Return to Contents page and Introduction

4. Dependency

Recent reports suggest that most older people are enjoying active and relatively healthy retirements.[34, 35] For example, only four per cent of over 65s require care in a residential or nursing home.[36] Increasing age is, however, generally associated with increasing disability, loss of independence, and functional impairments such as loss of mobility, sight and hearing.[37] This is reflected in the increase with age in the number of people requiring care in residential or nursing settings, illustrated in Table 4.1.1 and in section 4.5.

This chapter will examine data from a variety of sources both within and beyond the NHS. Some of the information is collected by local authority social services departments and held by the Local Government Data Unit – Wales (Data Unit). The latest data releases and further information are available from the Data Unit website accessible at www.dataunitwales.gov.uk

It should be noted that some of the variation between local authorities might be due to differences in definitions and methods of collecting data as well as differences in the level of service provision.[38]

4.1 Elderly living alone

Living arrangements are important for service provision, not least because older people living alone may place a greater demand on personal social services compared to older people with other living arrangements. Older persons who have a partner are often more likely to maintain their independence due to the support they can provide to each other.

Twenty two per cent of men and 44 per cent of women aged over 65 years live alone.[1] Percentages increase with advancing age (as shown in table 4.1.1). This is important for service provision,[1] as older people who live alone are more likely to utilise personal social services such as home helps or meals-on-wheels compared to people living in other kinds of household.[1]

Table 4.1.1 Living arrangements of people aged 65 years and over by age and sex, Wales, 2001 Source: Census 2001

Percentages

	Married couple family	Cohabiting couple[1]	Lone parent family	Living with others - not in family unit	Living alone	Living in communal establishment[2]	Total (=100%) (thousands)
Males							
65-74	*73.9*	*2.5*	*1.9*	*3.2*	*17.5*	*1.0*	2,045
75-84	*63.0*	*1.8*	*2.5*	*4.0*	*25.7*	*3.1*	1,168
85 and over	*39.7*	*1.4*	*3.7*	*6.1*	*36.9*	*12.2*	281
All aged 65 and over	*67.5*	*2.2*	*2.2*	*3.7*	*21.8*	*2.6*	3,494
Females							
65-74	*54.7*	*1.6*	*5.4*	*4.0*	*33.2*	*1.1*	2,322
75-84	*29.6*	*0.8*	*6.2*	*5.7*	*52.5*	*5.2*	1,765
85 and over	*7.9*	*0.5*	*6.7*	*7.6*	*54.5*	*22.9*	732
All aged 65 and over	*38.4*	*1.2*	*5.9*	*5.2*	*43.5*	*5.9*	4,819

1 A cohabiting couple family consists of two people living together as a couple but not married to each other, with or without their (unpartnered) child(ren). Cohabiting couples of the same sex are included.

2 A communal establishment is an establishment providing managed residential accommodation. Sheltered housing is treated as a communal establishment if less than half the residents possess their own cooking facilities.

Figure 4.1.1

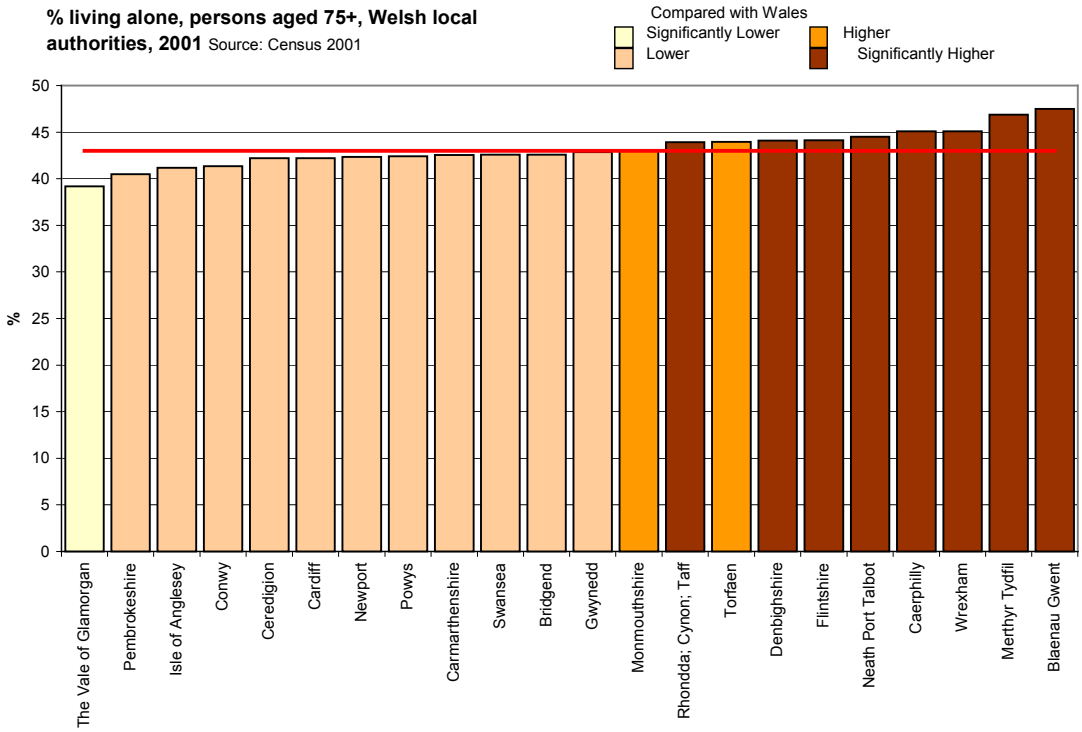


Figure 4.1.1 illustrates the proportion of persons aged 75 years and over who live alone. The chart shows that there are statistically significantly higher proportions in the south Wales valleys and northeast Wales.

Marital status and living arrangements may have a critical impact on older people's need for both support and access to carers should they become frail or disabled.[1, 39]

Longer life expectancy in females[40] explains why many men find themselves as part of a married couple throughout their adult lives, and why there are a greater number of women who live alone or in care homes.

Figure 4.1.2 % living alone, persons aged 75+, Welsh electoral divisions, 2001

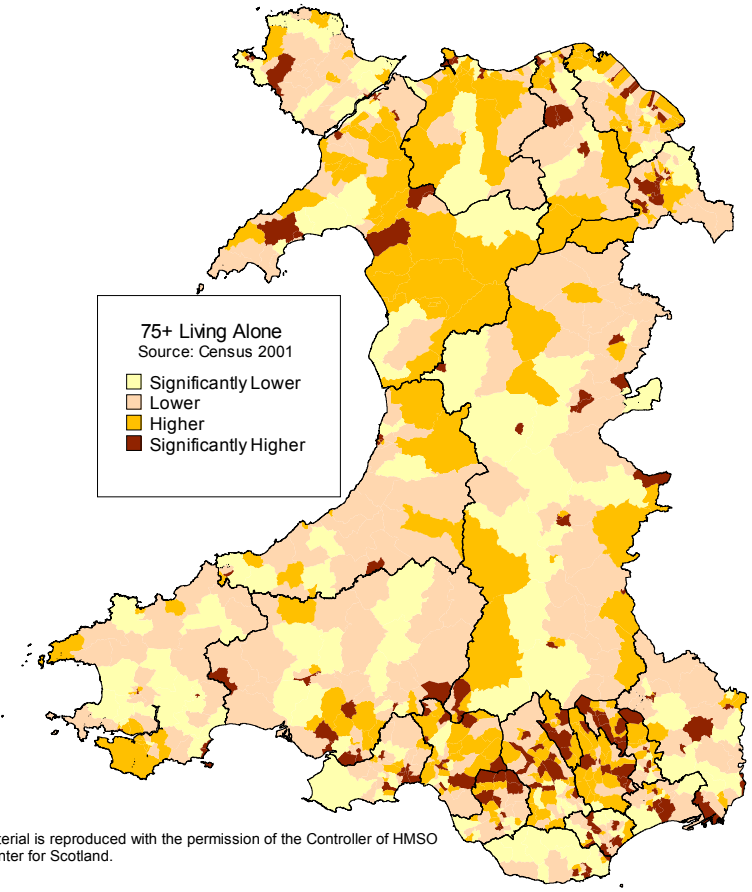


Figure 4.1.2 shows the proportion of the population aged 75 and over living alone compared with Wales at ediv level. The map shows that there tend to be higher percentages in the south Wales valleys, but there are also areas with higher percentages scattered across Wales. In general, rural areas appear to have lower percentages of older persons living alone. It is important to note however that living alone is not synonymous with living independently, as recognised by the Wales Care Strategy report.[41]

4.2 Social and community networks

The majority of people will be involved in providing care at some time during their lives, with the onset peaking in late middle and early older age. Higher than average incidence rates span three decades or more of adult life.[42]

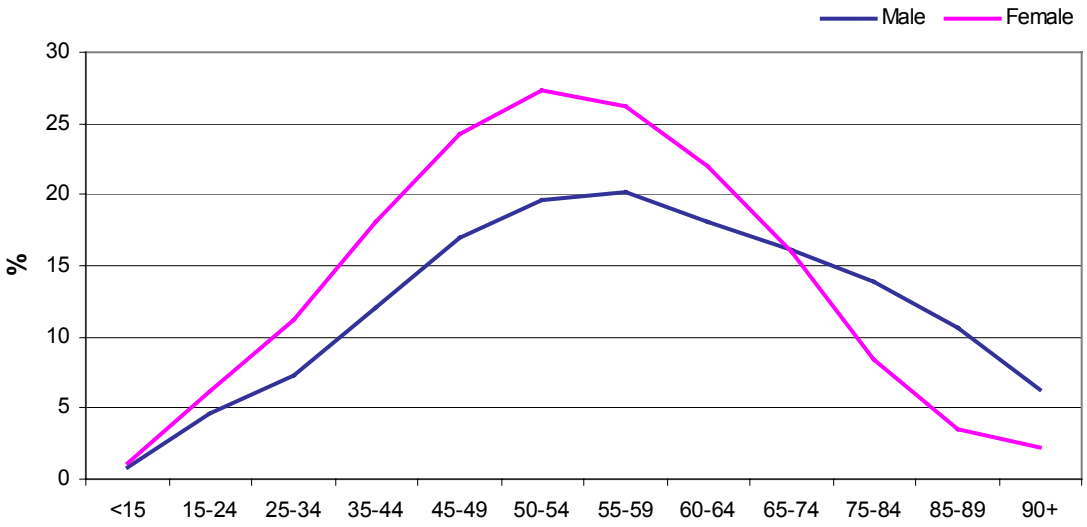
Data from the 2001 Census shows the provision of unpaid informal care by older people to family members, friends or neighbours who are 'sick, disabled or elderly'. This can be seen to increase with age. This is important because a number of social trends are likely to influence the extent of caring in the future. These include changes in marriage patterns, increases in single person household, lone parent families and mobility among family members. Such changes reduce the availability of informal carers when older people become sick, disabled, vulnerable or frail.[43]

Figure 4.2.1 shows the proportion of people providing unpaid care in Wales by age group. For both men and women, after peaking in later middle and early older age groups, the proportion providing unpaid care decreases with age. Older women are more likely to live alone, whereas older men are more likely to be married and are therefore more likely to be able to provide care to their partners.[1] This explains why in older age groups a higher proportion of men provide unpaid care compared with women. A Carers Assessment survey undertaken in July 2002 by the Data Unit illustrated that almost two thirds of service users had their care provided by their spouse.[44]

Figure 4.2.1

% providing unpaid care, persons by age group, Wales 2001

Source: Census 2001



In figure 4.2.2 the denominator is the population providing some care. The chart shows that the proportion of these people providing more than 50 hours of unpaid care increases with age. As with figure 4.2.1, it is only amongst the oldest age groups that the proportion is higher among men than women.

Figure 4.2.2

% (of those providing care) providing more than 50 hours unpaid care per week, Persons by age group, Wales 2001 Source: Census 2001

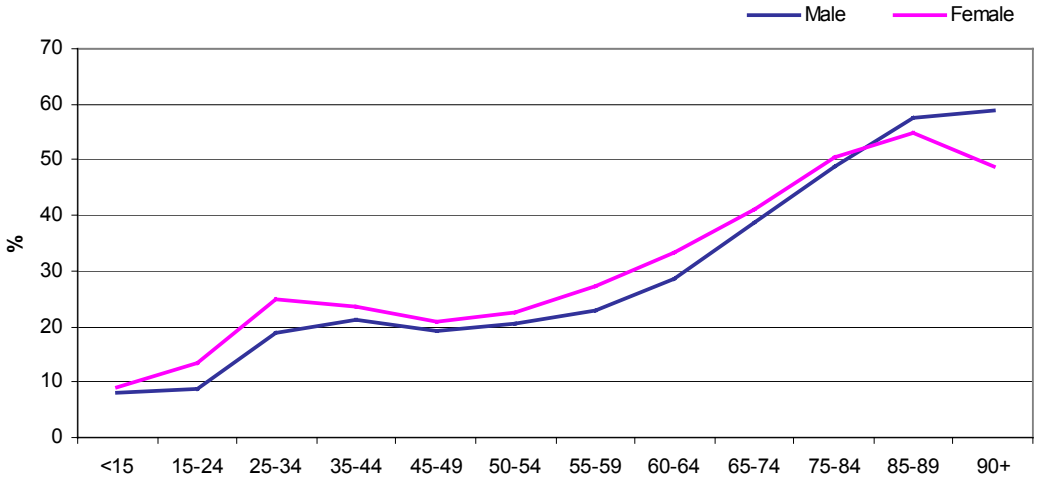
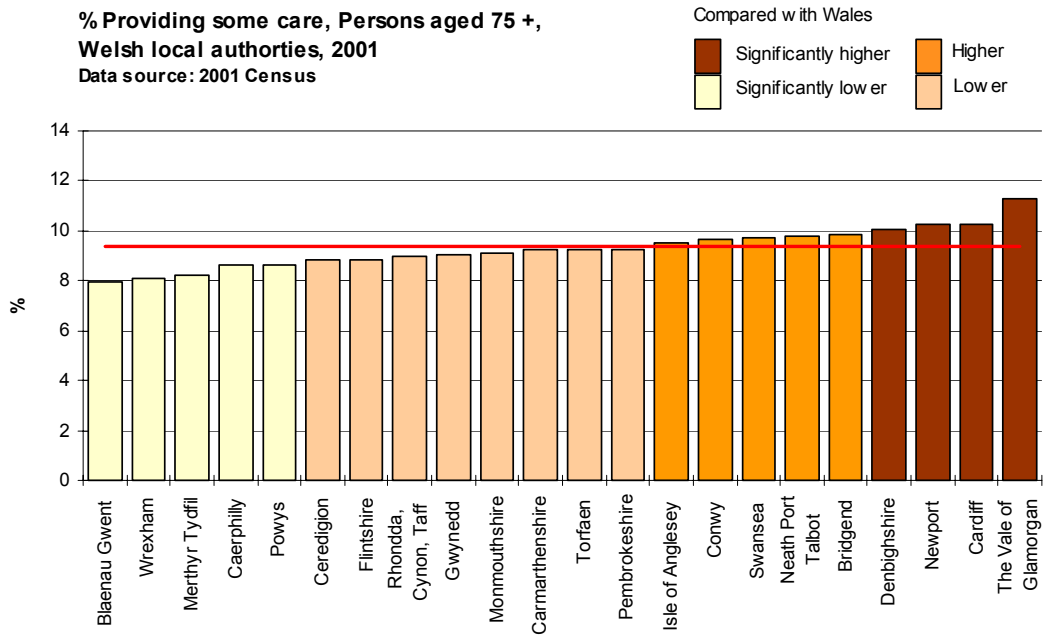


Figure 4.2.3 illustrates the variation in care giving among people aged 75 years and over by local authority. Although significantly higher rates of people providing unpaid care are evident in Cardiff, the Vale of Glamorgan, Newport and Denbighshire compared with the Wales average, the overall proportion of people providing unpaid care is low, ranging from eight per cent in Blaenau Gwent to 11 per cent in the Vale of Glamorgan.

Figure 4.2.3



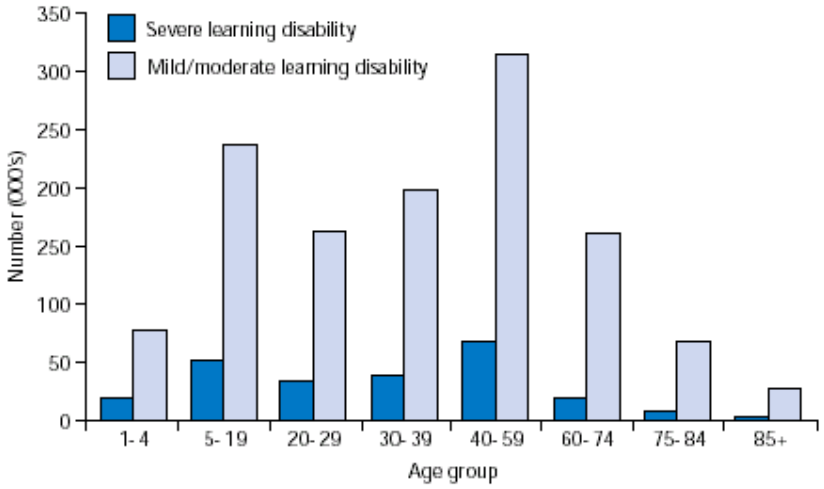
4.3 Disabilities: learning

Improved medical and social care means that many people with learning disabilities are living longer than in the past. [45, 16] In common with the rest of the population, women are surviving longer than men, although life expectancy is influenced by the severity of learning disability. For many people with a learning disability, difficulties associated with old age overshadow any problems associated with their learning disability, and their needs are very similar to those of the elderly population as a whole. [45, 16]

For others, the ageing process may begin at an earlier age than the population as a whole.[45, 16] This has important implications for service provision.

It is difficult to obtain data on the precise number of people with a learning disability. The data shown from local authority registers of people with learning disabilities later in this chapter are based on voluntary reporting, providing no indication of the severity of the disability. It is suggested that up to a quarter of people with a learning disability only become known to statutory agencies later in life when their carer becomes too old or frail to continue to care for their adult son or daughter.[45] Estimates of the number of people with a learning disability by age group and severity in England are shown in figure 4.3.1. The data show that the number of people surviving with severe disabilities decreases with age.

Figure 4.3.1 Number (000s) with learning disabilities, persons by age group, England 1999 Source: (DOH 2001a[45]).

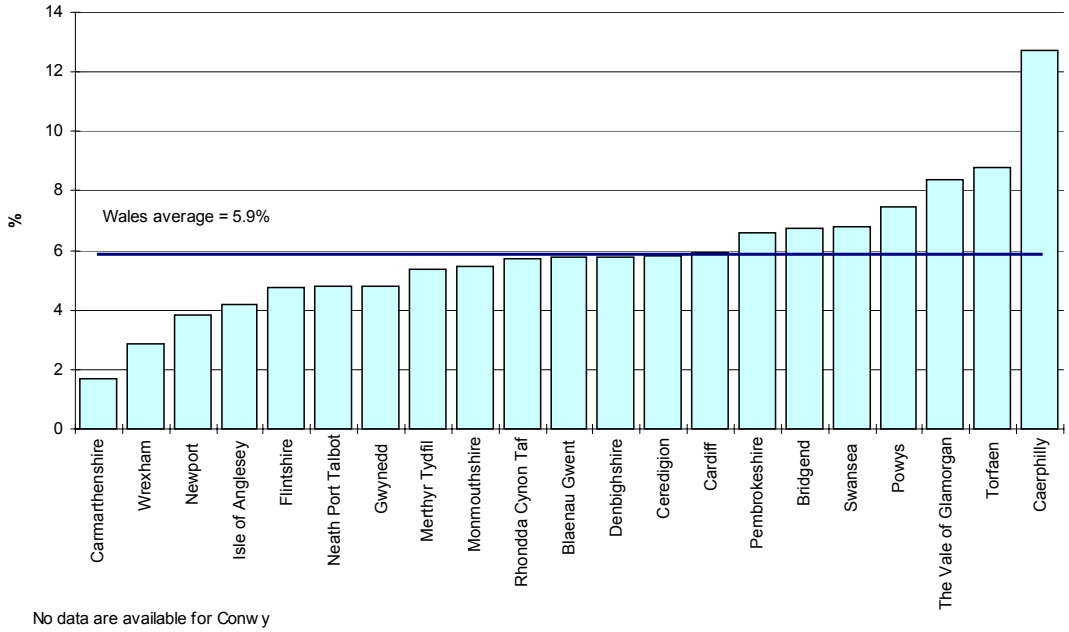


People with severe learning disabilities are those who need significant help with daily living.
People with mild/moderate learning disabilities will usually be able to live independently with support.

Figure 4.3.2 shows data from Welsh local authority registers of people with learning disabilities. It is important to note that the registers only include people identified as having a learning disability who are currently known to the local authority for purposes of planning or providing services. Approximately 12,600 people had a learning disability in Wales, of whom 5.9 per cent (approximately 600 people) were aged over 65 years. Figure 4.3.2 shows that rates are higher in Torfaen and Caerphilly and lower in Carmarthenshire, Wrexham, Newport and the Isle of Anglesey. It is important to note however that the data are based on voluntary reporting and therefore much of the variation between local authorities may be due to differences in data collection and reporting practices.[38]

Figure 4.3.2

Number of people registered as having a learning disability, aged 65+, as a percentage of total people with a learning disability, Welsh local authorities, March 2004
Source: Local Government Data Unit - Wales



No data are available for Conw y

It is estimated that a third of people with a learning disability live with a carer who is over 70 years of age.[45] In many cases the disabled person may also take on a caring role, however this is not generally recognised and the person may not be properly supported.

4.4 Disabilities: physical and sensory

Disability or impairment of function is an indicator of population health at all ages,[46] and although not an inevitable consequence of ageing,[16] increasing age is commonly associated with increasing disability and loss of independence, with function impairments such as loss of mobility, sight and hearing.[37]

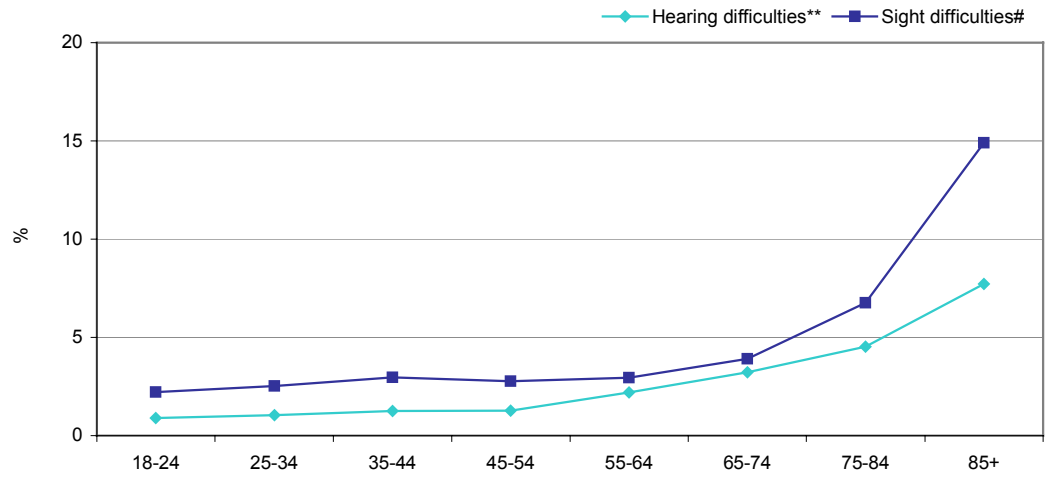
Whilst most over 65s report at least one chronic condition, the number of conditions reported increases with age.[37] The most common problems relate to movement, vision and hearing.[16] In older people, disability and impairment measures are especially useful, in quantifying the overall impact of several coexisting conditions on a person's ability to function.[46]

This is helpful because chronic conditions may vary in the way they affect an older person's life.[36] Section 5.1 examines health status in older people using data on limiting long-term illness (LLTI) from the 2001 Census. LLTI includes problems associated with old age. Data relating to both LLTI and general health in chapter 5 provide useful proxies for the prevalence of chronic conditions. However, it is important to note that even when symptoms are unremitting they may not readily be perceived as limiting if the person has adapted their life to cope.[36] This is important because disability influences individual well-being, the need for informal help and health care and long-term care needs and costs.[46, 47]

Figure 4.4.1 shows the proportion of people reporting eyesight or hearing difficulties by age group based on data from the Welsh Health Survey.[48] In the 65 years and over age group 4.3 per cent reported hearing difficulties compared with 1.3 per cent of those aged under 65 years. Six per cent of people aged 65 years and over reported vision difficulties, defined as difficulty seeing someone across a room, compared with 2.7 per cent of those aged under 65 years. Figure 4.4.1 shows that the proportion reporting hearing or sight difficulties increases sharply among the older age groups.

Figure 4.4.1

% reporting hearing or sight difficulties, persons by age group, Wales, 1998 Source: Welsh Health Survey 1998



- Based on those responding "No" to the question "Is your eyesight good enough to see the face of someone across a room (with glasses or contact lenses if you usually wear them)?"
** - Based on those responding "No" to the question "Can you hear what is said in a chat with another person (with a hearing aid if you usually wear one)?"

Registers of physical or sensory disabilities include people registered under Section 29 of the National Assistance Act 1948 who are ordinarily resident in the area of the local authority. As registration is voluntary and not all people choose to register, the registers are not considered to be a reliable guide to the prevalence of disability. Furthermore, data are not available by age group and so it is difficult to determine from the data how many people registered may have additional needs due to increasing age. Assessments for people with physical and sensory disabilities during the year ending 31 March 2004 suggested that over 80 per cent were for people aged over 65 years, corresponding to approximately 55,800 assessments.[49] Section 4.5 of this chapter includes data relating to older clients with physical and sensory disabilities.

4.5 Medical, residential and nursing care

Projections of the number of recipients of residential or home care based services in Wales suggest that, if the present pattern of services continues without change, the provision of social care services would need to increase by 24 per cent to maintain the same level of service by 2020. This increase corresponds to approximately 5,000 care home places and 15 thousand places for people seeking support in the home. This projection is based on the assumption that age specific dependency rates will remain fairly constant over the next 20 years. There is however, considerable debate about whether these will rise, fall or remain constant as life expectancy rises. Alternative scenarios range from no rise in demand for care homes (despite increasing numbers of older people) to a rise of almost 50 per cent in the demand for nursing residential and domiciliary care services between 2001 and 2020[41]

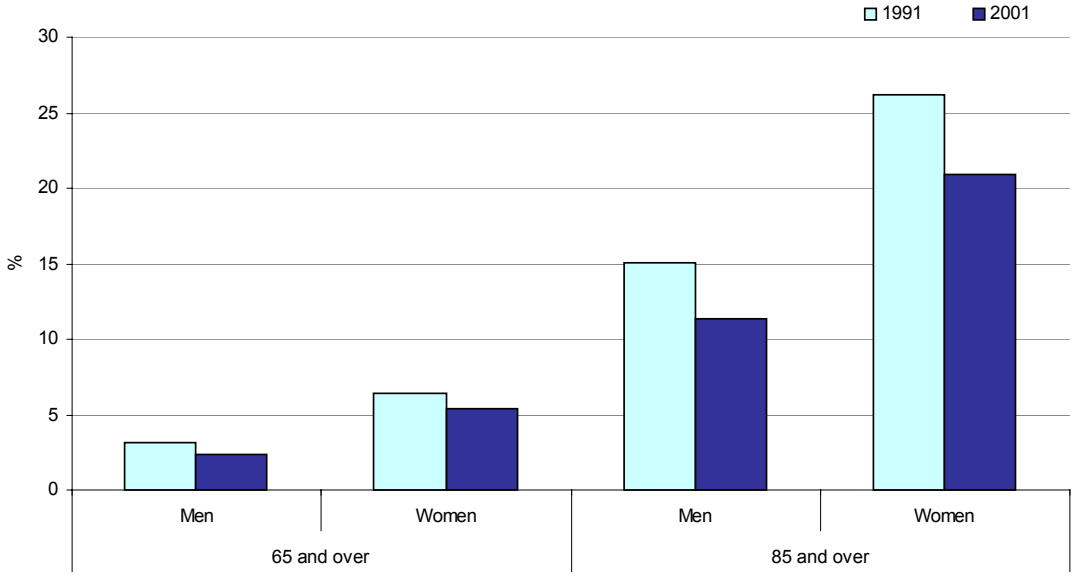
A communal establishment is defined as 'an establishment providing managed residential accommodation'. 'Managed' means full-time or part-time supervision of the accommodation,[50] and includes medical care nursing homes, hostels and hotels.

Table 4.1.1 shows data from the 2001 Census on the living arrangements of older people. In 2001, four per cent of people aged 65 years and over were resident in communal establishments in Great Britain. Figure 4.5.1 shows the number of people living in communal establishments based on data from the last two censuses. The data show that the proportion of men and women living in communal establishments has fallen since 1991, reflecting a policy shift towards keeping people in their own homes for as long as possible.[16] In addition, the increase with age in the percentage of people living in communal establishments is shown clearly.

Figure 4.5.1

% who live in communal establishments, males and females by age, Great Britain, 1991 & 2001

Source:Census, April 1991 and 2001, ONS, GROS



A similar increase with age is evident in the number of people requiring care in residential or nursing settings, with seven per cent of 65 and over and 18 per cent of 85 and over requiring care in residential or nursing settings.[36]

Figure 4.5.2

% residents in medical or care establishments, persons aged 65+, Welsh local authorities 2001

Data source: 2001 Census

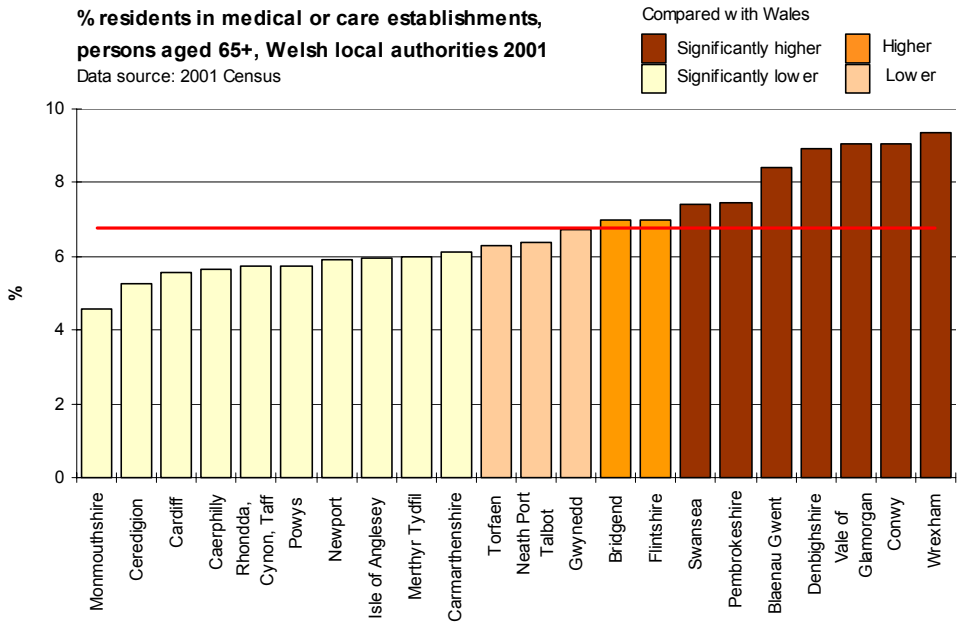


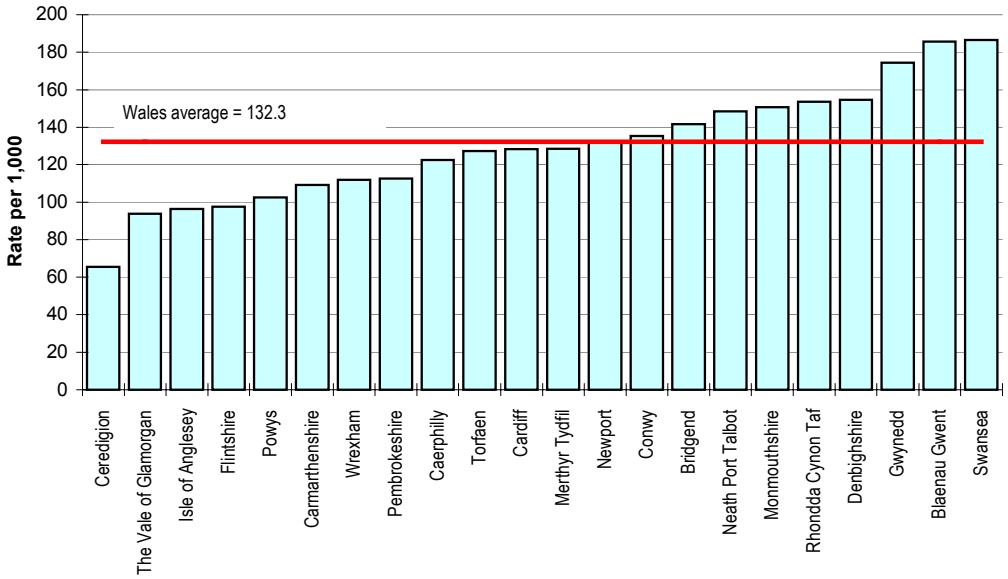
Figure 4.5.2 shows that, overall, 6.8 per cent of people aged 75 years and over are resident in medical or nursing care establishments based on data from the 2001 Census. At local authority level this ranges from 4.6 per cent in Monmouthshire to 9.3 per cent in Wrexham.

Data included in the remainder of this section are based on information collected by local authority social services departments in Wales and provided to the Local Government Data Unit – Wales, and refer to people aged 65 years and over. Data include older clients with physical and sensory disabilities, learning disabilities and mental health problems. It should be noted that some of the variation between local authorities may be due to differences in definitions and methods of collecting data as well as differences in the level of service provision.[38] Further information and new data releases are available from the Data Unit's website accessible at www.dataunitwales.gov.uk

Local authority social services departments are responsible for assessing people's need for community care services, arranging or providing these services and providing financial support for those who need places in care homes.[51] During the year ending 31 March 2004 just under 68 thousand people aged over 65 years were assessed for local authority services. Around a third of these people were aged 85 years and over. Figure 4.5.3 shows the number of assessments for the 65+ age group expressed as a rate per 1,000 population for each local authority. Community care services include a range of services either provided directly by or on behalf of local authorities by the private or voluntary sector. These can include meals on wheels, provision of aids to help with ordinary tasks of daily living, night sitting services, respite care, and care in a care home.[51]

Figure 4.5.3

Completed community care assessments, rate per 1,000, persons aged 65+, Welsh local authorities 2003-04 Source: Local Government Data Unit - Wales

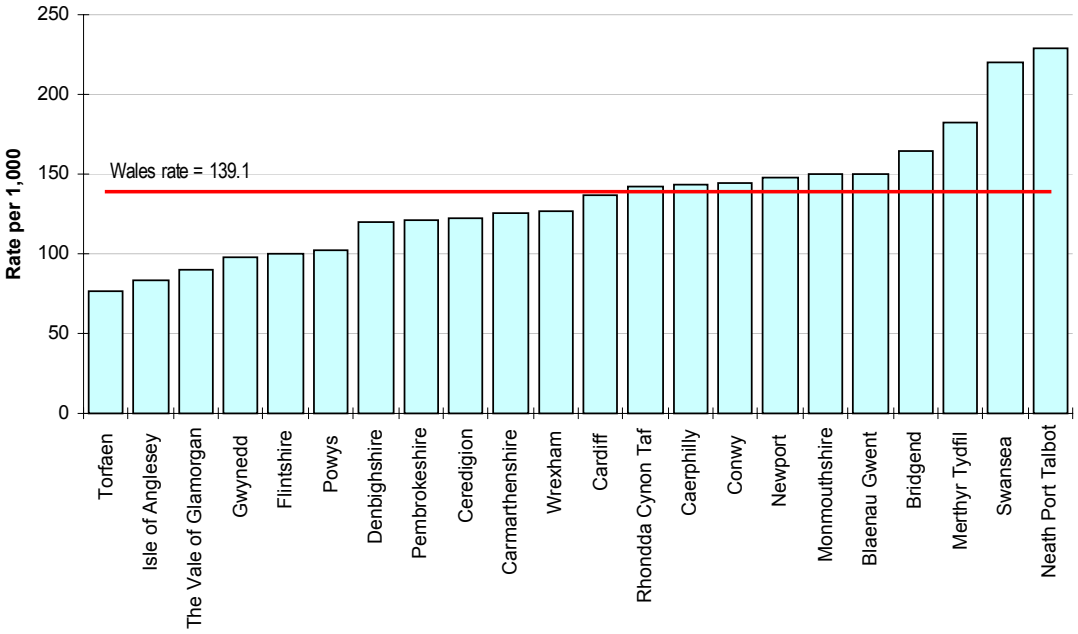


During the financial year 2003-04, approximately 71,500 older people received community based services. Figure 4.5.4 shows community care services expressed as a rate per 1,000 population aged 65 years and over. The rate of community based services for over 65 year olds for Wales is 139.1. At local authority level, rates can be seen to vary from 77.1 in Torfaen to 228.5 in Neath Port Talbot. However, as mentioned on the preceding page, much of this variation may be due to reporting practices.

Figure 4.5.4

Persons aged 65 and over in receipt of community based services, rate per 1,000, Welsh local authorities 2003-04

Source: Local Government Data Unit - Wales

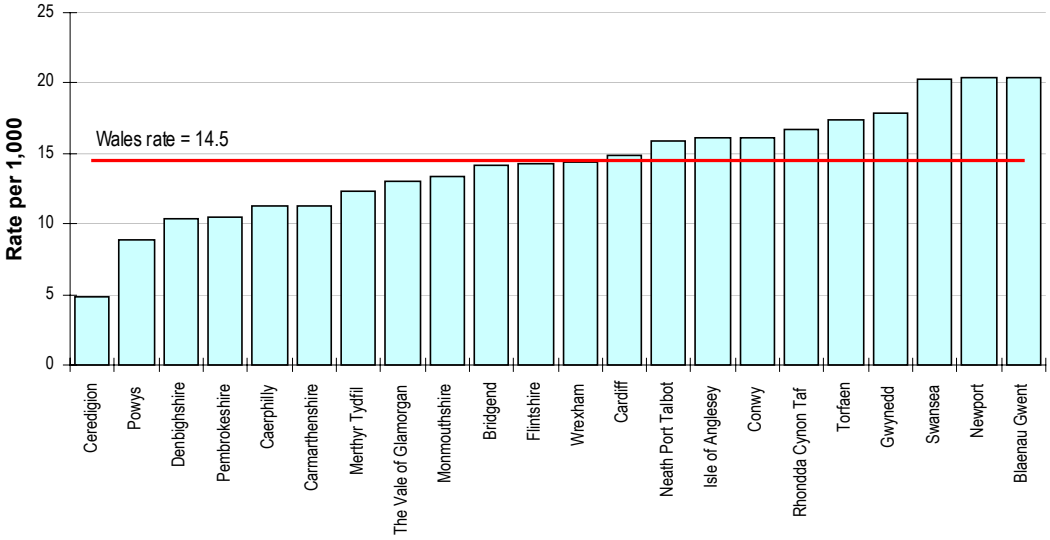


During the financial year 2003-04, almost 22 thousand older people were in residential placements of whom 34 per cent received nursing care in independent care homes, 21 per cent were in local authority residential placements and 45 per cent were in independent nursing homes without nursing care.

Figure 4.5.5 shows nursing care for local authorities. There were relatively high rates of older people receiving nursing care in Swansea, Blaenau Gwent and Newport and the lowest rates were in Ceredigion and Powys.

Figure 4.5.5

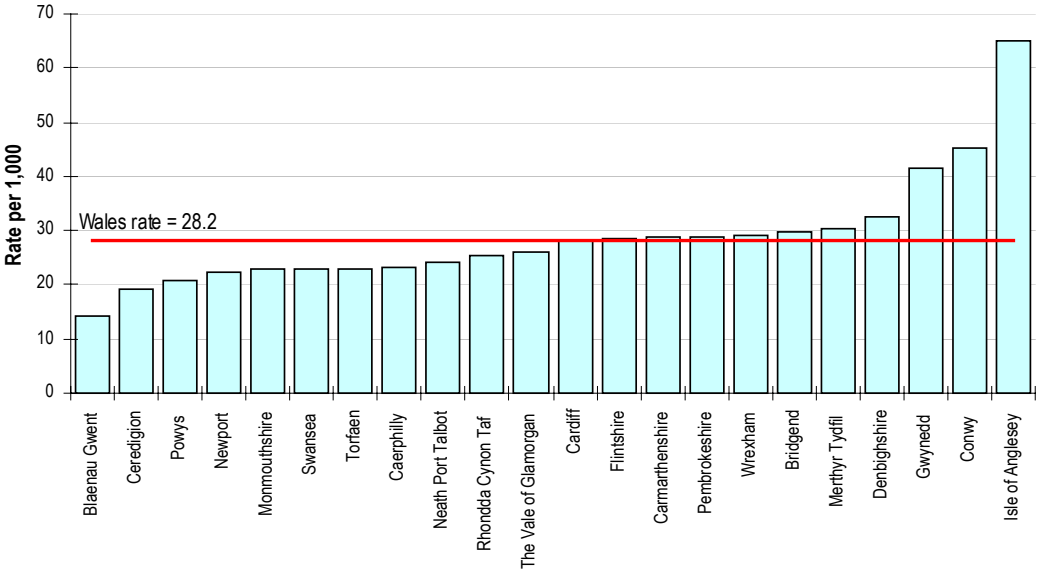
Persons aged 65+ in receipt of nursing care, rate per 1,000 people aged 65+, Welsh local authorities, 2003-2004 Source: Local Government Data Unit - Wales



High rates of residential care (without nursing care) in the local authority and independent sector (excluding nursing care) are evident in Conwy and the Isle of Anglesey with lower rates in Blaenau Gwent and Ceredigion (figure 4.5.6). However, once again, much of this variation may be due to reporting practices.

Figure 4.5.6

Persons aged 65+ in receipt of residential care*, rate per 1,000 people aged 65+, Welsh local authorities, 2003-2004 Source: Local Government Data Unit - Wales



4.6 Delayed transfers of care

The arrangements for transfer to a more appropriate care setting (either within the NHS or in discharge from NHS care) will vary according to the needs of each patient but are often complex and can sometimes lead to delays. These are known as delayed transfers of care. A delayed transfer of care (DToC) is experienced by an inpatient in a hospital who is ready to move on to the next stage of care but is prevented from doing so. In Wales, delayed transfers of care are counted using a definition and reporting system that includes eight main categories and 47 reasons for delay. These reasons are comprehensive and cover delays in the acute (District General Hospitals) and non-acute sectors (for example, mental health, community and rehabilitation) for health, social care and family/patient-related reasons, allowing the local partners to identify and address blockages throughout the whole system. The delayed transfer of care census database was introduced in April 2002. Timely transfer and discharge arrangements are important to ensure that the NHS manages emergency pressures effectively.[52]

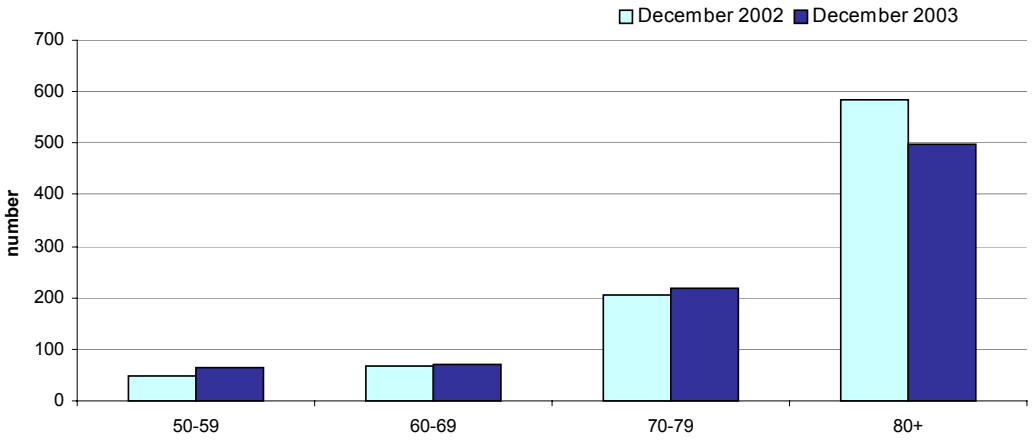
A note of caution has been sounded by a recent systematic review of the evidence on inappropriate delayed discharge from hospital [51], however, the review did not include any studies from Wales because none have been published. The problem of DToC has arisen against the context of rising demand, and the labelling of a delay as inappropriate may be beset by problems of subjectivity, particularly in older patients in acute hospital beds [51].

Data from the DToC database (established in April 2002) shown in figure 4.6.1 indicate that the number of delayed transfers of care increases with age.

Figure 4.6.1

Number delayed transfers of care, persons by age group, Wales 2002-03

Source: Welsh Assembly Government, 2004[53]

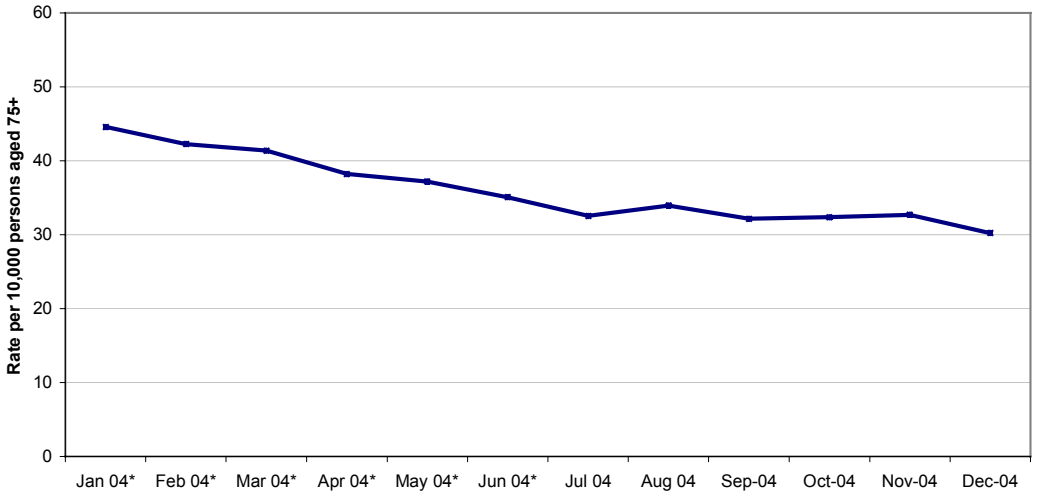


This profile contains current data as at December 2004, please consult the Welsh Assembly Government website for details of any subsequent DToC updates, available at http://www.wales.gov.uk/keypubstatisticsforwalesheadline/index.htm

The majority of DToC occur in older patients, with over two thirds occurring in patients aged 75 years and over. DToC are frequently expressed as a rate per 10,000 adults aged 75 years and over, as shown in figure 4.6.2. The chart shows a clear downward trend in the number of DToC occurring during 2004. This reduction in DToC has been achieved as a result of collective action by the Welsh Assembly Government, the NHS and local government.

Figure 4.6.2

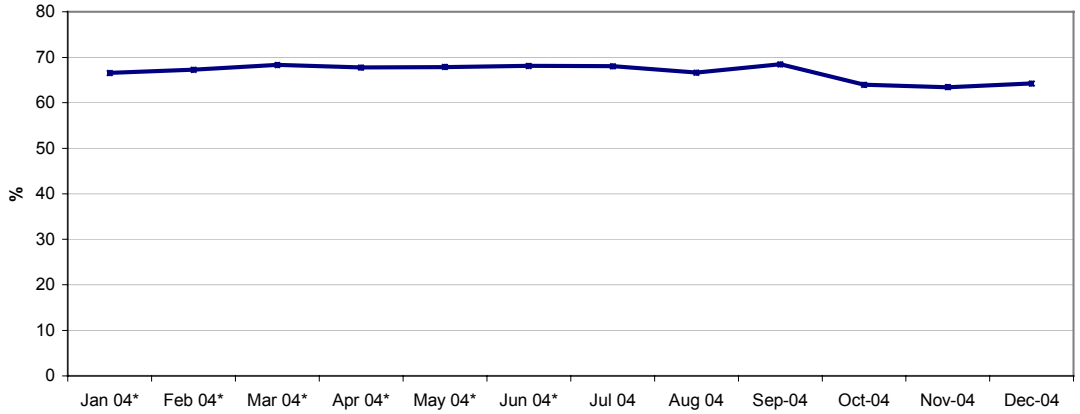
All delayed transfers of care, rate per 10,000 persons aged 75+, Wales, Jan - Dec 2004 Source: Delayed Transfers of Care Database



*Breakdowns for months Jan - June 2004 may not add to the census totals as they reflect the census 'snapshot' plus any amendments received up to the date of extraction.

Figure 4.6.3

% of total delayed transfers of care (DToC), who were persons aged 75+, Wales, Jan - Dec 2004 **Source: Delayed Transfers of Care Database**



*Breakdowns for months Jan - June 2004 may not add to the census totals as they reflect the census 'snapshot' plus any amendments received up to the date of extraction.

Figure 4.6.3 shows the monthly distribution of the proportion of all delayed transfers of care which occurred in patients aged 75 years and over. No seasonal variation is apparent and the proportion of DToC occurring in adults aged 75 years and over remains between 63 and 68 per cent.

Figure 4.6.4

Delayed transfer of care categories: percentage accounted for by age group, Wales, June 2004

Source: Delayed Transfers of Care Database

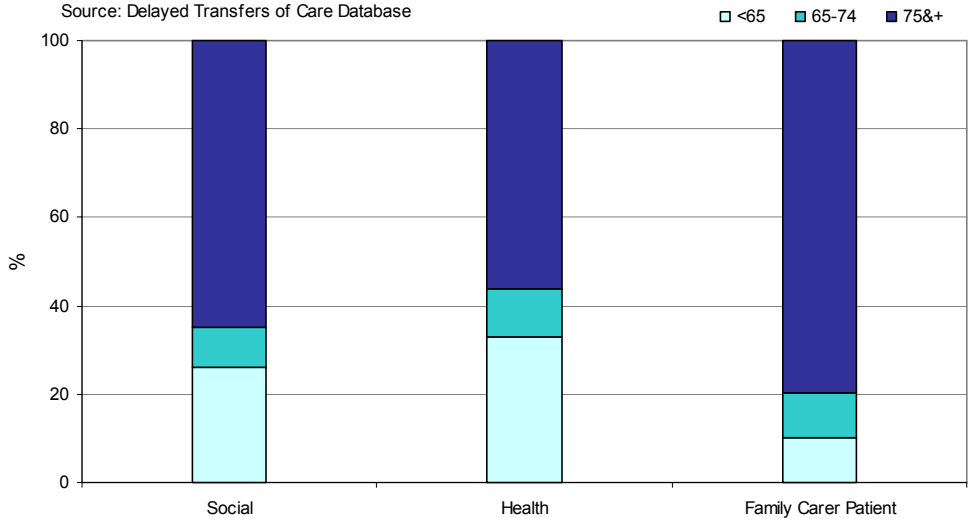


Figure 4.6.4 shows the percentage of DToC made up by each age group for each reason for delay during June 2004. The chart shows that DToC for all reasons increase with age (DToC due to 'other' causes are too small to include within the chart). The proportion of DToC due to family, carer or patient reasons can be seen to show

the greatest increase with age. Family, carer or patient reasons account for the highest proportion of delays for all ages. Further details on reasons for DToC are available from First Release SDR 52/2004 Delayed Transfers of Care: June 2004[52] available from the Welsh Assembly Government website Available at http://www.wales.gov.uk/keypubstatisticsforwalesheadline/index.htm Family carer or patient reasons include legal or financial reasons such as awaiting resolution of legal issues e.g. informed consent or financial assessment. Disagreements between one or all parties concerned are also included. Family carer or patient reasons covers choice or other reasons, this may include the family arranging care or selecting a residential or nursing home of choice.[52]

Figure 4.6.5

Delayed Transfers of Care (excluding mental health) for all reasons, rate per 10,000 population aged 75 and over, Welsh LHBs, June 2004 Source: DToC database

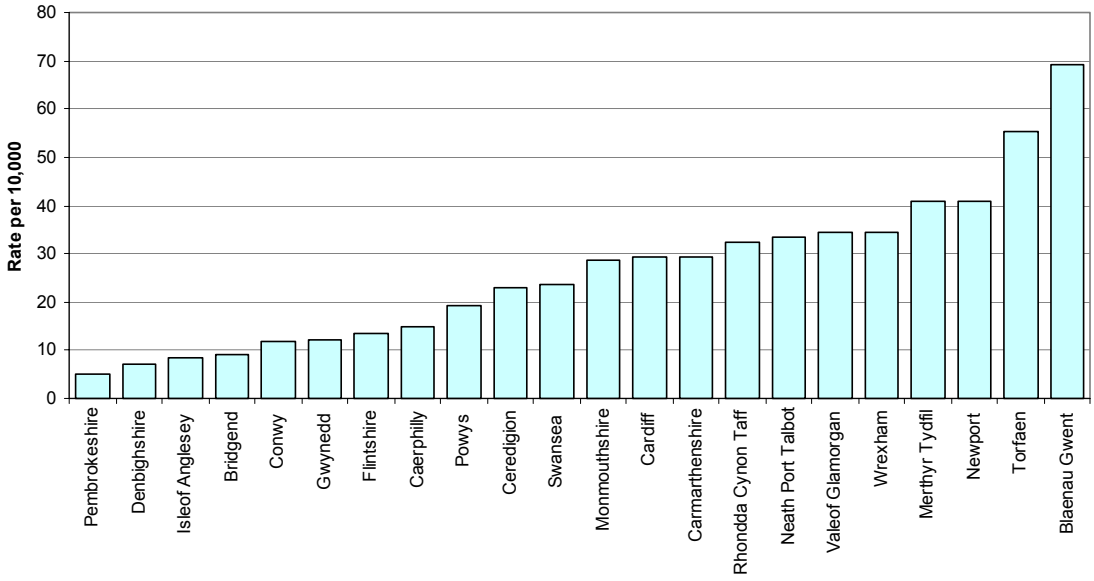


Figure 4.6.5 illustrates, by local health board, a rate per 10,000 of delayed transfers of care (excluding mental health). The chart shows high rates in Blaenau Gwent, Torfaen, Merthyr Tydfil and Newport. Low rates can be found in Pembrokeshire, Denbighshire, the Isle of Anglesey and Bridgend.

Go to Chapter 5 – Health Status