Length of Stay of Residents and Patients in Residential and Nursing Homes for Elderly People

R.A. Darton

Discussion Paper 990/2
March 1994

Published in *Research, Policy and Planning*, 1994, **12**, No. 3, 18-24.

LENGTH OF STAY OF RESIDENTS AND PATIENTS IN RESIDENTIAL AND NURSING HOMES FOR ELDERLY PEOPLE

R.A. Darton

Discussion Paper 990/2

Personal Social Services Research Unit,
University of Kent at Canterbury,
Canterbury, Kent CT2 7NF.

March 1994

ABSTRACT

From 1 April 1993, local authorities have assessed applicants for public funding in independent residential and nursing homes. The transfer of social security funds was phased using length of stay and turnover information. Local authority planners and care managers also need this information. However, most studies have estimated the average length of stay for current residents, *not* the completed length of stay. This paper presents length of stay, turnover, source of admission and source of finance information collected in three local authorities in 1992, and discusses the policy implications. For some types of home, uncompleted lengths of stay were not a reliable guide to completed lengths of stay.

INTRODUCTION

From 1 April 1993, local authorities have been responsible for assessing new applicants for public funding for private and voluntary residential and nursing home care, under the arrangements set out in the White Paper *Caring for People* (Secretaries of State for Health, Social Security, Wales and Scotland, 1989). Existing residents were given `preserved rights' to income support, and a government working party, the `Algebra Group', developed a formula for transferring social security funds for new applicants to local authorities. The phasing of the transfer of funds was calculated using information on turnover from two surveys of length of stay in residential care homes (Smart et al., 1992) and nursing homes (Baldwin et al., 1991). In order to obtain more information on length of stay and sources of admission of nursing home residents, the Association of County Councils commissioned a separate survey from researchers at Aberdeen University (Henry et al., 1993). For the first four years, the funds transferred to local authorities are being distributed partly according to local need, as given by the government's Standard Spending Assessment calculations, and partly according to the existing pattern of social security expenditure. A Local Authority Social Services Letter (Department of Health, 1992) shows the allocation to each local authority for 1993-94. It had been intended that information on the areas of origin of residents receiving income support would be obtained from a survey by the Benefits Agency, so that differences between authorities in cross-boundary flows of residents would be used in calculating local need. However, it was not possible to collect this information with sufficient accuracy and the compromise based on current levels of social security expenditure and need as calculated by Standard Spending Assessments was used instead (House of Commons, 1993).

Under the new community care arrangements, local authority planners and care managers also need information about the length of stay of residents in residential and nursing homes. Ideally, this should be related to individual characteristics, such as age, sex, and health and dependency status. Most studies of residential and nursing homes have been cross-sectional, and estimate the average length of stay for current residents, *not* the completed length of stay for discharged residents. Furthermore, the uncompleted length of stay will be underestimated in the expanding private residential and nursing home

sectors.

As a first stage in research on completed length of stay, the Personal Social Services Research Unit undertook a study in 1992, in collaboration with a London borough, a metropolitan district and a county council, to examine length of stay, turnover, source of admission and source of finance. The local authorities included in the study, Bexley, Bradford and Oxfordshire, were three of the four authorities already participating in a monitoring study being conducted by the PSSRU. Since (uncompleted) length of stay distributions are highly positively skewed (Department of Health Social Services Inspectorate, 1989; Darton and Wright, 1992), a study of a cohort of new admissions would have to be continued for a considerable period in order to collect sufficient information about the turnover of residents to estimate distributions of length of stay. In order to shorten the period of data collection, the turnover of existing residents over a fixed period, supplemented by information on new admissions during the period, was obtained. A period of one year was considered initially, but was reduced to three months to provide information by the middle of 1992, in the light of the requirements of the three authorities and the Department of Health for information for use in planning for the April 1993 changes. Health and dependency information were not collected, to minimise the burden on respondents and because a cohort study would be more appropriate for predicting length of stay from these factors. A full report of the survey is contained in Darton (1992).

DESCRIPTION OF THE SURVEY

The survey was conducted during the period 5 February to 5 May 1992, following local discussions between the local authorities and the representative organisations for independent residential and nursing homes. The survey covered all local authority residential homes for elderly people, all independent residential homes for elderly people and all independent nursing homes which catered for elderly people in each of the three authorities. In addition, in Bradford, local authority residential homes for younger people with a mental handicap or a mental illness and independent residential homes which

were registered for other categories than old age were included in the survey.

Three types of questionnaire were prepared for each home in the survey: Form 1 requested information about the home; Form 2 requested information about the residents or patients in the home at the time of the initial stage of the survey (5 February 1992); and Form 3 requested information about the residents or patients who entered the home between the initial stage of the survey and the follow-up (5 February 1992 to 5 May 1992). Separate forms were prepared for local authority residential homes and for independent residential and nursing homes, and the forms were colour-coded for ease of identification. The questionnaires used in the survey were designed in collaboration with the participating authorities and were based on the questionnaires used in the survey of nursing homes conducted by the Centre for Health Economics and the Social Policy Research Unit at the University of York in 1990 (Baldwin et al., 1991), and in the survey of independent residential and nursing homes conducted by the PSSRU and the CHE in 1986-87 (Darton and Wright, 1990, 1992). Forms 2 and 3 were designed so that information on whether the individual was still in the home at the time of the follow-up on 5 May 1992 could be recorded.

In the middle of January 1992, a standard initial letter was sent by each authority to each independent home to explain the purpose of the survey and the procedure for the fieldwork, and to invite questions about the survey. Separate arrangements were made for informing managers of local authority homes. At the end of January, homes were sent copies of the relevant versions of forms 1 and 2, together with guidance notes. The forms were returned to the local authority following completion, and each authority issued reminders to non-respondent homes. At the end of April 1992, the completed copies of Form 2 were returned to the homes, together with copies of Form 3 and a letter explaining the procedure for the follow-up stage. Where queries had arisen about the information provided in the initial stage of the survey, homes were asked to provide clarification. Again, the forms were returned to the local authority following completion, and each authority issued reminders to non-respondent homes.

All but two of the 58 local authority homes returned completed questionnaires in the initial stage of the survey, a response rate of 97 per cent, and these homes all responded in the follow-up stage.

Completed questionnaires were returned by 225 of the 263 independent homes in the initial stage of the survey, a response rate of 86 per cent, and 208 of the 225 initial stage respondents, 92 per cent, returned completed questionnaires in the follow-up stage, an overall response rate of 79 per cent. The mean size of homes which responded to the two stages of the survey corresponded closely to the mean size of all homes, for each category of home.

The majority of the results presented in this paper relate to residents and patients in the homes for elderly people who were resident in February 1992, although some information on residents admitted between the two stages of the survey has been included in the text. The information for local authority homes in Bradford for other client groups is not included, but the information collected for all independent homes is included since only a small number of homes were not recorded as registered for the old age category and the majority included elderly residents. The number of homes providing information in the initial stage of the survey and the number of residents and patients in these homes is shown in table 1. The remaining tables show the number of residents and patients for whom the corresponding information was obtained, since variable non-response occurred for individual questions. The figures presented have not been reweighted to adjust for non-response. As information on admissions and discharges was only collected for three months, the information collected on completed length of stay and turnover should be treated as illustrative rather than definitive.

RESULTS

Personal Characteristics

The proportion of females and the mean age of residents and patients in each type of home on 5 February 1992 are shown in table 1. For local authority homes, the proportion of females and the mean age of residents were similar to those in the 1988 survey undertaken by the Social Services Inspectorate of the Department of Health (1989), and for independent residential homes the figures were similar to

those found by Darton and Wright (1992). For nursing homes, the proportions of females were lower than in the survey by Darton and Wright but, as in the previous survey, voluntary homes had a larger proportion of males than private homes. Voluntary nursing homes also had a lower mean patient age than private homes, as found by Darton and Wright, although the difference between the mean ages of patients in the two types of home was smaller than in the previous survey.

Previous Home Address and Source of Admission

Table 2 presents information on the previous home address and source of admission of residents and patients who were in the home on 5 February 1992. Overall, 98 per cent of residents in local authority homes and approximately 80 per cent of residents and patients in independent homes for whom the information was available had their previous home address within the authority, although the proportions varied between the three authorities. A larger proportion of residents in local authority residential homes and private residential and nursing homes in Bexley came from outside the authority, while nearly all those in the voluntary residential homes, several of which had been transferred from the local authority sector, came from the authority. In Bradford, 87 per cent of residents in private residential homes and 69 per cent in voluntary residential homes came from the authority, compared with 70 per cent in both types of home in Oxfordshire, and in both authorities approximately 80 per cent of patients in private nursing homes came from the authority.

Hospitals provided the main source of admission of residents and patients, except in voluntary residential and voluntary dual registered homes which, together with private residential homes, had the largest proportion of residents who had been owner occupiers, living alone. Over 50 per cent of patients in nursing homes and 46 per cent of residents or patients in private dual registered homes had been admitted from hospital. In private residential homes 30 per cent of residents had been admitted from hospital and a further 26 per cent were previously owner occupiers, living alone. In local authority residential homes 24 per cent of residents had been admitted from hospital and a further 19 per cent had

moved from another home. With the exception of the two voluntary dual registered homes included in the survey, in which none of the residents or patients had been admitted from another home, between 10 and 15 per cent of residents and patients in independent homes had been admitted from another independent home. Residents and patients in independent homes who came from the authority were more likely to have been admitted from hospital (42 per cent) than from private housing, either living alone or with other people (34 per cent), while those who came from outside the authority were more likely to have been admitted from private housing (42 per cent) than from hospital (32 per cent).

Length of Stay

Table 3 shows the uncompleted length of stay distribution of residents and patients in the initial survey, and table 4 shows the mean uncompleted length of stay of these individuals and the mean completed length of stay of the long-stay residents and patients who subsequently left the home between 5 February and 5 May 1992. The uncompleted length of stay figures include short-stay residents and patients, but there will only be a small proportion of these at any given time, particularly in the independent sector.

Thirty-one per cent of residents in local authority homes and 30 per cent of residents in voluntary residential homes had been resident for less than one year at the time of the initial stage of the survey, but only 19 per cent of the local authority residents and three of the 25 residents in voluntary homes who were discharged between 5 February and 5 May had been in the home for less than one year. In private residential homes, 30 per cent of residents had been in the home for less than one year at the time of the initial stage of the survey, and 35 per cent of residents discharged had been in the home for less than one year. For private nursing homes the corresponding figures were 41 per cent and 48 per cent.

The mean uncompleted length of stay of residents in local authority homes was 37 months, ranging from 34 months in Bexley to 39 months in Oxfordshire. In private residential homes the mean

uncompleted length of stay was 31 months, ranging from 23 months in Bexley to 31 months in Bradford, and in private nursing homes the mean uncompleted length of stay was 21 months, ranging from 20 months in Bradford to 25 months in Bexley. The mean uncompleted length of stay of residents and patients in private dual registered homes was intermediate to the figures for private residential and private nursing homes. Overall, the mean uncompleted length of stay of residents in voluntary residential homes was greater than in private homes, as found by Darton and Wright (1990), whereas there was no difference between private and voluntary nursing homes. In Bradford, several voluntary homes were first registered in 1990 or later and, for both residential and nursing homes, the mean for voluntary homes was lower than that for private homes. The mean uncompleted length of stay of residents and patients in homes was positively related to the age of the home, as measured by the date the home opened or the date of first registration, except for voluntary residential homes in Bradford.

Although the uncompleted length of stay of residents and patients will be related to the age of the home, until a steady state of admissions and discharges is reached, any relationship between completed length of stay and the age of the home would only be indirect, for example if the residents and patients admitted to newer homes were more frail. There was no consistent relationship between the two measures of length of stay. For local authority and voluntary residential homes the mean completed length of stay was approximately two standard errors above the mean uncompleted length of stay, corresponding to the 5% level of statistical significance, although only 25 residents left the voluntary residential homes. For private nursing homes the mean completed length of stay was more than three standard errors below the mean uncompleted length of stay, a statistically significant difference at the 0.5% level. For private residential homes the mean completed length of stay was lower than the mean uncompleted length of stay, but the difference was not statistically significant. These comparisons are consistent with the proportions of residents or patients who had been in the home for less than one year at the time of the initial survey or on discharge, noted above.

Including residents and patients who were admitted between the two stages of the survey resulted in a reduction of approximately two months in the mean completed length of stay for local authority, private

and voluntary residential homes and private nursing homes, and a slightly larger reduction for voluntary nursing homes and private dual registered homes, although the number of individuals in voluntary residential and nursing homes and in private dual registered homes was small.

Turnover

Table 5 presents information on the turnover of long-stay residents and patients admitted to homes in the survey during 1991, and information on the discharge rates of long-stay residents and patients who were in the home on 5 February 1992. In 1991, the overall ratio of admissions of long-stay residents to the total number of places was approximately 33 per cent for local authority and private residential homes and voluntary nursing homes, 45 per cent for voluntary residential homes and private dual registered homes, and 60 per cent for private nursing homes. For independent homes, the proportion of recorded discharges of long-stay residents and patients was smaller than the proportion of recorded admissions, the difference being largest for nursing homes, although the discrepancies may be due to newer homes which had not reached a steady state of admissions and discharges. For short-stay residents and patients the figures for admissions and discharges were much more similar.

Discharge rates for long-stay residents and patients during the period 5 February to 5 May 1992 were similar to those for long-stay residents and patients for 1991, after adjusting the figures for the different lengths of time concerned, with two exceptions. For voluntary residential homes the discharge rate for the period 5 February to 5 May 1992 was 19 per cent per year, compared with 33 per cent for 1991, and for private dual registered homes the discharge rate for the period 5 February to 5 May 1992 was 47 per cent per year, compared with 37 per cent for 1991. However, there were only six private dual registered homes in the survey. Thus, for most types of home, the discharge rates for the period 5 February to 5 May 1992 appear to provide satisfactory estimates of the annual discharge rates.

Source of Finance

In Bexley, 16 per cent of residents in local authority homes paid the full cost charge, and 31 per cent paid the minimum. The corresponding figures were 9 per cent and 41 per cent in Oxfordshire, and 2 per cent and 34 per cent in Bradford.

Information on the source of finance of residents and patients in independent homes according to their previous home address is shown in table 6 and according to their source of admission in table 7. In Bexley, similar proportions of residents and patients in independent homes were supported by private means, income support with topping up and income support without topping up, although these varied considerably between the different types of home. In Oxfordshire, 50 per cent were supported by private means, ranging from 37 per cent in private nursing homes to 70 per cent in both private and voluntary residential homes, and 29 per cent were supported by income support without topping up, ranging from 12 per cent in private residential homes to 42 per cent in private nursing homes. In Bradford, 26 per cent were supported by private means, and 51 per cent were supported by income support without topping up. Overall, residents and patients from outside the authority were slightly more likely to be supported by private means, principally in private residential homes in Bradford and in private residential and nursing homes in Oxfordshire. Thirty-eight per cent of residents and patients from outside the authority and 32 per cent of those from within the authority were supported by private means. Residents and patients admitted from private housing were also more likely to be supported by private means (50 per cent), while those admitted from hospital were more likely to be supported by income support (74 per cent). As noted above, residents and patients from outside the authority were more likely to have been admitted from private housing.

DISCUSSION

Under the new arrangements for public funding of residents in independent homes, the length of stay and turnover of residents have important financial and administrative implications for local authorities. Underestimates of length of stay, and corresponding overestimates of turnover would lead to problems of finding sufficient places, probably resulting in increased fees charged by providers, and bed blocking in hospitals, while overestimates of length of stay would lead to underuse of facilities and increased unit costs. The differences between the uncompleted and completed lengths of stay for different types of home indicate that local authorities should not rely on using uncompleted lengths of stay. Unless newly-admitted residents have a much shorter length of stay than existing residents, the mean completed length of stay should exceed the mean uncompleted length of stay, as occurred for local authority and voluntary residential homes. However, although the uncompleted length of stay would tend to be underestimated in expanding sectors of provision, and thus result in a greater discrepancy between the uncompleted and completed length of stay, for private residential and private nursing homes the mean uncompleted length of stay was similar to or greater than the completed length of stay. The need for local authorities to obtain local estimates for planning for the new community care arrangements was emphasised by the Association of Metropolitan Authorities (1992). These results reinforce the need for local authorities to obtain local estimates of length of stay and turnover, related to the dependency profile of residents and patients and to the age profile of the homes in their area.

Comparisons between the information collected for local authority homes by the Social Services Inspectorate of the Department of Health and the information collected for independent residential and nursing homes in the PSSRU/CHE survey indicated that levels of physical disability, incontinence and confusion among residents of local authority homes were intermediate to those recorded for private residential and private nursing homes, while antisocial behaviour was more prevalent in local authority homes (Darton and Wright, 1992). One possible explanation for the greater mean length of stay for local authority homes than for private residential homes may be that residents with confusion have relatively long lengths of stay. As local authorities reduce their provider role, the profile of resident dependency in

independent homes may change, for example by receiving more long-stay residents with confusion, with consequent implications for length of stay and turnover.

The extent to which individuals move to independent homes in different areas depends on the amount and type of provision and its attractiveness. Homes catering for privately-funded residents tended to have higher charges, A high level of in-migration of such residents to independent homes will reduce the available provision locally, and tend to drive up the general level of charges.

In order to respond effectively to the changes introduced in April 1993, local authorities cannot rely on using information about overall levels of provision, but will have to monitor length of stay, turnover and migration, the resident characteristics related to length of stay, and the length of time local homes have been operating to create an accurate picture of the actual availability and the response of providers of residential and nursing home care.

ACKNOWLEDGEMENTS

The survey of length of stay was conducted by the Personal Social Services Research Unit, a research unit funded by the Department of Health, in collaboration with the London Borough of Bexley, the City of Bradford Metropolitan Council and Oxfordshire County Council. Responsibility for this paper is the author's alone. Staff of the three councils organised the fieldwork for the survey, and staff of the City of Bradford Metropolitan Council undertook a substantial part of the data preparation for the information collected in Bradford. The remaining data preparation was undertaken by Mrs J. Eade and Mr A. Rees at the University of Kent. Finally, without the cooperation of managers and proprietors of residential and nursing homes, the study would not have been possible, and their willingness to participate is gratefully acknowledged.

REFERENCES

ASSOCIATION OF METROPOLITAN AUTHORITIES (1992) *Calculating the Costs of Implementing Community Care. A Guide for Local Authorities.* London: Association of Metropolitan Authorities.

BALDWIN, S., CORDEN, A., SUTCLIFFE, E. and WRIGHT, K. (1991) *A Survey of Nursing Homes and Hospices, May 1990.* Centre for Health Economics and Social Policy Research Unit, University of York. June 1991.

DARTON, R.A. (1992) *Length of Stay of Residents and Patients in Residential and Nursing Homes. Statistical Report.* Discussion Paper No. 855/2. Personal Social Services Research Unit, University of Kent at Canterbury. December 1992.

DARTON, R. and WRIGHT, K. (1990) The Characteristics of Non-Statutory Residential and Nursing Homes. In Parry, R. (ed.) *Research Highlights in Social Work 18. Privatisation.* London: Jessica Kingsley Publishers.

DARTON, R. and WRIGHT, K. (1992) Residential and Nursing Homes for Elderly People: One Sector or Two? In Laczko, F. and Victor, C.R. (eds) *Social Policy and Elderly People. The Role of Community Care.* Aldershot: Avebury.

DEPARTMENT OF HEALTH (1992) *Community Care - Special Transitional Grant Conditions and Indicative Allocations.* LASSL(92)12 (Amended).

DEPARTMENT OF HEALTH SOCIAL SERVICES INSPECTORATE (1989) *Towards a Climate of Confidence.* Report of a National Inspection of Management Arrangements for Public Sector Residential Care for Elderly People.

HENRY, J.M., DONALD, S.C. and MACPHERSON, I.A. with DONALD, K., WATKINS, J. and GUEST, C. (1993) *Survey of Nursing Homes in the English Counties.* London: ACC Publications.

HOUSE OF COMMONS (1993) Health Committee, Third Report, Session 1992-93. *Community Care: Funding from April 1993.* HC309-I. London: HMSO.

SECRETARIES OF STATE FOR HEALTH, SOCIAL SECURITY, WALES and SCOTLAND (1989) *Caring for People: Community Care in the Next Decade and Beyond.* Cm 849. London: HMSO.

SMART, S., WITTENBERG, R. and IVINS, C. (1992) *Independent Residential Care Home Clients. A Survey of Lengths of Stay and Other Characteristics.* Discussion Paper No. 884. Personal Social Services Research Unit, University of Kent at Canterbury. July 1992.

Table 1.
Sex and Age of Residents and Patients

Type of home	No. of homes	No. of individuals[1]	Females %	Age	
				Mean	Standard deviation
Local auth. residential	56[2]	1774	72	82.9	8.7
Private residential	103	1585	80	83.3	10.1
Voluntary residential	22	548	79	80.7	16.9
Private nursing	85	2652	76	81.0	11.4
Voluntary nursing	7	182	62	74.2	17.8
Private dual registered	6	286	74	83.5	7.7
Voluntary dual registered	2	110	93	84.7	6.8

Notes:
1 Age missing for 39 (0.5%) residents/patients.
2 Including 8 homes for younger people with a mental handicap or a mental illness. Resident information based on remaining 48 homes.

Table 2.
Previous Home Address and Source of Admission of Residents and Patients

Type of home	No. of individuals (min.[1])	Address within authority	Source of admission	
			Hospital	Owner occ. - alone
		%	%	%
Local auth. residential	1552	98	24	14
Private residential	1531	82	30	26
Voluntary residential	537	81	10	21
Private nursing	2517	79	52	11
Voluntary nursing	182	86	57	14
Private dual registered	283	79	46	17
Voluntary dual registered	109	25	0	24

Note:
1 The base numbers of individuals differ due to differences in response rates for the two questions. The smaller base number is shown for each type of home.

Table 3.
Length of Stay Distribution of Residents and Patients

Type of home	Under 1 year %	1-2 years %	2-3 years %	3-4 years %	4-5 years %	5 years and over %
Local auth. residential	31	18	14	10	7	20
Private residential	30	21	16	11	7	15
Voluntary residential	30	23	12	9	7	19
Private nursing	41	27	13	9	5	5
Voluntary nursing	45	32	10	7	2	4
Private dual registered	41	20	14	13	4	8
Voluntary dual registered	18	6	9	7	8	51

Notes:
1 Base numbers of individuals are shown in table 4.
2 Percentages are rounded to whole numbers and may not sum to 100 due to rounding.

Table 4.
Uncompleted and Completed Length of Stay of Residents and Patients

Type of home	Length of stay measure	No. of individuals	Mean no. of months	Standard error
Local auth. residential	Uncompleted	1726	37	1.0
	Completed	148	46	4.0
Private residential	Uncompleted	1534	31	0.7
	Completed	112	29	2.6
Voluntary residential	Uncompleted	544	36	1.8
	Completed	25	56	10.7
Private nursing	Uncompleted	2621	21	0.4
	Completed	221	17	1.1
Voluntary nursing	Uncompleted	182	21	1.9
	Completed	9	17	3.1
Private dual registered	Uncompleted	283	25	1.8
	Completed	37	26	3.7
Voluntary dual registered	Uncompleted	110	85	7.2
	Completed	1	114	-

Table 5.
Turnover of Long-Stay Residents and Patients in 1991 and Discharges in the Period 5 February to 5 May 1992 for Long-Stay Residents and Patients in the Home on 5 February 1992

Type of home	No. of homes (min.[1])	Turnover rates, 1991			Discharge rates, 5/2/92-5/5/92[2]	
		Admiss: places %	Disch: places %	Deaths: places %	Disch: places %	Deaths: places %
Local auth. residential	45	34	19	19	15	16
Private residential	89	36	11	17	10	19
Voluntary residential	20	44	18	15	9	10
Private nursing	75	61	10	26	8	28
Voluntary nursing	7	31	3	16	4	14
Private dual registered	6	45	13	24	8	39
Voluntary dual registered	1	7	<1	8	0	6

Notes:
1 The base numbers of homes differ due to differences in response rates for the two questions. The smaller base number is shown for each type of home.
2 Annualised.
3 The symbol `<1' is used to denote non-zero percentages of under one per cent.

Table 6.
Source of Finance by Previous Home Address of Residents and Patients (Independent Homes)

Type of home	Previous home address	No. of individuals[1]	Private means %	IS with topping up %	IS without topping up %
Private residential	All	1536	39	22	34
	Within auth.	1225	37	22	35
	Outside auth.	260	50	19	24
Voluntary residential	All	546	36	24	36
	Within auth.	441	35	25	36
	Outside auth.	104	39	19	35
Private nursing	All	2637	28	15	52
	Within auth.	1964	28	16	53
	Outside auth.	538	28	15	49
Voluntary nursing	All	182	32	25	40
	Within auth.	156	31	22	44
	Outside auth.	26	42	38	15
Private dual registered	All	284	41	15	42
	Within auth.	221	35	17	47
	Outside auth.	60	65	7	25
Voluntary dual registered	All[2]	110	43	0	3
	Within auth.[3]	27	26	0	0
	Outside auth.[4]	82	49	0	4

Notes:
1 The figures for all previous home addresses include residents/patients whose previous address was missing.
2 Source of finance not known for 60 (55%) residents/patients.
3 Source of finance not known for 20 (74%) residents/patients.
4 Source of finance not known for 39 (48%) residents/patients.

Table 7.
Source of Finance by Source of Admission of Residents and Patients (Independent Homes)

Type of home	Source of admission	No. of individuals[1]	Private means %	IS with topping up %	IS without topping up %
Private residential	All	1536	39	22	34
	Hospital	462	31	24	40
	Priv. housing	672	51	21	23
Voluntary residential	All	546	36	24	36
	Hospital	53	34	19	40
	Priv. housing	284	45	17	35
Private nursing	All	2637	28	15	52
	Hospital	1369	19	14	62
	Priv. housing	624	49	14	32
Voluntary nursing	All	182	32	25	40
	Hospital	103	13	26	58
	Priv. housing	52	62	19	15
Private dual registered	All	284	41	15	42
	Hospital	131	27	16	55
	Priv. housing	97	58	14	26
Voluntary dual registered	All[2]	110	43	0	3
	Hospital	0	-	-	-
	Priv. housing[2]	109	42	0	3

Notes:
1 The figures for all previous home addresses include residents/patients whose source of admission was missing.
2 Source of finance not known for 60 (55%) residents/patients.