2025 increase in the NLW.[92] The NLW increase would add around £1.85 billion to the total wage bill for independent social care organisations in 2025/26, while changes to National Insurance Contributions rates and thresholds will add around £940m to their employer national insurance bill.[93]

The Minimum Price for Homecare in England is £32.14 per hour for 2025/26.[94] This is effective from April 2025, when the UK's statutory National Living Wage increases and changes to employers' National Insurance Contributions come into effect. This is a 13% increase on 2024/25, when the Homecare Association calculated it to be £28.53 per hour.[94]

Care providers have lower resilience to deal with new financial challenges.[66] CQC notes care provider dependency on agency staff and the associated costs have fallen, while fees paid by local authorities increased in 2023/24. However, they warn providers have faced higher costs in recent years due to inflation and workforce challenges, which has affected their financial position, for example, leading to a reduction in reserves and this means providers will have lower resilience to deal with new financial and operational challenges. It is also worth noting the reduced dependency on agency staff is in-part due to international recruitment. This will be less viable as changes to the Health and Care Worker visa come into force – as discussed in Chapter 4.

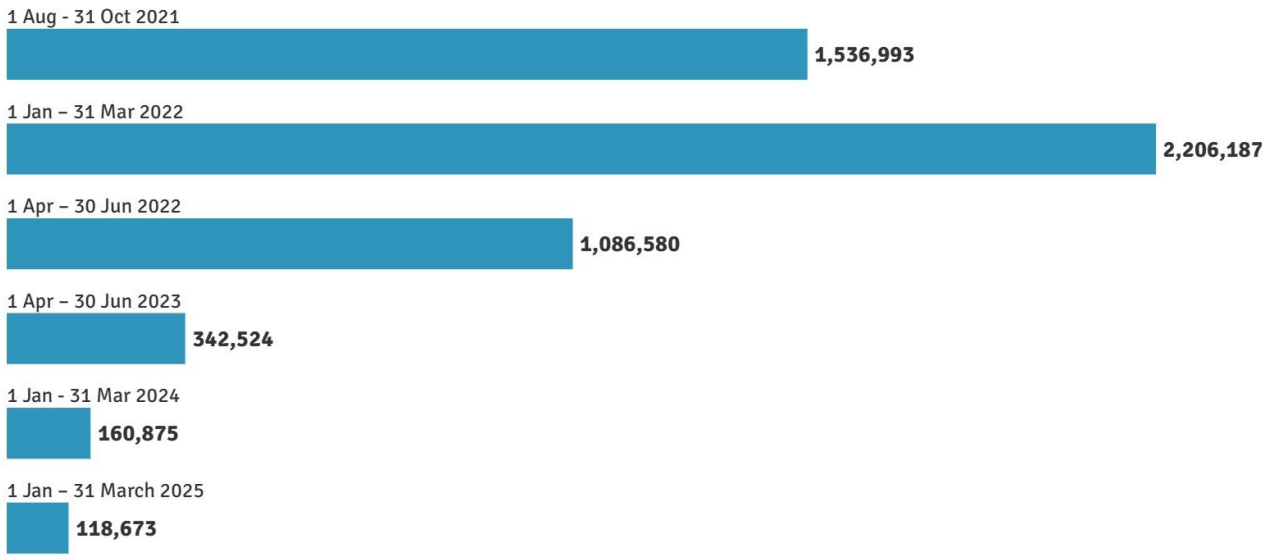
More than half (56%) of Directors of Adult Social Services reported residential and homecare providers in their area had closed or handed back contracts in 2024/25.[66] This is significantly higher than during the pre-pandemic period of October 2019 to March 2020, when 43% of Directors reported providers in their area to have closed or handed back contracts.[66] When asked what factors are contributing to contract hand backs, Directors ranked provider closure as the most important factor, followed by providers deciding against participating in council arrangements. Closures and

contract hand backs have consequences for people accessing care and support, their families and carers. Directors reported that more than 1,000 people drawing on services were affected by closures and contract hand backs in the six months to May 2025.

Fewer people are missing out on homecare because of staff capacity issues.[95] ADASS reports the number of hours of homecare delivered to have increased by 6% (45 million hours to 47.6 million hours) from April-June 2023 to January-March 2025.[66] However, data from providers in CQC's Market Oversight scheme suggests there has been a *reduction* in the number of homecare hours provided over the last two years.[96] The reasons for this discrepancy are not clear. ADASS reports local authorities were unable to deliver 118,673 hours of home care due to staff capacity (Figure 2.8).[66] This has plummeted from the peak of 2,206,187 hours not delivered in 2022 – something ADASS notes to be "largely attributable to the increase in international recruitment from 2022 to 2024" (the sustainability of which is explored in Chapter 4) – but still means some older people will not be having their needs met, despite those needs being assessed and recognised by their local authority.

Fig 2.8 Thousands of hours of homecare are not being delivered because of staff capacity issues

Number of homecare hours unable to be delivered by local authorities due to staffing capacity.



Source: ADASS (2025). ADASS Spring Survey 2025.

Health Foundation analysis found an additional £3.4bn investment is needed in adult social care by 2028/29, just to avoid services declining.[97] This would meet the growing demand for social care and cover rising costs to employers; rising to £9.1bn by 2034/35. To additionally improve access to care would require total investment of £6.4bn to 2028/29 and £12.7bn by 2034/35. To additionally improve services *and* boost pay would require total investment of £8.7bn by 2028/29 and £15.4bn by 2034/35.

Older people and families are making up shortfalls in public funding. Many people who receive publicly funded social care are expected to contribute towards it from their income. In 2023/24, a total of £4.1 billion was spent on these fees and charges [all adults].[98] People paying privately for services are also significantly cross-subsidising the system, with providers typically charging self-funders more for the same standard of care than those receiving state-funded services in order to mitigate the shortfall between what local authorities will pay and what it costs to deliver those services.[99]

An estimated 11% of care home residents had top-up fees paid on their behalf in 2024 in the UK.[100] A third-party top-up fee is the difference between the rate a local authority is willing to pay a care home and the chosen care home's fee. In theory, these should only apply when someone has chosen a more expensive care home after they have been offered suitable options within the local authority rates. This could be because a person would prefer to live in a care home that costs more than the local authority is prepared to pay for genuine extras (such as a large room, a better view, or a private balcony). Or it could be because they were previously self-funding their care home fees and want to stay in the same home now that they are eligible for local authority funding rather than move to one within the local authority rates.

2.4.3 Navigating health and social care

"The health and care system frequently fails to support care co-ordination across multiple care pathways and instead focuses on individual diseases or issues".[101] An investigation by the Health Services Safety Investigations Body (HSSIB) published in 2025, found this can leave people who have complex long-term conditions with uncoordinated care. It also found people who are unable to navigate the health and care system can experience deterioration of health, miss appointments or their care may become delayed or forgotten about, meaning they may need more intense treatment in the future or longer stays in hospital.

There is a relative lack of public awareness of social care compared to the health service. Research by the Health Foundation undertaken in November 2024[102] asked participants to what extent they agreed or disagreed with the statement, 'Social care services in my local area are good'. One quarter (25%) of respondents said they didn't know. When asked to what extent they agreed or disagreed with the statement, 'NHS services in my local area are good', only 2% did not know – highlighting the relative lack of public awareness of social care services compared to health services.

Navigating social care requires a range of skills that people may not have. As noted in last year's edition of this report, research by the National Institute for Health and Social Care Research (NIHR) undertaken in 2021[103] found people in England who pay for their own social care receive little assistance in making choices about their care, even though arranging care requires a range of skills that they may not have. These skills include searching for information, deciding on the level of care needed, weighing up options, managing a budget, and dealing with employment or care home contracts. The researchers concluded that getting it wrong can be expensive and could mean that needs are not met.

2.4.4 Medicine shortages and product restrictions

A large and increasing proportion of pharmacy staff face daily medicines supply issues and this is adversely impacting patients.[104] The Pharmacy Pressures Survey 2025 (of which

respondents are pharmacy owners and staff) found 87% reported facing daily medicines supply shortages in 2025, up from 67% in 2022. These shortages adversely impact patients, with 95% of pharmacy staff believing patients are inconvenienced by ongoing shortages, 73% reporting medicines supply issues are putting patient health at risk, and 90% of pharmacy staff reporting increased workload and stress due to supply problems.

Older people may be more heavily exposed to the risks of medicines shortage.[105] The majority of prescription items are dispensed to people aged 60+. Of the more than 1.3 billion prescription items dispensed in the community in 2024/25, 62% were dispensed to people aged 60+.

Health charities report drastic deterioration in some people's health and wellbeing due to shortages. A coalition of charities[106] reported survey results in 2024 that found 70% of respondents reported difficulties in accessing medicines in the previous year, 37% of people with epilepsy reported having seizures caused by switching or skipping medication, and 36% of respondents with Parkinson's said that facing this difficult choice led to their symptoms worsening.[107] While this was not a survey of a representative sample, it still illuminates some of the challenges people face due to medicine shortages.

Access to continence products is restricted in some English areas.[108] Research based on Freedom of Information requests published in the i Paper in December 2024, found 53% of English NHS trusts providing continence care have a daily cap on the number of continence products they provide to patients. One-third of these trusts have a cap of three products per patient, per day, while the remaining two-thirds have a cap of four products per patient, per day.

3. Impact on older people, their families, and acute care

3 IMPACT ON OLDER PEOPLE, THEIR FAMILIES, AND ACUTE CARE

3.1 High levels of unmet need

Local authorities are having to make savings and cut adult social care provision, despite the increasing need for care and support.[66] The Local Government Information Unit's annual finance survey found 27% of local authorities intend to cut adult social care services in 2025[109]; a large increase from 16% in 2024.[110] In 2025/26, Directors of Adult Social Services plan to deliver the highest level of savings since 2016/17 – £932 million – equating to about 4% of net adult social care budgets. Only 16% of Directors are fully confident they'll be able to deliver these planned savings in full. If local authorities successfully develop preventative approaches that increase independence and reduce need for care, then this is a positive ambition. However, spending on prevention – to help people live independent, healthier lives for longer – has fallen to £1.3bn "because of financial pressures and the need to prioritise those people with the highest level of need". Consequently, 74% of Directors either have partial or no confidence that their budgets are sufficient to meet their legal duties around prevention.

The increased complexity of older people's needs is significantly contributing to financial pressures. In their 2025 Spring Survey, ADASS asked Directors for the first time about a range of factors and how concerned they were about the impacts of these factors on their budgets. Directors reported being most concerned about the financial pressures associated with the increased complexity of need for older people (aged 65+) – a large majority of 89% of Directors reported being concerned. This was closely followed by increased costs due to care market pressures with 88%.

More than one-third of councils in England could effectively declare bankruptcy in the next five years, further impacting older people, their families, and carers.[109] One-third (35%) have warned they are likely to issue a section 114 notice in the next five years, and 6% said they are likely to issue such a notice within the next financial year. Section 114 notices are issued by a council's chief finance officer if they consider in-year expenditure is likely to exceed available resources, or if there is no prospect of setting a balanced budget for the year ahead. The Local Government Information Unit continues to warn of "a shift of section 114 notices from occurring in only the most exceptional circumstances to becoming a real possibility for the majority of councils in the long term".

Some older people funding their own care are also going without the care they need. Alongside these cuts to publicly funded social care, the Care Quality Commission has repeated its concerns that self-funders are also struggling to access care due to a combination of rising costs, increased provider fees, and limited capacity in the local care market.[111] As noted in last year's issue of this report, an estimated 2 million people aged 65+ have unmet needs for care and support.[112] This includes hundreds of thousands of people who are unable to complete three or more activities of daily living (ADLs*) and receive no help, or help that does not meet their needs. Age UK analysis found 4.5 million people aged 50+ need help with essential everyday tasks (Figure 3.1), including help with basic tasks like getting in and out of bed, using the toilet and eating.

* 'Activities of daily living' are routine, everyday tasks related to personal care and mobility about the home. They tend to be tasks we learn as young children, including walking (including getting up and down stairs), eating, toileting, bathing, and dressing.

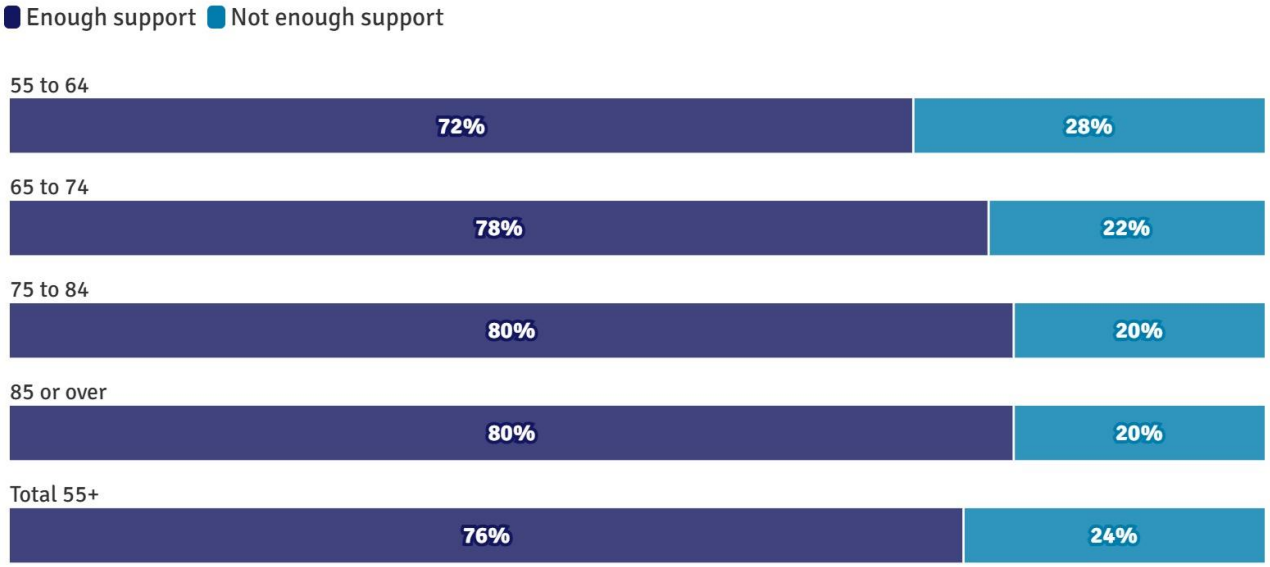
Fig 3.1 Around 4.5 million people aged 50+ need help with at least one daily activity, and 1.5 million need help with three or more

Source: Age UK analysis of English Longitudinal Study of Ageing (ELSA). Wave 10, 2021-23. ONS (2025). Estimates of the population for England and Wales.

More than one-quarter of people aged 55+ living with a long-term condition feel they do not have enough support to manage their condition.[13] The GP Patient Survey 2025 reports 28% of people aged 55-64 living with a long-term condition feel they have not had enough support from local services or organisations to manage their long-term health condition within the past 12 months. This figure is at 22% for those aged 65-74, and 20% for the 75-84 and 85+ groups (Figure 3.2).

Fig 3.2 One quarter of people aged 55+ who live with a long term condition say they do not receive enough support

Percentage of people with a long-term condition reporting whether or not they had enough support from local services or organisations to manage their long term health condition in the last 12 months.

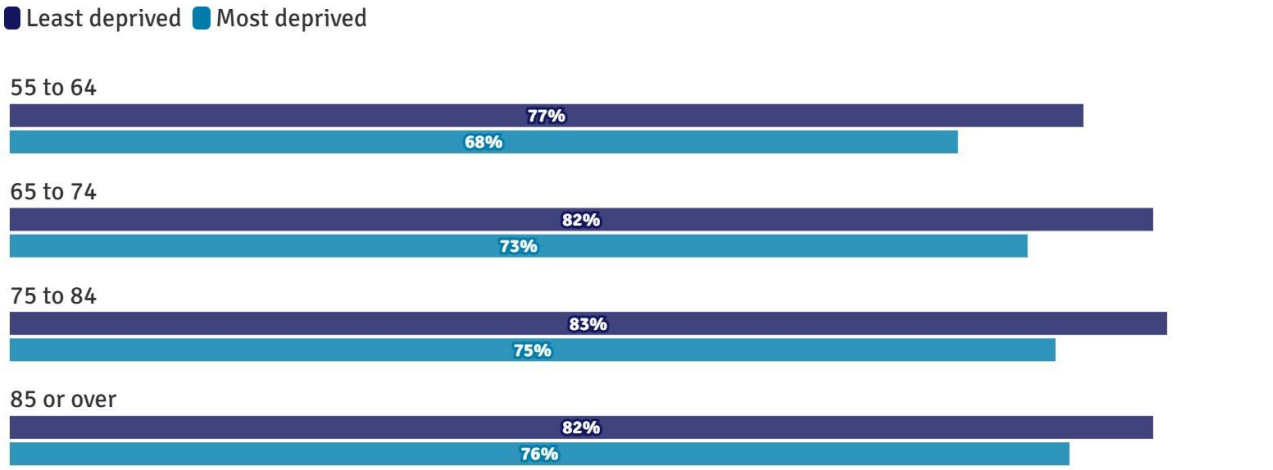


Source: Age UK analysis of NHS England (2025). GP Patient Survey.

Older people living in the most deprived areas of England are less likely to report they had enough support to manage their long-term conditions than people living in the least deprived areas.[13] As shown in Figure 3.3, this disparity exists across all older age groups. The largest difference (9%) between least and most deprived areas is seen across ages 55 to 64 and 65 to 74.

Fig 3.3 People living in the most deprived areas of England feel less supported to manage their long-term conditions

Percentage of people aged 55+ reporting they had enough support from their local services or organisations to manage their long-term condition(s), by deprivation, 2023/24, England.



Source: Age UK analysis of NHS England (2025). GP Patient Survey.

3.1.1 Private expenditure on healthcare

In total, 8.1 million people (subscribers and dependents) are covered by health insurance schemes, representing 12% of the UK population – the highest since 2008.[113] LaingBuisson reported in March 2025 that the value of the private health cover market grew by £825m to reach an unprecedented high of £7.6bn in calendar year 2023, with continued growth expected across 2024 and 2025, "albeit potentially at more conservative levels". [113]

Parts of the UK self-pay market continue to grow, but the rapid post-COVID boom has steadied and appears to have found a consistent level.[114] This particularly appears to be the case in relation to elective procedures and admitted care. Much of the recent growth has been driven by demand for private GP services, diagnostics and outpatient consulting, and lower acuity treatment. LaingBuisson's provider survey of the self-pay market found no respondent felt the market overall would decrease in the next three years: 30% believe it will grow by more than 10%, 30% by 5-10%, 10% by up to 5%, and 30% feel it will remain static.

Almost seven in ten of people (67%) say they would consider using private healthcare, with more than one third (34%) saying they would pay for treatment in the next 12 months if they needed it.[115] These were key findings of the Independent Healthcare Providers Network (IHPN)'s Going Private 2024 report – which explores public attitudes and behaviours around private healthcare. Further research by the Patients Association found people place such importance on diagnostics that 60% would consider paying for the tests they need if they faced a long wait on the NHS.[116]

Avoiding long delays on NHS waiting lists is a key factor in peoples' decision to 'go private'. Research published by the Private Healthcare Information Network (PHIN) found NHS waiting lists (71%) was the key factor for people who decided to go private in the past three years or are considering doing so in the next three years.[117]

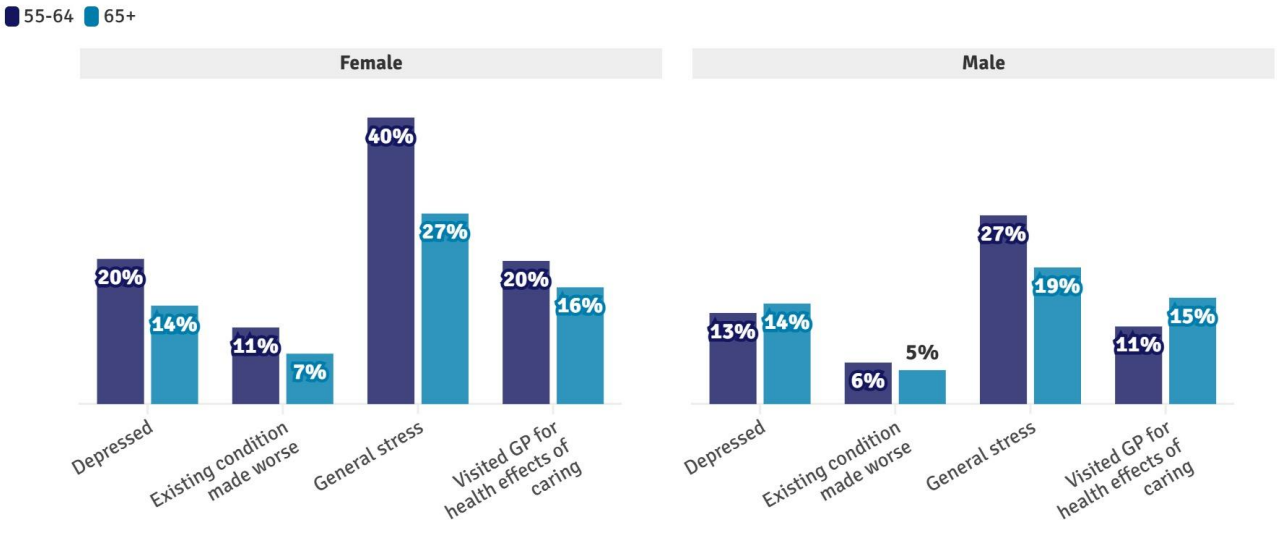
3.1.2 Growing pressure on unpaid carers

"Unpaid carers are being left to pick up the slack [in health and care provision] to the detriment of their own health and wellbeing".[66] Unlike healthcare, most social care is provided informally by unpaid partners, family and friends, who provide personal care, practical help and coordinate formal services. As noted in Chapter 2, ADASS reports that 76% of Directors saw an increase in the number of unpaid carers requiring support between 2023/24 and 2024/25, and 54% saw an increase in requests following carer breakdown over the same period. Carer burnout was the most important factor contributing to carer breakdown, followed by lack of access to healthcare / health support.

Female carers are more likely to report worse health outcomes as a result of caring.[118] Two in five (40%) of female carers aged 55-64 report general stress due to caring, compared to 27% of male carers (Figure 3.4). In the same age group, female carers are more likely to report being depressed (20%), having an existing condition made worse (11%) and visiting the GP for health effects of caring (20%), compared to male carers.

Fig 3.4 Female carers are more likely to report worse health outcomes as a result of caring

Estimated percentage of unpaid carers reporting adverse health effects, aged 55+, England.

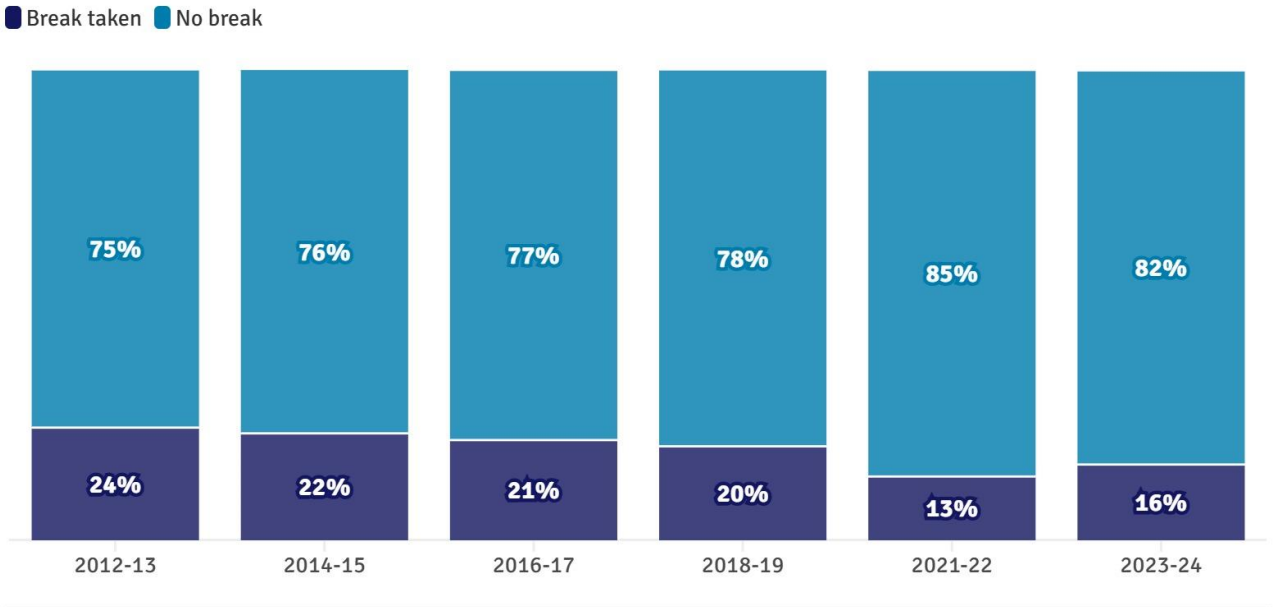


Source: Age UK analysis of ONS (2024). Health outcomes of unpaid carers using the Health Survey for England.

Many carers – especially those providing intensive levels of care – report needing some or more breaks from caring. Carers UK research published in 2025[119] found 57% of carers who responded to their annual State of Caring survey reported feeling overwhelmed 'often' or 'always', with the main reason (65% of carers feeling overwhelmed) being not getting a break from caring. Half (49%) of carers said they needed more breaks or time off from caring, but 54% said being able to have regular breaks from caring would be a challenge over the coming year. Figure 3.5 shows 82% of carers are unable to take a break from caring for more than 24 hours.

Fig 3.5 Over 8 out of 10 carers have not taken a break from caring for more than 24 hours

Percentage of adults that report whether or not they accessed support or services allowing them to take a break from caring for more than 24 hours, 2012/13 to 2023/24.



Source: Age UK analysis of NHS England (2024). Personal Social Services Survey of Adult Carers in England.

Carers are in increasing need of support from their local authority, but local authority support is reducing. Carers UK research published in 2025[67] found that more than half of carers (55%) said they needed more recognition of their needs from their local authority, compared to 46% in the previous year. Only 23% of carers had had a Carer's Assessment in the last 12 months, and 42% of carers who had had a Carer's Assessment said their local authority had not supported them after the assessment. Figure 3.6 shows there has been a reduction in direct support and information, advice and other universal services/signposting for carers over the past 5 years This is despite the demands on unpaid carers having increased, affecting their health – as outlined in Chapter 1.

Fig 3.6 Carers are getting less support from their local authority compared with 2020/21

Support provided to carers during the year, 2020/21 to 2023/24

Source: Age UK analysis of NHS England. Adult Social Care Activity and Finance Report, England - 2020/21 to 2023/24

Even when support is available, carers often struggle to access it, with inequalities recognised across the system.[120] CQC notes in their latest State of Health Care and Adult Social Care report: "All the local authorities we have assessed had work to do in identifying carers and raising awareness that they are entitled to an assessment and services to support them in their caring role. We found that this was more acute for people in ethnic minority groups who would not see themselves as carers". CQC also found access issues were "more pronounced in local authority areas where there were more staff vacancies or difficulties with recruitment", as well as for people who self-fund their care and people living in rural areas where poor infrastructure and lack of digital access create specific barriers.

Carers are increasingly struggling to look after themselves. Prior to the COVID-19 pandemic, the 2018/19 national survey of carers of adults (administrated by local authorities) found 52% of carers felt they could look after themselves in terms of having sufficient time to do things like get enough sleep and eat well.[121] This remained consistent at 49% in 2021/22[122] and fell further to 47% in the latest survey from 2023/24.[67] As noted in Chapter 1, in 2023/24 there was an increase in the percentage of carers developing their own health conditions and needing to see their own GP.

3.2 Stretched acute services

3.2.1 Accident and emergency attendance and admissions

Accident and Emergency (A&E) attendances offer another insight into the effectiveness of primary and neighbourhood care. One study of the social predictors of A&E attendance in deprived neighbourhoods found that geographic proximity to GP practices plays a substantial role in influencing A&E attendance. People who live further away from GP practices are more likely to attend A&E. There

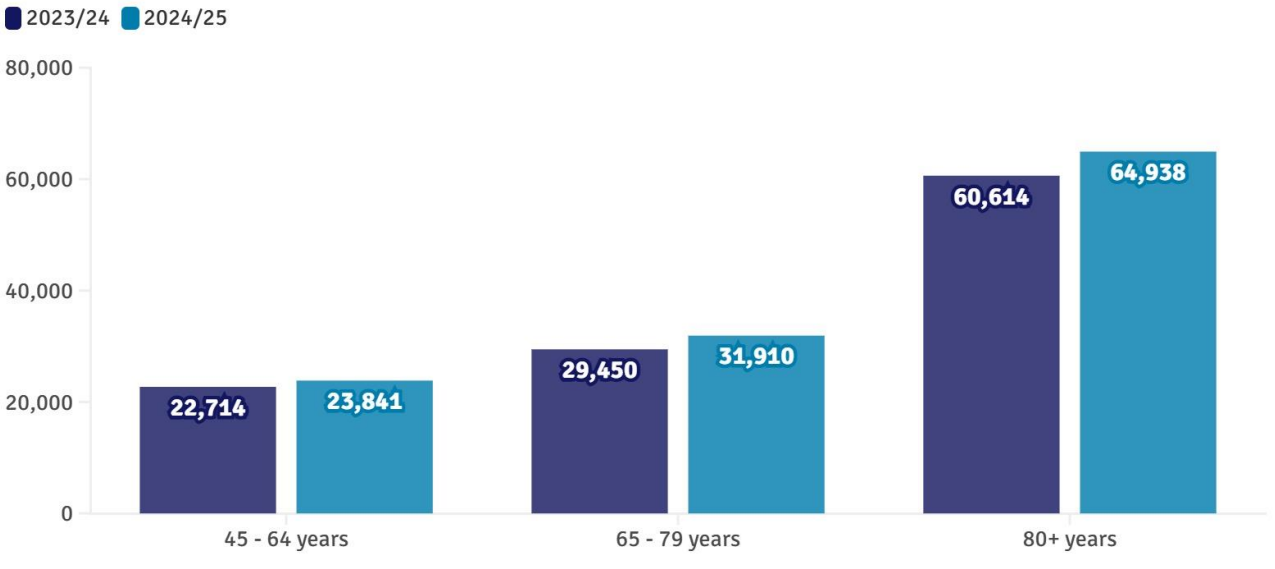
were 18 more A&E attendances per 100 population for each kilometre further the average person lived from a GP practice.[123] A further study by the ONS and King's College London[124] (linking Census 2021 data and the NHS Emergency Care data set) found people living in more deprived areas are more likely to access A&E services than those living in less deprived areas. These differences are not fully explained by differences in underlying health, with the researchers suggesting differences in access to primary care services could explain differences in A&E access.

A&E attendances continue to rise. In 2019/20, immediately prior to the pandemic, there were 25 million attendances at A&E.[125] Attendances reduced dramatically to 17.4 million in 2020/21[126], but rose again in subsequent years. They exceeded pre-pandemic levels in 2022/23 at 25.3 million,[127] rising to 26.3 million in 2023/24,[128] and 27.4 million in 2024/25.[129]

The likelihood of attending A&E rises significantly with age, but the number of people aged 65+ attending A&E is also increasing.[127][128] As shown in Figure 3.7, from 2024 to 2025 there has been a 8.4% increase in the rate of attendance at type 1* and 2 A&E departments for people aged 65-79 and a 7.1% increase for people 80+. Older people are also much more likely to be admitted, representing around 45% of all attendances to A&E that resulted in an admission to a ward.

Fig 3.7 There are more A&E attendances by people aged 65+

Type 1 and 2 accident and emergency (A&E) attendances, per 100,000 population, by age, July 2023 to June 2025, England.



Source: Age UK analysis of NHS England. A&E Attendances and Emergency Admissions: Supplementary ECDS Analysis, July 2023 to June 2025.

A&E performance remains below even amended NHS standards. There are several Government pledges on NHS waiting times, including a maximum 4-hour wait in A&E from arrival to admission, transfer or discharge. The operational standard in place since 2010 was that 95% of people attending

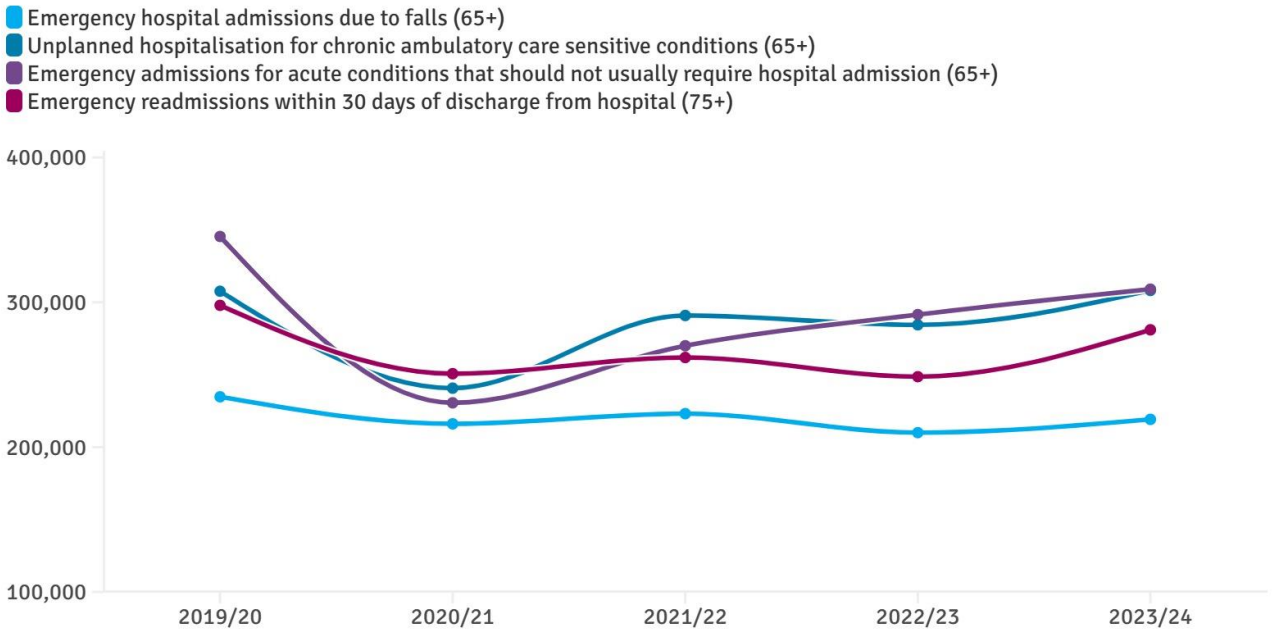
* Type 1 A&E department are those that are a consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.

A&E should be waiting no more than four hours to be admitted, transferred or discharged. Following years of this standard being missed, a new threshold target was introduced, with the new aim of 76% of people to be admitted, transferred or discharged within four hours by March 2024.[130] This had not quite been achieved (74% in March 2024[130]) at the point the Urgent and Emergency Care Plan for 2025/26 introduced a new minimum target of 78%.[131]

More older people are experiencing an emergency admission to hospital for lack of effective care in the community. Figure 3.8 below shows the number of ambulatory care sensitive conditions relate to exacerbations of chronic, long-term conditions such as COPD and Diabetes, as well as admissions for acute conditions that should not normally require an admission (urinary tract infection or cellulitis (deep skin infection, typically from pressure sores). Both have increased following a large dip in the first year of the pandemic as have readmissions within 30 days of discharge from a previous spell in hospital (75+). Alongside admissions for falls, this equates to over 1.1 million 65+ emergency admissions for potentially avoidable reasons in 2023/24.

Fig 3.8 Emergency admissions to hospital for reasons that could have been avoided in the community are increasing

Potentially avoidable emergency admissions (aged 65+) and readmissions (aged 75+) to hospital



Source: Age UK analysis of OHID (2024). Emergency hospital admissions due to falls in people aged 65 and over, NHS England (2025). NHS Outcomes Framework, NHS England (2025). Compendium - Emergency readmissions to hospital within 30 days of discharge

3.2.2 Ambulance responses and handovers

Ambulance waiting times have improved but are not yet meeting national standards.[132] Ambulance services are measured by the time it takes from receiving a 999 call to a vehicle arriving at the patient's location. All calls are triaged into four categories according to the patient's condition. Ambulances are now expected to reach people with life-threatening illnesses or injuries such as cardiac arrest or anaphylaxis (Category 1) in an average time of seven minutes. The average Category 1 response time has not been within seven minutes since April 2021.[132] In June 2025, the average response time was 7 minutes 55 seconds.[133]

Category 2 ambulance response times (for an emergency or potentially serious condition that may require rapid assessment, urgent on-scene intervention and/or urgent transport, such as stroke or suspected sepsis) should be responded to in an average of 18 minutes, though the NHS 2025/26 priorities and operational planning guidance sets a target of 30 minutes.[134] The average Category 2 response time has not been within 18 minutes since July 2020.[132] In June 2025, the average response time was 29 minutes and 37 seconds.[133] While no longer reported by NHS England, the last available data shows that older age groups are more likely to arrive at A&E by ambulance, with 65% of people aged 50+ doing so in 2022/23.[127]

Ambulance handover delays have risen year-on-year since 2020/21, both in terms of number and proportion of ambulance arrivals.[135] There were 81,988 ambulance handover delays of more than 30 minutes in 2020/21, accounting for 10% of all ambulance arrivals. This had risen to 249,626 ambulance handover delays in 2024/25, accounting for 30% of all ambulance arrivals. The national guidance states that patients arriving at an emergency department by ambulance must be handed over to the care of A&E staff within 15 minutes. However, data are currently only published on handover delays over 30 minutes, and only in winter.[136]

Ambulance handover delays cause harm to patients. A Health Services Safety Investigations Body investigation concluded: “Delays in the handover of patient care from ambulance crews to emergency departments are causing harm to patients”.[137] This is echoed by the RCEM which recently published a position statement noting: “It is clear that trying to deliver Emergency Medicine to patients in ambulances is neither safe nor effective, and results in a poor patient experience”.[138] NHS England has also recognised that ambulance handover delays “are risky because they delay assessment and treatment for those patients waiting in an ambulance queue at hospitals”.[139]

3.2.3 Corridor care

‘Corridor care’ refers to patients being cared for in non-clinical spaces (like corridors, waiting rooms, or even cupboards) in hospitals because there are no proper treatment cubicles in an emergency department or beds available on a relevant ward. Patients may spend hours, and sometimes days, waiting for a hospital bed to become available. These delays are at least in significant part due to poor patient flow through hospitals[140] – explored in Section 3.3.6.

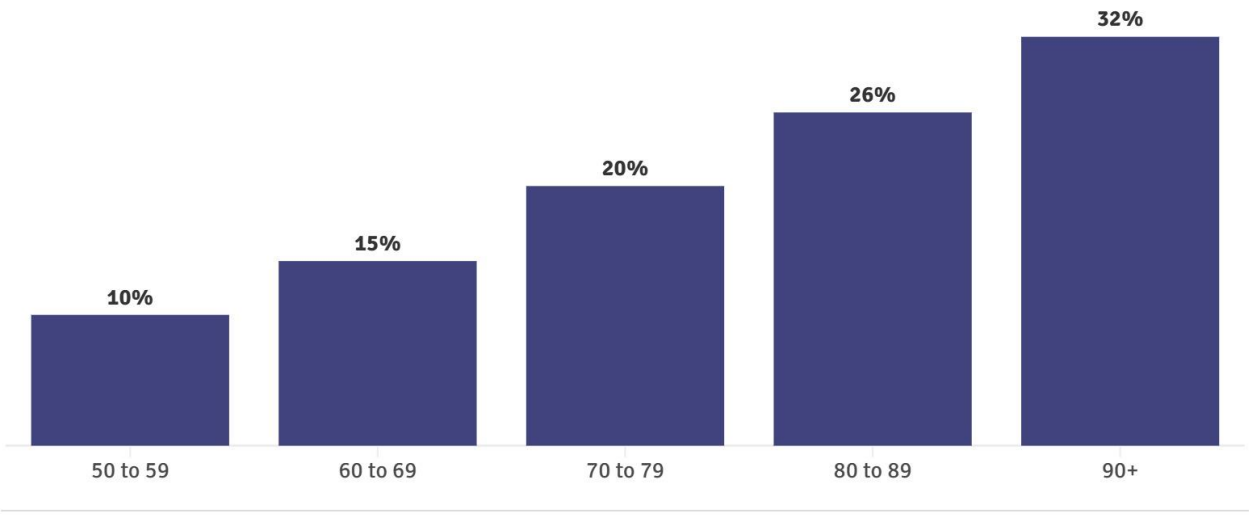
There has been a 525-fold increase in the number of people experiencing ‘corridor care’ of 12 hours or more over the past decade.[142] This is being experienced by people for whom the decision has been being taken to admit them yet they have waited 12 hours or more for a bed on the relevant ward. This does not include the time waited before the decision to admit, so the full time since arriving at A&E can be substantially longer. A wait of this kind of 12 hours or more used to be a relatively rare

occurrence. Ten years ago, 1,014 patients a year experienced a wait over 12 hours from decision to admit to admission (2015/16).[141] In 2024/25, this number reached 532,451, a 525-fold increase in a decade.[142]

The older a person is, the more likely they are to experience a long stay in A&E – "often on trolleys in corridors".[143] Figures obtained by the Royal College of Emergency Medicine (RCEM) reveal the likelihood of experiencing a 12 hour wait in the Emergency Department increases with the age of the patient (Figure 3.9). One in ten (10%) people aged 50-59 are waiting 12 hours or more, rising to one third (32%) of those aged 90 and above.[143]

Fig 3.9 The older a person is, the more likely they are to experience a long wait in A&E

Percentage of people attending emergency admissions waiting for 12 hours or more, by age, March 2025.



Source: Age UK analysis of Royal College of Emergency Medicine 2025 - FOI request.

Long trolley waits are dangerous. A study published in the Emergency Medicine Journal[144] found delays to hospital inpatient admission for patients of more than five hours from time of arrival are associated with an increase in all-cause 30-day mortality. The longer the wait, the higher the risk. For every 82 admitted patients whose time to inpatient bed transfer is delayed beyond 6 to 8 hours from time of arrival at A&E, there is one extra death compared to those who were not delayed beyond 6 to 8 hours.

'Corridor care' has become normalised. One-third (67%) of respondents to a UK-wide Royal College of Nursing (RCN) survey[145] said they're delivering care in overcrowded and unsuitable places daily, with 91% believing patient safety is being compromised. In September 2024, NHS England published 'Principles for providing safe and good quality care in temporary escalation spaces'[146], noting that while such care is not acceptable "the current healthcare landscape means that some providers are using temporary escalation spaces more regularly – and this use is no longer 'in extremis'… [and therefore] these principles have been developed to support point-of-care staff to

provide the safest, most effective and highest quality care possible when TES care has been deemed necessary".

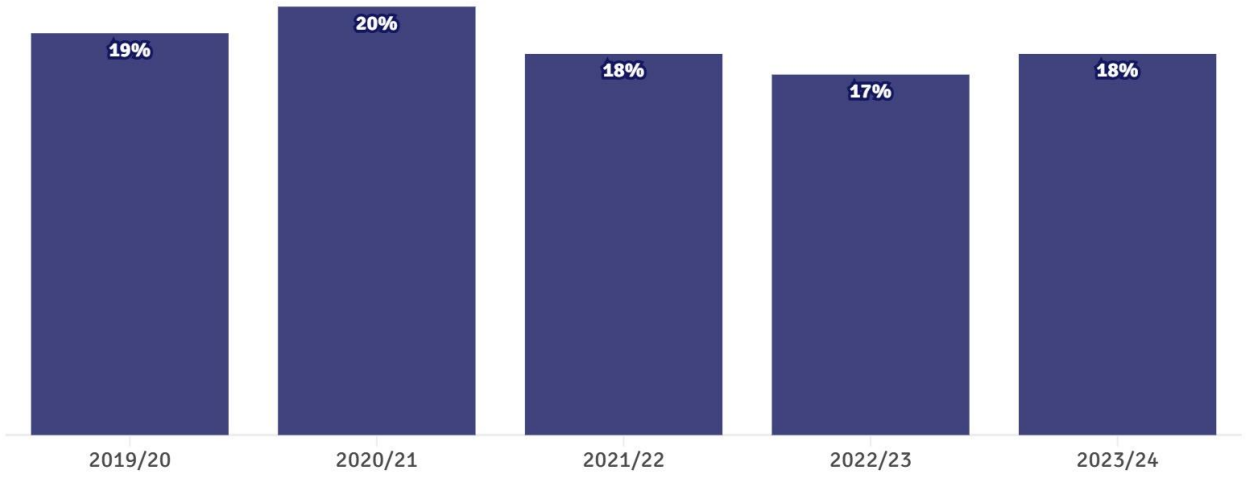
Corridor care is "unsafe, undignified and unacceptable".[147] The RCN survey also asked respondents to describe the last time they had to deliver care in an inappropriate setting, with many responses focused on the adverse impacts of corridor care on older people, including "sitting in soiled blankets", "not kept warm", "no facilities to eat and drink", "unable to use bathroom facilities due to limited mobility and toilets available being too small for equipment" – [with reference to older people] "it is so unsafe and undignified".

3.2.4 Emergency readmissions

In 2023/24, one in five (18%) people aged 75+ had an emergency readmission within 30 days of discharge (Figure 3.10).[148] An emergency readmission occurs when someone is admitted to hospital as an emergency within 30 days of their most recent discharge from hospital. Emergency readmissions may result from avoidable adverse events, though others may be due to unrelated or unforeseen causes of admission. Tracking emergency readmissions helps us understand how well people are supported to recover effectively at home following a stay in hospital.

Fig 3.10 Almost one in five people aged over 75 have an emergency readmission within 30 days of hospital discharge

Percentage of emergency readmissions within 30 days of discharge from hospital, age 75+, 2019/20 to 2023/24.



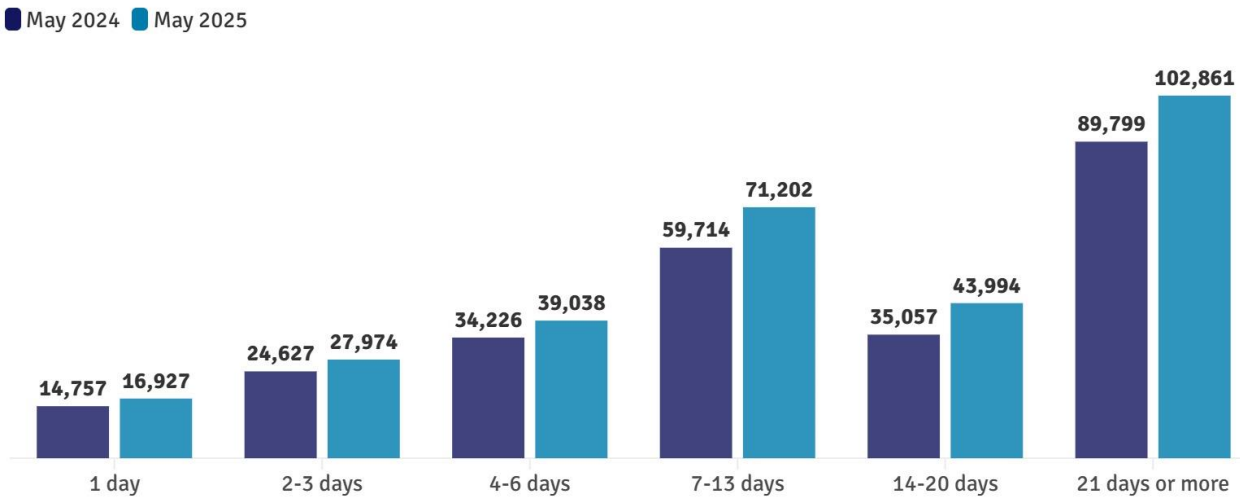
Source: Age UK analysis of NHS England (2024). Compendium of Population Health Indicators. Emergency readmissions within 30 days of discharge from hospital.

3.2.5 Hospital discharge and length of stay

Discharge delays* are contributing to people experiencing longer stays in hospital, with the majority of these people likely to be older. Figure 3.11 shows the total bed days used after the discharge ready date in May 2024 and May 2025 respectively. These are the cumulative number of days that beds within a hospital have been occupied after a person has been identified as fit for discharge. For those that waited three weeks or more to be discharged, 102,861 bed days were used in May 2025, up from 89,799 the previous year. These data are not disaggregated by age, but the National Audit Office estimated 85% of people delayed in hospital were aged 65+ in 2016, with this proportion now likely to be higher due to the demographic changes outlined in Chapter 1.

Fig 3.11 More patients are staying in hospital beds beyond their discharge ready dates

Total bed days after Discharge Ready Date for patients discharged within 1 - 21 days or more, May 2024-2025, England.



Age UK analysis of NHS England (2025). Discharge ready date - May 2024 and May 2025.

Delays are caused by waits for both healthcare and adult social care. [140] Analysis by the Nuffield Trust shows that in June 2025, 34% of people waiting for 7+ days had no plan or needed further assessment.[140] This means that while they had been determined to be medically fit for discharge, they were awaiting inputs such as formal decisions to discharge, medical reviews, or confirmation of immediate care needs. A further 19% were awaiting home or community care, 13% care or nursing home, 15% a short-term bed, and 19% 'other' inputs, such as waiting for an unpaid carer to establish their own arrangements to enable them to support the discharge.

The picture is slightly different for patients with a delayed discharge who have been in hospital for 21 days or more.[140] A higher proportion of these delays are attributed to services organised predominantly by social care. In June 2025, 18% of delays for longer stay patients were

*A delayed discharge occurs when a person is medically fit to leave acute or non-acute care and is still occupying a bed.

waiting for home or community care, 18% for care or nursing home, and 18% for a short-term bed. These delays impact the flow of patients through hospitals, leading to delayed ambulance handovers and long A&E waiting times.

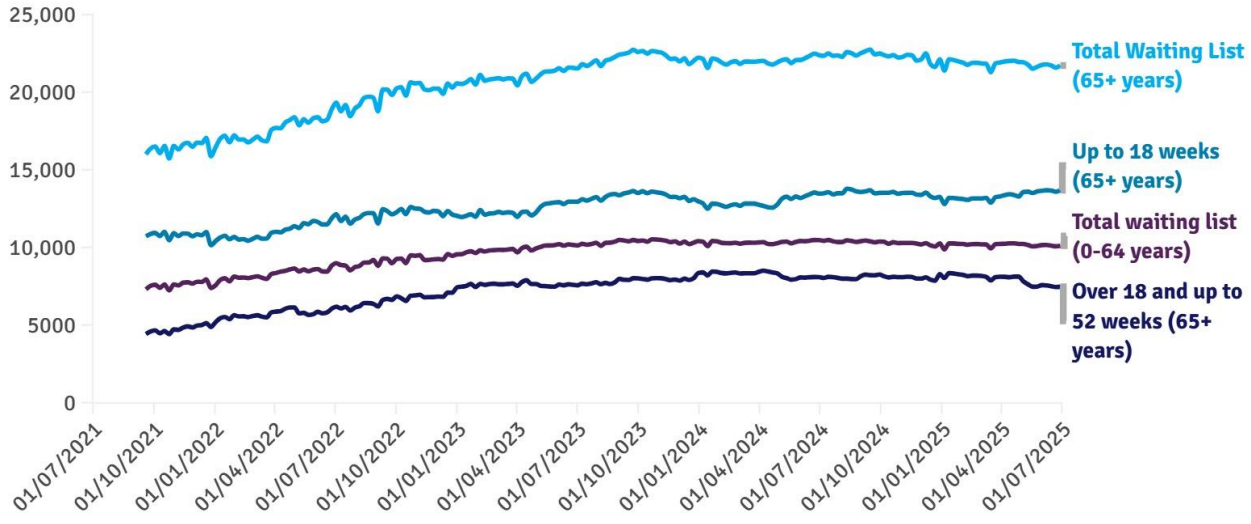
3.2.6 Waiting times for treatment

The total waiting list for non-urgent consultant-led treatment for those aged 65+ stood at 2.4 million in June 2025, a rise of 36% since September 2021.[149] The total number of people aged 65+ waiting for consultant-led treatment has risen from 15,998 to 21,717 per 100,000 population from September 2021 to June 2025. This means that for every 100 people aged 65+, there are 21.7 referrals for treatment on the elective waiting list, while for every 100 people aged under 65, there are 10.1.

Over the same period, there has been a 28% increase to 13,691 per 100,000 population for those waiting up to 18 weeks, and a 69% increase to 7,467 per 100,000 population for those waiting over 18 and up to 52 weeks (Figure 3.12).

Fig 3.12 More people aged 65+ are waiting for consultant-led treatment for longer, with the total waiting list increasing by 36% since 2021

Consultant-led referral to treatment waiting times, age 65+, per 100,000 population, 2021-2025, England.



Source: Age UK analysis of NHS England (2025). Waiting List Minimum Data Set (WLMDS) Information - June 2025.

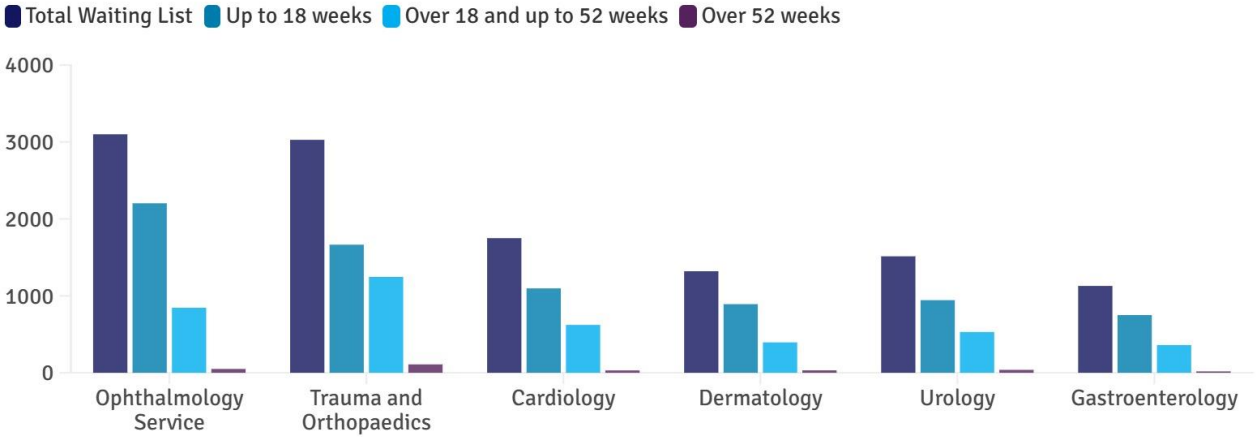
Fewer people are waiting for more than a year, but long waits persist. Before the pandemic, there was a policy that no one must ever wait longer than 52 weeks for non-urgent consultant-led treatment. As of June 2025, 58,730 people aged 65+ were waiting for longer than 52 weeks.[52]

As of June 2025, 63% of people aged 65+ were referred for consultant-led treatment within 18 weeks, remaining below target. The Handbook to the NHS Constitution states that patients referred for consultant-led treatment should start treatment within 18 weeks.[150] Historically, the target was for 95% of people to have been waiting for less than 18 weeks from the referral to treatment and the Government has committed to achieving 92% by the end of this parliament.

Trauma and Orthopaedics has the second largest waiting list for treatment for those aged over 65. This will include many older people waiting for joint replacement surgery (Figure 3.13). There is a total of 332,505 incomplete Trauma and Orthopaedics referral-to-treatment pathways for those aged 65+ in England in June 2025.* The highest is Ophthalmology, which will include those waiting for cataract surgery.

Fig 3.13 Trauma and Orthopaedics has the second largest waiting list for treatment for over 65s, with over 12,000 waiting over 52 weeks

Total incomplete treatment pathways by treatment function, age 65+, per 100,000 population, July 2025, England.



Source: Age UK analysis of NHS England (2025). Waiting List Minimum Data Set (WLMDS) Information - June 2025.

National Voices found the people in the poorest communities wait longer for care.[151] In regions like the Southwest, Southeast and East of England, those in the most deprived areas are up to seven percentage points less likely to be treated within 18 weeks than their wealthier neighbours. On ethnicity, analysis by National Voices people from Black and Mixed ethnic backgrounds across England face the longest waits for planned care – consistently falling behind other groups on access and outcomes. Ethnic disparities also persist across regions. In places like the East of England, access for Black communities is especially poor. Fewer than 54% of African patients and 56% of Caribbean patients are treated within 18 weeks – well below the national average.

* NB. Some people may be on more than one Trauma and Orthopaedics referral-to-treatment pathway, so the number of people waiting may be slightly lower. NHS England (2025). *Statistical Press Notice: NHS referral to treatment (RTT) waiting times data, May 2025*.

3.2.7 Bed numbers and capacity

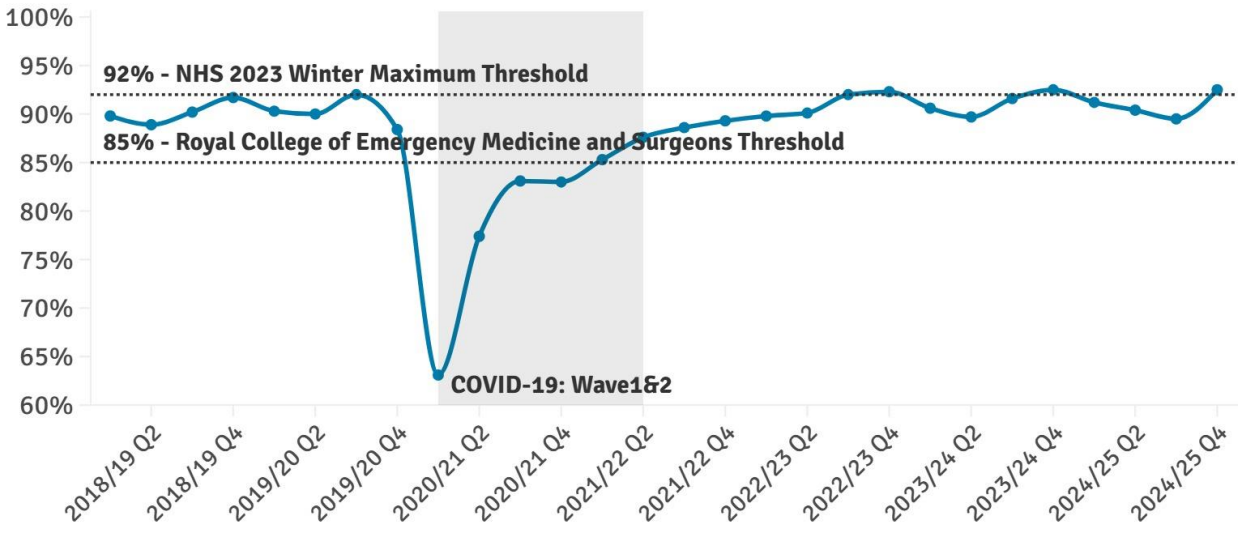
The number of general and acute hospital beds in England is the same as ten years ago, despite the demographic changes seen over the last decade.[152] General and acute beds account for around 80% of hospital beds in England, with the remaining beds being mental health (14%), maternity (6%) and learning disability (1%) beds. In the quarter ending March 2025, the NHS had an average of 132,178 beds available in England, of which 106,068 were general and acute beds. A decade ago (the quarter ending March 2015), the NHS had an average of 136,949 beds available in England, of which 106,250 were general and acute beds.

Bed occupancy levels have consistently failed to meet national standards. The National Audit Office has suggested that hospitals with average bed occupancy levels above 85% can expect regular bed shortages, periodic bed crises, and increased numbers of healthcare-acquired infections.[153] The 2020/21 NHS national planning guidance stated bed occupancy should be reduced to a maximum of 92% "through acute bed expansions, increasing community care, investment in primary care and improvements in length of stay and admission avoidance".[154]

Figure 3.14 shows the pandemic had a significant impact on the way hospitals manage and deliver services, which impacted on the availability and use of hospital beds. The bed occupancy rate was 92.5% as of Q4 2024/25 which remains above both The National Audit Office and NHS recommendations.

Fig 3.14 Hospital bed occupancy levels have repeatedly failed to meet national standards

Percentage of general and acute beds that are occupied overnight, 2018/19 Q1 to 2024/25 Q4, England.



Source: Age UK 2025. Adapted figure from Why are delayed discharges from hospital increasing? Seeing the bigger picture, The Health Foundation • Data originally sourced from NHS Digital (2025). Bed Availability and Occupancy (KH03) – Overnight 2024/25.

3.2.8 Reablement and rehabilitation

“National public data on intermediate care are limited and fragmented”.[155] As reported in the last edition of the State of Health and Care of Older People, the proportion of older people receiving reablement/rehabilitation after discharge from hospital to their own home (including residential or nursing) is lower than in 2014/15 when policies were put in place to promote its benefits. Despite the intentions of these policies, the percentage of older people receiving reablement/rehabilitation after discharge from hospital had slightly fallen from 3.1% in 2014/15 to 2.9% in 2022/23.[156] This data was not reported in 2023/24 and is being replaced by an alternative measure for 2024/25.[157]

Research suggests there is “room for improvement in discharge decision-making so patients receive the most appropriate support in the right place at the right time”.[158] The key objectives of step-down intermediate care are to facilitate timely discharge from hospital, reduce the risk of readmission and maximise the independence of patients. However, analysis by the Health Foundation found many adults who receive intermediate care end up back in hospital soon afterwards, with 37% of step-down care episodes in England resulting in a hospital admission within six weeks in the period July 2020 to September 2023. The analysis showed people receiving step-down care were generally older.

4. Health and care workforce and infrastructure

4 HEALTH AND CARE WORKFORCE AND INFRASTRUCTURE

A 10 Year Workforce Plan will be published before the end of the year[159] **that will replace the NHS Long Term Workforce Plan published in 2023.**[160] Commissioned by the previous UK Government, the 2023 plan warned: "The lack of a sufficient workforce, in number and mix of skills, is already impacting patient experience, service capacity and productivity, and constrains our ability to transform the way we look after our patients. A growing shortfall would mean growing challenges and lost opportunities". It set out actions to address projected staffing shortfalls, along with growth targets for doctors, nurses, allied health professionals, support workers, and training places across the professions. Published under the current UK Government, the 10 Year Health Plan for England announced that this would be superseded by a 10 Year Workforce Plan due before the end of the year. The new plan will place less emphasis on growing the workforce and more on strategically developing and deploying staff skill mix alongside digital technology and automation.

The roles and responsibilities around NHS workforce planning are also shifting. In May 2025, NHS England published a 'blueprint' for Integrated Care Boards[161] which set out various changes ICBs should pursue with an aim to becoming increasingly strategic health system leaders and commissioners. These include transferring some workforce planning, development, education and training functions upstream to regional and national bodies, and some downstream to providers.

Frustrated by the lack of equivalent focus on adult social care workforce planning, the sector developed its own 15-year strategy.[162] Led by Skills for Care, the strategy takes an iterative approach to workforce planning and will be regularly updated considering changing circumstances and new evidence. Some policy initiatives aimed at addressing workforce issues have been taken forward by the government, including the development of a care workforce pathway career structure.[163] However, long-term plans remain in development or have lengthy timetables. A Fair Pay Agreement has been cautiously welcomed within the sector, but the negotiating body to take this forward will not be provided for in legislation until October 2026, with the onward timetable for negotiation, implementation planning and delivery currently unclear.[164] In May 2025, the Health and Social Care Committee expressed concern about the pace and scope of change, as well as the sustainability of international recruitment.[165]

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

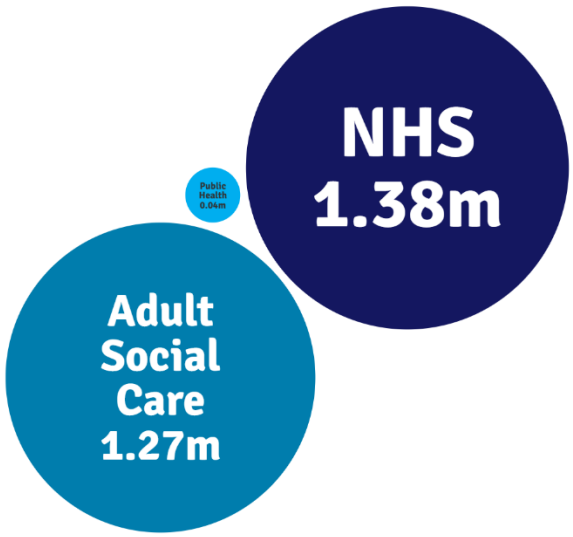
4.1 Workforce size

The combined health and care workforce is estimated to make up around 1 in 10 of the total workforce in England.[166] As depicted in Figure 4.1, there are an estimated 1.38 million full-time

equivalent staff working in the NHS[167] and a further 1.27 million full-time equivalent staff are estimated to work in England's adult social care sector.[168] However, the adult social care headcount is slightly larger than that of the NHS, with 1.59 million staff[168] compared to 1.55 million.[169] A further 40,000 people work in core public health roles.[170]

Fig 4.1 The combined health and care workforce makes up around 10% of the total workforce in England

Full-time equivalent (FTE) workforce for the NHS, Adult Social Care, and Public Health, 2024/25.



Source: NHS England (2025). NHS Workforce Statistics - March 2025, Skills for Care (2024). The state of the adult social care sector and workforce in England – 2024, NHS (2025). The core public health workforce.

The NHS workforce is growing, and this has translated into increased NHS activity, but NHS performance across a broad range of measures remains worse than prior to the pandemic. There were an estimated 1.28 million full-time equivalent staff working in the NHS in March 2023[171], which increased to 1.35 million in March 2024[172] and to 1.38 million in March 2025.[173] The Institute for Fiscal Studies (IFS) noted in November 2024 that the increase in the number of patients treated by NHS hospitals in England is greater than the increase in clinical staffing over the same period, which suggests there has been an improvement in the productivity of staff within those hospitals.[174] However, the IFS concluded this has "not translated into quite as many treatments from the waiting list as might have been expected, and the NHS is still lagging behind its elective recovery plan".[175]

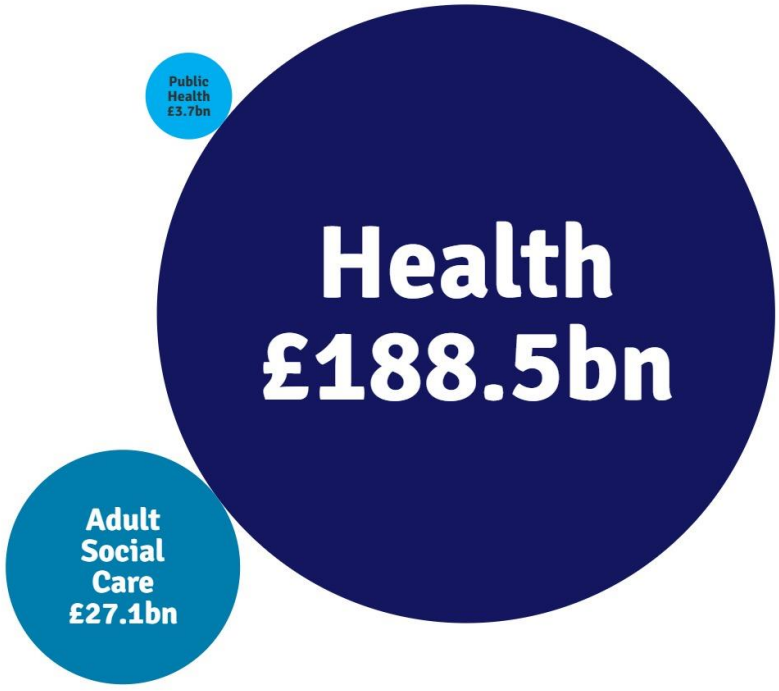
The full-time equivalent adult social care workforce is increasing in size. It increased from 1.17m in 2021/22[176] to 1.19m in 2022/23[177] and to 1.27m in 2023/24.[168] The adult social care workforce comprises care workers, social workers, occupational therapists, support and outreach workers, personal assistants, registered nurses, and registered managers. As noted above, the adult social

care workforce is employed across independent and local authority organisations, as well as people in receipt of direct payments. There are an estimated 18,500 adult social care organisations in England, providing care across 40,000 establishments.[168]

4.2 Workforce structure

The NHS is the country's largest employer,[178] **while the adult social care workforce is employed across multiple sectors and thousands of organisations**.[168] The majority of people in the social care workforce (79%) are employed in the independent (private and voluntary) sector, with 7% in local authorities, 7% working for people in receipt of direct payments, and 7% working in adult social care posts filled in the NHS.[168] Figure 4.2 illustrates the relative public spend, across health, adult social care and public health.

Fig 4.2 Public spending on Health, Adult Social Care, and Public Health.



Source: Public Expenditure. Statistical Analyses 2024, NHS England (2024). Adult Social Care Activity and Finance Report, England, 2023/24, DHSC (2025). Local authority circular: Public health ring-fenced grant 2024 to 2025

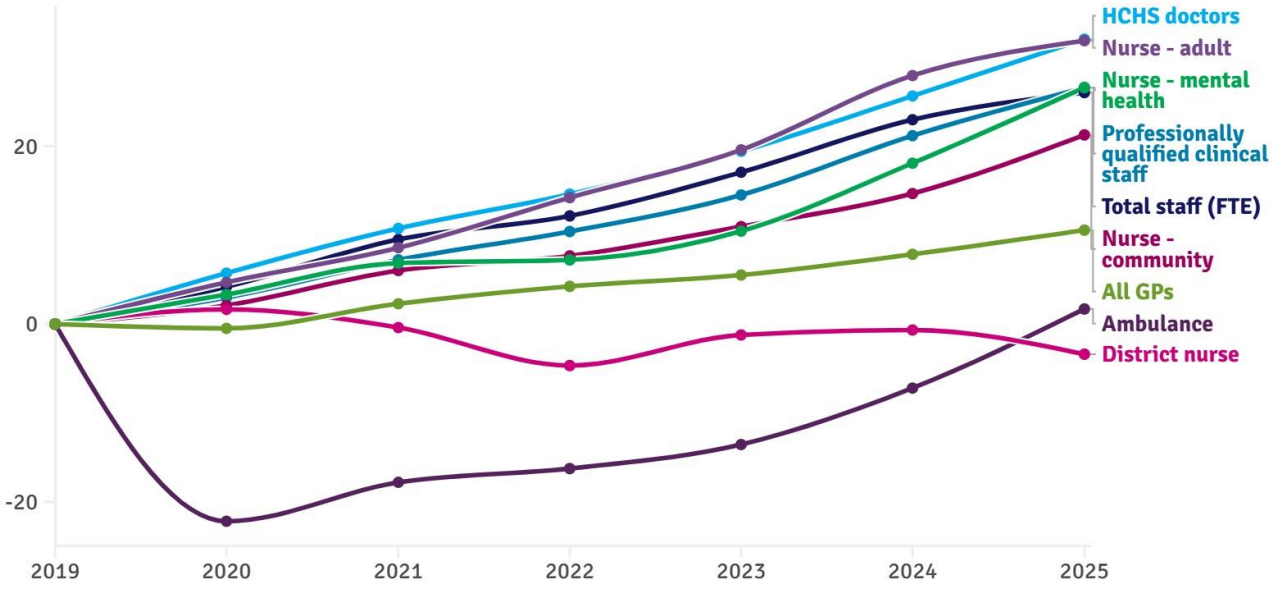
Most NHS staff directly provide hospital, mental health, community, or ambulance services, or support the staff who do so. This accounts for 1.16 million of the 1.38 million full-time equivalent workforce, with the remaining 221,000 providing NHS infrastructure support, including central

functions, property and estates, and senior management.[179] More than half (54%) of full-time equivalent staff are professionally qualified clinical staff.[181]

Despite a longstanding policy objective of shifting NHS care away from hospitals and closer to people's homes, growth in staff numbers is heavily tilted toward acute care. This is shown in Figure 4.3, with slower growth in community and primary care staffing from March 2019, and a decline in district nurses of 3.5% in March 2025. Lord Darzi's independent investigation of the NHS reported UK community services to be significant outliers in international comparisons of resources, with far fewer nurses working outside of hospital compared with other countries. Darzi's analysis suggested that the UK may be as much as 86.7% below the OECD average in the numbers of nurses and midwives working outside of hospital settings.[180] In contrast, the UK leads the world in the number of healthcare workers employed in hospitals.[181]

Fig 4.3 Growth in community staff continues to lag behind growth in hospital staff

Change in full-time equivalent (FTE) workforce from March 2019 to March 2025.

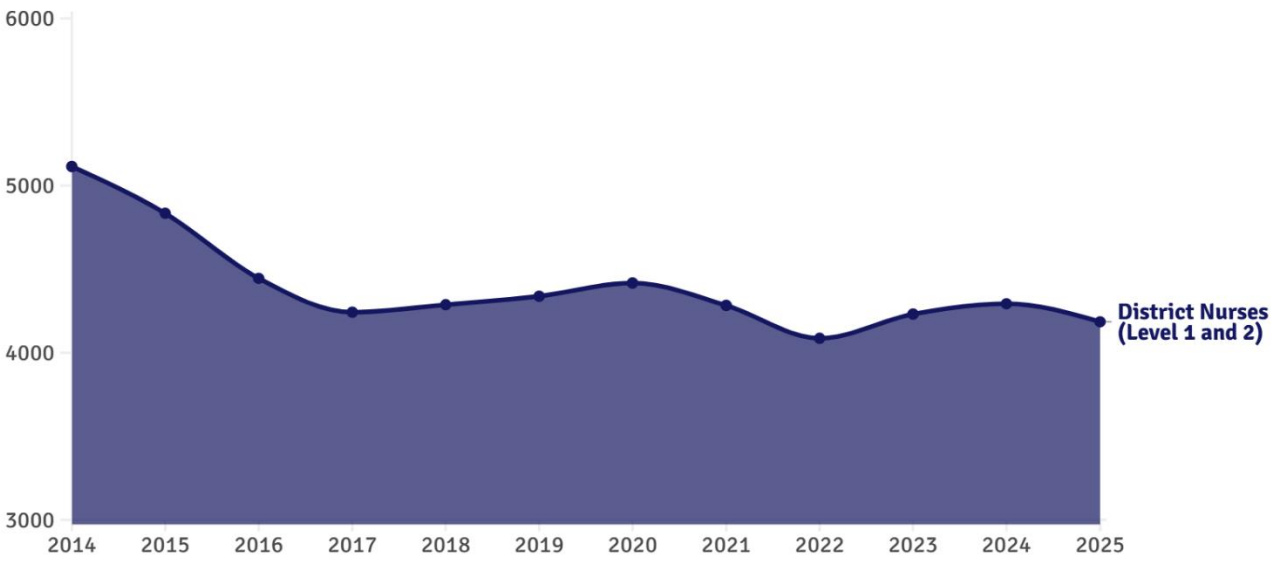


Source: Age UK analysis of NHS England (2025). NHS Workforce Statistics - April 2025 (Including selected preliminary statistics for May 2025), NHS England (2025). General Practice Workforce, 30 June 2025 • March of each year is depicted.

The number of NHS district nurses has reduced by 19% in the decade since the NHS Five Year Forward View commitment to "shift care closer to home".[182] The number of district nurses reduced by one fifth (19%) from 5,170 in October 2014 when the NHS Five Year Forward View was launched to 4,185 in April 2025 (Figure 4.4).[168] District nurses manage teams of community nurses and support workers, as well as visit house-bound patients to provide treatment, care and advice, including wound management, catheter and continence care, and medication support.

Fig 4.4 The number of district nurses has declined by 19% since the NHS Five Year Forward View was published, committing to shift care closer to home

Number of full-time equivalent district nurses, 2014 to 2025.



Source: Age UK analysis of NHS England (2025). NHS Hospital & Community Health Service (HCHS) monthly workforce statistics

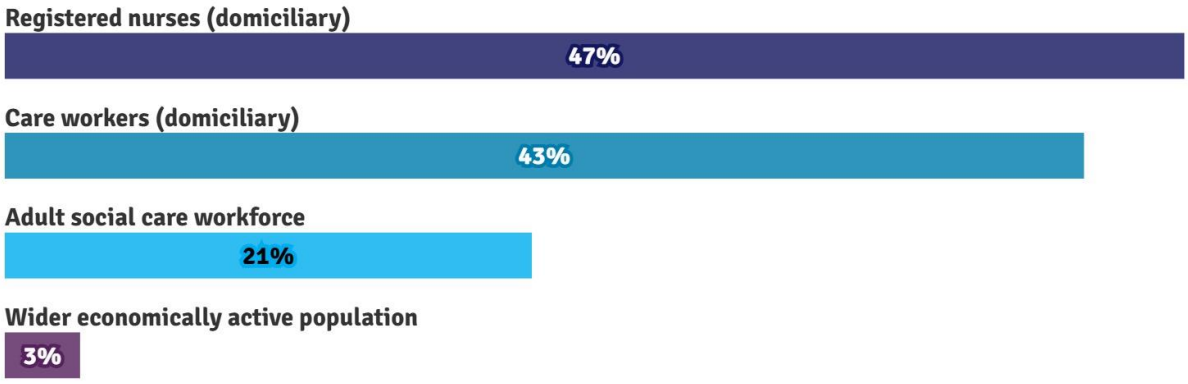
District nurses report issues around workload capacity impacting their ability to undertake care to professional satisfaction. A study by the Queen's Nursing Institute into recruitment and retention issues within district nursing identified a workforce with unmanageable caseloads, working large amounts of unpaid overtime, and having insufficient time to devote proper care to patients.[183] The QNI study found almost one-third (31.9%) of district nurses report having to delay or defer visits every day because of capacity issues.

A further 32.6% report having to do so most days, 25.8% once a week, and 8.0% less than once a week. Only 1.7% of district nurses report never having to delay or defer visits. District nurses also report having to turn down referrals: 18.5% of respondents said they refuse them daily and 12.8% at least once a week. The most common aspects of care that district nurses report not being done/not undertaken to their professional satisfaction because of capacity issues are psychological care (43.3% of respondents), assessment (38.6%), and managing continence (30.8%).[184]

Over a fifth of the adult social care workforce (21%) were employed on zero-hours contracts in 2023/24.[168] As shown in Figure 4.5, this compares with 3% of the wider economically active population in England between January and March 2025.[185] The highest proportions of zero-hours contracts were in domiciliary care services for registered nurses (47%) and care workers (43%).[168]

Fig 4.5 One in five people working in adult social care are on zero-hours contracts

Percentage of adult social care and wider economically active workforce on zero-hours contracts.



Source: Skills for Care (2024). The state of the adult social care sector and workforce in England – 2024, Age UK analysis of ONS (2025). EMP17: People in employment on zero-hour contracts - May 2025

The largest proportion (48%) of the Public Health Specialist workforce is based in local authorities. This is followed by 19% at the UK Health Security Agency, 17% in the NHS, 14% in Higher Education Institutes, and 4% at the Office for Health Improvement and Disparities.[*] Women make up most of the Public Health Specialist workforce in all but the Higher Education Institutes sector.[186]

4.3 Workforce diversity

The NHS and adult social care workforces are the most diverse they have ever been. One in four (26%) NHS staff[187] and one in three (32%) adult social care staff[168] are from ethnic minorities, compared with 20% of the working age population.[188] This is an increase of seven percentage points since 2022/23 (26%), which is largely due to international recruitment.[168] Around 6% of NHS staff in England have declared a disability on their NHS Electronic Staff Record,[189] but 25% of respondents to the relevant question in the 2022 NHS Staff Survey indicated they have a disability.[190] This is more reflective of the 24% of people who self-reported they have a disability through the UK's Family Resources Survey.[191]

This diversity is not yet fully reflected in senior leadership. Staff from ethnic minorities make up only 11% of very senior managerial positions in the NHS.[192] Ethnic minority members of the adult social care workforce are also underrepresented in managerial roles, making up 22% of registered managers and 19% of senior management positions.[193] The NHS workforce is disproportionately

[*] The fifth census of Public Health Specialists in England took place in October 2022. It incorporates Public Health Specialists and Directors of Public Health, i.e. all staff on the specialist registers regardless of their job title. Available through: Edbrooke-Hyson, V. (2023). *A Capacity Review - Public Health Specialists in 2022*. Health Education England.

female (76%[168]), but only 37% of very senior managers[*] are women.[194] The adult social care workforce is also skewed towards a female profile (79% of all job roles in 2023/24), with women holding 68% of senior management roles.[195]

4.4 The future workforce gap

The UK Government is "developing a workforce plan that aligns with the strategic direction set out by the 10 Year Plan [that will address] the size, shape, capacity and capability of the future workforce".[196] Modelling commissioned by the previous UK Government and undertaken by NHS England in 2023 for the NHS Long Term Workforce Plan, projected the NHS would face a workforce gap of 260,000–360,000 staff by 2036/37 without "concerted and immediate action".[160] The 2023 plan anticipated an additional 60,000 to 74,000 doctors, 170,000 to 190,000 nurses, 71,000 to 76,000 allied health professionals, and 210,000 to 240,000 support workers, alongside an expansion of medical associate professional roles (including physician associates and anaesthesia associates).[197]

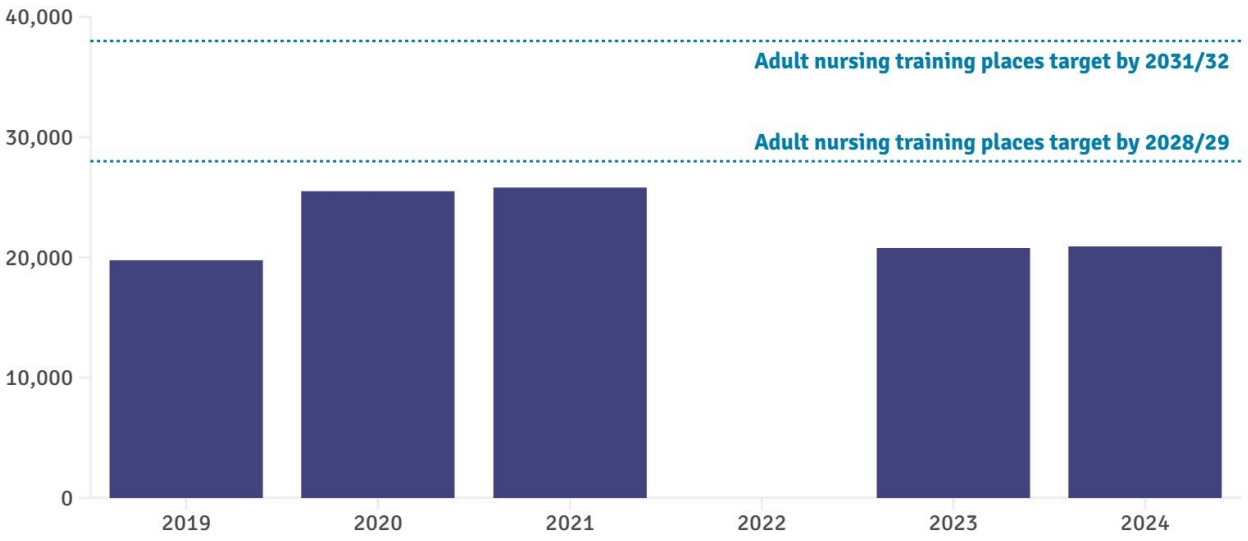
However, the current UK Government has determined this level of expansion to be "implausible".[198] Of the forthcoming workforce plan, the UK Government states: "While, by 2035, there will be fewer staff than projected in the 2023 Long Term Workforce Plan, those staff will be better treated, more motivated, have better training and more scope to develop their careers".[199]

The number of acceptances onto nursing degrees remains well below the 2021 peak. The Royal College of Nursing (RCN)[200] reports the number of acceptances onto nursing degrees saw only a marginal increase of 1% (130 students) in 2023 to 20,920 in 2024 (Figure 4.6). This is an 18% drop from 2020 (25,510). The RCN notes the growth from 2023 to 2024 is equivalent to less than one additional new nurse for each of the 215 NHS Trusts in England.[53] Even considering the Government's distancing from previous targets, this suggests a very real risk of a shortage of registered nurses, particularly given the challenges outlined in section 4.6 on retention.

[*] In the NHS the term 'very senior manager' refers to a specific category of high-level leadership roles. These are top-tier executive positions typically outside of the standard Agenda for Change pay scales, and include Chief Executive Officers, Chief Finance Officers, Chief Operating Officers, Chief People Officers, Medical Directors, Directors of Nursing, Directors of Strategy, and Directors of Transformation (or similar). More information can be found in the NHS very senior manager pay framework.

Fig 4.6 Enrolment onto adult nursing degrees remains well below the government's target

Number of acceptances onto nursing degrees, 2019-2024, UK.



Source: NHS England (2023). NHS Long Term Workforce Plan, Royal College of Nursing (2024). Nurse universities admission figures show government NHS reforms under 'direct threat', says Royal College of Nursing

There has been an increase in the number of medical students in England, but there are not enough training places to accommodate them. Higher Education Statistics Agency data shows the number of medicine and dental enrolments in England increased from 48,230 to 58,545 over the five years between 2019/20 to 2023/24, which was an increase of 21%.[201] Medical school intakes sharply increased during the 2020/21 and 2021/22 academic years due to the Covid-19 pandemic,[202] but the rate of growth has slowed, with just a 1% increase between 2022/23 and 2023/24.[203]

The scale of demand for training places is such that half of medical school students may be unable to secure a post upon graduation. In 2024, there were 26,138 applicants[204] for 12,743 training posts[205] – a competition ratio of 1:2. As noted in last year's State of Health and Care of Older People, an increase in newly qualified staff may reduce safety in the short-term and needs to be planned for[206], and expanding training places does not necessarily result in people enrolling on training, completing training, or going on to practise their profession.[168]

There is a shortage of consultant geriatricians. British Geriatrics Society (BGS) research[207] found for every 700 individuals aged 85+ in the UK, there is one consultant geriatrician. This fails to meet the BGS's recommendation of one consultant geriatrician per every 500 people aged 85+ and means 1,786 additional geriatricians are needed by 2030 to make up the shortfall. If including geriatricians' intended retirement plans, this shortfall increases to 2,566. The BGS research found most consultant geriatricians reported a substantial level of rota gaps and vacancies in their department, with many reporting an associated negative impact on patient care.

The adult social care workforce needs an extra 540,000 people by 2040 to keep pace with demand. This is a 'base case' projection by Skills for Care, based on the projected number of older people who will be aged 65+ in 2040.[168] In addition, the adult social care workforce may lose hundreds of thousands of workers in the next 10 years if those aged 55+ (currently just over 27% of all adult social care job roles[168]) decide to retire.

4.5 Recruitment and retention

There are more, but still not enough, people working in the NHS. The vacancy rate for FTE staff in English NHS trusts stood at 7% as at 31 March 2025, with 100,114 vacancies remaining unfilled.[208] Of these vacant posts, 25,632 were FTE registered nurse vacancies (6% vacancy rate) and 7,679 were FTE registered doctor vacancies (5% vacancy rate).

In 2024, a record number of UK doctors (18%) reported considering leaving the profession or moving to practice abroad, with 16% having taken steps[209] to do so.[210] Only 3% of doctors reported having taken steps to leave the UK profession in 2019.[210] In 2024, the GMC reported 13% of doctors practising in the UK said they were 'very likely' to move abroad to practise medicine in the next 12 months, and a further 17% said they were 'fairly likely'.[211] One quarter (25%) of those who said they were likely to leave were found to be 'deeply discontented', i.e. they are dissatisfied on multiple fronts with the political environment, UK healthcare systems and its effects on their wellbeing.[211]

Losing NHS doctors early is costly to taxpayers. Analysis by the BMA[212] found losing doctors early from the NHS is costing taxpayers in England a minimum of £1.6bn and up to £2.4bn a year at the current rate. The BMA notes attrition looks set to rise, along with its associated cost, which could reach £5bn a year if action isn't taken to retain doctors' services. The analysis identifies four critical areas for intervention to improve doctor retention: reversing real-terms pay erosion and addressing student debt; enhancing working conditions to reduce burnout and improve work-life balance; promoting diversity and inclusion to combat discrimination; and providing better opportunities for professional development and support. The BMA emphasises the inefficiency of focusing on recruitment without concurrently addressing retention issues.[212]

The NHS is reducing its dependency on temporary staff which is associated with a higher risk of patients dying.[213] Temporary staffing includes both internal 'banks' of staff and external agency workers. Since 2015, there have been caps on the hourly rates paid for all agency staff in the English NHS that are designed to ensure agency pay is in line with equivalent, directly employed NHS staff. Agency spending in England reduced by a third in just two years to £2.9bn in 2017/18 and then remained relatively flat going into the COVID-19 pandemic.[214] However, the price caps include 'break glass' provisions that allow trusts to override them "in exceptional circumstances and where there are risks to patient safety and clinical quality".[215]

In 2022/23, as the NHS began to shift focus from pandemic response to pandemic recovery[216], NHS providers spent £3.46bn on agency staff.[217] NHS England now reports cash spending on agency staff to be lower as a percentage of total pay than at any point since 2017 (when the current data goes back to).[218] Cash spending on agency staff is currently forecast at £2.1 billion for 2024/25, which would be a reduction of £1.4 billion from 2022/23 (~38% reduction). The Government's 10 Year Health Plan committed to eliminating agency staffing by the end of this Parliament, moving entirely to staff banks.[219]

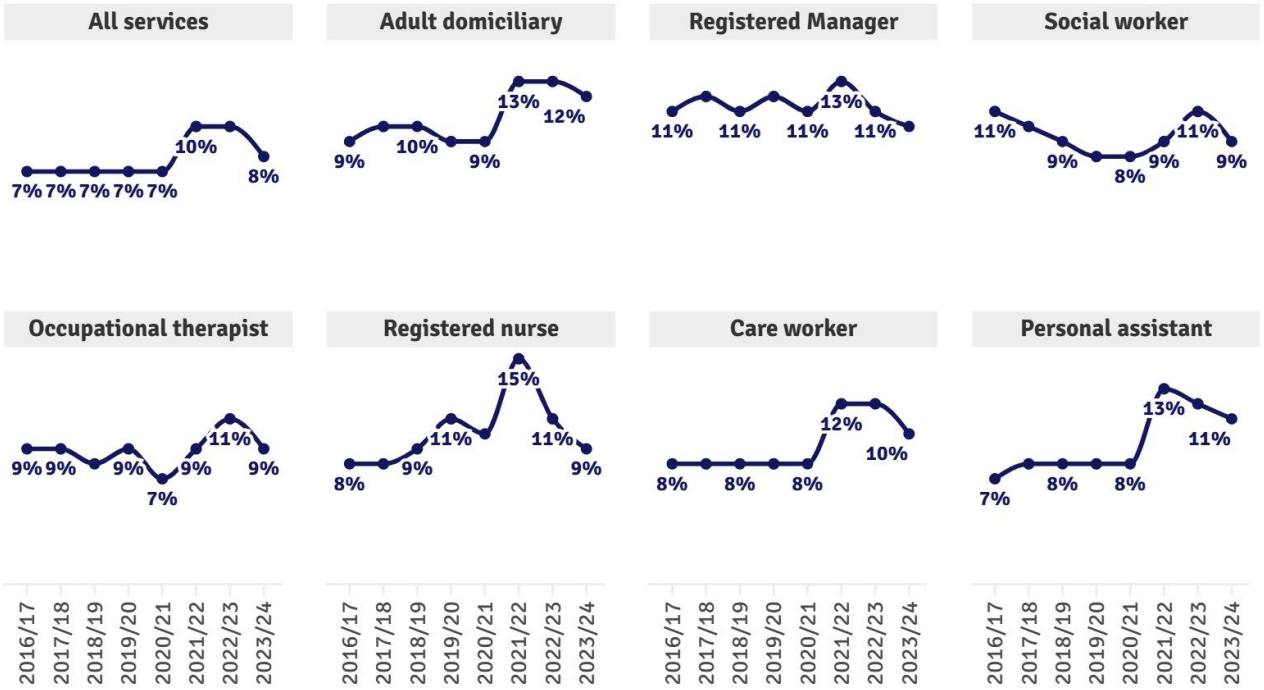
However, there remain concerns about safe staffing levels. There is no set formula for calculating safe staffing levels or ratios, but analysis of OECD and NHS data by the British Medical Association (BMA) found England has fewer doctors per capita than other comparable countries.[220] The BMA warns both patient and staff safety are at severe risk without safe staffing legislation being implemented to establish minimum safe staffing levels across the NHS.[221] Similarly, the Royal College of Nursing has called for 'safety-critical' nurse-to-patient ratios in all care settings.[222]

There is increasing recognition that safe staffing does not guarantee safe care. Dr Penny Dash recently published her independent review of six organisations overseeing the safety of care, with ten main findings and nine recommendations.[223] Headline findings include relatively small improvements being achieved, despite a shift towards safety and "considerable resources deployed". Safe staffing tools have their place, but systematically considering the allocation of resources to maximise quality of care or the optimal provider structures necessary to support quality are also important. Dash also noted that while many reviews take place, "the overwhelming majority of recommendations lack data as to the cost of implementation or the expected impact", which makes it difficult for local provider boards and clinical teams to implement them.

There are not enough people working in adult social care. There is an average of 131,000 vacant posts in 2023/24 and the vacancy rate for adult social care is almost three times that of the wider economy (2.8%).[168] The fall in the vacancy rate, from a historic high of 11% in 2021/22[224] to 8% in 2023/24[168], was driven by a sharp increase in the number of overseas staff recruited to work in adult social care.[225] From 2012/13 to 2023/24, the vacancy has almost doubled for adult domiciliary care roles to 11.6%, as well as across all services, from 4.2% to 8.1% (Figure 4.7).

Fig 4.7 One in ten posts in some key adult social care roles are vacant

Workforce vacancy rate (%) trends for key adult social care roles, 2016/17 to 2023/24



Source: Age UK analysis of Skills for Care (2024). The state of the adult social care sector and workforce in England - 2024.

Adult social care providers report difficulties recruiting staff, particularly in care of older people.[226] A survey of 206 small, medium and large social care providers found 33% reported a decrease in domestic applications, with providers of older people's social care seeing a greater decrease in applications compared to providers of care to adults aged 18-64.[227] Pay rates were the most cited barrier to recruitment at 86%, followed by poor perceptions of the social care sector as a career at 61%, and the challenging nature of the work at 58%.[228]

Many people are leaving their adult social care roles, with a quarter leaving their roles each year. The turnover rate in the local authority and independent sectors was 24.8% in 2023/24, which is the equivalent of approximately 350,000 leavers over the year.[168] Care Quality Commission research found high staff turnover can lead to poor practice as there are not enough established staff to mentor new staff.[229] High turnover impacts continuity of care, with adult social care providers noting the recruitment and retention of staff with the appropriate skills and experience to provide consistent care for people living with dementia to be particular challenge.[229] Skills for Care reports particular difficulties in retaining younger staff across the sector (the ONS found people aged 16-24 were almost three times more likely to change job in 2021 than their older colleagues[229]), and notes that internationally recruited care workers are less likely to leave than domestically recruited care workers.[229]

There are significant nursing workforce challenges in adult social care.[168] The vacancy rate for registered nurses[168] in 2023/24 was 9.0% or 2,900 vacant posts. Registered nurses have been included on the Shortage Occupation List since 2013, due to the shortage of resident workers available to fill these roles and are also a listed occupation on the 'Skilled Workers' visa route. There was a large decrease of 13% (5,100 registered nurses) in filled posts between 2017/18 (when workforce monitoring began) and 2023/24. Registered nurses also had a relatively high turnover rate (31%), equivalent to around 8,900 leavers, compared to other regulated professions such as social workers (17%) and occupational therapists (22%).[168]

There are almost 2,000 absent registered managers in care homes across England for at least one of their registered regulated activities. The Northwest (14%) and East Midlands (14%) have the highest percentage of absent registered managers across care homes in their respective regions. The role of a registered manager is critical in the adult social care sector. All services that are regulated by the Care Quality Commission (CQC) must be managed by a CQC-approved registered manager. They are legally responsible to meet the requirements of regulations at their establishments. As at 2023/24, the vacancy rate for these posts stood at 10%. Around 31% of workers in filled registered manager posts will reach State Pension age in the next 10-15 years. Additionally, there are around 2,800 vacant registered manager posts in adult social care in England.[168]

4.6 Issues impacting recruitment and retention

NHS workforce burnout, emotional exhaustion and illness because of work-related stress remain very high. The 2024 NHS Staff Survey in England report 34% of staff find their work emotionally exhausting, 30% report feeling burnt out because of their work, and 42% report feeling unwell as a result of work-related stress. The survey also found that 42% of staff report feeling worn out by the end of their working day/shift, with 19% of staff saying they find every waking hour to be tiring. Analysis of more than one million survey responses submitted by shift workers across the UK and Ireland in 2024/25[230] found 38% of those submitted by workers in doctors' offices and medical clinics were "unhappy" or "stressed" - the highest proportion of reported 'unhappy shifts'. Critical and emergency service workers and those working in care services were also among the unhappiest shift workers. Conversely, shift workers in vape shops, sit down restaurants, fast food providers and florists were among the happiest. The research notes that addressing burnout, improving staffing levels, and creating pathways to more predictable and supportive work environments may be critical for improving sentiment in essential industries.

Workforce burnout and exhaustion can contribute to patient harm. The Health Services Safety Investigation Body (HSSIB) notes[231] the NHS does not recognise fatigue as a hazard supported by formal fatigue risk management systems as in other industries. Instead, staff fatigue is considered a wellbeing concern to be self-managed, rather than a critical patient and staff safety risk routinely considered in patient safety event reporting or learning reviews. The BMA recognised these findings and the link to patient safety, expressing concern about the long, back-to-back shifts faced by health staff, as well as the impact of workforce shortages.[232]

Although care worker pay has increased in adult social care, it's still amongst the lowest of the economy.[168] The ONS defines low-paid jobs as those paid below two-thirds of median hourly earnings. In April 2024, low-paid jobs in the UK were those paid below £11.39 per hour, and 3.4% of

all UK employee jobs were low paid (a record low).[233] In 2023/24, care workers were paid a mean hourly rate of £11.23 in the independent sector and a mean hourly rate of £12.43 in the local authority sector, while personal assistants were paid a mean of £11.87 an hour.[168] The median hourly rate for care workers nominally increased by 89p (8.8%) to £11.00 between March 2023 and March 2024 however, taking inflation into account, it has increased in real terms by 57p (5.4%).[168] The pay gap between a social care support worker in England and their NHS Band 3 counterpart stood at 30%, or £7,120 per year, in 2024/25.[168] The Health and Social Care Committee's inquiry into the cost of inaction on Adult Social Care reform heard care workers often feel "undervalued and underpaid".[234]

Experienced social care staff earn almost the same as new starters.[168] In 2023/24, care workers who stayed in role as a care worker had a slight reduction in their pay relative to the National Living Wage whereas care workers who changed roles had a relative increase in pay. This indicates that pay progression usually requires promotion into a different role - something likely to impact continuity of care. Care workers continue to have lower hourly rates (median of £11.00) compared to NHS healthcare assistants who were new in role (median of £11.67) and with two or more years of experience (median of £12.45).[168]

The UK Government has committed to establish a new Fair Pay Agreement (FPAs) in the adult social care sector.[168] FPAs are essentially a form of collective bargaining, which is the official process through which trade unions represent workers and negotiate anything from an improved pay offer to better working conditions and pensions. There is no pre-existing law on sectoral agreements in the social care sector. Historically, the bargaining power of care workers has been low, partly because of low unionisation rates. The Resolution Foundation estimates union membership is just 20% for direct care workers, while across the economy they are generally higher (at 41%).[168]Establishing an employer association that "appropriately represents the whole sector will be a challenge".[235] The Employment Rights Bill – which makes provision to amend the law relating to a wide range of employment rights – provides for the establishment of the Adult Social Care Negotiating Body, with a remit to negotiate remuneration and terms and conditions for adult social care workers. Regulations will set out the detail, including any other matters within the negotiating body's remit. These are due in October 2026.[168]

Improved pay is associated with delivering better quality care. In England, the Care Quality Commission inspects care homes and gives them quality ratings of 'outstanding', 'good', 'requires improvement' or 'inadequate'. A University of Kent study[236] of 2,500 care homes in England over three years found that residents have better quality of life in care homes rated 'good' or 'outstanding', and that there is a positive relationship between care quality and staff wages. Homes that were short-staffed or struggled to keep staff tended to be of poorer quality. A 10% increase in the average care worker wage increased the likelihood of a 'good/outstanding' rating by 7%.

In adult social care, the number of days lost to staff sickness is reducing but is still higher than before the COVID-19 pandemic. The average number of sickness days (local authority and independent sectors only, as trend data is not available for those employed through direct payments) was 5.3 per employee in 2023/24.[168] This has reduced (6.2 sickness days per employee in 2022/23) but has not quite returned to pre-pandemic levels (4.7 sickness days per employee in 2019/20).[168] On average, sickness rates in 2023/24 were higher within local authorities (10.7 days) than in independent sector providers (4.9 days), which may reflect differing terms and conditions.[168] People employed to be personal assistants through direct payment had a much lower sickness rate in 2023/24, at 1.7 days.[168]

4.6.1 Discrimination at work

Ethnic minority staff are more likely to experience harassment, bullying, abuse from other staff, and personal discrimination from colleagues at work than their White counterparts.[237] Only 46% of staff from ethnic minorities believed their NHS Trust provides equal opportunities for career progression or promotion, compared to 59% of White staff. Just 39% of staff from a Black background felt they had equal opportunities; the lowest among all ethnic groups.[237] The NHS Equality, Diversity and Inclusion Improvement Plan recognises and sets out actions to address 'the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce'.[237]

Nearly 1 in 10 staff report personally experiencing discrimination at work from staff and patients. A total of 9% of respondents to the NHS Workforce Survey in England[238] said they had personally experienced discrimination at work in 2024 from managers, team leaders or colleagues – a plateau since 2022. 9% also reported they had personally experienced discrimination at work from patients, people using services, their relatives or other members of the public. The Health Services Journal (HSJ) found that more than half of respondents reported this to be due their ethnic background, with Muslim staff a group that consistently reports the highest levels of discrimination, as well as a marked rise in the percentage from staff who report their religion to be Jewish.[239]

4.6.2 International recruitment

One in five NHS staff were recruited from overseas in 2024. The proportion of overseas NHS staff in England has risen from 10% in September 2014 to 20% in September 2024.[240] As of September 2024, Indian (5%), Filipino (2%) and Nigerian (2%) are the most-commonly reported nationalities after British (78%).[*] The increase in the proportion of staff reporting EU nationality that was seen in the early 2010s stopped after the EU referendum and the proportion has since fallen.[241]

The number of international medical graduates (IMGs) joining the UK workforce has overtaken the supply from UK medical schools.[242] Over two thirds (68%) of doctors joining the UK medical register in 2023 were non-UK graduates, which is an increase from less than half (47%) in 2017.[242] UK graduates are more likely to revalidate their license to practice than international medical graduates.[243]

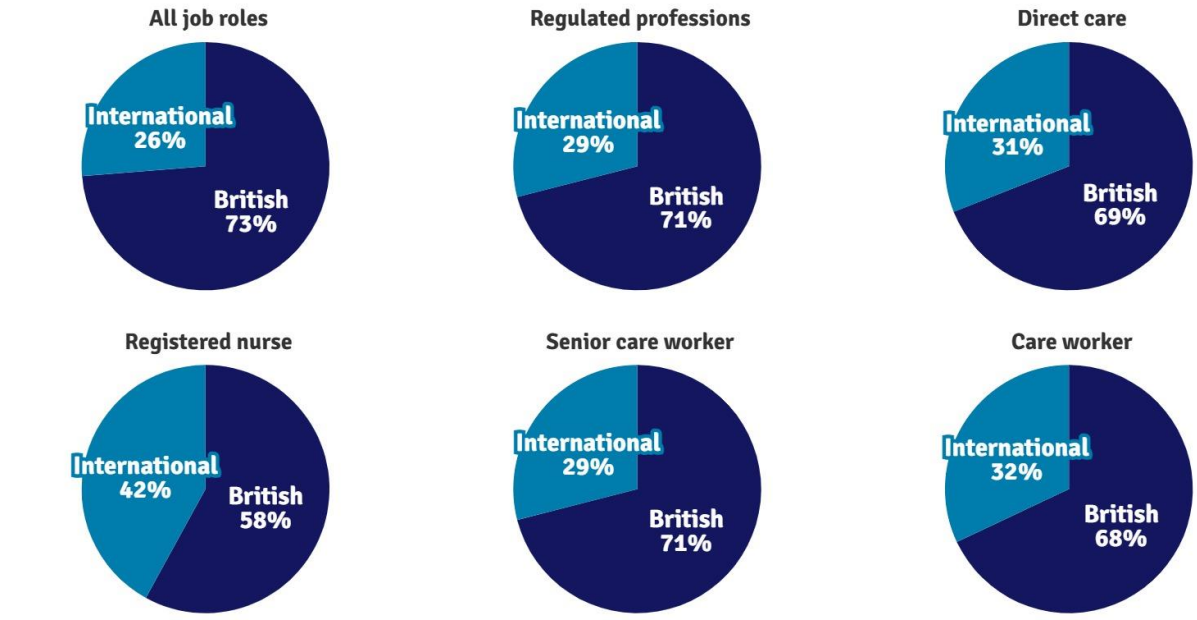
More nurses who trained outside of the UK are joining the English workforce and more UK-registered nurses are moving to other countries. The Nursing and Midwifery Council's register[244] showed there were 592,672 nurses registered to practice in England in September 2024. This is a 14% increase since September 2019, comprising a decrease of 20,557 (-5%) nurses trained in the UK and an increase of 52,840 (+61%) nurses trained outside of the UK. Heath and social care organisations in England must not actively recruit from the countries the World Health Organisation recognises as having the most pressing health and care workforce-related challenges (known as 'red-list' countries).[245] However, concerns have been raised about a rise in recruitment from red-list countries, including Nigeria, Ghana and Zimbabwe, with the Secretary of State for Health noting it has placed the NHS in "an immoral position".[246]

[*] NB. This includes all staff who reported their nationality to be English, Northern Irish, Scottish or Welsh, as well as those who reported their nationality to be British. NHS England (2024). *NHS Workforce Statistics: NHS Hospital and Community Health Services: All staff by Nationality and Staff Group, in NHS Trusts and other core organisations*.

International staff account for 1 in 4 (26%) adult social care staff; up from 1 in 5 last year.[168] Between March 2022 and March 2024 an estimated 220,000 Health and Care Worker visas were granted to main applicants, of which around 141,000 were issued to care workers and senior care workers.[247] However, Skills for Care estimates that closer to 185,000 people arrived in the UK to start direct care providing roles in the independent sector during that period; noting some international recruits will have moved into social care from another role, while others will have arrived on family permits. Both calculations represent a substantial increase in international recruitment on previous years. Figure 4.8 shows registered nurses, senior/care workers and direct care staff make up the largest proportions of international staff. Skills for Care notes a correlation, at least in part, with the increase in filled posts and the reduction in vacant posts seen over the same period.[168]

Fig 4.8 Over one quarter (26%) of the adult social care workforce in England rely on international staff

Nationality of the adult social care workforce, England, 2023/24.



Source: Age UK analysis of Skills for Care (2024). Adult social care workforce estimates.

International recruitment into adult social care fell when care workers were no longer permitted to bring dependents on their visa. Announced in March 2024, care providers sponsoring international recruits were also required to register with the CQC.[248] In the year ending June 2024 there was a 26% decrease in visas granted to Health and Social Care Worker applicants. There was also a notable fall in visa applications between April and June 2024, 81% lower than the same period in 2023. In the quarter April to June 2024, there were an estimated 8,000 international recruits joining the workforce in direct care roles in the independent sector in England. This is a substantial decrease on the previous year where there was an average of 26,000 per quarter.[168]

The UK Government made further restrictions to international recruitment in early 2025. From April 2025, the UK Government tightened the system further by preventing care providers in England from recruiting from overseas unless they had first tried to fill roles with overseas workers left unemployed because their employers had had their visa sponsorship licences revoked.[249] Between July 2022 and December 2024, the government revoked more than 470 sponsor licences from care sector employers, preventing them from recruiting from abroad and leaving many sponsored staff without a job.[250] The UK Government also raised the minimum salary required for an overseas recruit on a Skilled Worker visa, including care workers, to £25,000, or £12.82 an hour, above the national living wage (£12.21).

The UK Government will end overseas recruitment of care workers entirely in 2025, with a "transition period" until 2028.[251] During this transition period, people already in the country with working rights will be permitted to extend visas, switch to a social care job if on a different type of immigration visa, and/or switch to a new sponsor, though these arrangements will be kept under review.[251] The UK Government has cited reforms including the Fair Pay Agreement and Employment Rights Bill as long-term solutions to the issues of recruitment and retention in adult social care. However, several bodies within the sector (including Care England[252], the Association of Directors of Adult Social Services[253], and the Homecare Association[254]) have noted that these reforms remain years away from delivery. They have expressed concern about the likely impacts of the policy change, including an increased reliance on agency staff, an increase in the number of people – "especially women"[255] – having to give up work to care for loved ones, and the risk of some people being unable to access care altogether.

Modern slavery, debt bondage and financial exploitation are on the rise in the care sector.[256] The national Modern Slavery Helpline reported an 11-fold increase in recording of potential victims of modern slavery in the adult social care sector pre- and post- care workers being added to the Shortage Occupation List – from 63 in 2021 to at least 800 in 2023.[257] Migration Observatory report the care route in 2023 "was pretty much the wild west — it is clear that exploitative practices were widespread".[258] Efforts to tighten the rules and protect workers began to be introduced in late 2023.[258] The Home Office reported in March 2025 that more than a quarter of care workers (39,000) who came to the UK on Health and Care Worker visas were hired by the 470 employers who had lost their licence to sponsor visas.[259] The UK Government has committed £12.5 million to 15 regional partnerships in 2025/26 to support them to "prevent and respond to unethical international recruitment practices in the sector", including "support for international recruits to understand their employment rights to switch employers, to remain working in the care sector when they have been impacted by their sponsor's license being revoked".[260]

4.7 Wider infrastructure

Lord Darzi found the NHS to have been "starved of capital", with the capital budget "repeatedly raided to plug holes in day-to-day spending".[261] He also noted a huge shortfall in capital investment compared to England's peer countries, with the lack of investment negatively impacting productivity. This is despite the UK Government's five-year Health Infrastructure Plan (2019) which recognised capital spend to be "fundamental to high-quality patient care, from well-designed facilities that promote quicker recovery, to staff being better able to care for patients using the equipment and technology that they need".[262]

4.7.1 Estates

The NHS backlog of building maintenance will take an estimated £13.8bn to resolve.[263] The government's health estate portfolio for England comprises three distinct categories: community health services (primary care), NHS Trust hospitals (secondary care), and residential and care facilities. It does not include administrative buildings (which are included within the government's office portfolio) or laboratories science estate (which are included in the government's science portfolio). The freehold value of the health estate portfolio in England is £66.4bn.[264] However, many assets do not meet the demands of a modern health service. In 2022/23, 42% of the estate had been built before 1985, with 14% pre-dating the NHS itself and including many Victorian buildings.[265]

The shortfall in capital spending over the past 15 years is estimated to be closer to £37bn.[261] What Lord Darzi describes as "a staggering" capital gap opened between the UK and other countries in the 2010s. Had we matched the average capital investment of all peer countries, this would have amounted to an additional £37bn. Lord Darzi notes that the shortfall has severely hindered the NHS' ability to maintain and upgrade its infrastructure, leaving many facilities urgently needing modernisation, and the failure to invest in community-based services has frustrated efforts to move care closer to home.

The NHS routinely underspends its capital allocation, despite it being insufficient to begin with.[261] Capital expenditure limits are imposed on NHS trusts by HM Treasury that cannot be exceeded, even if the funds to make such investments are available. Lord Darzi, in his 2024 independent report on the state of the NHS in England, noted "the capital approvals process is so byzantine that it is hard to find an NHS senior manager who understands it".[261] In her 2023 review, Patricia Hewitt noted "a lack of capital, inflexibility in use of capital and the layering of different capital allocation and approvals processes from different departments and agencies are major barriers to improvement and productivity" and recommended a cross-government review of the entire NHS capital regime to improve the value delivered form existing capital budgets.[266] NHS providers have also noted that capital expenditure limits create difficulties with cross-boundary flow, which makes holding contracts with multiple Integrated Care Boards or Trusts difficult, despite the opportunities for scale and efficiencies.[267] The UK Government extended capital departmental expenditure limits from one year to four years in its 2025 Spending Review – setting them to 2029/30.[261]

The Primary Care Utilisation and Modernisation Fund allocates £102 million to modernise the estate of over 1,000 GP surgeries across England in 2025/26.[268] The fund was launched in response to Lord Darzi's finding that "the primary care estate is plainly not fit for purpose", with one fifth of GP estates pre-dating the NHS and half being more than 30 years old.[269] It covers physical upgrades (but not digital projects) and aims to enhance the use of existing infrastructure, create additional capacity for the GP and practice workforce, and enable additional patient appointments.[268]

There has been a "lack of progress" in terms of improving hospitals and building new ones.[270] In late July 2024, the newly elected UK Government announced they would "reset" the New Hospital Programme and set out a new costed timetable for delivery[271] and in September 2024, they announced 21 schemes would go ahead.[272] Plans were set out for another 25 in January 2025, with work starting in two phases and 18 schemes warned they will have to wait until 2032 or later for construction to start.[273] The 10 Year Health Plan set out proposals to set 5 year capital budgets; to simplify the approval process for capital projects; and a return to the original vision for NHS Foundation Trusts to have much greater control over spending, including re-investing budget

surpluses in buildings and equipment. The plan further signals the likely return of private finance arrangements in some places to spread the cost of larger projects.

Upgrades to infrastructure need to be made in an environmentally sustainable and responsible way. There was a 52.7% rise in overheating incidents triggering a risk assessment from 2016/17 (2,980 incidents[274]) to 2023/24 (4,551[275]), with a peak in 2022/23 (6,822)[276] that likely reflected the record 40-degree temperatures in July 2022.[277] The number of serious flooding incidents, where water caused disruption such as by breaching a building or flooding a road, rose from 176 in 2021/22[278] to 358 in 2023/24[275] – doubling over just two years.

Rectification of reinforced autoclave aerated concrete (RAAC) issues has added billions to capital costs. As of October 2024, there were a total of 47 hospital sites with confirmed RAAC. A further 13 sites have eradicated previously confirmed instances of RAAC since the programme began in 2021.[279] Seven of the 47 hospital sites with RAAC have been added to the New Hospital Programme as they require entire or near-entire rebuilding.[280] The National Audit Office reports an average estimated cost of £1bn to rebuild each of these hospitals.[281] The Secretary of State for Health and Social Care has commissioned an updated site-by-site report on RAAC hospitals that is due in Summer 2025 and may impact timelines, but all seven RAAC remediation schemes are currently due to commence construction between 2025 and 2030.[282]

Limited capital investment in the adult social care sector has "increased costs and driven pressures on wider public services".[283] The Health and Social Care Committee inquiry into the cost of inaction on Adult Social Care reform[284] heard providers, particularly larger ones, wanted to invest in the sector but found planning delays result in inflated costs and a lack of income certainty increases borrowing costs. The Committee also heard that the precarious and reduced funding available for capital investment is resulting in projects, particularly those aimed at meeting specialist or complex needs, being much reduced.

Large capital investments in public health infrastructure are also required, with a multi-billion pound investment committed to a National Biosecurity Centre. The total funding for the project is yet to be confirmed, but "£250m will be spent by the government over this Parliament".[285] The National Audit Office reported in 2024 that financial modelling for the project undertaken by the previous UK Government significantly underestimated the costs and timescales for delivery.[286]

4.7.2 Equipment

The UK has fewer CT, MRI and PET scanners than any of our comparator countries.[287] Lord Darzi's independent investigation into the NHS found this to be the case using both OECD and industry benchmarks.[261] This is despite a commitment in 2019's NHS Long Term Plan for capital investment to be made into new equipment, including CT and MRI scanners.[288]

NHS machines are often old and outdated. Lord Darzi's investigation found that NHS equipment is frequently less powerful than newer models. This means diagnostic interventions like scans take longer, as well as more time being lost due to breakdown and maintenance.[261]

The lack of modern equipment frustrates timely access to diagnosis and treatment. Lord Darzi's review found that underinvestment in diagnostics extends the stay of patients in hospital.[261] Leading dementia charities flagged concerns about whether there are sufficient PET and MRI scanners to

ensure timely and equitable access to new dementia treatments for people across the country.[289] Their analysis concluded England has the lowest per capita number of PET scanners of any G7 country (1.20 per 1 million people) and the lowest number of MRI scanners (6.31 per 1 million people).

4.7.3 Sustainability of the third sector.

The financial stability of third sector organisations fell significantly during the pandemic. Research from 360 Giving found there has been a decline in the overall number of third sector infrastructure organisations.[66] Local infrastructure organisations bring community organisations together, build capacity, foster partnerships, and provide leadership.[66]

Fewer councils are taking a positive investment strategy in the third sector. The proportion of Directors of Adult Social Services who reported their council taking a positive investment strategy in the third sector fell from 29% in 2023/24 to 15% in 2024/25.[66] While the proportion of Directors reporting their council disinvested in the sector in 2024/25 was relatively small at 8%, it has doubled in just a year – from 4% in 2023/24.[66] The sustainability of the third sector is of particular concern as – as shown in Section 2.1.2 – more than half of requests for support made to councils by older people result in no service being provided, universal services or signposting elsewhere.

"Essential public services are at risk due to underfunded contracts held by charities".[290] One quarter of contracts held by charities have been uplifted in line with inflation. The National Council for Voluntary Organisations (NCVO) reports charities deliver almost £17bn worth of public services every year, plus many "also provide support when public services fall short, without receiving any public funding at all". [291] NPC found 62% of charities believe they do not receive the full value it costs to deliver a public sector contract, with the average charity contributing 35% the value of a contract. NPC estimates charities "prop up state services by £2.4bn a year" – equivalent to 23 times the emergency support package the Government provided charities in 2023 to help them cope with the cost-of-living crisis.[292] NCVO warns charities delivering public sector contracts will "increasingly have to choose between using charitable funds to make up any shortfall or take the hard decision to withdraw from delivering services".[291]

Third sector organisations that provide contracted services to local authorities and the NHS are not exempted from increased National Insurance (NI) contributions. The policy lowered the threshold at which employers start paying NI on each employee's salary to £5,000 from £9,100 and increased the rate from 13.8% to 15% from April 2025. The National Council for Voluntary Organisations (NCVO), supported by more than 7,000 voluntary organisations and charities, estimated the changes would cost charities £1.4bn and warned that this would lead to cuts in services.[293] The Chancellor replied, acknowledging the essential contribution of the third sector while confirming there would be no specific exemption for third sector organisations.[294]

References

[1] WHO (2020). Healthy ageing and functional ability.
[2] Preston, J. & Biddell, B. (2021). The physiology of ageing and how these changes affect older people.
[3] Kivimäki, M. et al (2025). Proteomic organ-specific ageing signatures and 20-year risk of age-related diseases: the Whitehall II observational cohort study.
[4] WHO (2020). Decade of Health Ageing: Baseline Report.
[5] Age UK (2024). We have to take it one day at a time.
[6] ONS (2025). Population projections for regions by five-year age groups and sex, England 2022-based.
[7] ONS (2024). National life tables – life expectancy in the UK: 1980 to 2023.
[8] Law, A. et al. (2025). Estimating changes in life expectancy in Hong Kong during the COVID-19 pandemic: a longitudinal ecological study.
[9] ONS (2024). Healthy life expectancy in England and Wales: between 2011 to 2013 and 2021 to 2023.
[10] Resolution Foundation (2025). Ageing in the fast and slow lane: Examining geographic gaps in ageing.
[11] ONS (2025). Healthy life expectancy by national area deprivation, England: between 2013 to 2015 to 2020 to 2022.
[12] ONS (2025). Public opinions and social trends, Great Britain: Personal wellbeing and loneliness [5 to 30 March 2025 edition of the dataset].
[13] NHS England (2025). GP Patient Survey 2025.
[14] Kantar research for Age UK undertaken September 2024. Kantar online polling of 2694 UK adults aged 50+ for Age UK, conducted 17th to 30th September 2024
[15] Litsardopoulos, et al. (2025). Work and health: international comparisons with the UK.
[16] NIHR (2021). Multiple long-term conditions (multimorbidity): making sense of the evidence.
[17] NHS England (2024). Health Survey for England, 2022 Part 2.
[18] Valabhji J. et al. (2023). Prevalence of multiple long-term conditions (multimorbidity) in England: a whole population study of over 60 million people.
[19] Hayanga, B. et al. (2023). Ethnic inequalities in age-related patterns of multiple long-term conditions in England: Analysis of primary care and nationally representative survey data.
[20] Valabhji J et al. (2023). Prevalence of multiple long-term conditions (multimorbidity) in England: a whole population study of over 60 million people.
[21] Steell L. et al. (2025). Multimorbidity clusters and their associations with health-related quality of life in two UK cohorts.
[22] British Geriatrics Society (2018). Frailty: what's it all about?
[23] NHS England (2022). Ageing well and supporting people living with frailty.
[24] NHS England (2025). GP Contract Services – England 2024/25.
[25] Gobbens, R.J et. al. (2024). Associations of individual chronic diseases and multimorbidity with multidimensional frailty.
[26] NICE (2016). Multimorbidity: clinical assessment and management, NICE guideline NG56.
[27] Yang, Z-C. (2023). Frailty Is a Risk Factor for Falls in the Older Adults: A Systematic Review and Meta-Analysis
[28] Cheng, M.H. & Chang, S.F. (2017). Frailty as a risk factor for falls among community-dwelling people: Evidence from a meta-analysis.
[29] Office for Health Improvement & Disparities (2022). Falls: applying All Our Health.
[30] OHID (2025). Public health profiles. 2025: Emergency hospital admissions due to falls in people aged 65 and over.
[31] NHS England (2022). Going further for winter: Community-based falls response.
[32] Kim, K-M et al. (2022). Recent fall and high imminent risk of fracture in older men and women.
[33] Kumar, A. et al (2014). Which factors are associated with fear of falling in community-dwelling older people?
[34] Asai, T et al. (2022). The association between fear of falling and occurrence of falls: a one-year cohort study.
[35] NHS England (2025). Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/24
[36] Ray-Chaudhuri, S. & Waters, T. (2024). Recent trends in and the outlook for health-related benefits.
[37] IFS (2025). The role of changing health in rising health-related benefit claims.
[38] International Longevity Centre UK (2023). Mind the age gap: Making mental health matter across the life course.
[39] Unmind (2025). Workplace mental health trends.
[40] DEFRA (2025). Statistical Digest of Rural England: 1 – Population.
[41] ONS (2024). Families and households
[42] Nakou, A. et al. (2025). Loneliness, social isolation, and living alone: a comprehensive systematic review, meta-analysis, and meta-regression of mortality risks in older adults.

[43] Abell, J. & Steptoe, A. (2021). Why is living alone in older age related to increased mortality risk? A longitudinal cohort study.
[44] ONS (2025). Childbearing for women born in different years.
[45] Age UK analysis of data from wave 12 of Understanding Society, collected 2020-22, scaled up to the UK age 65+ population using ONS mid-year population estimates for 2021.
[46] Nakou, A. et al. (2025). Loneliness, social isolation, and living alone: a comprehensive systematic review, meta-analysis, and meta-regression of mortality risks in older adults.
[47] Yin, J. et al (2019). Exploring the bidirectional associations between loneliness and cognitive functioning over 10 years: the English longitudinal study of ageing.
[48] National Institute of Ageing (2019). Social isolation, loneliness in older people pose health risks.
[49] Age UK (2024). You are not alone in feeling lonely: Loneliness in later life.
[50] Kantar Public (2016). Trapped in a bubble: An investigation into triggers for loneliness in the UK. British Red Cross and Co-op.
[51] Age UK analysis of data from wave 14 of: University of Essex, Institute for Social and Economic Research (2025). Understanding Society: Waves 1-14, 2009-2023, 19th Edition. UK Data Service. SN: 6614.
[52] ONS (2024). Sandwich carers, UK: January 2021 to May 2023.
[53] ONS (2024). Unpaid care expectancy and health outcomes of unpaid carers, England: April 2024.
[54] Carers UK (2025). State of Caring: The impact of caring on carers' mental health and the need for support from social care services.
[55] Age UK (2025). 1.6 million carers worry whether they'll be able to keep caring or providing support to their loved ones.
[56] NHS England (2025). Appointments in General Practice, March 2025.
[57] NHS England (2025). General Practice Workforce, 31 March 2025
[58] The King's Fund (2025). Public satisfaction with the NHS and social care in 2024 (BSA).
[59] The Health Foundation (2025). Public perceptions of health and social care polling (wave 7): November 2024. Conducted by Ipsos for the Health Foundation.
[60] Public Health England (2019). What is known about the oral health of older people in England and Wales.
[61] The Dentist (2023). Annual NHS dental statistics for England report released.
[62] Public Accounts Committee (2025). Fixing NHS Dentistry: Twenty-First Report of Session 2024-25.
[63] NAO (2024). Investigation into the NHS dental recovery plan.
[64] NHS England (2024). Adult Social Care Activity and Finance Report, England, 2023/24.
[65] NHS England (2024). Adult Social Care Activity and Finance Report, England, 2022/23.
[66] ADASS (2025). 2025 Spring Survey.
[67] NHS England (2024). Personal Social Services Survey of Adult Carers in England 2023/24.
[68] No data is available as to the experiences of people 'outside the system'.
[69] Ministry of Housing, Communities & Local Government (2020). English Housing Survey 2018: accessibility of English homes - fact sheet
[70] Institute of Fiscal Studies (2018). The use of housing wealth at older ages.
[71] MHCLG & DHSC (2024). Our Future Homes: Housing that promotes wellbeing and community for an ageing population.
[72] Foundations (2025). DFG Performance Report: From the annual data returns.
[73] Age UK (2024). The Disabled Facilities Grant: A step change – improving delivery of the DFG.
[74] Department of Health (2011). Talking Therapies: A four-year plan of action.
[75] NHS England (2024). NHS Talking Therapies, for anxiety and depression, Annual Reports 2023/24.
[76] Department of Health (2015). Prime Minister's Challenge on Dementia 2020.
[77] Health and Social Care Committee (2021). Supporting people with dementia and their carers. House of Commons.
[78] NHS England (2025). Primary Care Dementia Data, May 2025.
[79] Alzheimer's Society (2025). Our response to the NHS dementia diagnosis target cuts.
[80] House of Commons Debate. 3 June 2025. Dementia Care, Volume 768: Column 275. Hansard.
[81] Mattke, S et al. (2024). Estimated Investment Need to Increase England's Capacity to Diagnose Eligibility for an Alzheimer's Treatment to G7 Average Capacity Levels.
[82] ONS (2025). Population projections for regions by five-year age groups and sex, England 2022-based.
[83] The King's Fund (2025). Public satisfaction with the NHS and social care in 2024 (BSA).
[84] The Health Foundation (2025). Public perceptions of health and social care polling (wave 7): November 2024.
[85] BMA (2025). Safe working guidance: a handbook for general practice in England.
[86] Parr, E. (2024). GPs report average of 31 patient contacts a day.
[87] IfG (2025). General practice across England: How patient and staff numbers are related to patient experience.
[88] NHS England (2025). General Practice Workforce, June 2025.
[89] Evans, R. (2025). Majority of GPs still turn up to work even when feeling mentally unwell, survey finds.

[90] Health and Social Care Committee (2025). Adult Social Care Reform: The cost of inaction – Second Report of Session 2024/25. House of Commons.
[91] HM Government (2025). National Minimum Wage and National Living Wage rates.
[92] Skills for Care (2025). Pay in the adult social care sector in England.
[93] Curry, N., Lobont, C. & Hemmings, N. (2024). Will the Autumn Budget push the social care beyond breaking point?
[94] Homecare Association (2024). Minimum Price for Homecare – England 2025/26.
[95] ADASS (2025). 2025 Spring Survey.
[96] CQC (2024). The state of health care and adult social care in England 2023/24.
[97] Health Foundation (2025). Extra £3.4bn needed to save adult social care services from decline.
[98] The King's Fund (2025). Key facts and figures about adult social care.
[99] Health and Social Care Committee (2025). Adult Social Care Reform: The cost of inaction – Second Report of Session 2024/25. House of Commons.
[100] Laing, W. (2025). Care Homes for Older People: UK Market Report – Thirty-Fifth Edition.
[101] HSSIB (2025). Workforce and patient safety: primary and community care co-ordination for people with long-term conditions.
[102] The Health Foundation (2025). Public perceptions of health and social care polling (wave 7): November 2024. Conducted by Ipsos for the Health Foundation.
[103] NIHR (2021). People who fund their own care receive little help to navigate the system.
[104] Community Pharmacy England (2025). Pharmacy Pressures Survey: Medicines Supply Report.
[105] NHS Business Services Authority (2025). Prescription Cost Analysis – England 2024/25.
[106] Epilepsy Action, Epilepsy Society, Parkinson's UK and SUDEP Action.
[107] Epilepsy Action (2024). Medicine Shortages.
[108] Francis, A. (2024). Hospitals ration hygiene products as NHS trusts face tight budgets. The i Paper.
[109] LGiU (2025). The State of Local Government Finance in England 2025.
[110] LGiU (2024). The State of Local Government Finance in England 2024.
[111] CQC (2024). The state of health and adult social care in England 2023/24.
[112] Age UK analysis of English Longitudinal Study of Ageing (ELSA). Wave 10. 2021-23.
[113] LaingBuisson (2025). Private health cover market hits record high as strong demand continues. Healthcare Markets.
[114] Heath, L. (2024). Self-pay demand: should we be concerned? Healthcare Markets.
[115] IHPN (2024). Going Private 2024.
[116] Patients Association (2024). Patients place huge importance on diagnostic services but face barriers to access.
[117] PHIN (2024). Patient Priorities.
[118] ONS (2024). Health outcomes of unpaid carers using the Health Survey for England, England, 2015, 2017 and 2019
[119] Carers UK (2025). State of Caring: The impact of caring on carers' mental health and the need for support from social services.
[120] CQC (2024). State of Health Care and Adult Social Care in England 2023/24.
[121] NHS England (2019). Personal Social Services Survey of Adult Carers in England 2018/19.
[122] NHS England (2022). Personal Social Services Survey of Adult Carers in England 2021/22.
[123] Giebel, C. et al. (2019). What are the social predictors of accident and emergency attendance in disadvantaged neighbourhoods? Results from a cross-sectional household health survey in the Northwest of England.
[124] Gethings, O. et al. (2023). Inequalities in Accident and Emergency department attendance by socio-economic characteristics: population-based study
[125] NHS England (2020). Hospital Accident & Emergency Activity 2019/20.
[126] NHS England (2021). Hospital Accident & Emergency Activity 2020/21.
[127] NHS England (2023). Hospital Accident & Emergency Activity 2022/23.
[128] NHS England (2024). Hospital Accident & Emergency Activity 2023/24.
[129] NHS England (2025). A&E Attendances and Emergency Admissions: Quarter 3&4 (2024/25) & NHS England (2024). A&E Attendances and Emergency Admissions: Quarter 1&2 (2023/24),
[130] NHS Digital (2024). A&E Attendance and Emergency Admissions: March 2024 Statistical Commentary.
[131] NHS England (2024). Urgent and Emergency Care Plan.
[132] Nuffield Trust (2025). Ambulance response times.
[133] NHS England (2025). Statistical Note: Ambulance Quality Indicators.
[134] NHS England (2025). 2025/26 priorities and operational planning guidance.
[135] Nuffield Trust (2025). Ambulance handover delays.
[136] NHS England (2025). Urgent and Emergency Care Daily Situation Reports.
[137] HSSIB (2023). Harm caused by delays in transferring patients to the right place of care.
[138] RCEM (2025). Position statement regarding treating patients in the back of ambulances.

[139] NHS England (2025). Reducing hospital handover delays.
[140] Nuffield Trust (2025). Delayed discharges from hospital.
[141] NHS England (2015). A&E Attendances and Emergency Admissions 2015/16.
[142] NHS England (2025). A&E Attendances and Emergency Admissions 2024/25..
[143] RCEM (2025). 'An alarming threat to patient safety' – over a million older patients endured 12-hour waits in England's A&Es last year.
[144] Jones, S. et al (2022). Association between delays to patient admission from the emergency department and all-cause 30-day mortality.
[145] RCN (2025). On the Frontline of the UK's Corridor Care Crisis.
[146] NHS England (2024). Principles for providing safe and good quality care in temporary escalation spaces.
[147] RCN (2025). On the Frontline of the UK's Corridor Care Crisis.
[148] NHS England (2024). Emergency readmissions to hospital within 30 days of discharge from hospital.
[149] NHS England (2025). Waiting List Minimum Data Set (WLMDS) Information - June 2025.
[150] DHSC (2025). Handbook to the NHS Constitution for England.
[151] National Voices (2025). New NHS data exposes inequalities in elective care access.
[152] NHS England (2025). Bed Availability and Occupancy.
[153] National Institute for Health and Social Care Excellence (NICE) (2018). NICE guideline 94: Bed occupancy.
[154] NHS England and NHS Improvement (2020). NHS Operational Planning and Contracting Guidance 2020/21.
[155] Fraser, C. et al (2024). Briefing: Are intermediate care services stretched too thin? Health Foundation.
[156] NHS England (2023). Adult Social Care Activity and Finance Report, England 2022/23.
[157] DHSC (2024). The adult social care outcomes framework: handbook of definitions.
[158] Fraser, C. et al (2024). Briefing: Are intermediate care services stretched too thin? Health Foundation.
[159] UK Government (2025). Fit for the Future: 10 Year Health Plan for England.
[160] NHS England (2023). NHS Long Term Workforce Plan.
[161] NHS England (2025). Model Integrated Care Board – Blueprint v1.0.
[162] Skills for Care [with partners] (2024). A Workforce Strategy for Adult Social Care in England.
[163] DHSC (2024). Care workforce pathway for adult social care.
[164] Department for Business and Trade (2025). Roadmap revealed to boost rights for half of all UK workers and provide certainty for employers.
[165] Health and Social Care Committee (2025). Adult Social Care Reform: The cost of inaction – Second Report of Session 2024-25.
[166] Age UK analysis of NHS and adult social headcount totals as a proportion of people in employment, using: NHS England (2025). NHS Workforce Statistics – March 2025, Skills for Care (2024). The state of the adult social care sector and workforce in England – 2024 & NOMIS (2025). Labour Market Profile – England. ONS.
[167] NHS England (2025). NHS Workforce Statistics – March 2025.
[168] Skills for Care (2024). The state of the adult social care sector and workforce in England – 2024.
[169] NHS England (2025). NHS Workforce Statistics – March 2025.
[170] NHS (2025). The core public health workforce.
[171] NHS England (2023). NHS Workforce Statistics – March 2023.
[172] NHS England (2024). NHS Workforce Statistics – March 2024.
[173] NHS England (2025). NHS Workforce Statistics – March 2025.
[174] Harvey-Rich, O., Warner, M. & Zaranko, B. (2024). NHS hospital productivity: some positive news.
[175] Harvey-Rich, O., Warner, M. & Zaranko, B. (2024). NHS hospital productivity: some positive news.
[176] Skills for Care (2022). The state of the adult social care sector and workforce in England – 2022.
[177] Skills for Care (2023). The state of the adult social care sector and workforce in England – 2023.
[178] Nuffield Trust (2024). The NHS workforce in numbers.
[179] NHS England (2025). NHS Workforce Statistics – March 2025.
[180] Darzi, A (2024), Independent Investigation of the National Health Service in England: Technical Annex
[181] Darzi, A (2024), Independent Investigation of the National Health Service in England: Technical Annex
[182] Hunt, J. HC Debate – Five Year Forward View (23 October 2014). Volume 589. Column 1044.
[183] Queen's Nursing Institute (2024). District Nursing Today: The View of District Nurse Team Leaders in the UK.
[184] Queen's Nursing Institute (2024). District Nursing Today: The View of District Nurse Team Leaders in the UK.
[185] ONS (2025). EMP17: People in employment on zero-hour contracts. May 2025.
[186] Edbrooke-Hyson, V. (2023). A Capacity Review - Public Health Specialists in 2022. Health Education England.
[187] NHS England (2024). NHS Workforce Race Equality Standard (WRES) 2023 data analysis report for NHS trusts.
[188] HM Government (2025). Working age population. [Age UK analysis]. 'Working-age population' is defined by the Office for National Statistics as everyone aged 16 to 64.

[189] NHS England (2025). Workforce Disability Equality Standard: 2024 data analysis report for NHS trusts.
[190] NHS England (2024). Workforce Disability Equality Standard: 2024 data analysis report for NHS trusts.
[191] DWP (2025). Family Sources Survey: financial year 2022 to 2023.
[192] NHS England (2024). NHS Workforce Race Equality Standard (WRES) 2023 data analysis report for NHS trusts.
[193] Skills for Care (2025). Social Care Workforce Race Equality Standards.
[194] NHS England (2023). NHS equality, diversity, and inclusion improvement plan.
[195] Skills for Care (2024). The state of the adult social care sector and workforce in England – 2024.
[196] Secretary of State for Health and Social Care, Wes Streeting MP, cited in: Health and Social Care Committee (2025). Oral Evidence: The Ten Year Health Plan, HC 386 – 14 July 2025.
[197] NHS England (2023). NHS Long Term Workforce Plan.
[198] Secretary of State for Health and Social Care, Wes Streeting MP, cited in: Health and Social Care Committee (2025). Oral Evidence: The Ten Year Health Plan, HC 386 – 14 July 2025.
[199] UK Government (2025). Fit for the Future: Ten Year Health Plan for England: Executive Summary.
[200] RCN (2024). Nurse universities admission figures show government NHS reforms under 'direct threat', says Royal College of Nursing.
[201] HESA (2025). Higher Education Student Statistics: UK, 2023/24.
[202] GMC (2024). The state of medical education and practice in the UK: Workforce report 2024.
[203] HESA (2025). Higher Education Student Statistics: UK, 2023/24.
[204] NHS England (2025). Freedom of Information Request: Applications of medical students to more than one specialty. What Do They Know.
[205] Specialty Applications (2025). 2024 Specialty Training Competition Ratios.
[206] Kelly, E., Propper, C. & Zaranko, B. (2022). Team composition and productivity: evidence from nursing teams in the English National Health Service. Health, Econometrics and Data Group, University of York
[207] Arora, A., Aldridge, L. & Gordon, A. (2024). The state of the consultant geriatrician workforce: An analysis of the RCP census. British Geriatrics Society.
[208] NHS England (2025). NHS Vacancy Statistics, England, April 2015 - March 2025, Experimental Statistics.
[209] Steps include actions such as contacting a recruiter, applying for or attended training to prepare for a new role or applying for a role outside of medicine or overseas.
[210] GMC (2024). The state of medical practice and education in the UK: Workplace experiences 2024.
[211] GMC (2024). Identifying groups of migrating doctors.
[212] BMA (2024). When a doctor leaves: Tackling the cost of attrition in the UK's health services.
[213] Aiken, L et al. (2013). Hospital use of agency-employed supplemental nurses and patient mortality and failure to rescue.
[214] O'Dowd, A. (2024). NHS temporary staffing bill "skyrockets" to £10.4bn.
[215] Monitor (2015). Price caps for agency staff: impact assessment.
[216] DHSC (2022). The Government's 2022-23 Mandate to NHS England.
[217] Garratt, K. et al (2024). Research Briefing: The NHS Workforce in England. House of Commons Library.
[218] Kelly, J. (2025). Financial performance update (NHS England Board paper – meeting of 27 March 2025).
[219] UK Government/NHS England (2025), Fit for the Future: 10 Year Health Plan for England.
[220] BMA (2025). Medical staffing in the NHS.
[221] BMA (2024). BMA organisational submission to Change NHS:
[222] Ford, M. (2024). 'Substantial' pay rise for all nurses among RCN manifesto calls..
[223] Dash, P. (2025). Review of patient safety across the health and care landscape.
[224] Skills for Care (2022). The state of the adult social care sector and workforce in England – 2022.
[225] The King's Fund (2025). Social care 360: workforce and carers.
[226] CQC (2024). The state of health care and adult social care in England 2023/24.
[227] HfT and Care England (2025). Sector Pulse Check: Adult Social Care Review – a snapshot of the key financial and workforce challenges in 2024.
[228] HfT and Care England (2025). Sector Pulse Check: Adult Social Care Review – a snapshot of the key financial and workforce challenges in 2024.
[229] CQC (2024). The state of health care and adult social care in England 2023/24.
[230] Deputy (2025). Shift Pulse Report: Insights from the global people platform for hourly work.
[231] HSSIB (2025). The impact of staff fatigue on patient safety.
[232] BMA (2024). Fatigue and sleep deprivation.
[233] ONS (2024). Low and high pay in the UK: 2024.
[234] Health and Social Care Committee (2024). Adult Social Care Reform: the cost of inaction: Second Report of Session 2024-25.
[235] Turner-Berry, F. (2024). Opinion: How Fair Pay Agreements could work in social care. Caring Times.

[236] Towers, A-M., et al (2021). Care home residents' quality of life and its association with CQC ratings and workforce issues: the MiCareHQ mixed-methods study. Health and Social Care Delivery Research 2021:9(19).
[237] NHS England (2024). NHS Workforce Race Equality Standard 2023. WRES Indicator 6-8 [Age UK analysis].
[238] NHS Survey Coordination Centre (2025). NHS Staff Survey 2024: National Results Briefing.
[239] Collins, A. & Kituno, N. (presenters) (2025). HSJ Health Check podcast: The ups and downs of the NHS staff survey.
[240] NHS England (2024). NHS Workforce Statistics: NHS Hospital and Community Health Services: All staff by Nationality and Staff Group, in NHS Trusts and other core organisations.
[241] Baker, C. (2023). NHS staff from overseas: statistics. House of Commons Library.
[242] GMC (2024). The state of medical education and practice in the UK: Workforce report 2024.
[243] Nageswaran P, Nageswaran P, Gajanan K. (2023). Improving international medical graduates' understanding of the UK appraisal system: an interventional study. Future Healthcare Journal. 2023 Nov;10(3):296-300.
[244] NMC (2024). The NMC Register England mid-year update 2024 [data tables].
[245] DHSC (2025). Code of practice for the international recruitment of health and social care personnel in England.
[246] Campbell, D. (2025). Post-Brexit reliance on NHS staff from 'red list' countries is unethical, Streeting says. The Guardian.
[247] Home Office (2025). Accredited official statistics: Why do people come to the UK? Work.
[248] Home Office, DHSC & DWP (2024). New laws to cut migration and tackle care worker visa abuse.
[249] Home Office & DHSC (2025). New rules to prioritise recruiting care workers in England.
[250] Samuel, M. (2025). Government curbs overseas recruitment with providers required to prioritise staff already in England. Community Care.
[251] HM Government (2025). Restoring Control over the Immigration System [white paper].
[252] Care England (2025). From Crisis to Collapse: Care England expresses concern over sudden end to overseas recruitment.
[253] ADASS (2025). ADASS responds to the government's immigration white paper.
[254] Homecare Association (2025). Homecare Association raises alarm over careworker [sic] visa crackdown.
[255] ADASS (2025). ADASS responds to the government's immigration white paper.
[256] Ravikumar, S. (2025). UK's migrant care workers face widespread exploitation, survey shows. Reuters.
London: House of Commons.
[257] Booth, R. (2024). Modern slavery in social care surging since visa rules eased. The Guardian.
[258] Home Office & DHSC (2025). New rules to prioritise recruiting care workers in England.
[259] Strauss, D. (2025). More than a quarter of UK care visas went to 'rogue' employers, Home Office admits. Financial Times.
[260] UK Parliament (2025). Question for DHSC: Care Workers: Recruitment, UIN 48547, tabled 28 April 2025.
[261] Darzi, A. (2024). Independent Investigation of the National Health Service in England.
[262] DHSC (2019). Health Infrastructure Plan.
[263] NHS England (2024). Estates Returns Information Collection, Summary page and dataset for ERIC 2023/24.
[264] Government Property Function (2025). Government Estate: Annual Data Publication 2023/24.
[265] Kirk-Wade, E. (2024). Hospital building in England: Plans and Progress. House of Commons Library [analysis of NHS Estates data].
[266] Hewitt, P. (2023). The Hewitt Review: An independent review of integrated care systems.
[267] NHS Confederation (2025). Capital efficiency: How to reform healthcare capital spending.
[268] DHSC (2025). Primary Care Utilisation and Modernisation Fund 2025 to 2026.
[269] Darzi, A. (2024). Independent Investigation of the National Health Service in England.
[270] Public Accounts Committee (2023). The New Hospital Programme: First Report of Session 2023/24.
[271] Oral statement to Parliament: Chancellor statement on public spending inheritance, 29 July 2024. HM Treasury
[272] DHSC (2024). New Hospital Programme review: Terms of reference.
[273] DHSC (2025). New Hospital Programme: Plan for implementation.
[274] NHS England (2017). Estates Returns Information Collection, ERIC dataset 2016/17.
[275] NHS England (2024). Estates Returns Information Collection, ERIC dataset 2023/24.
[276] NHS England (2023). Estates Returns Information Collection, ERIC dataset 2022/23.
[277] NHS England (2025). 4th Health and climate adaptation report.
[278] NHS England (2022). Estates Returns Information Collection, ERIC dataset 2021/22.
[279] DHSC (2024). Reinforced autoclaved aerated concrete (RAAC) in hospitals: management information.
[280] Public Accounts Committee (2023). The New Hospital Programme: First Report of Session 2023/24.
[281] NAO (2023). Progress with the New Hospital Programme.
[282] UK Parliament (2025). Question for DHSC: Hospitals: Construction, UIN 48223, tabled 25 April 2025.
[283] HC-One written evidence submitted to and cited in: Health and Social Care Committee (2024). Adult Social Care Reform: the cost of inaction: Second Report of Session 2024-25.

[284] Health and Social Care Committee (2024). Adult Social Care Reform: the cost of inaction: Second Report of Session 2024-25.
[285] DHSC & UKSHA (2025). Huge biosecurity centre investment to boost pandemic protection.
[286] NAO (2024). Investigation into the UK Health Security Agency's health security campus programme.
[287] Mallorie, S. (2023). Comparing the NHS to the health care systems of other countries: five charts.
[288] NHS (2019). The NHS Long Term Plan.
[289] Mattke, S., Shi, Z., Hanson, M. et al. (2024). Estimated Investment Need to Increase England's Capacity to Diagnose Eligibility for an Alzheimer's
Treatment to G7 Average Capacity Levels. The Journal of Prevention of Alzheimer's Disease.
[290] Clay, T. et al (2024). State of the Sector 2024: Ready for a reset. New Philanthropy Capital (NPC).
[291] NCVO (2024). Open letter to the chancellor on the impact of increased employer National Insurance Contributions for charities.
[292] Clay, T. et al (2024). State of the Sector 2024: Ready for a reset. New Philanthropy Capital (NPC).
[293] NCVO (2024). Open letter to the chancellor on the impact of increased employer National Insurance Contributions for charities.
[294] Reeves, R. (2024). Letter dated 25 November 2024 from the Chancellor of the Exchequer to NCVO and ACEVO: Impact of increased employer National Insurance contributions on the voluntary sector.

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