The changing role of care homes

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Summary

This report provides a brief overview of the development of residential and nursing home care in the UK from the historical precursors of residential care through the expansion of private care in the 1980s to the present day increased emphasis on the provision of nursing care for residents with high support needs for a short period towards the end of life.

A profile of care home residents today is provided by an analysis of results from the 2009 Bupa census of residents in its care homes in the UK, Australia, New Zealand and Spain. Nearly three quarters of residents in Bupa care homes in the UK are receiving 'nursing care' although there is considerable overlap between the profiles of residents receiving 'nursing' and 'residential' care.

Residents aged 65 and over make up 93% of the Bupa care home population in New Zealand, 94% in the UK, 95% in Australia and 97% in Spain.

Ninety percent of Bupa care home residents in the UK have 'high support needs', just under 70% experience some form of incontinence and nearly one half (47.6%) have severe mobility problems.

Three quarters of Bupa UK care home residents experience some form of neurological or mental disorder. The most commonly occurring disorders are Dementia (44%), Stroke (20%), Depression (20%), Epilepsy (6%) and Parkinson's disease (5%).

The proportion of residents with dementia has increased from 36% in 2003 and 38% in 2006 to 44% in 2009.

The most commonly occurring non-neurological or mental conditions in Bupa care homes in the UK are Heart disease (21%), Arthritis (18%), Diabetes (14%), Fractures (12%), Osteoporosis (9%), Lung or chest disease (8%) and Cancer (7%).

Levels of diabetes in Bupa UK care homes have increased from 8% in 2003 and 9% in 2006 to 14% in 2009.

Lengths of stay in Bupa care homes are declining and, if present trends continue, by 2015 the median length of stay for residents receiving 'dementia care' will be just over one year (367 days) and for 'frail elderly' residents will be a little under 9 months (265 days).

Counter-intuitively, the oldest old residents (ages 95 and over) have better continence and lower levels of dementia, stroke, depression, diabetes and lung or chest disease than residents aged 65 to 94. Possible reasons for this phenomenon are explored in the report.

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Executive briefing

This report on long-term residential and nursing care for older people in the United Kingdom first looks briefly at the historical context and more recent developments in care home provision then, using the results of Bupa care homes censuses carried out in 2003, 2006 and 2009, it seeks to build up a profile of the current Bupa UK care home resident population and to identify possible future trends. The 2009 census was also carried out in Bupa care homes in Australia, New Zealand and Spain allowing the possibility of international comparison.

Long-term residential and nursing care for older people in the United Kingdom has undergone substantial changes since the days of the Victorian Workhouse and the early Poor Law hospitals but, in certain respects, the reforms may have gone full circle.

Today the 4% or so of the older population in long-term residential care equates roughly with the proportion who were in-house paupers in 1892. An emphasis on community rather than state support, with a major provision of care by the private and charitable sectors, is once again to the fore, although in more recent times that care may be funded either wholly or in part by the state.

The Bupa census shows that, for Bupa, three quarters of care home care is 'nursing care', although there is a great deal of overlap between 'nursing care' and 'residential care'. The substantial decline in the number of hospital beds for older people and the associated transfer to nursing home care has led to the increased medicalisation of care home care and greater levels of dependency among care home residents. The narrowing distinction between nursing and residential care may be closer in character to the nineteenth century poor law model and the Victorian laissez-faire philosophy of intervention only as a last resort may be close to the increasingly prevalent notion of care homes as a location of last resort only used for a relatively brief period, near the end of life, by those with the highest dependency and the greatest need.

There can be no doubt that the quality of residential care accommodation has improved substantially since Peter Townsend visited 173 public, voluntary and private residential care homes as part of his research for *The Last Refuge* (1962). Central heating is now standard, shared rooms a rarity and en-suite toilet facilities the norm. Quality of care is however more than quality of accommodation and good staffing is essential. It is generally recognised that quality of care is better provided by a reasonably stable workforce, but high staff turnover, with 42% of care staff leaving within 12 months of joining and 61% leaving within 2 years, is a continued source of concern for care providers. Trends in globalisation and women's migration as well as economic disparity and the free movement of labour within the European Union have led to a high proportion of care home staff being from overseas.

Probably the most significant change in the provision of care home care in the last thirty years has been the much greater involvement of the private sector. In 1980

local authorities provided 63% or residential care home places and the private sector 17% but by 2002 the positions had been reversed and that trend continues to the present day. At the same time there has been a substantial growth in the number of, mainly privately provided, nursing home places replacing large numbers of NHS hospital beds. Between 1987–88 and 2009–10 there has been a 60% reduction in the numbers of NHS overnight beds for both geriatric and mental illness care. Meanwhile, between 1985 and 2005 there was a 360% increase in the number of care home nursing care places giving over four times as many places as before.

One of the major triggers for private care home expansion in the 1980s was that, from 1983 until the 1993 implementation of the NHS and Community Care Act 1990, private residential and nursing home care could be paid for by the DHSS from uncapped 'supplementary benefit' payments. This provided a perverse incentive to be cared for in private residential care rather than at home.

The boom in care home provision peaked at around 575,500 places in 1996 and it has been declining ever since. It may be more than coincidental that these market changes can be traced to the periods following the 1979 and 1997 UK general elections, each bringing about a change of governing party with the attendant political and economic consequences.

Around the millennium, the introduction of the National Minimum Wage and new National Minimum Standards for care homes brought about the closure of a number of, mainly smaller, homes that were too expensive to adapt.

This has been part of a general trend towards larger care homes owned by corporate entities rather than by individuals or families. Although by 2005, organisations running 11 or more care homes owned or ran 20% of care homes in the UK and 30% of care home places, over 50% of homes and 40% of places were still run by organisations with a single care home.

Care homes are getting larger on average. In 2004 the average care home in England had 23.13 places but by 2010 this had risen to 25.17 places. Council homes are on average the largest, followed by private, voluntary and NHS homes. Nursing homes are on average more than twice as large as residential care homes.

Not all care home residents are supported to pay for their care. Detailed figures and trends over time are difficult to come by, but estimates generally place the number of 'self funders' at 30% to 33% of all residents. There is evidence that around one in five homes charge 'self funders' more than local authority funded residents for a similar room and similar care.

There are substantial regional variations in the provision of care home places for older people per 1,000 of the older population. Inner London, where care is expensive, is the lowest but provision is made by paying for resident places in care homes in Outer London and beyond. The highest proportions are in rural and coastal areas, but again, places may be paid for and filled from 'out of area'.

It is estimated that over half of all people with dementia in the United Kingdom are in care homes but the number of care home places has fallen substantially in recent years. Projections of future demand indicate that more than double the current number of care home places will be required by 2043 to maintain the current ratio of institutional to community services for dementia.

The Bupa census

An up to date profile of residents in Bupa care homes in the UK, Australia, New Zealand and Spain is provided by the Bupa care home census carried out in 2009. Similar censuses were carried out in the UK in 2003 and 2006.

Care home residents are admitted because of their special needs and so residents' health and general profiles will often not match those found in the community.

- Nearly three quarters (73%) of Bupa care home residents are receiving 'nursing care'. Residents are predominantly female and aged over 65 but, for residents aged under 65, in the UK gender is evenly split and in Australia, New Zealand and Spain, for residents aged under 65, the majority of residents are male.

- Residents aged 65 and over make up 93% of the care home population in New Zealand, 94% in the UK, 95% in Australia and 97% in Spain.

- Residents have a skewed age distribution with a long tail of younger residents. In all four countries the median age of residents is 85. Male residents tend to be younger than female residents and, in the UK, male residents have a median age of 81 and for female residents it is 86.

The Bupa census data can be used to calculate 'length of stay to date' but this cannot be easily be used to estimate total length of stay. Bupa however separately collects length of stay data when residents leave as a result of death.

- Residents who are receiving care for reasons of dementia but who may be in relatively robust physical health tend to stay longer on average than residents who are physically frail. In both cases the average length of stay is shortening and, if present trends continue, by 2015 the median length of stay for dementia care residents will be around one year (367 days) and for older frail residents will be just under nine months (265 days). Regional data shows that care home stays in Scotland tend to be longer than for London or the English regions.

- The proportion of residents with dementia is increasing. The Bupa data on residents at the time of death indicates that the proportion of residents who at the time of death were classified as 'frail elderly' has decline from 77% in 2001–2 to 60% in 2010 while the proportion at death receiving 'dementia care' has increased from 14% in 2001–2 to 23% in 2010.

- In 2009, three quarters (75%) of Bupa care home residents in the UK were experiencing some form of neurological or mental disorder. Residents may have more than one neurological or mental condition but the proportion with at least one neurological or mental disorder declines consistently with the age of the resident from 87.7% for the under 65s to 52.2% for residents aged 95 and over. The most commonly occurring disorders are Dementia (43.6%), Stroke (20.2%), Depression (11%), Epilepsy (5.6%) and Parkinson's disease (4.9%).

- As already indicated, the proportion of care home residents with dementia is on the increase. The proportion of UK Bupa care home residents with dementia has risen from 36% in the 2003 census to 38% in 2006 and just under 44% in 2009. The proportion of care home residents with dementia is always much greater than the proportion with dementia for the equivalent age group in the community, except for residents aged 95 and over where the community and care home rates are much the same. Residents with dementia are more than twice as likely to exhibit challenging behaviour than those without.

- Although the proportion of residents with dementia, in the UK, has increased over the three censuses, the proportion recorded as 'confused or forgetful' has not. This may indicate that at least part of the increase in recorded dementia may arise from improved levels of clinical assessment or an increased willingness to diagnose the condition. Recorded levels of Dementia are considerably higher in Australian and New Zealand care homes than in the UK but these are likely to have resulted from the more extensive, and mandatory, clinical assessments that are carried out in those countries before entry into care.

- In the United Kingdom, stroke is the second most common neurological/mental condition among Bupa care home residents, after dementia. The prevalence of stroke in Bupa care homes in the UK has declined very slightly from 22% in 2003 to 21% in 2006 and 20% in 2009.

- Stroke levels in New Zealand for residents aged 65 and over are roughly three times those in Spain. The reason for this large variation is not known but is likely to be a combination of variations in detection rates, the basis for care home admission and the prevalence of the condition in the community, perhaps as a result of variations in diet.

- The most commonly occurring non-neurological or mental conditions in Bupa care homes in the United Kingdom in 2009 were Heart disease (20.6%), Arthritis (18.3%), Diabetes and Endocrine (14.4%), Fractures (12%), Osteoporosis (9.1%), Lung or chest disease (7.8%) and Cancer (7.3%).

- The proportion of residents with particular conditions varies considerably with age. Heart disease, Arthritis, Fractures, and Osteoporosis all increase consistently with the age of the resident. Over 25% of Bupa residents in the UK, age 95 and over, suffer from Arthritis.

- Levels of diabetes in Bupa UK care homes have increased from 8% in 2003 and 9% in 2006 to 14% in 2009. At the same time, for residents aged 65 and over, residents in the younger age groups (65–74 onwards) have higher levels of this, currently incurable, long term condition than the older residents. This may herald even higher levels of diabetes in care homes in the future.

- Just under 70% of all Bupa care home residents in the UK experience some form of incontinence and nearly one half (47.6%) have severe mobility problems.

- If we define 'High Support Needs' as having one or more of dementia, confusion, challenging behaviour, dual incontinence, severe hearing or visual impairment or total dependence in mobility then 90% of Bupa care home residents in the UK have high support needs.

The management and care of residents who exhibit 'challenging behaviour' poses a particular problem for care home staff. Challenging behaviour is commonly exhibited by younger male residents who are fully mobile but Huntingtons disease, psychotic disorders or dementia can also be major contributors. Multiple Sclerosis on its own is an indicator of low levels of challenging behaviour but MS in combination with dementia is an indicator of much higher levels of challenging behaviour than would be expected from residents with just dementia on its own. The observed links between 'challenging behaviour' by residents and individual conditions, or combinations of conditions, may help inform the improved management of such behaviour.

Counter-intuitively, the oldest old residents (ages 95 and over) have better continence and lower levels of dementia, stroke, depression, diabetes and lung or chest disease than residents aged 65 to 94.

The reason for this may lie in the 'reason for admission'. For residents age 95 and over, the majority (53.7%) of admittances are for frailty, housing or family reasons rather than specific health conditions. The reliability of the 'frailty' assessment for over 95s has been questioned and may be a manifestation of medical ageism with multiple co-morbidities being lumped together in a single term, however, in corroboration of the thesis that the oldest old are less likely to be admitted into care homes as a result of specific medical conditions, the proportion of residents who are admitted for residential rather than nursing care also increases with the age of the resident.

- Three quarters of Bupa care home residents, in the UK in 2009, were experiencing some form of neurological or mental disorder, 70% were

suffering from dementia or confusion, 70% had some form of incontinence and a very large proportion (90%) of care home residents have 'high support needs' of one form or another. That makes it more difficult to provide the necessary level of care, for these residents, outside a care home.

The Bupa census of care homes reinforces the view that care homes are moving away from being an alternative form of housing for frail older people towards a location of last resort for individuals with high support needs near the end of life.

A historical perspective: the precursors of residential care

When Albert Chevalier (1861–1923) plaintively sang the old music hall song *My Old Dutch*, his audiences understood that the refrain – 'we've been together now for 40 years and it don't seem a day too much; there ain't a lady living in the land that I'd swap for my dear old Dutch' – was a social comment. Many hearing that lyric since have assumed that he had been widowered, but, in fact, he performed in front of a backdrop portraying a workhouse. Liza, his 'old Dutch' and he were 'aged paupers', forced to enter its forbidding portals, and thus compelled to separate. George R.Sims' infinitely parodied monologue, *It is Christmas Day in the Workhouse*, was another agonised tale of an old couple compelled to part if they accepted the last resort of the workhouse.

To be fair to the old-time workhouse authorities, all the accommodation was, as in hospital wards, single-sex dormitory style, although, in the case of younger couples, segregation provided the preventative measure of avoiding pregnancies, with the likelihood of adding further tiny burdens to the poor rate. More importantly, and although this intrusion on married togetherness was much reviled by critics of the poor law, it was by no means as widely practised as was suggested. The aim of the workhouse was, if one may deploy an anachronistic modernism, to 'incentivise' the able-bodied to seek employment, with its harsh conditions deliberately worse than the most lowly paid job, a goal several governments have since vainly struggled to score. If one were 'aged' and/or 'infirm (and the two adjectives were used almost synonymously) one fell outside this 'less eligibility principle', and the payment of doles – 'outdoor relief' – was much more common.

To take a typical example, on 1 January 1892 268,000 people over 65 in England and Wales were in receipt of poor relief, and, during the year ending Lady Day 23 March 1892, 402,000 over the age of 65 had required relief at some point. This amounted to just under a third of the 1.1 million people in that age-range. In an interesting comment on the perpetual nature of the problem, figures for the 1790s and 1800s suggest that usually about a third of the over-60s population – 160,000 out of 0.5 million – made calls on the old poor law, operated by the parishes initially under the enduring Elizabethan statute of 1601.

Significantly, only 100,000, a quarter of these 400,000 or so 'aged paupers' of 1891/92 had been in workhouse dormitories, and, during the twelve months in question, there had normally been some 60,000 so accommodated on any one night.

These 'indoor' paupers represented the first attempts of government in the industrial era to meet such needs. They were an element of the New Poor Law, established in 1834, but the union workhouse (that is, the agency of the 'union' of parishes merged for poor law purposes by the 1834 Act) had plenty of predecessors. From Tudor times, there had been 'houses of industry' and poorhouses; London alone had over a hundred poorhouses and allied agencies by the end of the 18th century. In particular, there were, across the nation, 'tenantries' and almshouses intended for older people, some of them supplied by the churches.

Some early English hospitals, London's St Bartholomew's (1123) and St Thomas's (1200) among them, began as merely nursing shelters, offering a place to the sick, many of them, of course, from the older age groups. As the state, through the medium of the Poor Law Unions, were drawn more fully into the care equation, there emerged in the late Victorian period the Poor Law hospitals – Greater Manchester's Withington and Crumpsall hospitals are illustrations – which catered for the ailing aged pauper. Of that average of 60,000 people during 1891/92 who were enumerated as 'indoor' aged paupers, some of them would have been found on what, much later, came to be called the geriatric wards of such hospitals.

A pattern gradually becomes clear. The post-1834 target of vastly reducing the outlay on outdoor relief by enforcing a strict 'Workhouse Test' failed for a number of reasons, not least the fact that, especially in periods of economic slump, such as the Lancashire Cotton Famine during the American Civil War of the 1860s, not even the largest workhouse could cope with the thousands who, however hard they searched, simply could not find employment. Another reason was the existence, then as now, of 'non-able-bodied' (the jargon of the day) indigents, the great majority of them old people. In practice, it made more sense to pay them a weekly allowance, so much so that, by the end of the 19th century, more than half the 'outdoor' paupers were over 65.

They usually received the equivalent of between 13p and 15p a week, plus frequent supplements of 10p to 15p – and in January 1909 that translated for 400,000 older people (once more, a little less than a third of the total of 1.5m over 65s in England and Wales) to the five shillings or 25p of the first Old Age Pension. Incidentally, that was a quarter of the average manual wage of £1.00 – and, apart, briefly, from the relatively generous 1948 post-war settlement, the Old Age Pension, based on the poor law root of four or five shillings, has never improved on that 25% proportion of the average national wage.

There has long been a residential option but it has always been a minority call. It was an option very much tied up with the conjunction of oldness with illness. This was a process accelerated by the medical profession's use, from about the 1890s, of 'senile' as a synonym for decrepit, where hitherto it had meant merely 'senior', along with infantile and juvenile, both of which terms have also been devalued although not to the same extent.

Thus the aged and infirm, very often, the same people, were accorded some form of residential care in the workhouse dormitories or infirmaries. That average of 60,000 in-house paupers of 1892 constituted 4% of their age-echelon. Curiously, today's figure of those in state supported residential care is also about 4% of the age group. Of course, that is the snapshot figure at any one time. In both ancient and modern cases, the relatively sharp turnover means that rather more of the age-range in question actually experience residential care at some point towards the end of the life-cycle. Apart from this consistency of need and/or provision over a hundred or so years, the rather low numbers involved has been a pertinent feature.

One should always recall that, in both eras, another enduring aspect was the existence of a commercial, usually rather coyly described as 'private', sector covering temporary and permanent residency, embracing care homes and nursing homes. The charitable sector, too, has been active in both old and new times, although today parts of both the commercial and charitable components may well be funded, in part or whole, by the public purse.

A third consistent element is the focus on ill-health. The Victorian distinction of 'able-bodied' and 'infirm' has been largely replaced by the modern jargon of 'independence' and 'dependency'. Institutional care placements have mainly been dictated by medical rather than social forces. The majority – for there were some who were simply homeless – of aged in-house paupers in the 'New Poor Law' period were 'infirm' and could no longer care for themselves. Nowadays the level of dependency in residential care accommodation is high – higher than it was thirty years ago. There was a point, possibly in the 1970s and early 1980s, when there was just a gleam of evidence that residential care could be a social life-style option rather than a clinical necessity. In other words, there were some older people, in not unreasonable health, who chose to live in a residential care setting for its communal benefits and to avoid social isolation.

This proved, in the main, to be much too luxurious or progressive an alternative for a state-funded scheme. Residential care is increasingly medical and nursing care, with the distinction between this activity and the work of a conventional nursing home much narrower than in the recent past. Indeed, it is closer in character to the poor law model. A parallel might be sought in the post-war interlude when there was a glimmer of aspiration that the council estate might have been cross-class in nature, giving it a chance of remaining socially balanced and stable. The harsh dictates of economic viability soon overwhelmed that vision and 'social housing' soon became the last welfare hope of the impoverished, with the current plan to limit tenure a final blow to that original dream.

In brief, the historical continuum demonstrates that, over against the Beveridge-style argument for the 'universalism' of services and financial relief, the fiscal imperative tends to insist on the priority, almost to the point of exclusivity, of the severe social casualty, be the symptom medical or monetary. The public realm reacts when it is forced to do so, to remedy an ill, rather in a general or preventative fashion, to treat a client, not to foster a citizen. Historians speak of much Victorian social reform as being ruled by the theory of 'Intolerability' – the enforcement of action, sometimes reluctantly, to meet a socially and politically unbearable situation, often where the reigning ideology was *laissez-faire*.

It may seem a stern verdict, but the discussion of early 21st century provision may have to be guided by similar conditions. It may, then, be of salutary value to those analysing current policy to have some awareness of the longer perspective.

Eric Midwinter, January 2011

Recent trends in the development of residential care

In conducting research for *The Last Refuge* (1962), Peter Townsend visited 173 public, voluntary and private residential care homes for older people in England. In research conducted in 2005/6, Julia Johnson, Sheena Rolph and Randall Smith revisited some of the private homes to record how they had fared and how home care has changed in the intervening period (Johnson, Rolph and Smith, 2010).

There can be no doubt that the quality of residential care accommodation has improved greatly over the period. In 1959 few homes had central heating, and it was common to share both a room and toilet facilities. Central heating is now standard, shared rooms a rarity and en-suite toilet facilities the norm. The researchers noted that, in the intervening period, the management of care homes revisited has become much more structured and they also noted the high proportion of current care home care staff drawn from overseas.

Quality of care is not however just a function of the quality of accommodation or level of training for staff but also of overall staff attitudes, quality of management and, in effect, human nature. It is therefore open to question whether the quality of care home care has improved equally over the same period.

Research carried out in Surrey, covering all announced inspection reports for 2002–3, and using the number of inspection standards failed as an indicator of quality of care, found that a higher risk of failing standards was associated with being a for-profit small business, registered before 2000, accommodating publically funded residents and registered to provide nursing care. Fewer failures were associated with homes that were corporate for-profit, holding specialist registration and charging higher maximum fees. High scores on managerial standards correlated with fewer failures on other standards (Gage et al, 2009).

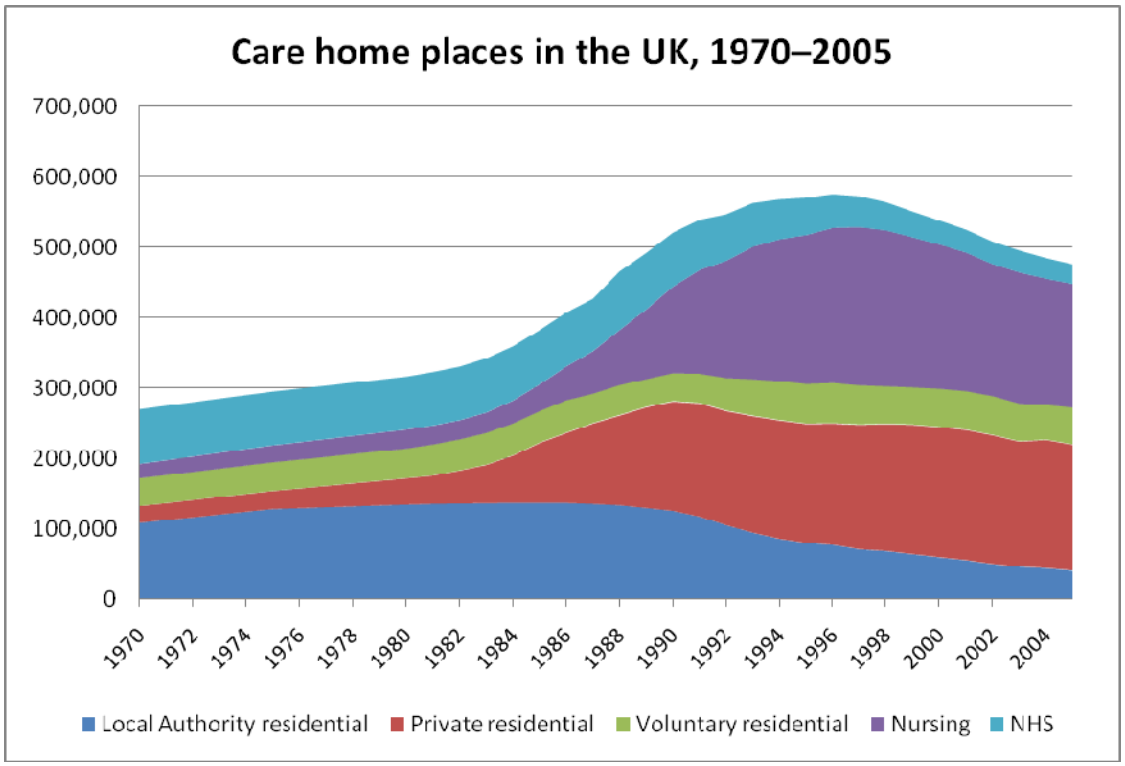
One of the most significant changes in care home care in the last 30 years has been the wholesale transfer of residential care places from public to private sector provision. According to Christina Victor, the proportion of long-term places in the independent sector rose from 18% in 1980 to 85% in 2001 (Victor, 2005).

The number of residential care places in the United Kingdom peaked at around 321,000 places in 1990 and has been declining steadily ever since (Chart 1).

Private sector residential care provision in the United Kingdom began to increase in the mid 1970s increased more rapidly in the early 1980s and was taking up most of the slack created by a declining public sector provision from the late 1980s onwards (Chart 2).

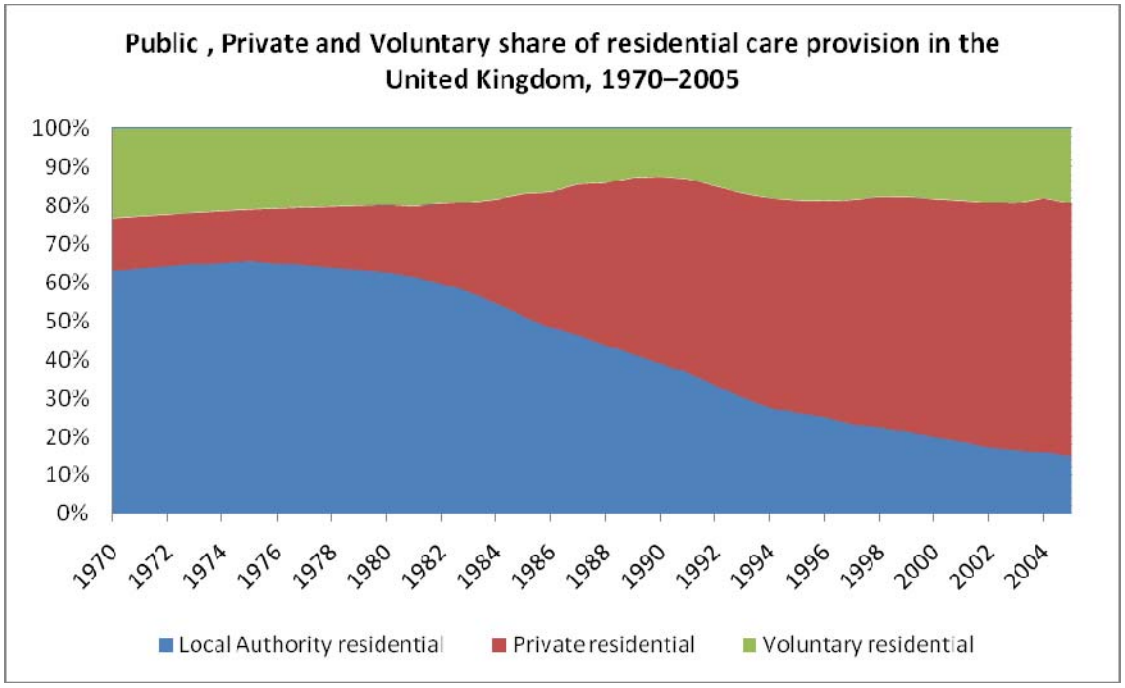
From the late 1980s the number of NHS places declined significantly and from the mid 1980s to 1998 there was a very rapid rise in, mainly private, nursing care provision in care homes (Chart 1).

Chart 1



Source: Laing & Buisson Care of elderly people market survey 2005

Chart 2



Source: Laing & Buisson Care of elderly people market survey 2005

The organisation of care home care reflects political, and the attendant economic, change as can be seen following the 1979 and 1997 UK general elections both of which brought about a change of the political party in power (Chart 1).

In 1983, at the same time as the funding available to local authorities was being reduced through rate and poll tax capping, the then DHSS agreed to meet the full cost of care in private residential and nursing homes for those receiving what was then called 'supplementary benefit'. This, in the 1980s and early 1990s, was a significant stimulus for both the supply of and demand for private residential and nursing home places (Walker, 1997).

The total number of care home places of all types in the UK peaked in 1996 and has been declining ever since. In the years around the millennium the number of care home closures was a cause for concern and studies were undertaken to find out what type of homes were closing and why. Homes found themselves under increased financial pressure. Two thirds of care home provision is purchased by local authorities who were themselves under pressure to hold down fees paid and support increasing numbers of people in the community. The *National Minimum Wage* was introduced in 1999, affecting staff costs, and new *National Minimum Standards* for care homes in England requiring, among other things, newly registered care homes to provide 80% of their occupancy in single rooms by 2007, were introduced in 2001 and amended in 2003 (Netten et al, 2005). The homes that closed tended to be the smaller homes with low occupancy levels and were often the only home run by the organisation. Homes on more than one floor but without a lift, with a high proportion of shared bedrooms and a low proportion of en-suite facilities were also more likely to close because of the potential costs of reaching the new minimum standards. Ironically the research also found that homes with a more positive social attitude were the ones more likely to close (Darton, 2004).

The net result has been a move towards a smaller number of larger, corporate run homes (Table 1). By 2005, organisations owning or running 11 or more care homes, owned or ran 20% of care homes in the UK and 30% of care home places (Office for Fair Trading, 2005). However, over 50% of homes and 40% of places were still controlled by organisations with a single care home.

Teble 1: Top six care home providers in the UK, April 2006

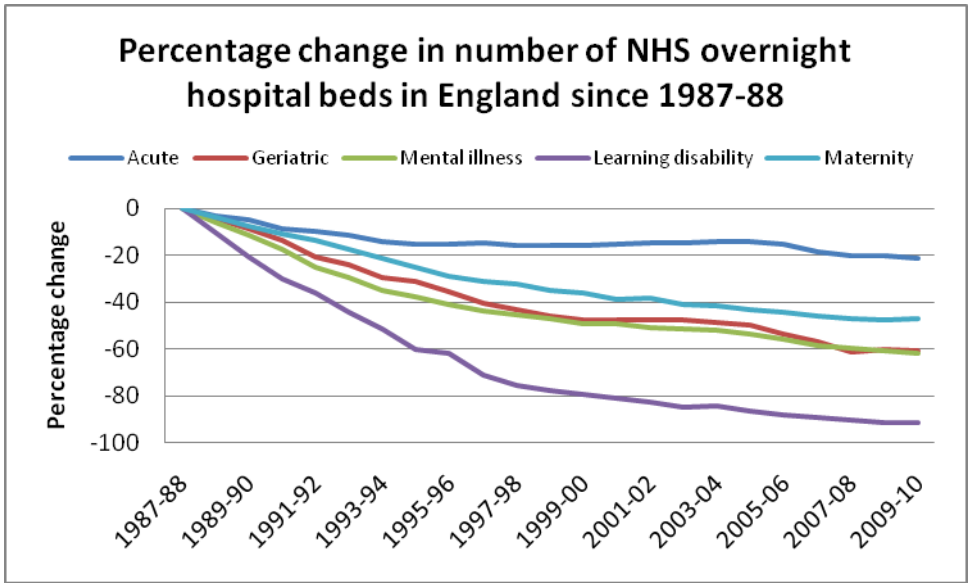
Organisation	Homes	Beds	Market share	Type
Southern Cross Healthcare	527	27,744	8.1%	Private
Bupa Care Homes	294	21,036	6.2%	Private
Four Seasons (JDM)	316	16,416	4.8%	Private
Barchester Healthcare	156	10,021	2.9%	Private
Anchor Trust	97	4,286	1.3%	Voluntary
Order of St John Care Trust	74	3,216	0.9%	Voluntary

Source: Philpot, Residential Care: A positive future, 2008

The number and proportion of care home nursing places has risen rapidly since the late 1980s reaching a peak in around 1998 (Chart 1). This has been matched by a large decline in the number of available NHS hospital beds of all categories (except

day beds). In the period from 1987–88 to 2008–09, acute beds have reduced in number by 20%, geriatric and mental health beds by 60% and learning disability beds by a massive 92% (Chart 3).

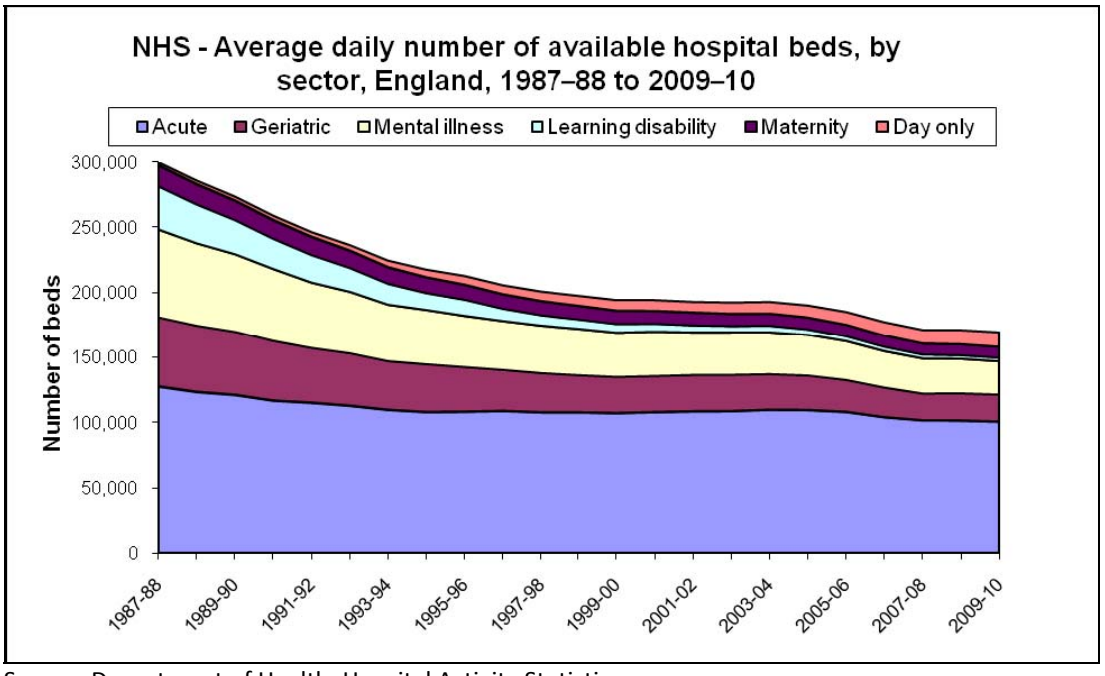
Chart 3



Source: Department of Health, Hospital Activity Statistics

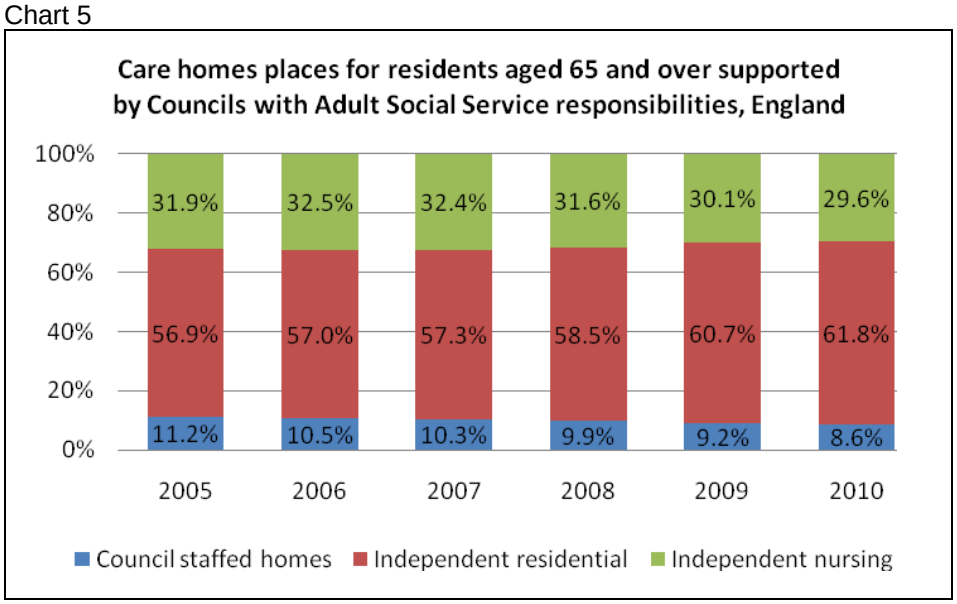
While most hospital beds experience occupancy rates of 80% - 85% and maternity beds around 60% - 65%, geriatric beds tend to experience occupancy rates of around 90% - 95%, indicating the greater pressure on these facilities.

Chart 4



Source: Department of Health, Hospital Activity Statistics

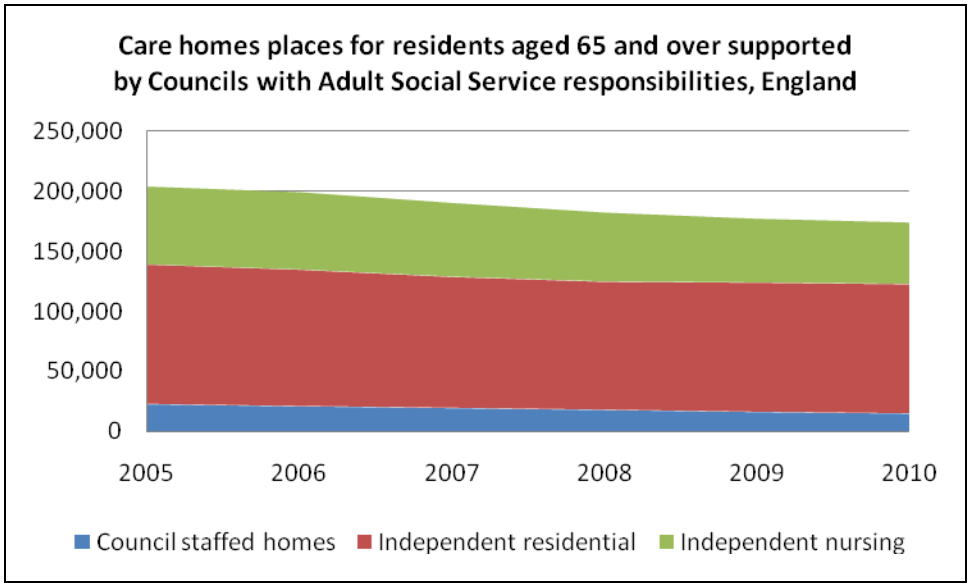
Chart 5



Source: NHS Information Centre

The most recent figures from the NHS Information Centre for care home places supported by Councils with Adult Social Service Responsibilities (CASSRs) show the continued reduction in the proportion of places provided by local authorities and the increasing proportion from independent residential care providers (Chart 5). They also show the continued decline in the number of supported care home places for over 65s in England, both overall and in homes managed by local authorities (Chart 6).

Chart 6



Source: NHS Information Centre

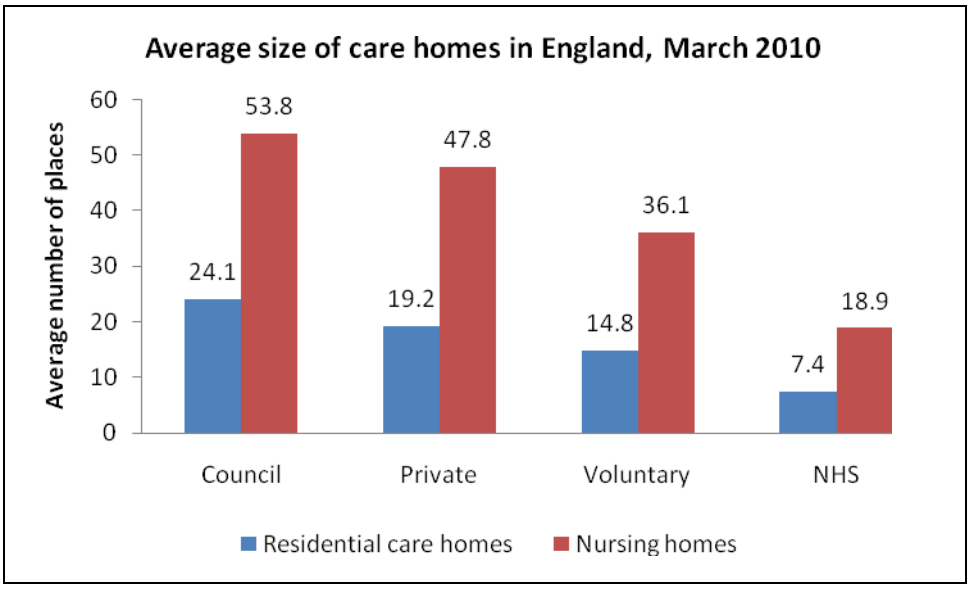
Long term changes in the numbers and proportions of care home residents, who are not supported through health or social care bodies (self funders), are difficult to determine. A 2001 care home survey, commissioned by the Department for Work and Pensions and carried out by PSSRU, estimated that around 30% of care home places (138,000 places) were self funded (Netten et al, 2002). Laing and Buisson's

estimates generally place the proportion of self funders at just under one third (Laing and Buisson, 2005) and the Commission for Social Care Inspection, in 2005, concluded that at least 30% of residential places are occupied by people paying for their own care. This is likely to be a slight underestimate since around 10,000 people, who pay for their own care but whose care is managed by a local authority, may be recorded as local authority supported (CSCI, 2005; Henwood, 2006).

Research carried out by the Office for Fair Trading showed that around one in five homes charge self funders more than Authority funded residents for a similar room and similar care (OFT, 2005).

Care homes in England are, on average, increasing in size. According to the Care Quality Commission, the number of care homes in England fell from 19,646 in 2004 to 18,255 in 2010, a fall of over 7% but, at the same time, the number of care home places rose from 454,463 to 459,448 (CQC, 2010). The average care home size therefore rose from 23.13 places in 2004 to 25.17 places in 2010.

Chart 7



Source: CQC, 2010

Local authorities manage a declining number of homes but local authority homes are, on average, larger than private, voluntary sector or NHS homes. Nursing homes are, in 2010, on average, over twice as large as residential care homes.

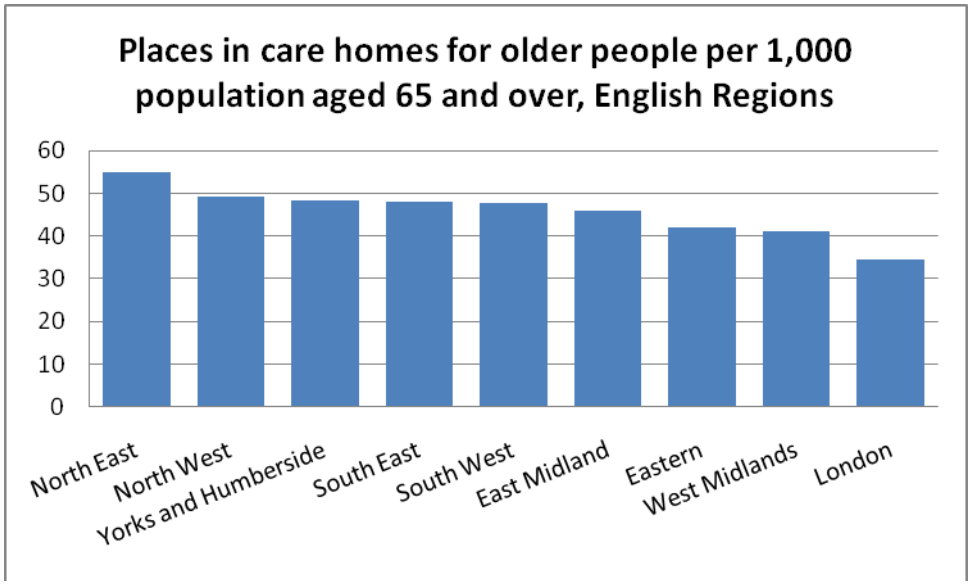
Patterns of care home development have not been uniform across the United Kingdom and there are notable regional variations.

Over the past years, areas with high care home costs, for example the Inner London boroughs, have outsourced their care home provision to less expensive areas such as Outer London or beyond (CQC, 2010).

Analysis of 1991 and 2001 national Census data shows a higher proportion of older people in rural and coastal areas living in care homes in 2001. The analysis also shows regional variations in care home change patterns with, from 1991 to 2001, the number of care homes in the North West of England falling by over 20% and in Wales by 18% while the number of care homes in the East of England showed little change and the number in Scotland rose by 10% (Banks et al, 2006).

The level of care home provision for older people per head of population over 65 also varies widely by region (Chart 8).

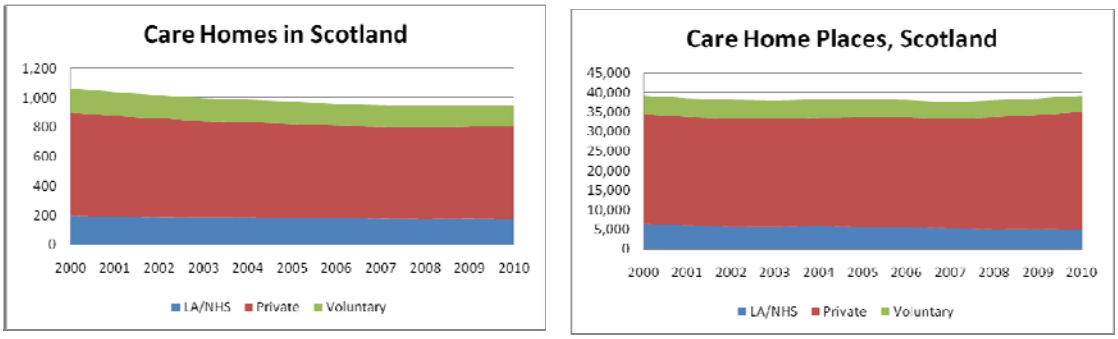
Chart 8



Source: CQC, The adult social care market and the quality of services, 2010

In Scotland, although the number of care homes has declined by 11% in the past ten years, the number of care home places has held steady (Chart 9).

Chart 9



Source: ISD Care Home Census 2010, Scotland

Demographic changes in care home provision are only part of the picture of care home change. Changes in the legislative and regulatory framework are equally important and have only been touched on here.

The quality of care provided in care homes and the staffing regime is of equal importance. It is generally recognised that quality of care is better provided by a reasonably stable workforce but high staff turnover with 42% of care staff leaving within 12 months of joining and 61% leaving within 2 years is a continued source of concern for care providers (Kelly, 2008)

Current trends in population ageing, globalisation and women's migration have come together to increase the proportion of the care home workforce drawn from overseas. Economic disparity coupled with the free movement of labour within an expanded European Union has also contributed to the trend (Browne and Braun, 2008).

It is estimated that over half of all people with dementia in the United Kingdom are in care homes but the number of care home places has fallen substantially in recent years. Projections of future demand indicate that more than double the current number of care home places will be required by 2043 to maintain the current ratio of institutional to community services for dementia (Macdonald and Cooper, 2007).

The large scale transfer of long-term nursing care for older people from long-stay hospital beds to nursing home facilities raises questions about whether nursing homes are able to cope with the demands placed on them and whether they can provide the specialist nursing care that may sometimes be required (Turrell, 2001).

Care homes today: a profile of residents in Bupa care homes

Bupa carried out a census of its care home residents in the United Kingdom, Australia, New Zealand and Spain in 2009. The census of 30,000 residents generated a response rate of 95%. A similar census of 15,000 residents of Bupa care homes in the UK had been carried out in 2003 and of 32,000 Bupa and non Bupa UK care home residents in 2006.

The census provides a valuable insight into the profile of care home residents and a snapshot of care home care at the time of the census. This analysis focuses on key aspects of residents in UK care homes but makes comparison with other countries where this may provide an additional insight.

Nearly three quarters (73%) of Bupa UK care home residents in the 2009 census are receiving nursing care with just under one quarter (24%) receiving residential care. For 3% the type of care is not recorded.

Gender

The vast majority of care home residents are female. In the United Kingdom, in 2009, just under 72% of residents were female while in Spain three quarters (75.4%) were female and in Australia (67.3%) and New Zealand (66.5%) it was around two thirds. Despite this, in Spain, Australia and New Zealand a clear majority of care home residents aged under 65 are male (Tables 2–5).

Table2:

United Kingdom		Resident Age Group					
		Under 65	65–74	75–84	85–94	95 and over	All Ages
Gender	Female	50.2%	53.9%	67.8%	79.2%	87.4%	71.7%
	Male	49.8%	46.1%	32.2%	20.8%	12.6%	28.3%
Total		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

n=15,477

Table 3:

Australia		Resident Age Group					
		Under 65	65–74	75–84	85–94	95 and over	All Ages
Gender	Female	42.4%	47.6%	64.1%	72.6%	85.2%	67.3%
	Male	57.6%	52.4%	35.9%	27.4%	14.8%	32.7%
Total		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

n=3,520

Table 4:

New Zealand		Resident Age Group					
		Under 65	65–74	75–84	85–94	95 and over	All Ages
Gender	Female	46.7%	51.2%	59.6%	75.8%	82.6%	66.5%
	Male	53.3%	48.8%	40.4%	24.2%	17.4%	33.5%
Total		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

n=2,735

Table 5:

Spain		Resident Age Group					
		Under 65	65–74	75–84	85–94	95 and over	All Ages
Gender	Female	42.5%	60.6%	73.0%	81.1%	85.1%	75.4%
	Male	57.5%	39.4%	27.0%	18.9%	14.9%	24.6%
Total		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

n=3,776

Age of residents

The great majority of Bupa care home residents are older people. Residents aged 65 and over make up 93% of the care home population in New Zealand, 94% in the UK, 95% in Australia and 97% in Spain.

Table 6:

United Kingdom		Resident Age Group					
		Under 65	65–74	75–84	85–94	95 and over	Total
Gender	Female	4.2%	8.3%	30.9%	45.6%	11.0%	100.0%
	Male	10.5%	17.9%	37.2%	30.3%	4.0%	100.0%
All		6.0%	11.0%	32.7%	41.3%	9.0%	100.0%

n=15,477

Table 7:

Australia		Resident Age Group					
		Under 65	65–74	75–84	85–94	95 and over	Total
Gender	Female	3.3%	5.9%	30.0%	50.4%	10.4%	100.0%
	Male	9.2%	13.4%	34.5%	39.1%	3.7%	100.0%
All		5.2%	8.4%	31.5%	46.7%	8.2%	100.0%

n=3,520

Table 8:

New Zealand		Resident Age Group					
		Under 65	65–74	75–84	85–94	95 and over	Total
Gender	Female	4.7%	8.2%	29.3%	48.3%	9.4%	100.0%
	Male	10.7%	15.5%	39.4%	30.5%	3.9%	100.0%
All		6.7%	10.6%	32.7%	42.4%	7.6%	100.0%

n=2,735

Table 9:

Spain		Resident Age Group					
		Under 65	65–74	75–84	85–94	95 and over	Total
Gender	Female	1.8%	6.9%	36.1%	48.0%	7.2%	100.0%
	Male	7.4%	13.8%	40.8%	34.2%	3.9%	100.0%
All		3.2%	8.6%	37.2%	44.6%	6.4%	100.0%

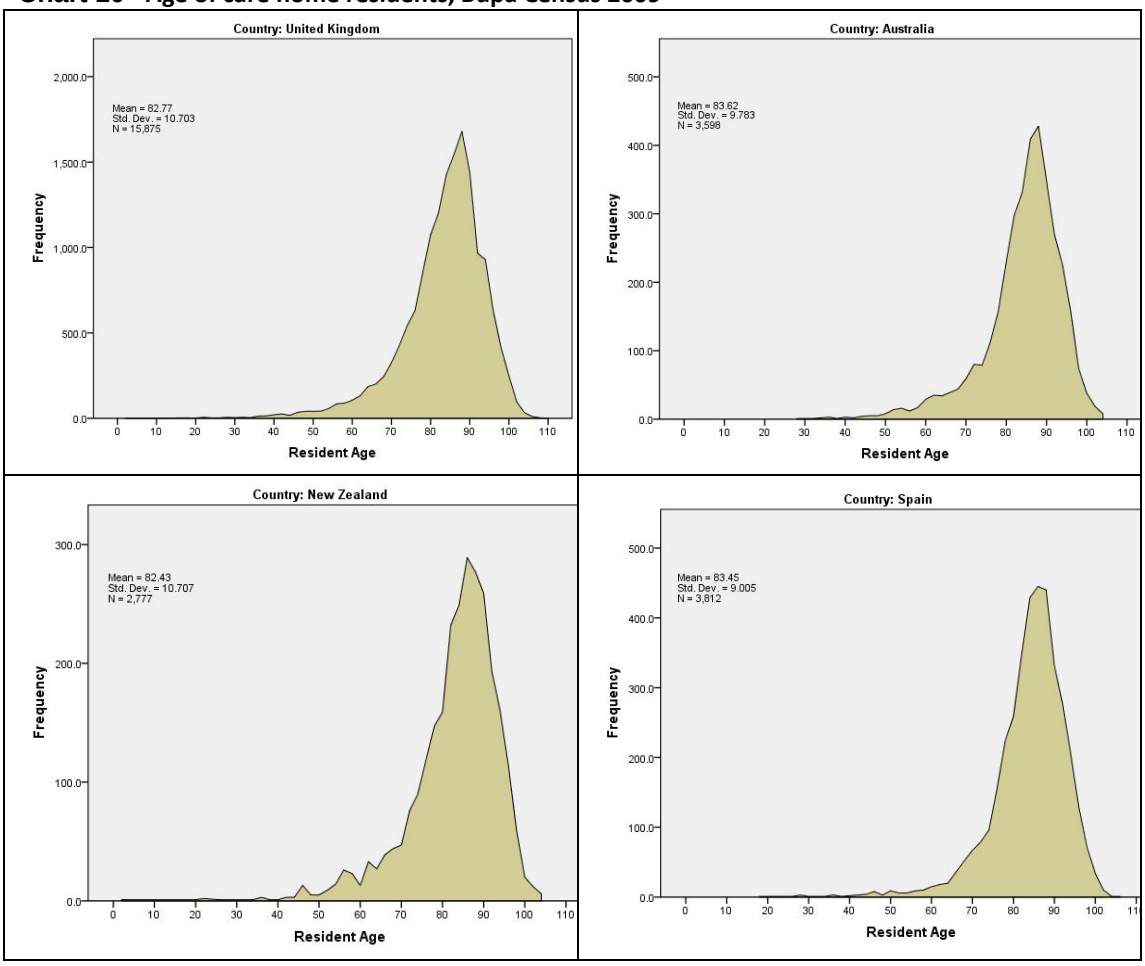
n=3,776

Although residents under the age of 65 make up only a small proportion of Bupa care home residents, many of these are much younger than 65 and the age distribution of residents is skewed with a long tail.

The skewed age distribution causes the mean age of residents to be rather less than the median which is a better indicator of average age in these circumstances. In all four countries the median resident age, with roughly half the residents above and half below this age, is 85.

Male residents tend to be younger than female residents. In the UK the median age for male residents is 81 and for female residents is 86.

Chart 10 Age of care home residents, Bupa Census 2009



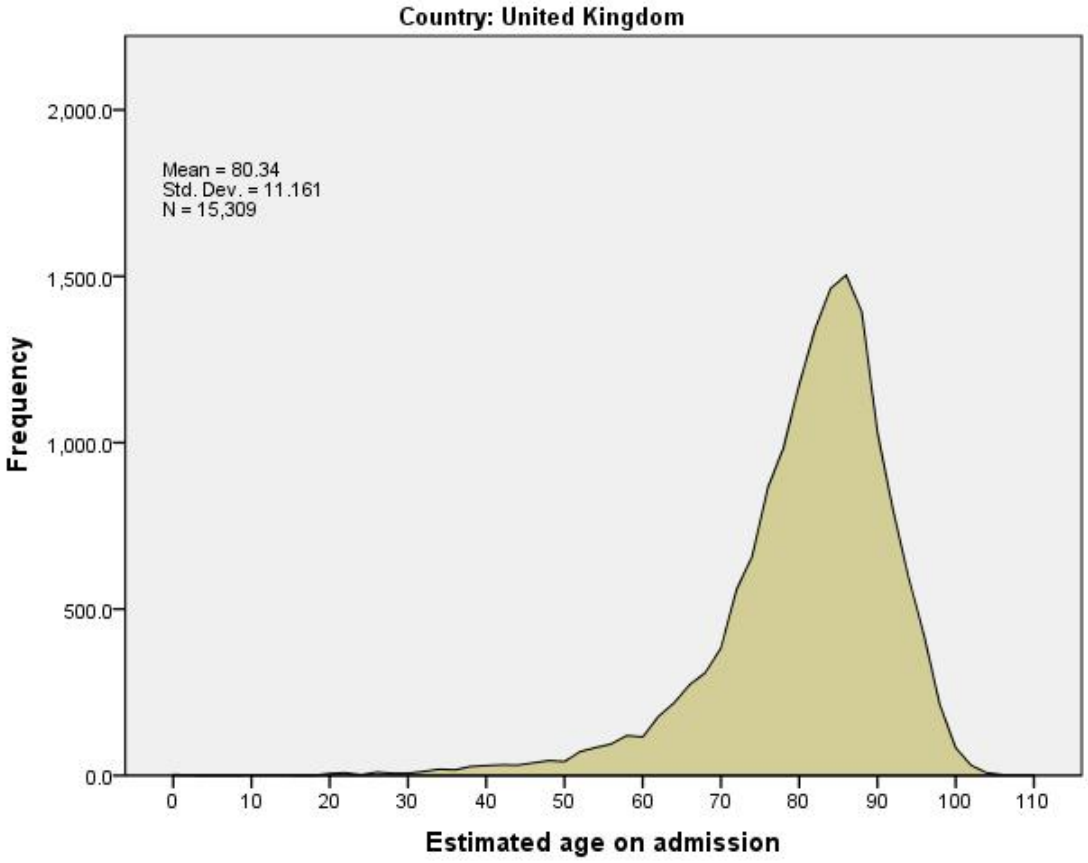
From the census data the age of the resident on admission can also be estimated. Estimated age on admission shows the age on admission of the current resident population. It cannot reflect changes in the overall age distribution of residents at the time of admission since residents who were older at a particular date of admission are less likely to have survived to take part in the present census. The median estimated age on admission of the current resident population is 82 in the UK, Spain and New Zealand and 83 in Australia.

Table 10:
Bupa Census 2009 - Average age of care home residents and average estimated age on admission.

		UK	Australia	New Zealand	Spain
Age of resident	Median	85	85	85	85
	Mean	82.77	83.62	82.43	83.45
Estimated age on admission	Median	82	83	82	82
	Mean	80.34	81.17	79.91	81.03

For the resident population in 2009, men tend to have been admitted at a younger age than women with, in the UK, a median estimated age on admission of 79 for men and 83 for women.

Chart 11



Length of stay

The Bupa census provides information on the length of stay to date of Bupa residents. Bupa census data cannot provide information on the total length of stay of residents, since current residents have, by definition, not yet completed their stay and the census will be biased towards longer stay residents who have a greater chance of being in the home on a particular day and therefore of being included in the census.

Length of stay to date

In 2009 the length of stay to date followed similar patterns in each of the four countries with large numbers of residents having stayed for a relatively short period and a much smaller number staying for a prolonged period.

Chart 12

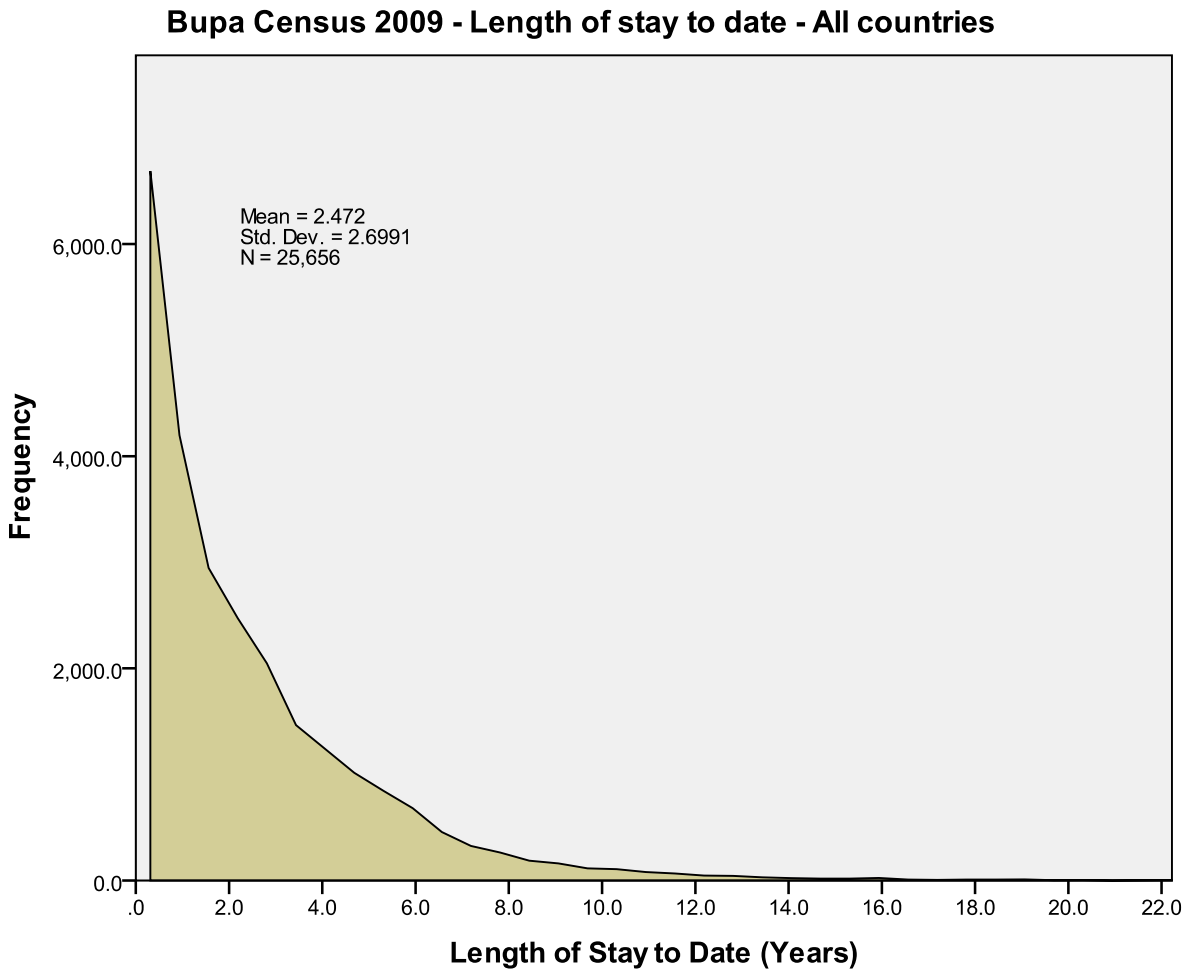


Table 11: Bupa Census 2009 –Resident length of stay to date (years)

Country	Mean	Median	Maximum
United Kingdom	2.473	1.603	39.4
Australia	2.494	1.734	26.8
New Zealand	2.496	1.622	40.1
Spain	2.428	1.885	17.1

Table 12: Bupa Census 2009 – United Kingdom – Resident length of stay to date (years) - Percentiles

Cumulative Percent	5	10	15	20	25	30	35	40	45	50
Length of stay to date (years)	0.068	0.153	0.252	0.397	0.548	0.729	0.916	1.109	1.326	1.603

Table 12: continued...

Cumulative Percent	55	60	65	70	75	80	85	90	95	
Length of stay to date (years)	1.877	2.178	2.556	2.962	3.444	4.090	4.883	5.906	7.801	

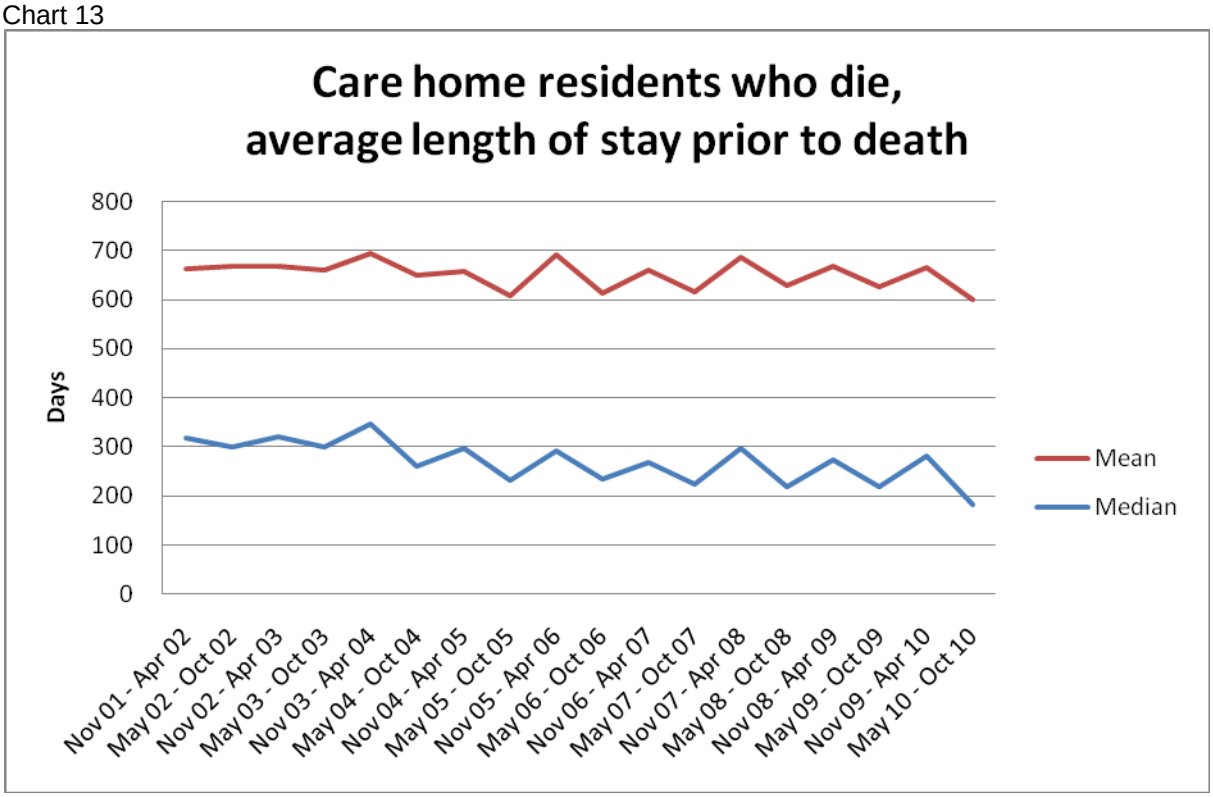
The table of 'length of stay to date' percentiles for the United Kingdom shows that half of residents have stayed for 19 months or less and nearly one quarter have been resident for less than six months. A large majority, just under 80%, of residents have had a stay to date of less than four years.

In line with expected life-spans, women tend to have stayed longer in Bupa care homes than men. In the United Kingdom in 2009 the median length of stay to date for female residents was 1.72 years and for male residents was 1.26 years.

Length of stay to death

In addition to its census data, Bupa records the length of stay for residents who have died while in the care home. By definition, this 'length of stay at death' data excludes residents who have returned home after a short spell in the care home, but trends in 'length of stay at death' data are almost certainly indicative of trends in overall length of stay.

Chart 13



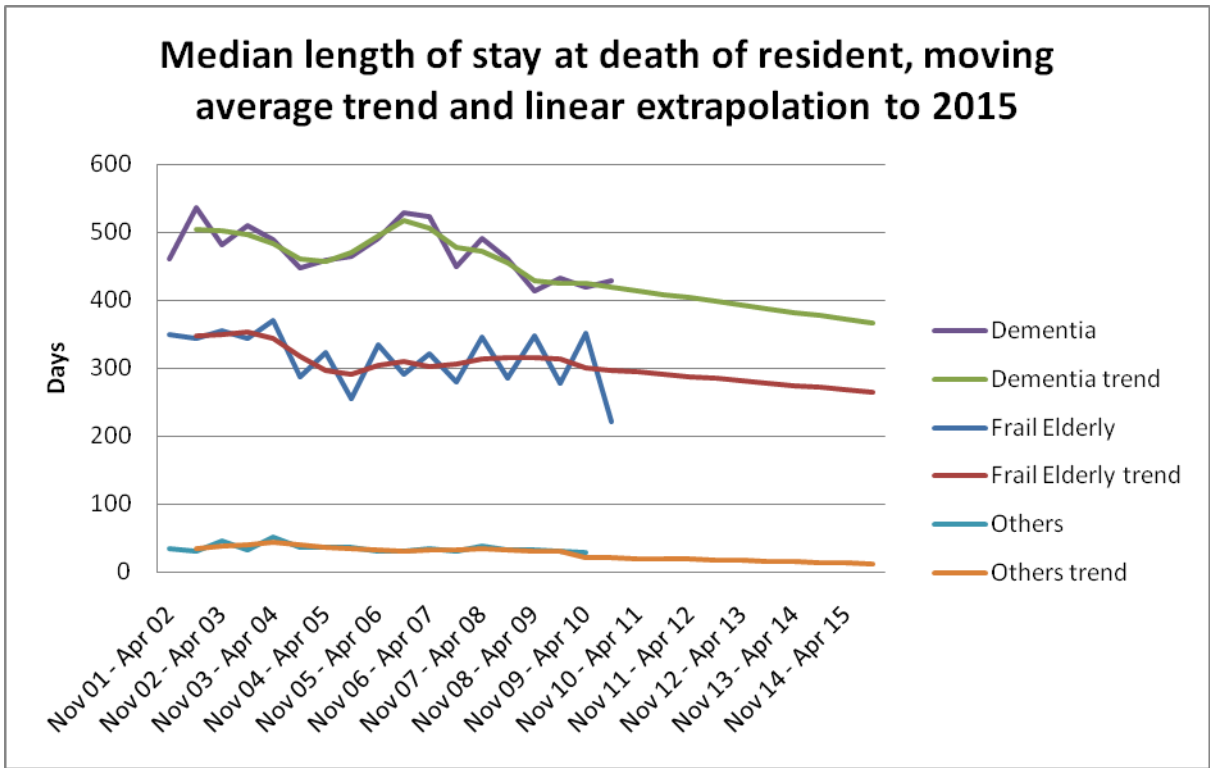
As indicated earlier the small number of residents who stay for a long time causes the mean length of stay to death to always be greater than the median but both

measures exhibit a noticeable shortening in average length of stay in the period from 2001 to 2010.

Unsurprisingly, residents who are receiving care for reasons of dementia but who may be in good physical health, tend to stay longer in the care home than residents who are physically frail.

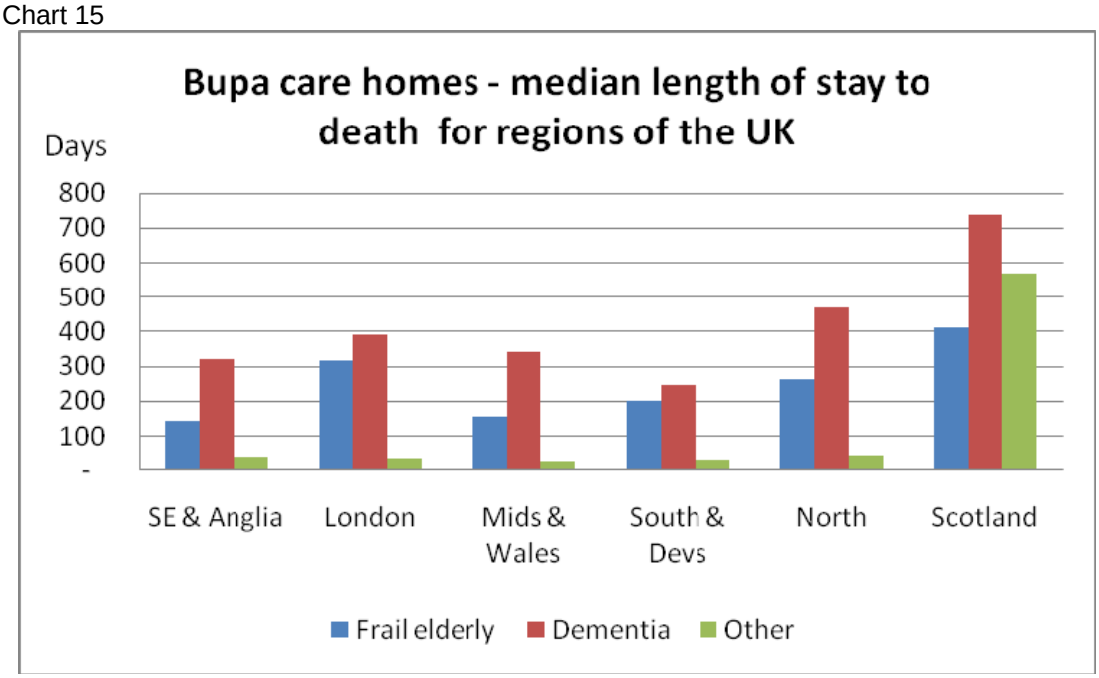
In both cases the average length of stay is shortening and, if present trends continue, by 2015 the median length of stay for dementia care residents will be around one year (367 days) and for older frail residents will be just under nine months (265 days).

Chart 14



In addition to variation in the length of stay for male and female residents and by type of care there are also regional variations in length of stay to death for the different part of the UK. Bupa length of stay to death data shows that care home stays in Scotland tend to be longer than for London or the English regions.

Chart 15

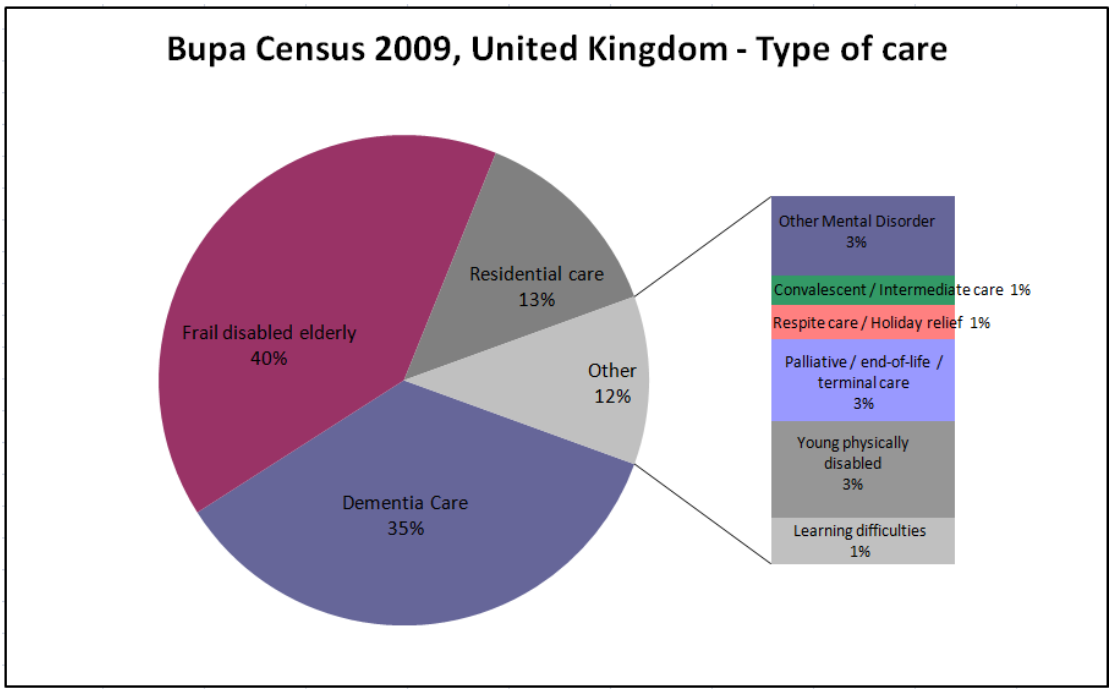


Type of care

In addition to the broad categorisation of residential or nursing care discussed later under 'Reasons for admittance', in the census, Bupa care home residents are assigned to a number of 'Care categories'.

Three quarters of Bupa care home care in the UK is either 'frail disabled elderly' or dementia care (Chart 16).

Chart 16



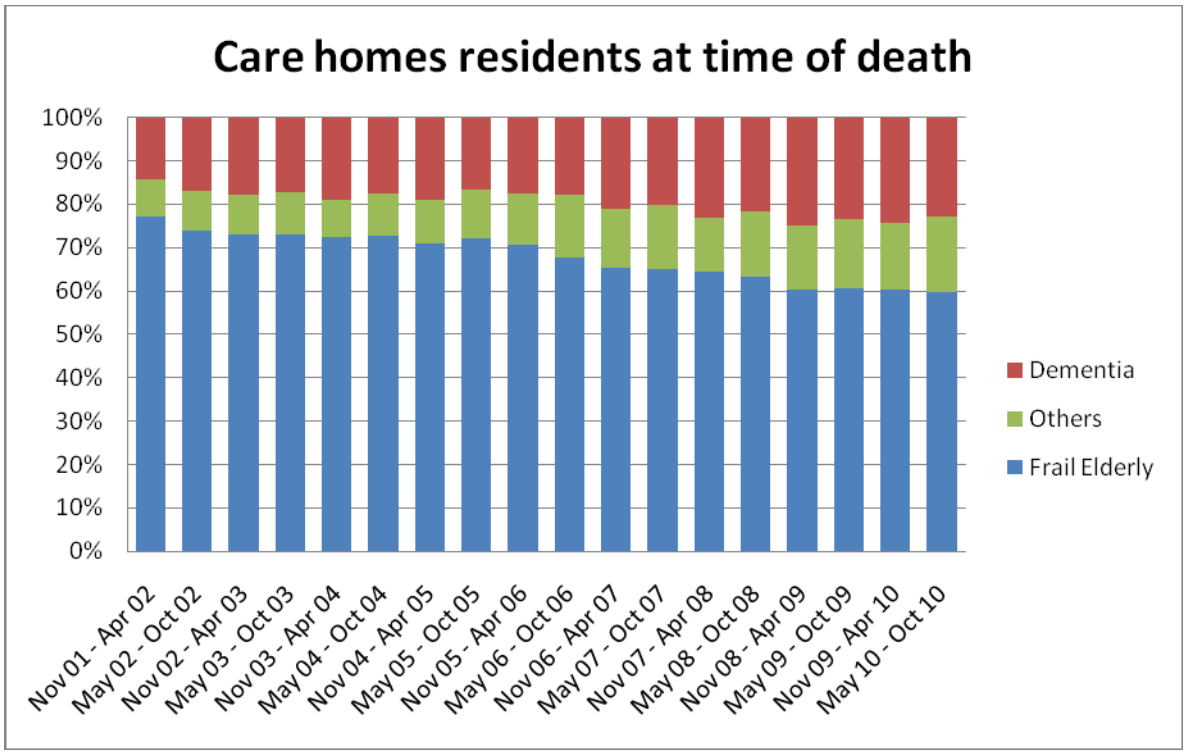
Type of care varies substantially with the age of the resident. For residents under the age of 65, over 45% are 'Young physically disabled' while 13% have learning difficulties, 6% are receiving palliative or end-of-life care and fewer than 16% are receiving dementia care.

Table13: Bupa Census 2009, UK - Care Category by Resident Age Group

% within Resident Age Group	Resident Age Group					
Care Category	Under 65	65–74	75–84	85–94	95 and over	All Ages
Dementia Care	15.7%	41.6%	42.5%	34.0%	21.4%	35.4%
Other Mental Disorder	6.8%	6.3%	2.2%	1.2%	1.0%	2.4%
Convalescent / intermediate care	1.4%	.8%	1.0%	.8%	.4%	.9%
Respite care / holiday relief	2.5%	1.4%	1.0%	.9%	.4%	1.0%
Palliative / end-of-life / terminal care	6.1%	3.0%	2.4%	2.0%	2.0%	2.5%
Young physically disabled	45.7%	1.9%	.1%	.0%	.1%	2.9%
Learning difficulties	13.0%	2.8%	.7%	.2%	.2%	1.4%
Frail disabled elderly	5.0%	34.7%	38.4%	45.1%	53.7%	40.2%
Residential care	3.7%	7.6%	11.8%	15.8%	20.7%	13.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

n=15,480

Chart 17



The proportion of residents with dementia is increasing and the proportion of 'frail elderly' is declining.

A separate survey of Bupa care home residents at the time of death indicates that the proportion of residents who, at death, are 'frail elderly' has declined from 77% in 2001–2 to 60% in 2010 and the proportion who, at death, are receiving 'dementia care' has increased from 14% in 2001–2 to 23% in 2010. (Chart 17)

Neurological and mental disorders

In 2009, three quarters (75%) of Bupa care home residents in the UK were experiencing some form of neurological or mental disorder.

Chart 18

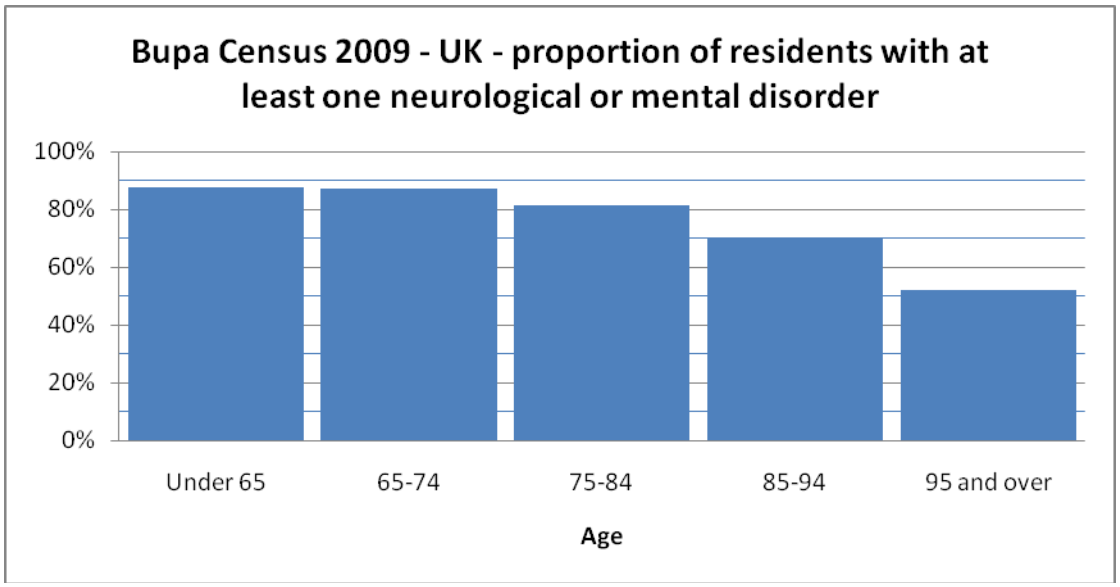
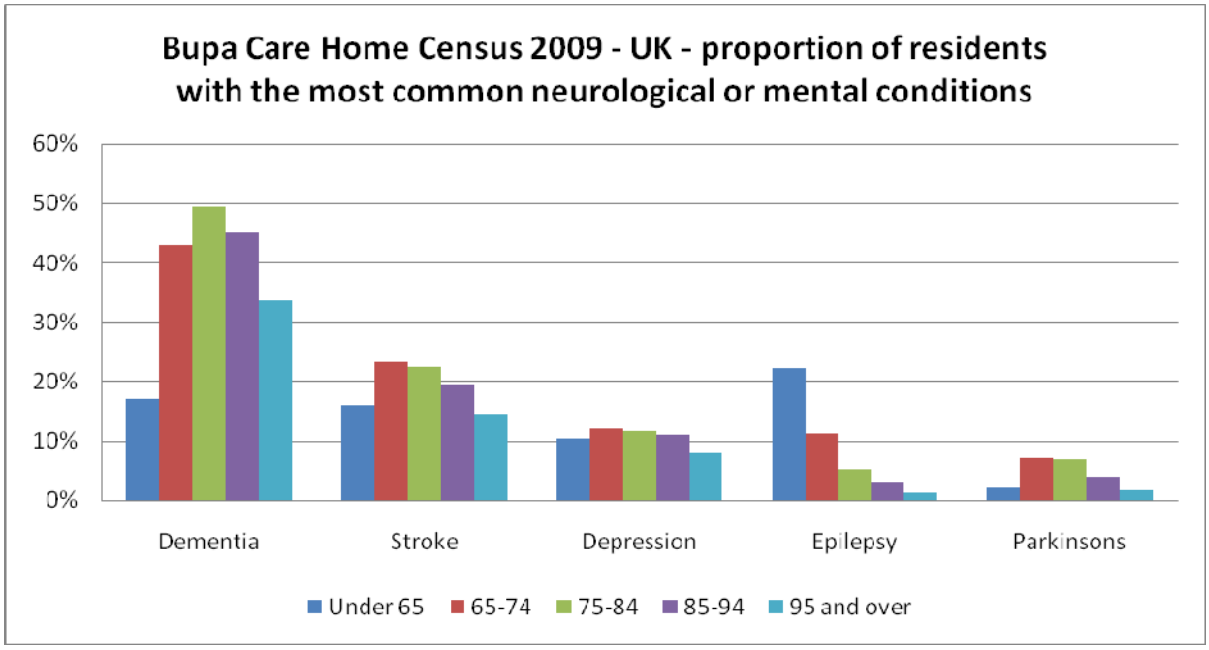


Chart 19



Residents may have more than one neurological or mental condition but the proportion with at least one neurological or mental disorder declines consistently with the age of the resident from 87.7% for the under 65s to 52.2% for residents aged 95 and over (Chart 18).

The most commonly occurring disorders were Dementia (43.6%), Stroke (20.2%), Depression (11%), Epilepsy (5.6%) and Parkinson's disease (4.9%) (Chart 19).

Dementia

As already indicated, the proportion of care home residents with dementia is on the increase. The proportion of UK Bupa care home residents with dementia has risen from 36% in the 2003 census to 38% in 2006 and just under 44% in 2009.

The proportion of care home residents with dementia is always much greater than the proportion with dementia for the equivalent age group in the community, except for residents aged 95 and over where the community and care home rates are much the same. Surprisingly, unlike for dementia prevalence rates in the community, the Bupa 2009 census reveals that the proportion of Bupa care home residents with dementia does not increase consistently with the age of the resident.

Table 14: Dementia prevalence rates in the community and in Bupa UK care homes in 2009

Dementia % within Age Group	Age Group					All Ages
	Under 65	65–74	75–84	85–94	95 and over	
UK Community*	0 – 0.16%	1.3% – 2.9%	5.9% – 12.2%	20.3% – 28.6%	32.5%	1.1%
Bupa UK Care Homes	17.1%	43.0%	49.5%	45.1%	33.6%	43.6%

* Community rates – Consensus estimates from Knapp et al, 2007. Prevalence rate ranges shown are for the first five year period to the last five year period of the age group.

In Bupa care homes in the UK, the proportion of residents age 95 and over with dementia is lower than for the 65 – 94 age groups. A possible reason for this and other similar findings is explored in the section on 'Reason for admittance'.

This finding, while consistent with other findings in the Bupa census for the UK, is at variance with earlier estimates of the prevalence of dementia among older people in care homes in the UK which set the prevalence rate for residents aged 95+ at 66.4% (Knapp et al., 2007).

The proportion of Bupa care home residents with dementia varies not only by age but also varies substantially between the countries of the Bupa census. The UK pattern, of residents over the age of 95 being less likely to have dementia than those aged 65 to 94, is repeated in both Australia (75 to 94) and New Zealand (Table 15).

Table 15: Percentage of residents with dementia as a primary or secondary diagnosis

	Resident Age Group					
	Under 65	65–74	75–84	85–94	95 and over	All Ages
Australia	26.0%	43.9%	55.1%	57.8%	54.9%	53.9%
New Zealand	23.7%	45.3%	54.5%	52.6%	42.7%	49.8%
Spain	12.1%	31.5%	43.9%	50.4%	53.9%	45.4%
United Kingdom	17.1%	43.0%	49.5%	45.1%	33.6%	43.6%
All countries	18.7%	41.9%	49.8%	48.6%	39.6%	45.9%

Residents with dementia are more than twice as likely to exhibit challenging behaviour than those without. In the UK, 26.6% of residents with dementia exhibit challenging behaviour compared with just 10.3% for those who do not have the condition.

Although the proportion of residents with dementia, in the UK, has increased over the three censuses, the proportion recorded as 'confused or forgetful' has not (Table 16). This may indicate that at least part of the increase in recorded dementia may arise from improved levels of clinical assessment or an increased willingness to diagnose the condition. Recorded levels of Dementia are considerably higher in Australian and New Zealand care homes than in the UK (Table 15). These are likely to have resulted from the more extensive, and mandatory, clinical assessments that are carried out in those countries before entry into care.

Table 16: Bupa census 2009 – UK proportion of residents with dementia and confusion

UK	2003	2006	2009
Confused or forgetful	62%	63%	63%
Dementia	36%	38%	44%

Depression

Depression in older people often goes unrecognised. Only one half (49.5%) of Bupa residents in the UK who were assessed as having 'depression' were also described by staff as having a 'depressed or agitated' mental state. Overall, 11% of residents of Bupa care homes in the UK in 2009 were assessed as having 'depression'.

Table 17: Proportion of Bupa UK care home residents with Depression

Age	Under 65	65–74	75–84	85–94	95 and over
Percentage with Depression	10.4%	12.1%	11.6%	11.1%	8.0%

In UK Bupa care homes the proportion of residents with depression, although relatively low for the under 65s, declines from age 65 onwards, falling to 11.1% for the 85-94 age group and 8% for residents aged 95 and over. This contrasts markedly with community based assessments of levels of depression, including the Health Survey for England (HSE-2005) and the Psychiatric Morbidity Survey (PMS-2000)

both of which show levels of depression generally increasing with age and with HSE levels of depression for those aged 85+ at around 40% although PMS levels are only one tenth of that. (McCrone et al, 2008; Craig et al, 2007) A possible explanation for observed lower levels of depression in residents aged 95 and over is given in the section on 'Reason for admittance'.

Stroke

In the United Kingdom, stroke is the second most common neurological/mental condition among Bupa care home residents, after dementia. The prevalence of stroke in Bupa care homes in the UK has declined very slightly from 22% in 2003 to 21% in 2006 and 20% in 2009.

The proportion of residents with stroke varies considerably from country to country and with the age of the resident. In every country residents aged 95 and over have the lowest proportion with stroke. A possible explanation for the UK is given in the section on 'Reason for admittance'.

Stroke levels in New Zealand for residents aged 65 and over are roughly three times those in Spain. The reason for this large variation is not known but is likely to be a combination of variations in detection rates, the basis for care home admission and the prevalence of the condition in the community.

Table 18: Percentage of residents with Stroke as a primary or secondary diagnosis

	Resident Age Group					
	Under 65	65–74	75–84	85–94	95 and over	All Ages
Australia	15.6%	20.6%	20.5%	17.7%	15.5%	18.5%
New Zealand	22.0%	28.7%	24.7%	21.2%	18.5%	23.0%
Spain	12.9%	8.2%	9.9%	7.9%	4.9%	8.7%
United Kingdom	16.1%	23.3%	22.4%	19.5%	14.6%	20.2%
All countries	16.5%	21.7%	20.4%	17.7%	14.0%	18.6%

Non-neurological or mental conditions

Table 19: Bupa Census 2009 – Proportion of residents with various non-neurological conditions

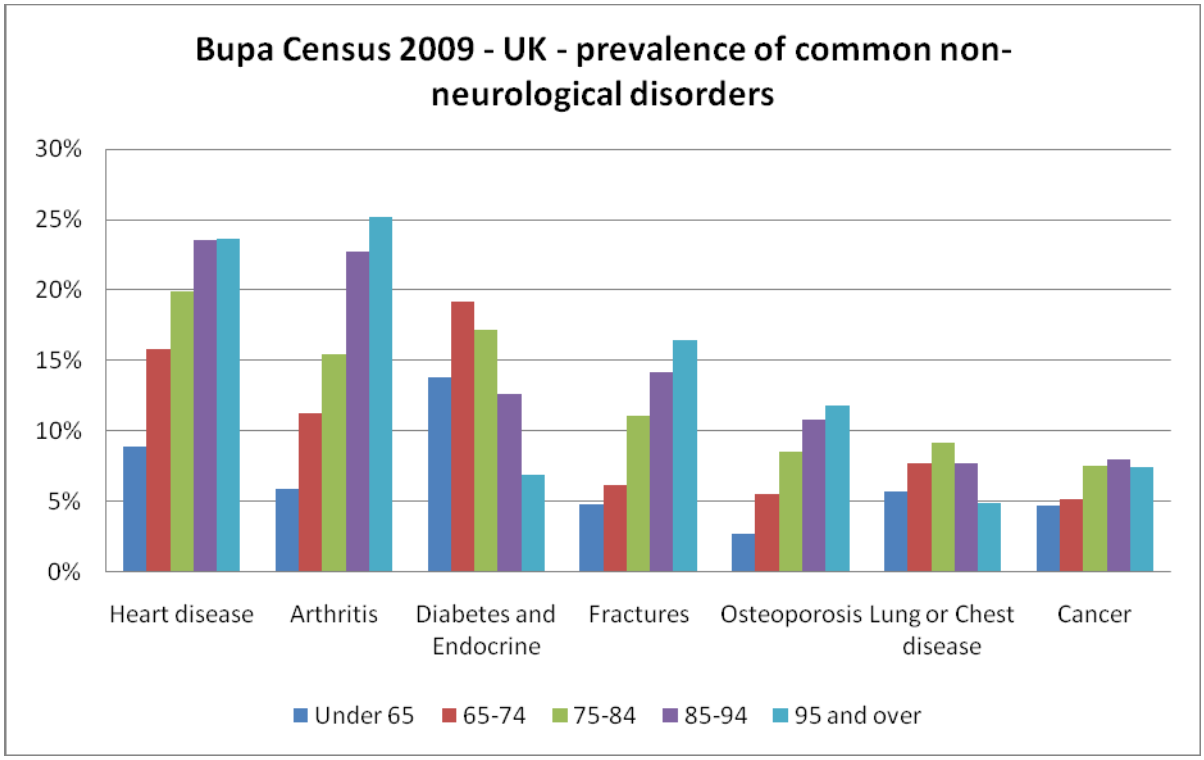
	UK	Australia	New Zealand	Spain
Heart disease	20.6%	38.3%	47.1%	27.7%
Arthritis	18.3%	24.4%	18.2%	16.0%
Diabetes and Endocrine	14.4%	18.0%	19.7%	20.4%
Fractures	12.0%	14.1%	12.7%	19.4%
Osteoporosis	9.1%	18.7%	15.9%	17.3%
Lung or chest disease	7.8%	12.3%	16.7%	12.2%
Cancer	7.3%	10.8%	10.0%	5.7%

The most commonly occurring non-neurological or mental conditions in Bupa care homes in the United Kingdom in 2009 were Heart disease (20.6%), Arthritis (18.3%), Diabetes and Endocrine (14.4%), Fractures (12%), Osteoporosis (9.1%), Lung or chest disease (7.8%) and Cancer (7.3%) (Table 19).

These proportions vary substantially between the countries of the census. To find the reasons for these variations would require a much deeper analysis but they may arise from a combination of variations in assessment procedures, admission criteria and the prevalence of the condition in the community. The higher levels of most conditions observed in Australia and New Zealand have most probably, at least in part, arisen from the mandatory full clinical assessments carried out in those countries before entry into a care home.

The proportion of residents with particular conditions also varies considerably with age. Heart disease, Arthritis, Fractures, and Osteoporosis all increase consistently with the age of the resident. Over 25% of Bupa residents in the UK, age 95 and over, suffer from Arthritis.

Chart 20



Levels of diabetes in Bupa UK care homes have increased from 8% in 2003 and 9% in 2006 to 14% in 2009. At the same time, for residents aged 65 and over, residents in the younger age groups (65–74 onwards) have higher levels of this, currently incurable, long term condition than older residents (Table 20). This may herald even higher levels of diabetes in care homes in the future.

Table 20: Bupa care home census 2009 - Proportion of UK residents with diabetes / endocrine disorder

	Under 65	65–74	75–84	85–94	95 +	All ages
Diabetes/ endocrine	13.8%	19.2%	17.2%	12.6%	6.9%	14.4%

Continence

Just under 70% of all Bupa care home residents in the UK experience some form of incontinence (Table 21).

Table 21: Bupa Resident Census – UK – 2009 – Continence by Age group

Continence	Resident Age Group					
% within Age Group	Under 65	65–74	75–84	85–94	95 and over	All Ages
Continent	29.7%	29.1%	29.6%	31.8%	33.9%	30.8%
Urinary incontinence	12.6%	13.8%	13.9%	16.2%	17.3%	15.0%
Faecal incontinence	1.1%	.6%	.4%	.7%	.8%	.6%
Dual incontinence	56.6%	56.5%	56.2%	51.4%	48.0%	53.5%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

n=15,875

Levels of urinary incontinence alone increase consistently with the age of the resident but the overall proportion who are continent changes little with age. Counter-intuitively, residents over the age of 95 are those most likely to be rated as 'continent' and least likely to experience 'dual incontinence'

Continence may be viewed differently by different respondents. For some, a resident whose incontinence is managed effectively by catheterisation or wearing pads may be viewed as 'continent'. In the United Kingdom 4.9% of residents wearing pads and 6.6% of residents who were catheterised were described as 'continent'. In New Zealand the percentages were 11.2% and 10.0% respectively.

Reason for admittance, residential and nursing care

A possible explanation of why the oldest residents, age 95 and over, have lower levels of neurological and mental disorder, including dementia, and better levels of continence than residents in the 65–94 age groups may lie in the reason for admittance.

The proportion of residents admitted for non-clinical reasons increases with age and the proportion admitted for clinical reasons declines. For residents age 95 and over, the majority (53.7%) of admittances are for frailty, housing or family reasons rather than specific health conditions (Table 22).

The reliability of the 'frailty' assessment for over 95s has been questioned and may be a manifestation of medical ageism with multiple co-morbidities being lumped together in a single term. Nearly three quarters (73%) of residents are receiving nursing care but, in corroboration of the thesis that the oldest old are less likely to be admitted into care homes as a result of specific medical conditions, the proportion of residents who are admitted for residential rather than nursing care increases with the age of the resident (Table 23).

Table 22 Bupa Resident Census 2009 - UK – Reason for Admittance by Age Group

Count and % within age group		Resident Age Group					
		Under 65	65–74	75–84	85–94	95 and over	All Ages
Reason for Admittance	Clinical	546	939	2636	3006	602	7729
		57.5%	54.0%	50.8%	45.8%	42.0%	48.7%
	Family/Social Reasons	33	45	79	96	19	272
		3.5%	2.6%	1.5%	1.5%	1.3%	1.7%
	Frailty (Unspecified)	143	331	1354	2145	593	4566
		15.1%	19.0%	26.1%	32.7%	41.3%	28.8%
	Housing	163	308	830	1002	159	2462
		17.2%	17.7%	16.0%	15.3%	11.1%	15.5%
	Unknown	64	115	290	315	62	846
		6.7%	6.6%	5.6%	4.8%	4.3%	5.3%
Total		949	1738	5189	6564	1435	15875
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table 23: Bupa Resident Census 2009 - UK – Type of Care by Age Group

Residential / Nursing care Count and % within Age Group		Resident Age Group					
		Under 65	65–74	75–84	85–94	95 and over	All Ages
	Not recorded	31	44	139	216	41	471
		3.3%	2.5%	2.7%	3.3%	2.9%	3.0%
	Nursing	826	1402	3833	4532	982	11575
		87.0%	80.7%	73.9%	69.0%	68.4%	72.9%
	Residential	92	292	1217	1816	412	3829
		9.7%	16.8%	23.5%	27.7%	28.7%	24.1%
Total		949	1738	5189	6564	1435	15875
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Nursing care residents are three years younger on average (82.0 years) than those in residential care (85.0 years) and have a slightly longer average length of stay to date.

Unsurprisingly, residential care residents have better levels of continence and lower levels of most medical conditions except arthritis and depression, although the difference in the proportions with dementia is perhaps not as great as might be expected (residential=41%, nursing=45%) (Table 24).

Table 24: Proportion of residents in nursing and residential care with specific conditions.

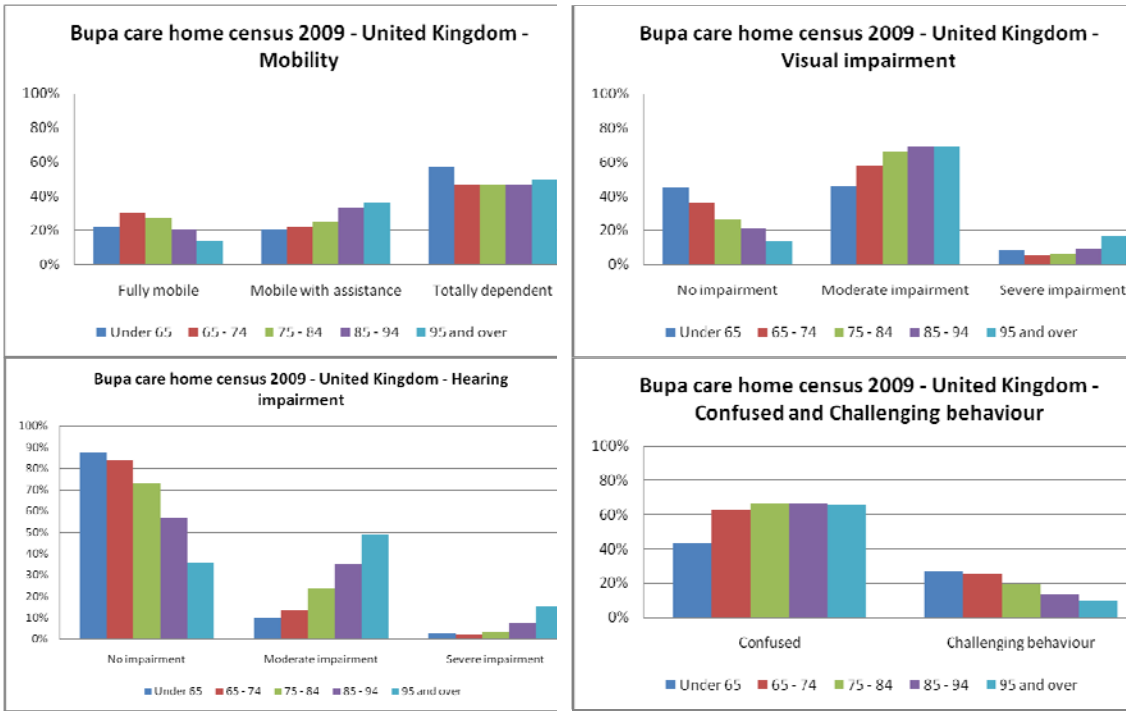
Condition	Nursing	Residential	Condition	Nursing	Residental
Arthritis	18.0%	19.7%	Learning diffs.	2.1%	1.9%
Bi-polar	1.1%	0.9%	Lung and chest	8.3%	5.9%
Cerebral Palsy	0.6%	0.2%	Missing limbs	1.4%	0.5%
Dementia	45.0%	40.9%	Motor neurone	0.5%	0.1%
Depression	10.6%	11.6%	Multiple sclerosis	1.9%	0.3%
Diabetes & Endocrine	15.4%	11.6%	Neurological trauma	2.7%	0.9%
Epilepsy	6.4%	2.8%	All neurological	78.3%	65.5%
Fractures	12.9%	9.3%	Osteoporosis	9.6%	7.6%
Heart disease	22.3%	15.6%	Parkinsons	5.4%	3.7%
Huntingtons	0.5%	0.1%	Schizophrenia	2.2%	1.3%
Incontinence	77.2%	65.0%	Stroke	23.1%	11.9%

A small proportion of residents, 3.4% in the UK, are on temporary placements, perhaps as respite for carers. A resident may have a number of temporary placements in a year. The median length of stay to date for residents on temporary placement is less than one month (26 days) in the UK although it is lower in Australia (19–20 days) and New Zealand (9 days) but considerably higher in Spain (43 days).

Impairment and residents with high support needs

Nearly one half (47.6%) of Bupa care home residents in the UK have severe mobility problems being totally dependent on others for their mobility. Other than the under 65s, who have the highest proportion dependent, mobility generally declines as residents get older (Chart 21).

Chart 21



The proportion of Bupa UK residents with severe visual impairment (8.7%) or hearing impairment (6.2%) is considerably lower than for mobility dependency but as before,

except for the under–65s, the level of impairment tends to increase with age. (Chart 21)

Over 70% of Bupa UK care home residents either have dementia or are 'confused' and 17.4% exhibit challenging behaviour. Except for those aged 95 and over, confusion tends to increase with the age of the resident but challenging behaviour declines with age. (Chart 21)

If we define 'High Support Needs' as having one or more of dementia, confusion, challenging behaviour, dual incontinence, severe hearing or visual impairment or total dependence in mobility then 90% of Bupa care home residents in the UK have high support needs.

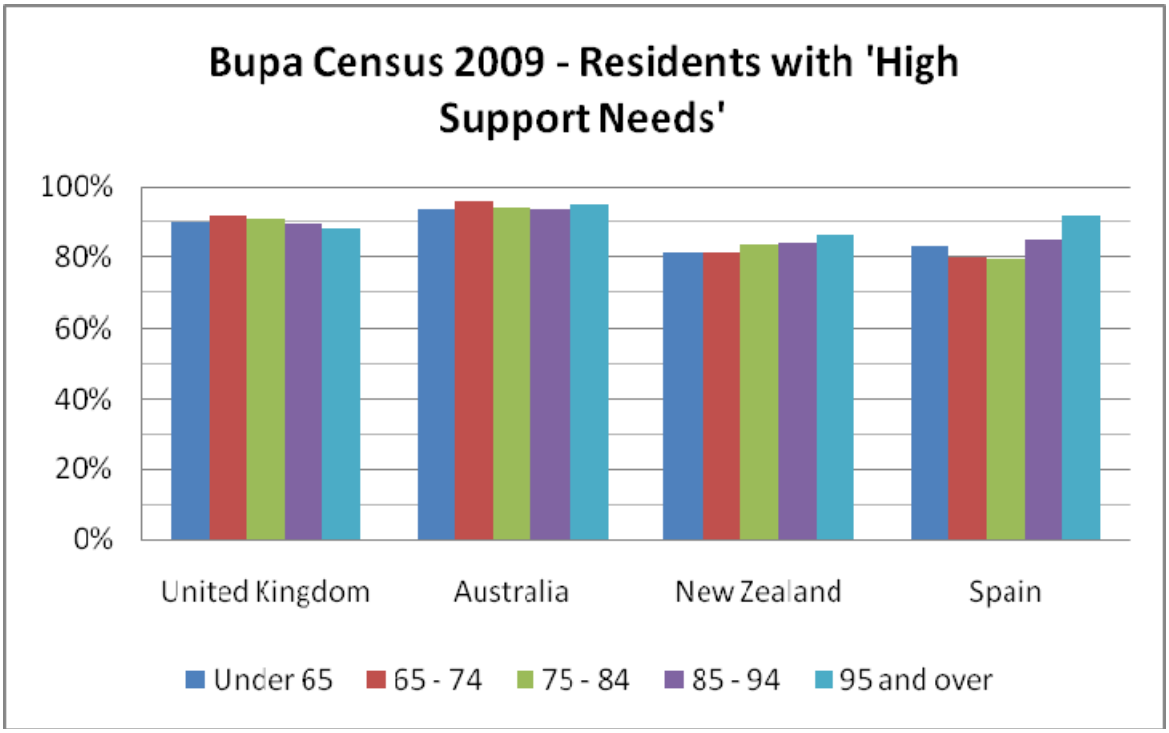
This varies very little with the age of the resident but is marginally lower (88.4%) for those aged 95 and over.

Table 25: Bupa Census UK 2009, Residents with high support needs

Age	Under 65	65–74	75–84	85–94	95 and over	All Ages
Percentage with high support needs	90.0%	92.0%	91.0%	89.4%	88.4%	90.2%

The proportion of residents with high support needs is higher in Australia (94.1%) but lower in New Zealand (84.0%) and Spain (83.0%) (Chart 22).

Chart 22



Quality of care – urinary incontinence and challenging behaviour

The proportion of residents in the UK with urinary only incontinence has improved noticeably over the period of the three censuses from 20% in 2003 and 17% in 2006 to 15% in 2009. At the same time the proportion of residents in the UK exhibiting challenging behaviour has fallen slightly from 19% to 17%. It has been suggested that improvements in urinary incontinence and challenging behaviour are indicators of better care home management and improved quality of care (Table 26).

Table 26:
Bupa census UK – proportion of residents with urinary incontinence or challenging behaviour

	2003	2006	2009
Urinary incontinence	20%	17%	15%
Challenging behaviour	19%	18%	17%

Exhibiting challenging behaviour is very much associated with other characteristics of a resident and its overall prevalence may be affected by changes in the resident profile. The strongest single factor is having Huntingtons disease, where 49% of residents show challenging behaviour, or a psychotic illness (Schizophrenia=37%, Bi-polar disorder=34.5%).

Table 27: Bupa census UK, 2009.
Proportion of residents exhibiting challenging behaviour, for various characteristics or conditions.

Huntingtons disease	49.2%	Learning difficulties	31.9%	Aged 65–74	25.7%
Depressed or agitated	37.4%	Neurological trauma	30.2%	Mobility: fully mobile	24.5%
Schizophrenia	37.1%	Aged under 65	26.7%	Gender: Male	24.2%
Bi-polar disorder	34.5%	Dementia	26.6%	Dual incontinence	21.9%

Having more than one of the associated conditions may again increase the chances of exhibiting challenging behaviour. For Bupa UK care home residents with both dementia and schizophrenia for example, although the numbers are small, 48.7% show challenging behaviour. Sometimes a combination of factors may be the trigger. Although only 10% of residents with multiple sclerosis exhibit challenging behaviour, a proportion well below the overall average of 17.4%, if a resident has both MS and dementia the proportion exhibiting challenging behaviour rises to 38.5% which is well above the 26.6% for residents with dementia but without MS (Table 28).

Table 28: Bupa census UK, 2009 – Proportion of residents exhibiting challenging behaviour

		Dementia		All
		No	Yes	
Multiple Sclerosis	No	10.3%	26.6%	17.5%
	Yes	8.8%	38.5%	10.4%
All		10.3%	26.6%	17.4%

Conditions linked to urinary incontinence alone are less obvious although the proportion of Bupa UK residents with either arthritis, osteoporosis or MS who have urinary incontinence is 19% compared with 15% overall and the proportion for those with motor neurone disease is 23%. Other conditions such as cerebral palsy,

Huntingtons disease, Parkinsons disease or stroke, that may lead to a reduction in continence, often lead to dual incontinence.

Summary profile and conclusion

Care home residents are admitted because of their special needs and so residents' health and general profiles often will not match those found in the community.

Bupa care home residents are predominantly female and aged over 65 although men may be in the majority for the under–65 age group. Nearly three quarters (73%) are receiving nursing care with 24% receiving residential care and for 3% the type of care is not recorded.

Lengths of stay are declining and the median length of stay is likely to be less than one year by 2015. The proportion of residents with dementia is increasing and in 2009, in the UK, was just under 44%.

Three quarters of Bupa care home residents, in the UK in 2009, were experiencing some form of neurological or mental disorder, 70% were suffering from dementia or confusion, 70% had some form of incontinence and a very large proportion (90%) of care home residents have 'high support needs' of one form or another. That makes it more difficult to provide the necessary level of care, for these residents, outside a care home.

The exception is the oldest old residents (aged 95 and over) who continue to be admitted as a result of frailty or for social reasons and have better continence and lower levels of dementia, stroke, depression, diabetes and lung or chest disease than residents aged 65 to 94.

The increasing proportion of residents with diabetes in Bupa care homes, and the higher prevalence among younger residents aged 65 and over, may be a herald of increasing health inequality problems including obesity that will be experienced by care homes and health services in the future.

The management and care of residents who exhibit 'challenging behaviour' poses a particular problem for care home staff. Challenging behaviour is commonly exhibited by younger male residents who are fully mobile but Huntingtons disease, psychotic disorders or dementia can also be major contributors. The observed links between 'challenging behaviour' by residents and individual conditions, or combinations of conditions, may help inform the improved management of such behaviour.

The Bupa census of care homes reinforces the view that care homes are moving away from being an alternative form of housing for frail older people towards a location of last resort for individuals with high support needs towards the end of life.

The distinction between 'nursing care' and 'residential care' is becoming increasingly difficult to make and a medical model of care is, of necessity, moving to the fore.

This analysis of Bupa care home residents clearly illustrates the importance of understanding the changing demographics within care. It is evident that defining the purpose of residential care is important to understanding its vital contribution to the whole spectrum of care and in particular where it fits within the concept of personalised care. Future innovative service provision will undoubtably require residential care integrated within the community and offering a positive choice to those older people with increasing complex high support needs.

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