Health Survey for England 2018
Social care for older adults

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This report examines the need for and receipt of social care among adults aged 65 and over in England in 2018. It compares social care needs and receipt by age, sex, household income, area deprivation, longstanding illnesses and health status.

Key findings

- 22% of men and 31% of women aged 65 and over needed help with at least one Activity of Daily Living (ADL) and 20% of men and 32% of women respectively needed help with at least one Instrumental Activity of Daily Living (IADL).
- 19% of men and 28% of women aged 65 and over had some unmet need for help with at least one ADL, and 12% and 15% respectively had unmet need for help with at least one IADL.
- Unmet need for ADLs in both men (32%) and women (48%) in the most deprived areas was at least double that of men (12%) and women (24%) in the least deprived areas. There was a similar pattern for IADLs.
- Over two thirds of adults (69%) with at least one severe health-related problem reported on the EQ-5D had unmet need with at least one ADL, compared with 19% with slight or moderate problems and 3% with no reported problems. There was a similar but less pronounced difference for IADLs.
- The majority (84%) of adults aged 65 and over who were receiving help with at least one ADL or IADL in the last month had not received a local authority assessment of care needs in the last 12 months.

Authors: Franziska Marcheselli and Katherine Ridout, NatCen Social Research

Responsible Statistician: Stephanie Gebert, Population Health

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This report may be of interest to members of the public, policy officials, people working in public health and to commissioners of health and care services to see the social care needs of older adults in England.

Introduction

Contents

The Health Survey for England (HSE) has included questions on social care for adults aged 65 and over every year since 2011. This report describes older adults' need for social care and to what extent care is provided, including analysis by age, sex, income, area deprivation and health status. The data are based on a representative sample of the adults aged 65 and over living in private households who participated in the Health Survey for England in 2018.

Background

Social care is the provision of help with personal care and domestic tasks to help enable individuals to live as independently as possible. Social care impacts the lives of almost everyone in England at some point, either personally or second-hand.[1] Individuals of all ages receive social care but those 65 years and older are the most likely to, due to longstanding physical or mental illness; disabilities and other age-related problems.[1] Over 1.9 million new requests to local authorities regarding social care support were made in 2018/19, a 3.8 % increase from 2017/18. These requests came from 1.3 million individuals; on average, 1.4 requests for care, per person.[2] Adults aged 65 years and over accounted for 71.2% (1,364,000) of all social care and support requests and 65% (548,435) of long-term support receipt in 2018/19.[2]

The current demand for social care services is expected to increase due to several factors. These include demographic factors such as the ageing population, increased life expectancy, changes in family structures, and migration between urban and rural areas, as well as changes in expectations.[3] Adults aged 65 and over are the fastest growing population group in the UK, and it is predicted that one in four people in the UK will be aged 65 years and over by 2038.[4] As age increases so does the likelihood of disability and experiencing multiple chronic and complex health conditions.[5] In particular, the increase in the numbers of adults living with dementia is expected to exert substantial pressure on care services.[1,6]

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[1] HM Government. *Caring for our future: reforming care and support*. Cm 8378, The Stationery Office, Norwich, 2012. https://www.gov.uk/government/publications/caring-for-our-future-reforming-care-and-support

[2] NHS Digital. *Adult social care activity and finance report: detailed analysis, England 2018-19.* https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2018-19

[3] Department of Health. *Independence, well-being and choice: our vision for the future of social care for adults in England*. Cm 6499. The Stationery Office, London, 2005.

[4] ONS. *Overview of the UK population: August 2019.* https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/august2019#the-uks-population-is-ageing

[5] *ONS. (2018) Living longer - Office for National Statistics.* https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/livinglongerhowourpopulationischangingandwhyitmatters/2018-08-13

[6] Department for Communities and Local Government. *Lifetime Neighbourhoods.* DCLG, London, 2008. https://www.gov.uk/government/publications/lifetime-neighbourhoods--2

Enabling people to remain independent in their own homes for as long as possible has been a central aspect of recent government policy. Emphasis has been put on personalisation of services and increases in preventative interventions.[1,5,7,8] A range of longstanding issues have been raised by policy makers in the provision of social care; identifying greater focus on reactive care, inconsistencies in levels and quality of services, a lack of good information and advice and a lack of coordination between services involved in social care.[1,5]

The NHS long-term plan published in early 2019 addresses a number of these concerns. It highlights objectives to have more action on prevention and developing a new service model; offering more options, and better support and connections over the next 10 years.[9] Social care services are integral to this.

The Care Act 2014 implemented several national strategies to improve care and support in the UK.[7,10] National eligibility criteria have been introduced to set a standard for local councils to follow; regarding payments, carers' rights to assessment and support, and access to information and advice on the care system for individuals paying for their own care.

At the forefront of the Care Act 2014 and the NHS long-term plan is the aim to provide help to improve people's independence and wellbeing.[8,9] The Care and Support (Eligibility Criteria) Regulations 2014 defined outcomes that adults should be able to achieve covering basic personal care, family and social relationships and access to community activities and services. [11]

Methods and definitions

Methods

The current module of social care questions was developed in 2009 and 2010 and first used in the HSE 2011. The aim of the module is to deliver robust data on the need for, receipt and provision of social care services, the characteristics of people providing and receiving unpaid care, and on people receiving formal care and support. More detailed information about the module can be found in the 2011 report.[12]

The module was intended to provide information on need for, receipt and provision of social care services among the population aged 65 years and over in private households; it does not cover those living in care institutions. It focuses on older

[7] Department of Health. *Modernising Social Services: Promoting Independence, Improving Protection, Raising Standards*. Cm 4169, The Stationery Office, London, 1998.
[8] The Care Act 2014. http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
[9] NHS. Long term plan, 2019. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf
[10] Department of Health. *Guidance: Care and support: what's changing?* DH, London, 2014.
[11] The Care and Support (Eligibility Criteria) Regulations 2014. http://www.legislation.gov.uk/ukdsi/2014/9780111124185
[12] Craig R, Mindell J (eds). *Health Survey for England 2011: Volume 1 Health, Social Care and Lifestyles*. Health and Social Care Information Centre, Leeds, 2012. http://digital.nhs.uk/catalogue/PUB09300

people, who constitute the largest group receiving care.[13] The full module is asked every other year, and a shorter version asked in the alternate years.

HSE 2018 included the full version of the social care questions. As with HSE 2016, the questionnaire included the revised questions on social care provision and payment that reflect changes in the Care Act 2014. A question was also included about whether older adults with care and support needs had received an assessment or review of their care needs in the last 12 months.

The full questionnaires can be found within the survey Documentation.[14]

Definitions

Measuring need for and receipt of social care: ADLs and IADLs

The need for and receipt of social care is measured using a number of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). ADLs are activities relating to personal care and mobility about the home that are basic to daily living. IADLs are activities which, while not fundamental to functioning, are important aspects of living independently. A total of thirteen ADLs and IADLs were used in the HSE and are shown in Table A; these were carefully selected to represent a full range of key activities[15].

Table A: Summary of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

ADLs	IADLs
Having a bath or shower	Doing routine housework or laundry
Using the toilet	Shopping for food
Getting up and down stairs	Getting out of the house
Getting around indoors	Doing paperwork or paying bills
Dressing or undressing	
Getting in and out of bed	
Washing face and hands	
Eating, including cutting up food	
Taking medicine	

[13] While social care may be needed by and provided for people of any age, the sample size for the HSE (and most general population surveys) does not deliver sufficient numbers of social care recipients in children and adults aged under 65 for robust analyses of the patterns of need and receipt of care among different groups.

[14] Available via the report website https://digital.nhs.uk/pubs/hse2018

[15] The ADLs and IADLs included in the social care module allow an approximation of the Barthel Index, a measure of ability to live independently at home for older people. For further details see Craig R, Mindell J (eds). Health Survey for England 2011; full reference in note 11

ADLs and IADLs and the Care Act 2014 eligibility criteria

The Care Act 2014 outlines the eligibility criteria for accessing adult care and support under The Care and Support (Eligibility Criteria) Regulations 2014.[16] Under these guidelines, a person is eligible for care if they cannot achieve two or more specified outcomes in their day-to-day life, and as a result experience significant impact on their well-being. This criterion differs to the HSE definition of need which defines adults aged 65 and over to be in need of care and support if they said there was at least one ADL or IADL that they could manage on their own with difficulty, could only do with help, or could not do at all.

Although the national eligibility criteria threshold appears to be higher, there are differences between the outcomes it uses and the ADLs and IADLs measured in the HSE. In some ways the outcomes in the eligibility criteria are broader and they do not distinguish between types of activity as the HSE does for ADLs and IADLs. An instrumental activity such as getting around in the community safely and being able to use facilities such as public transport, is one outcome alongside others focused on more personal activities, such as being able to dress and being appropriately dressed.

Table B compares the national eligibility criteria with the ADLs and IADLs where there is an obvious correspondence.

Table B: Comparison between national eligibility criteria, ADLs and IADLs

National eligibility criterion	ADL	IADL
Managing and maintaining nutrition.	Eating, including cutting up food.	Shopping for food.
Maintaining personal hygiene.	Having a bath or shower. Washing face and hands.	
Managing toilet needs.	Using the toilet.	
Being appropriately clothed.	Dressing and undressing.	
Being able to make use of [their] home safely.	Getting up and down stairs. Getting around indoors. Getting in or out of bed.	
Maintaining a habitable home environment.		Doing routine housework or laundry.
Making use of necessary facilities or services in the local community, including public transport and recreational facilities or services.		Getting out of the house.

[16] The Care and Support (Eligibility Criteria) Regulations 2014. https://www.legislation.gov.uk/ukdsi/2014/9780111124185

There are no direct equivalents among the eligibility criteria for the ADL 'taking medicine' or the IADL 'doing paperwork and paying bills'. Similarly, several of the national eligibility criteria – developing and maintaining family or other personal relationships; accessing and engaging in work, training, education or volunteering; and carrying out childcare responsibilities – have no equivalent ADLs or IADLs. Some of the ADLs and IADLs affect more than one criterion, for example being able to get in or out of bed, get up and down stairs and get around indoors all have an impact on most of those eligibility criteria concerned with daily home life, for example maintaining personal hygiene and managing toilet needs.

Although the two measures are not directly comparable, both sets of criteria identify adults with multiple needs for care and support, and there is likely to be some overlap between those needing help with two or more ADLs or IADLs and those qualifying under the national eligibility criteria.

Need for help and unmet need

For each ADL and IADL, participants aged 65 and over were asked whether they could:

- carry out the activity on their own,
- manage on their own with difficulty,
- only do the activity with help, or
- could not do it at all.

Where 'need' for help is discussed in the report, it refers to people in the last three categories.

If participants indicated that they needed help for any ADL or IADL, they were then asked whether they had received any help in the last month. For the IADLs relating to shopping, housework and paperwork, participants were asked to exclude help which was provided simply because of the way household responsibilities were divided.

Unmet need has been identified where participants indicated that they needed help with a particular ADL or IADL but had not received any help with it in the last month. Participants could thus be receiving help with one or more activity but also have unmet needs for other ADLs or IADLs.

Age standardisation

Adult data within this report have been age-standardised to allow comparisons between groups after adjusting for the effects of any differences in their age distributions. When different sub-groups are compared in respect of a variable on which age has an important influence, any differences in age distributions between these sub-groups are likely to affect the observed differences in the proportions of interest. For information about the method used, see Section 8.6 of the HSE 2018 Methods report.[17]

[17] Unlike other age-standardised estimates in other HSE 2018 reports, in this report the age categories used to standardise the data are: 65 to 69 years, 70 to 74 years, 75 to 79 years, 80 to 84 years, and 85 years and over.

About the survey estimates

The Health Survey for England, in common with other surveys, collects information from a sample of the population. The sample is designed to represent the whole population as accurately as possible within practical constraints, such as time and cost. Consequently, statistics based on the survey are estimates, rather than precise figures, and are subject to a margin of error, also known as 95% confidence interval. For example, the survey estimate might be 24% with a 95% confidence interval of 22% to 26%. A different sample might have given a different estimate, but we expect that the true value of the statistic in the population would be within the range given by the 95% confidence interval in 95 cases out of 100.

Where differences are commented on in this report they reflect the same degree of certainty that these differences are real, and not just within the margins of sampling error. These differences can be described as statistically significant.[18]

Confidence intervals are quoted for key statistics within this report and are also shown in more detail in the Excel tables accompanying this report. Confidence intervals are affected by the size of the sample on which the estimate is based, Generally, the larger the sample, the smaller the confidence interval, and hence the more precise the estimate.

Care needs of adults aged 65 and over

Ability to perform ADLs and IADLs in the last month, by sex

Adults aged 65 and over were asked how well they could carry out each of 13 Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Those who said that they were not able to carry out the activity on their own have been combined into one group to show adults aged 65 and over who had some level of difficulty in completing ADLs or IADLS, and consequently had some need for help.[19]

Where help was needed, participants were most likely to say that they could do the activities with difficulty but manage on their own. A much smaller proportion of adults aged 65 and over said that they could do these activities only with help, or not do them at all.

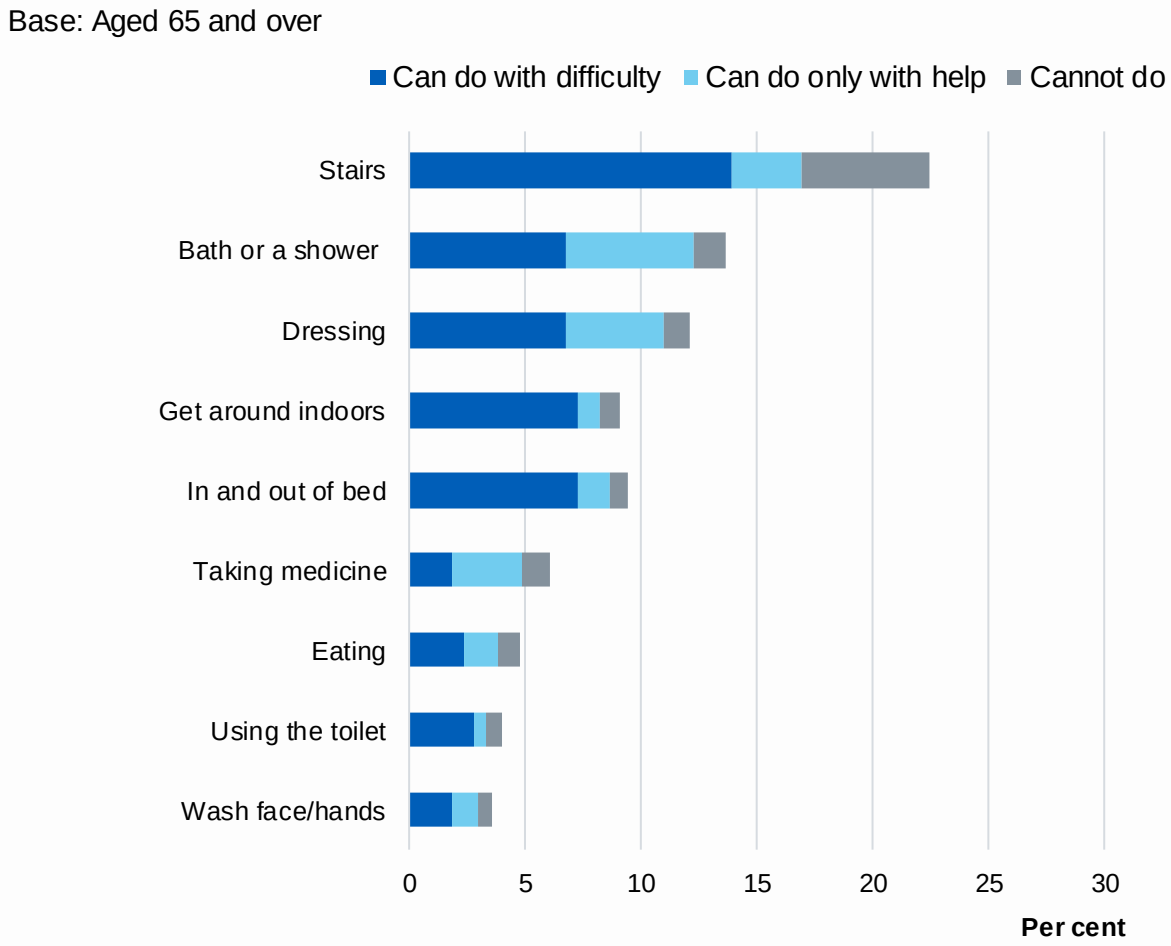
Adults aged 65 and over who needed some help with ADLs were most likely to need help with getting up and down the stairs (22%), having a bath or shower (14%) and dressing and undressing (12%). IADLs that participants were most likely to need help with were shopping for food and doing routine housework or laundry. One in five adults aged over 65 said they needed help with these two IADLs (21% and 20% respectively).

Figures 1 and 2, Table 1

[18] Statistical significance does not imply substantive importance; differences that are statistically significant are not necessarily meaningful or relevant.

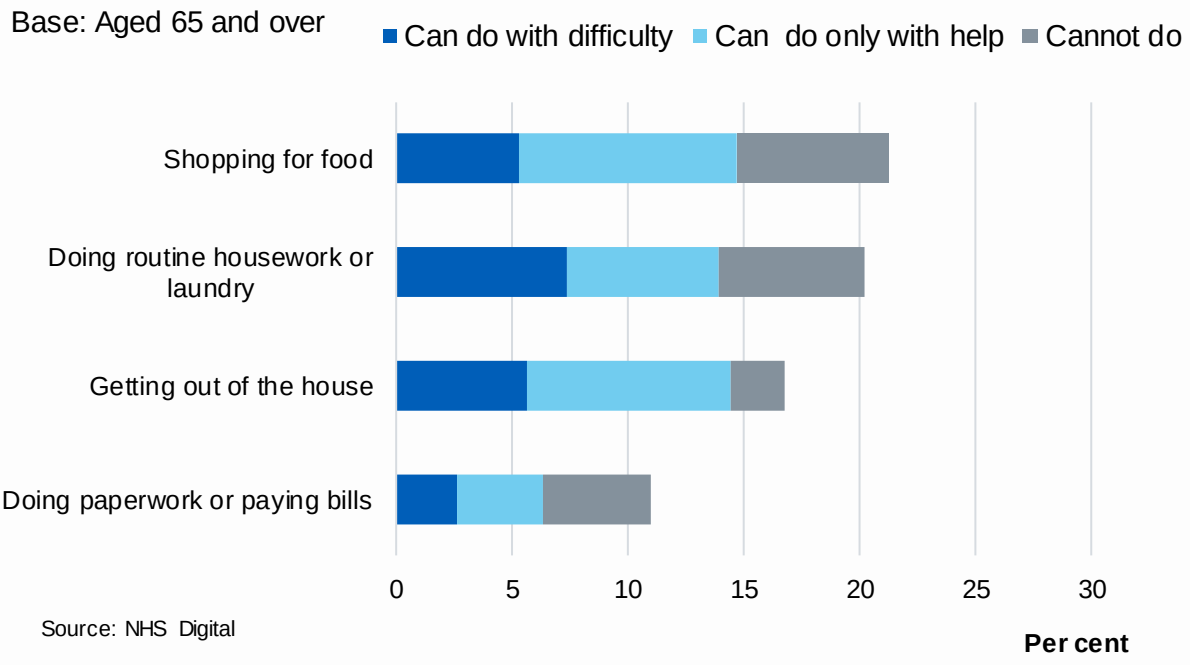
[19] For each activity, these comprised those who said they could manage on their own with difficulty, those who could only do the activity with help, and those who could not do the activity at all.

Figure 1: Ability to perform ADLs in the last month



Source: NHS Digital

Figure 2: Ability to perform IADLs in the last month



Source: NHS Digital

One in four adults aged 65 and over needed help with at least one ADL in the last month (27%). A similar proportion also needed help with at least one IADL (26%).

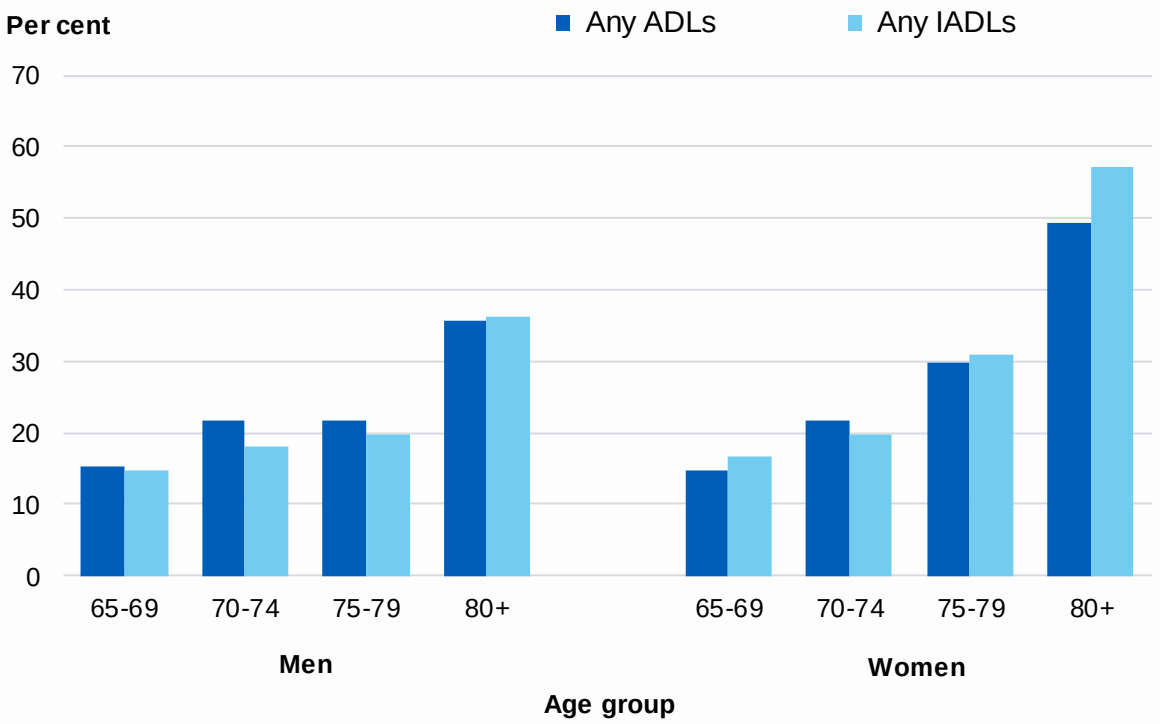
A higher proportion of women than men needed help in the last month; 31% of women needed help with at least one ADL compared with 22% of men, and 32% of women needed help with at least one IADL compared with 20% of men. This pattern was seen in all age groups.

The need for help with ADLs increased broadly in line with age from 19% of adults aged between 65 and 69 to 47% of those aged 80 and over, and there was a similar pattern for IADLs.

Figure 3, Table 3

Figure 3: Needed help with ADLs and IADLs in last month, by age and sex

Base: Aged 65 and over



Source: NHS Digital

Need for help with multiple ADLs and IADLs, by age and sex

Two thirds of adults aged 65 and over (68%) reported that they could perform all of the ADLs and IADLs on their own without help. This decreased from between 78% and 79% of adults aged under 75 to 44% of those aged 80 or over. Where help was needed, participants were likely to say that they needed help with two or more ADLs or IADLs in the last month. One in four adults (25%) reported that they needed help with two or more ADLS or IADLs.

A higher proportion of women than men needed help, and this was accounted for by the proportions who needed help with two or more ADLs or IADLs (30% of women and 19% of men). This pattern was seen in all age groups.

Need for help with two or more ADLs or IADLs increased with age. Among adults aged 65 to 69, less than one in five (17%) needed help with two or more ADLs or IADLs, and similar, though slightly lower, among adults aged between 70 and 74. Thereafter the proportion increased steeply with age to 27% of adults aged 75 to 80 and 43% of adults aged 80 and over. This age-related pattern was evident for both men and women. In the oldest age group, a third of men (31%) and more than half of women (53%) needed help with two or more ADLs or IADLs.

Table 2

Need for and receipt of help in the last month, by age and sex

One in four adults aged 65 and over needed help with at least one ADL in the last month (27%). A similar proportion also needed help with at least one IADL (26%).

One in ten adults had received help in the last month with at least one ADL (11%), and almost twice as many (20%) had received help in the last month with at least one IADL.

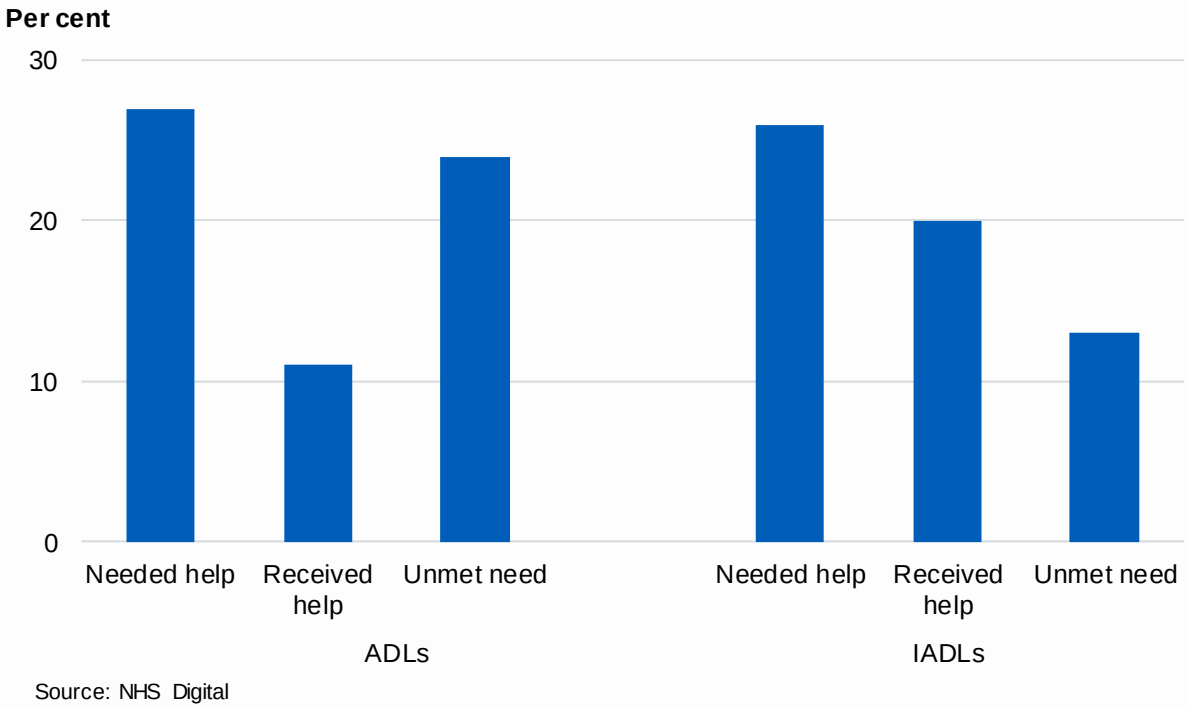
Adults who had some need of help with an ADL or IADL but who had not received help with that activity in the last month were categorised as having unmet need.[20] One in four adults had some unmet need for help with ADLs (24%); unmet need for help with IADLs was lower (13%). Unmet need for help with ADLs was higher among women than men (28% and 19% respectively), and the same was true for unmet need for help with IADLs (15% and 12%).

Unmet need for help increased with age. Among adults aged 65 to 69, less than one in five (17%) had some unmet need for help with ADLs, and this proportion was slightly lower (15%) among adults aged between 70 and 74. The proportion then increased steeply with age to 25% of adults aged 75 to 79 and 41% of adults aged 80 and over. This age-related pattern was evident for both men and women. Unmet need for help with IADLs was at lower levels but followed a similar pattern.

Figure 4, Table 3

Figure 4: Need for help, receipt of help and unmet need for help with ADLs and IADLs in the last month

Base: Aged 65 and over



Source: NHS Digital

[20] It was possible to have received help with some ADLs or IADLs and still have unmet need for help with others.

Trends in need and receipt of help and unmet needs

The need for help with ADLs and IADLs has declined since 2011, when 32% of adults aged 65 and over needed help with ADLs and 33% needed help with IADLs.

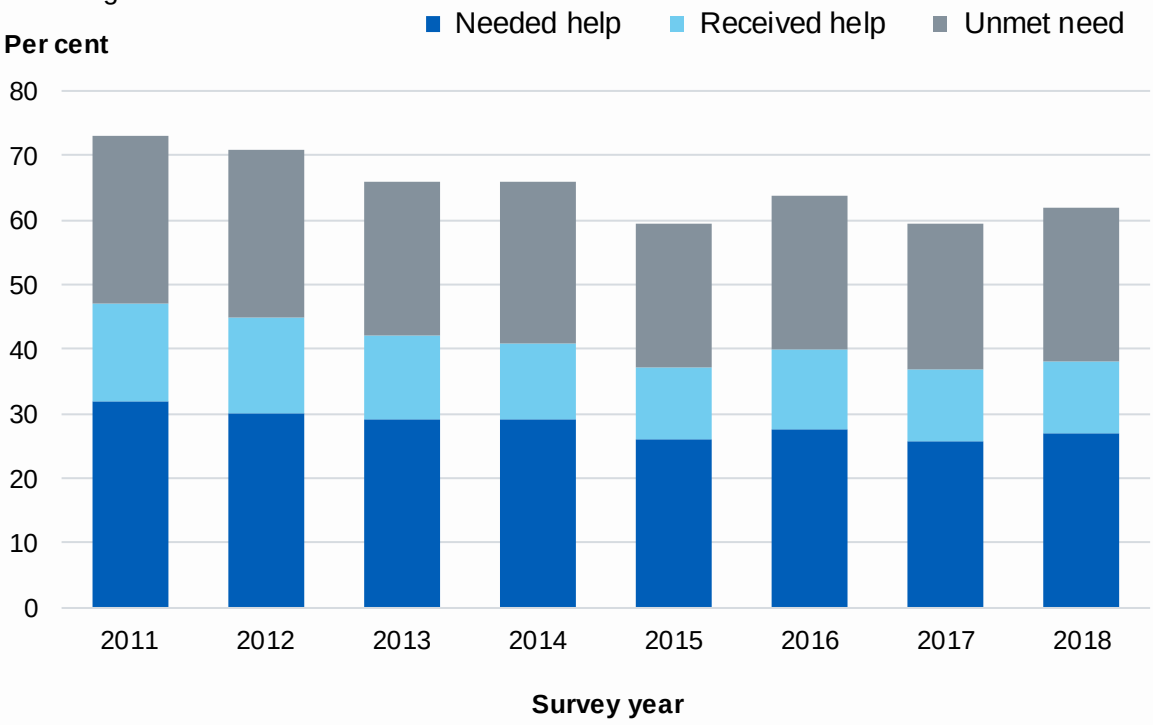
The proportion of adults aged 65 and over who have received help in the last month has also declined since 2011, from 15% of adults in 2011 receiving help for ADLs to 11% receiving help for ADLs in 2018. For IADLs this has decreased from 27% to 20% respectively.

The proportion of unmet need for help with ADLs and IADLs has remained relatively stable; 26% in 2011 compared with 24% in 2018 for unmet need with ADLs, and 15% compared with 13% over the same period for unmet need with IADLs.

Figures 5 and 6, Table 4

Figure 5: Need for help, receipt of help and unmet need for help with ADLs in the last month, 2011-2018

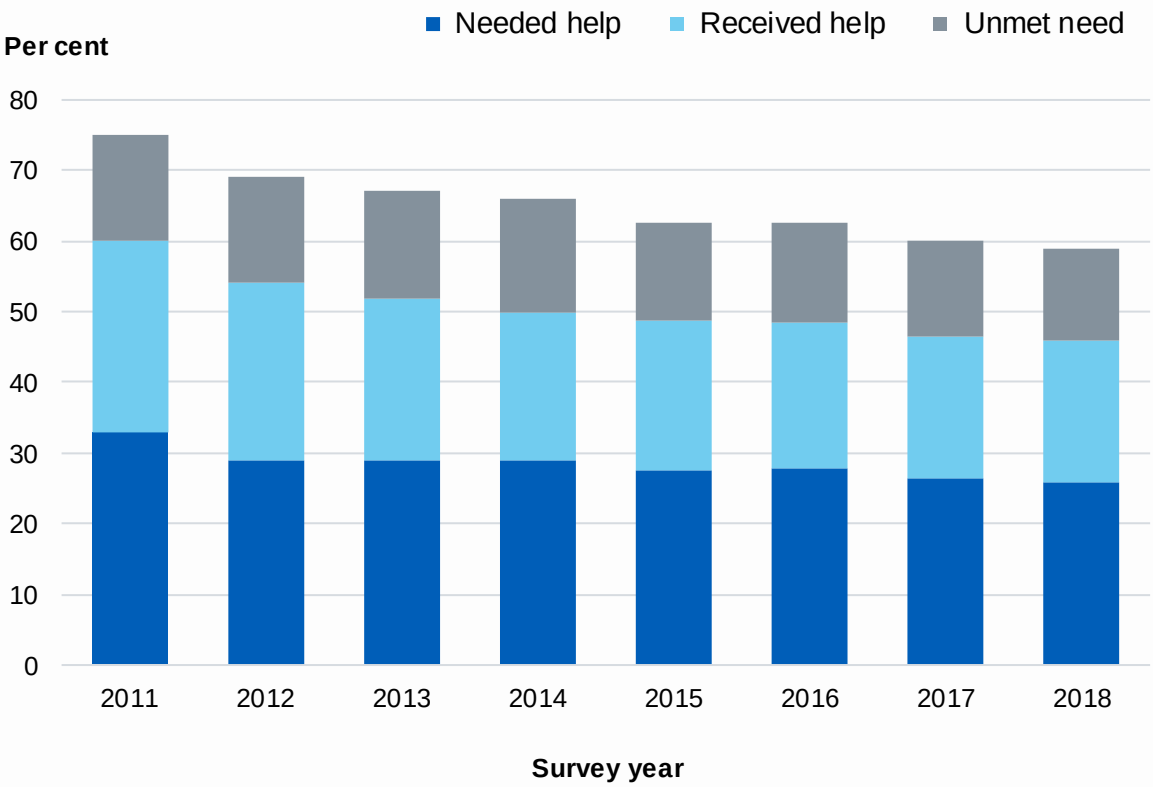
Base: Aged 65 and over



Source: NHS Digital

Figure 6: Need for help, receipt of help and unmet need for help with IADLs in the last month, 2011-2018

Base: Aged 65 and over



Source: NHS Digital

Need for and receipt of help in the last month, by equivalised household income and sex

The HSE uses the measure of equivalised household income, which takes into account the number of adults and dependent children in the household as well as overall household income. In this report, households are divided into tertiles (thirds) based on this measure.[21] The age profile of the income quintiles have been age-standardised to account for differences in age profiles between households.

For information about how equivalised income is calculated, see Chapter 8 and Appendix B: Glossary in the HSE 2018 Methods report.

[21] This grouping is based on the total sample. Because the distribution of income in households with one or more adults aged 65 or over differs from the general population, there are relatively few people in the highest tertile.

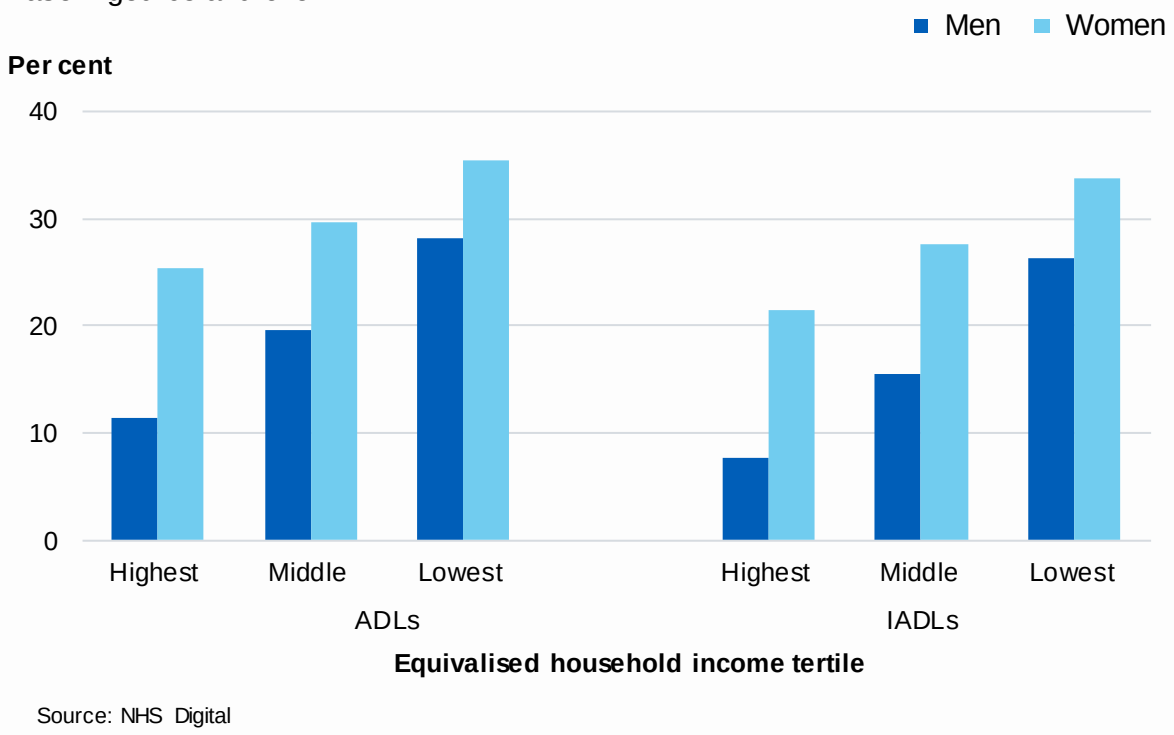
The proportion of adults aged 65 and over who needed help with at least one ADL or IADL varied by household income. Among all adults, 32% in the lowest household income group needed help with ADLs, compared with 18% in the highest household income group. Similarly, 30% in the lowest household income group needed help with IADLs, compared with 14% in the highest household income group.

Men in the lowest household income group were more than twice as likely as those in the highest income group to need help with ADLs and IADLs. 28% of men in the lowest income households needed help with ADLs and 26% needed help with IADLs, compared with 11% and 8% respectively in the highest income households. Among women, 35% in the lowest household income group needed help with at least one ADL, compared with 25% of women in the highest household income group, and the corresponding proportions needing help with at least one IADL were 34% and 21%.

Figure 7, Table 5

Figure 7: Need for help with ADLs and IADLs in the last month, by equivalised household income and sex

Base: Aged 65 and over



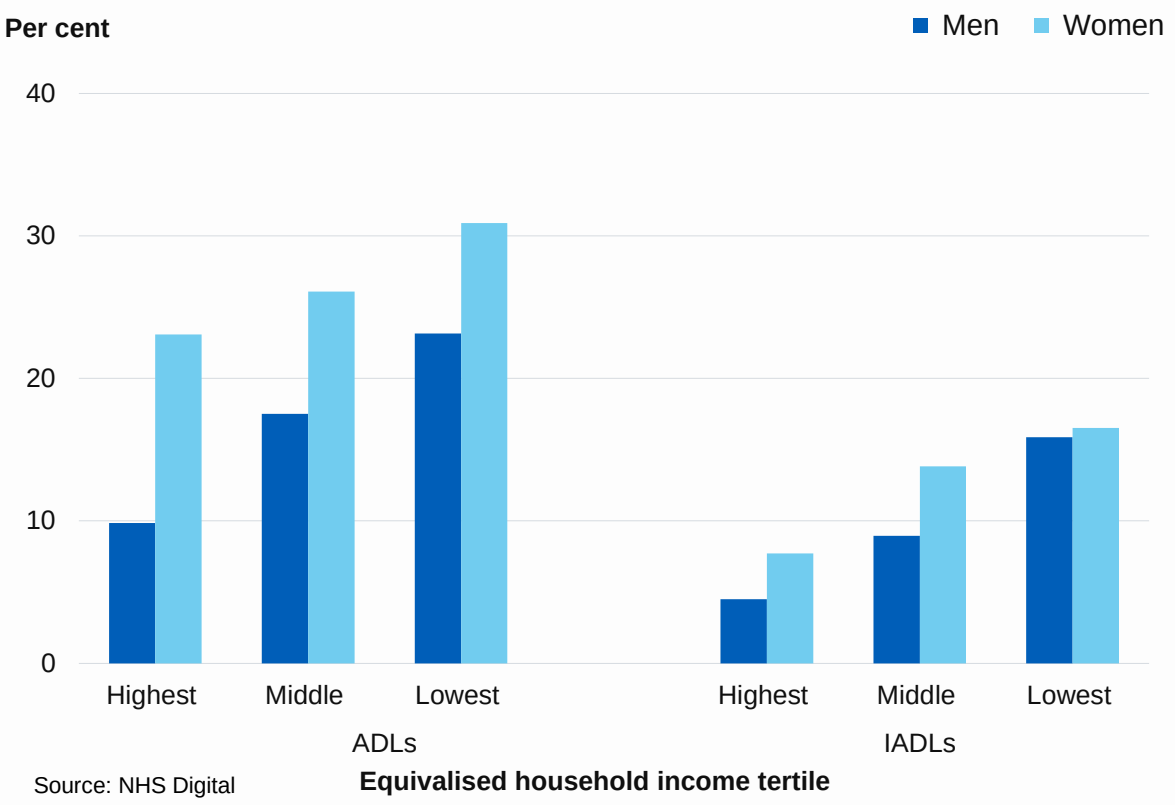
Source: NHS Digital

The proportion of men and women aged 65 and over receiving help with ADLs and/or IADLs also increased as household income decreased, as did the proportions with unmet need. For ADLs, 23% of men and 31% of women in the lowest household income groups had unmet need for help, compared with 10% of men and 23% of women in the highest household income group. Unmet need for help with IADLs was at lower levels but followed a similar pattern.

Figure 8, Table 4

Figure 8: Unmet need with ADLs and IADLs in the last month, by equivalised household income and sex

Base: Aged 65 and over



Source: NHS Digital

Need for and receipt of help in the last month, by Index of Multiple Deprivation (IMD) and sex

The English Index of Multiple Deprivation (IMD) is a measure of area deprivation, based on 37 indicators, across seven domains of deprivation.[22] IMD is a measure of the overall deprivation experienced by people living in a neighbourhood, although not everyone who lives in a deprived neighbourhood will be deprived themselves. To enable comparisons, areas are classified into quintiles (fifths). The age profile of the IMD quintiles have been age-standardised to account for different area age profiles.

[22] The seven domains used to calculate IMD are: income deprivation; employment deprivation; health deprivation and disability; education; skills and training deprivation; crime; barriers to housing and services; and living environment deprivation.

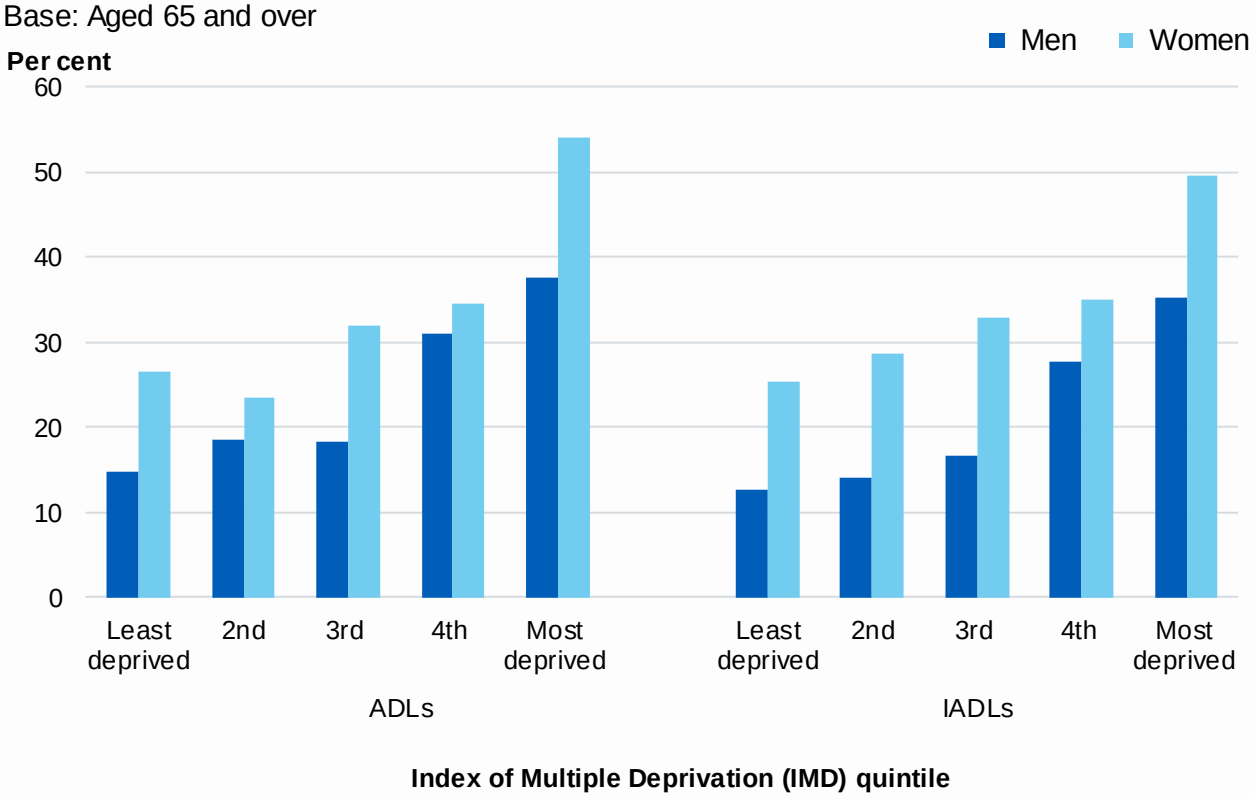
For further information about the IMD, see Chapter 8 and Appendix B: Glossary in the HSE 2018 Methods report.

Need for help varied by area deprivation among adults aged 65 and over. More than half of women needed help in the most deprived areas (54% with ADLs, 50% with IADLs) and more than a third of men in these areas also needed some help (38% with ADLs, 35% with IADLs). In the least deprived areas, 15% of men and 26% of women needed help with ADLs, with similar proportions needing help with IADLs. There was very little difference in the need for help among men in the three least deprived quintiles, or among women in the two least deprived quintiles.

Figure 9, Table 6

Figure 9: Need for help with ADLs and IADLs in the last month, by Index of Multiple Deprivation (IMD) and sex

Base: Aged 65 and over



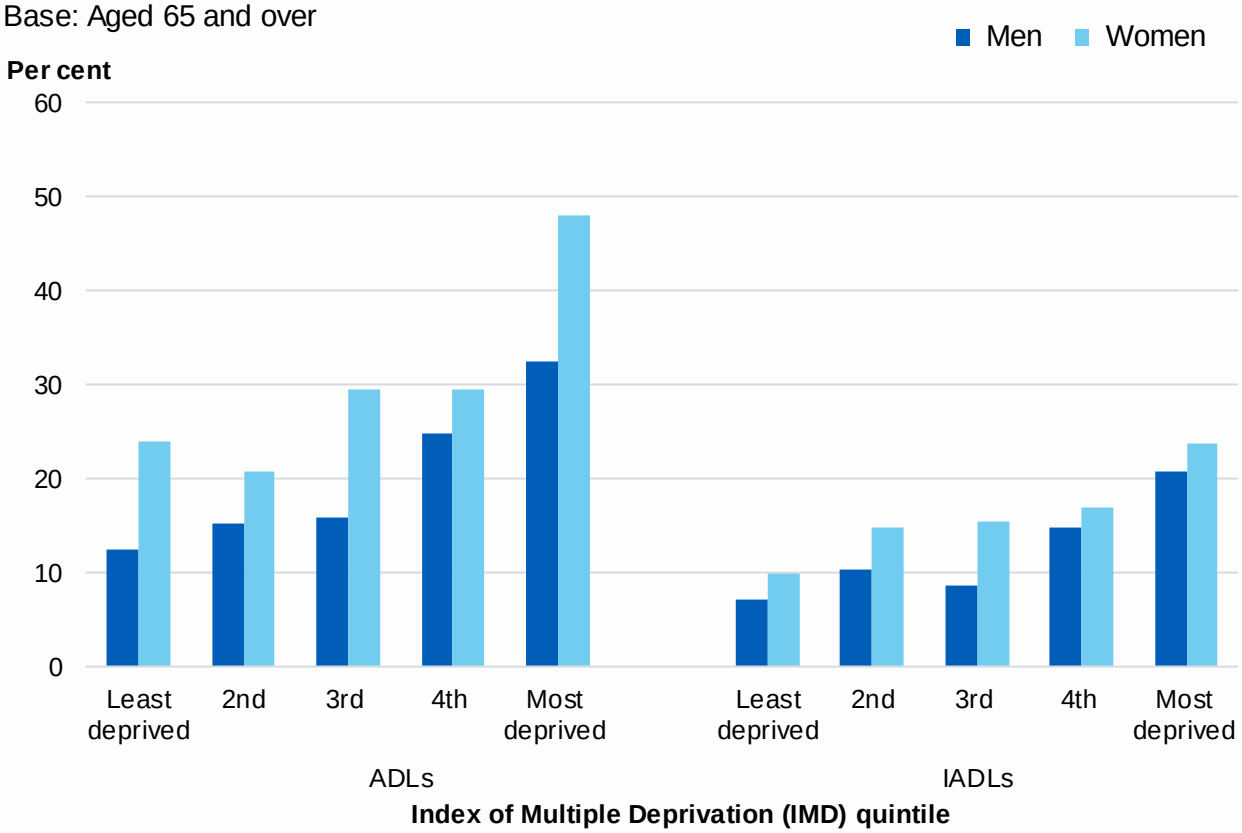
Source: NHS Digital

The proportions receiving help with ADLs and IADLs were also highest in the most deprived areas, lowest in the least deprived areas, as were the proportions with some unmet need for help. Unmet need for help with ADLs and IADLs for men was highest in the most deprived areas (32% and 21% respectively), less than half those levels in the least deprived areas (12% and 7%). The pattern for women was slightly more complex. Between a fifth and a quarter of women had some unmet need for help with ADLs within the two least deprived quintiles (24% in the least deprived, 21% in the second least deprived), compared with nearly half in the most deprived quintile (48%). The proportion of unmet need for help with IADLs varied from 10% of women in the least deprived areas to 24% in the most deprived.

Figure 10, Table 6

Figure 10: Unmet need with ADLs and IADLs in the last month, by Index of Multiple Deprivation (IMD) and sex

Base: Aged 65 and over



Source: NHS Digital

Need for and receipt of help in the last month, by limiting longstanding illness

Longstanding illness is defined as 'any physical or mental health condition or illness lasting or expected to last 12 months or more'. A longstanding illness is defined as limiting if the participant reports that it reduces their ability to carry out day-to-day activities. More than a quarter (26%) of adults aged 65 and over had a limiting longstanding illness; this proportion did not vary significantly across age groups.[23]

More than half of adults aged 65 and over who had a limiting longstanding illness needed help with at least one ADL (54%), compared with less than one in ten of those with no or non-limiting longstanding illness (8% and 9% respectively). The pattern was similar with help needed for IADLs.

A higher proportion (24%) of adults aged 65 years and over with a limiting longstanding illness received help with at least one ADL in the last month, compared with those with no limiting longstanding illness (2% of those with no longstanding illness, 1% of those with a non-limiting longstanding illness). Participants with a limiting longstanding illness were even more likely to receive help with IADLs; 42% with a limiting longstanding illness received help with IADLs compared with 4% who did not have a limiting longstanding illness.

Just under half the proportion of adults with limiting longstanding illness had some unmet need for help with ADLs (46%), and one in four adults aged 65 and over had some unmet need for help with IADLS (26%). Among those with no limiting longstanding illness, 8% had some unmet need for help with ADLs and 4% to 5% had unmet need with IADLs.

Table 7

Need for and receipt of help in the last month, by health status

Health status was assessed using the EQ-5D questionnaire, a standardised instrument that comes in two parts: a descriptive system and a visual analogue scale (VAS).[24]

The descriptive system consists of five dimensions: mobility, self-care, usual activities, pain or discomfort, and anxiety or depression. For each dimension, study participants are asked to rate their health state 'today' on a five-point scale ranging from no problem to extreme problems.

One in six (15%) of adults aged 65 and over reported at least one severe problem.

Among adults aged 65 and over, over three quarters (79%) of those who had at least one severe problem reported needing help with at least one ADL compared with 21% who had some problems that were not severe and 4% who had no problems. Help needed with IADLs followed a similar pattern.

[23] For further information on the prevalence and impact of longstanding illness, see the HSE 2018 report on Longstanding Conditions.

[24] EuroQol Group. *EQ-5D.* www.euroqol.org

Adults aged 65 years and over with at least one severe problem were more likely to have received help in the last month with ADLs (39%) and IADLs (66%) than those with non-severe problems (4% and 13% respectively) or no problems (1% and 2% respectively).

Over two thirds (69%) of adults with at least one severe problem had unmet need with at least one ADL, compared with 19% with non-severe problems and 3% with no problems. In addition, one third (34%) of adults with at least one severe problem had unmet needs with IADLs compared with 11% with non-severe problems, and 3% with no problems.

Table 8

Local authority assessment of care needs in last 12 months, by age

Among adults aged 65 and over who were receiving help with at least one ADL or IADL in the last month, the majority (84%) said they had not received a local authority assessment of their care needs within the last 12 months. This proportion was similar for adults aged between 65 and 79 and for those aged 80 and over (83% and 85% respectively).

Table 9

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0300 303 5678

enquiries@nhsdigital.nhs.uk

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