

# Planning4care summary report for Demoshire

## Strategic needs assessment of long-term social care for older people

June 2010

Planning4care data version 2.0

planning4care

Care Equation and Oxford Consultants for Social Inclusion (OCSI)



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### *About Planning4care Release 2.0*

This report is based on Release 2.0 of the Planning4care data, released in March 2010. See Appendices A to E for details of the model.

- *Release 2.0, March 2010:* This release includes a representation of current service provision (including division between needs groups) based on the most recent NASCIS data and an enhanced range of future planning scenarios.
- *Release 1.4, August 2009:* Updated KIGS data.
- *Release 1.3, November 2008:* Included revised national population projections (based on the most recent sub-national population projections); incorporation of other projections including GLA London projections; new KIGS data (from the 2006/7 returns); and revised dementia estimates (from Dementia UK 2007).
- *Release 1.2, May 2008:* Included revised data from KIGS to update the publicly-funded costs and take-up rates used in the Planning4care model.
- *Release 1.1, March 2008:* Included a revision to how LA-funded clients are distributed between the "high" and "moderate" needs groups, to more closely reflect the national shift towards focusing publicly funded care on the higher needs groups.
- *Release 1.0, October 2007.*

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## 2 Introduction

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### Background

This report provides our analysis of the likely social care needs and service requirements for older people across Demoshire over the next 20 years. The report summarises the current demographic profile and projected changes across the area, current and projected levels of social care needs for older people, and likely future service requirements for supporting older people with social care needs.

### About the Planning4care tool

Planning4care provides information and analysis on future needs and service requirements to support effective commissioning and service development. The tool is based on a predictive needs model, linked to projected demographic trends and risk factors, to estimate projected levels of care need at local level, and service requirements and service costs under a range of different planning scenarios.

The Planning4care model incorporates local socio-economic risk factors, so goes beyond simply applying national prevalence data to local populations. As a result, the Planning4care data provides more robust local estimates of the numbers of older people with particular levels of social care need; it is also linked to predicted levels of service requirements and likely costs.

Planning4care provides key data input to the development of the Joint Strategic Needs Assessment (JSNA). The purpose of the JSNA is to enable local services to plan ahead for the next 10 to 15 years and to support the development of the wider health and social care market – including those who have the ability to pay for social care themselves. Guidance on core data sets for JSNA was published in 2009; some of this data is now available on the National Adult Social Care Intelligence Service (NASCIS).

Piloting of Planning4care was supported by funding from the DH Care Services Improvement Partnership (CSIP), and Planning4care is now used by 20 upper-tier Local Authorities to support older people commissioning teams.

For further information on the Planning4care tool, see Appendices A to E.

### Future scenarios

Predicting the future is an inherently risky business, and should not be based on a single view of what is likely to happen. In this project, we have assessed a number of different scenarios and their impact on likely future need for residential care<sup>1</sup> across Demoshire (see Appendix C for further details):

- Population projection scenarios
- Increases in Healthy Life Expectancy
- Impact of low-level preventative care
- Trends in patterns of service provision.

### *What this report contains*

This report contains the following sections:

- Demographic profile and projections for older people in Demoshire (Section 4)
- Current and projected levels of social care need for older people in Demoshire (Section 5)
- Likely future service requirements for supporting older people with social care needs (Section 6)
- Planning4care methodology: definitions and assumptions (Appendix A)
- Needs groups used in Planning4care (Appendix B)
- Planning4care future scenarios (Appendix C)
- Data Sources (Appendix D)
- How to use Planning4care to improve commissioning (Appendix E).

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<sup>1</sup> Residential care refers throughout to personal or nursing care in a registered care home.

## 3 Overview of Demoshire older people social care needs, service costs and requirements

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### Introduction

This section presents a brief overview of Demoshire older people's social care needs, service costs and requirements. We have pulled out the key messages from the information presented in this report (Sections 4 to 6).

### Demographic profile and projections for older people in Demoshire (Section 4)

#### *Current position*

The most recent estimates show the 2010 65+ population of Demoshire as 107,300 with 14,400 aged 85+. Compared with England, the profile of the 65+ population in Demoshire is very similar, with comparable proportions of older people aged 85+ (around 13%), 75-84 (around 33%) and 65-74 (around 53%).

#### *Demographic projections*

The size of the 65+ population is projected to grow significantly in Demoshire over the next 20 years - an 18% increase in all 65+ groups to 2015 (18% also for 85+) and a 57% increase in 65+ to 2030 (127% for 85+). This projected increase is likely to drive increased demand for social care in the county. This is particularly the case as the fastest increases are seen in the oldest age-groups, those most likely to need social care

Compared with other Local Authorities across the Demo Region, Demoshire shows one of the highest levels of projected increase in the older population.

#### *Impact of varying migration and life expectancy levels on the projected numbers of older people in Demoshire*

The population projection scenario used for the ONS sub-national population projections is based on a set of assumptions on how levels of in- and out-migration, life expectancy, and fertility will vary in future. Varying these assumptions through additional scenarios gives a range in projected increases

of the older population in Demoshire, of 51% to 62% by 2030 for the numbers of people aged 65+, and from 110% to 145% by 2030 for the numbers aged 85+.

### Current and projected levels of social care need for older people in Demoshire (Section 5)

#### *Social care needs classification*

The social care needs classification set out in the Wanless Social Care review<sup>2</sup> takes a five point scale from 'no care needs' to 'very high care needs'.

We have used this classification for Planning4care estimates of social care need, based on local populations (by age, gender and receipt of attendance allowance) and additional 'risk' factors (including measures of local income and deprivation levels) to estimate the level of social care need in Demoshire and to project how levels of social care need may change in the future based on alternative scenarios.

#### *Current numbers of older people with social care needs in Demoshire*

Of the total population aged 65+ in Demoshire (2010), 34,500 (32%) are estimated to have some level of social care needs; of these 23,420 are estimated to have 'moderate' to 'very high' needs, and 8,420 (8%) to have 'very high' needs. 28,420 are potentially in need of formal care, whilst 6,060 are estimated to be well supported by informal care.

4,360 of those with moderate to very high need receive care funded by the Local Authority<sup>3</sup> (2,700 of these are estimated to have 'very high' needs).

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<sup>2</sup> Wanless D (2006), *Securing Good Care for Older people – Taking a Long-Term View*, Kings Fund.

<sup>3</sup> Publicly-funded levels based on NASCIS 2008/09 data. Calculated as the sum of those supported in residential and nursing home care, plus those receiving home care.

15,720 of those with moderate to very high need are estimated to be either unsupported or funding their own care (including 4,930 with 'very high' needs).

Of the total 'very high needs group', 3,190 are estimated to have severe functional disability resulting from a high level of cognitive impairment (primarily dementia).

The proportion of older people across Demoshire estimated to have some level of social care need (32%) is below the regional average (37%). By district, this ranges from 28% in District B to 39% in District C.

### *Projections of social care need*

Based on Planning4care estimates and ONS published data on projected increases in the numbers of people aged 65+, the number aged 65+ with some level of social care need in Demoshire is projected to rise by 68% over the next 20 years (above both the regional rise of 50% and the national rise of 54%). The number of people in Demoshire with very high social care needs is expected to rise by 71% over the same period.

### *The impact of changes to healthy life expectancy and preventative initiatives on future social care needs in Demoshire*

The potential impact of improvements in Healthy Life Expectancy and effective preventative care interventions on projected numbers with social care need is significant:

- The optimistic '2-in-10' scenario<sup>4</sup> results in 1,960 fewer people having any form of social care need by 2015 (500 fewer with very high social care need) compared to the 'base' projection, and 9,250 fewer people by 2030 (2,060 fewer with very high social care need)
- The 'Preventative care 10%' scenario results in no change to numbers with any level of social care need, but a decrease of 1,000 people with very high needs by 2015 compared to the base projection, and 1,240 by 2030.

## **Likely future service requirements and costs for supporting older people with social care needs in Demoshire (Section 6)**

### *Projected service requirements*

Section 6 gives estimates of likely service requirements and costs – both for publicly funded services provided or commissioned by the council, and for whole population requirements. These are based on the estimates in the previous section of the projected numbers of people in Demoshire with different levels of social care needs, together with information on current patterns of service delivery.

It is estimated that Demoshire is currently commissioning 29% of the estimated total (65+) population requirement for home care and day care provision, and funding 36% of the total estimated requirement for residential placements.

Assuming continuation of current patterns of care, the number of LA-commissioned home care hours would expect to increase from 24,100 to 41,300 per week between 2010 and 2030, day care placements from 830 to 1,420, and supported residential placements from 1,840 to 3,150.

The total population requirement for home care would increase from 84,300 to 144,400 hours per week, day care placements from 2,840 to 4,870 and residential placements from 5,050 to 8,650.

In line with the demographic projections, all of these represent a projected increase of 71%, compared to 50% at regional level and 54% nationally.

### *Projected costs*

Costs (derived from the application of local unit costs) would similarly mirror a projected zero-inflation increase of 71%.

### *Impact of alternative population projections, changes to healthy life expectancy, preventative initiatives and alternative service patterns*

The application of alternative scenarios can have a significant effect on these projections. The optimistic '2-in-10' Healthy Life Expectancy scenario reduces the projected increase to 46%, while the 'higher population' projection increases it to 79%. The 'preventative care 10%' scenario predicts an 8%

<sup>4</sup> See Appendix C for explanation of scenarios

reduction in overall costs. A shift from residential to community-based care indicates some reduction in cost but relatively little, given the likely high

intensity of community care required for people in this group.

## 4 Demographic profile and projections for older people in Demoshire

### Introduction

In this section we describe the demographic profile of older people in Demoshire, and look at how the population of older people is likely to change, based on government population projections. We also explore how the numbers of older people in Demoshire would vary under alternative scenarios of migration levels, changes in life expectancy, and varying levels of fertility.

### Demographic profile and projections for older people in Demoshire

#### *Older people in Demoshire*

The most recent estimates show the 65+ population of Demoshire as 107,300 with 14,400 aged 85+<sup>5</sup>. Table 1 highlights how this group breaks down by age and gender.

Recent trends have seen the 65+ population in Demoshire increase from 89,800 to 107,300 (19%) over the period 2001 - 2010, a faster increase than across the region (11.1%) and England (9.4%)<sup>6</sup>.

Table 1 Demographic profile for older people in Demoshire

Group	Number in Demoshire (2010)	% of total 65+ population (2010)		
		Demoshire	Demo Region	England
All people 65+	107,300	100.0	100.0	100.0
Women 65+	58,900	54.8	55.6	55.7
Men 65+	48,400	45.1	44.3	44.2
People aged 65-74	57,800	53.8	53.2	52.2
People aged 75-84	35,100	32.7	33.6	33.9
People aged 85+	14,400	13.4	13.1	13.7

#### *Comparison with regional and national projections*

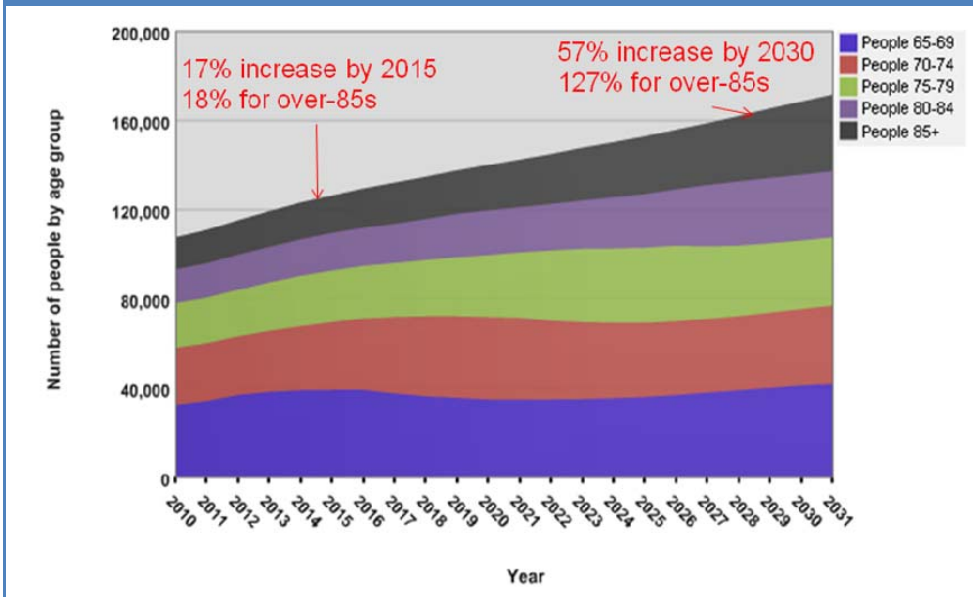
The size of the 65+ population in England is projected to grow significantly over the next 20 years, driven mainly by increases in life expectancy. This projected increase is likely to drive increased demand for social care in the county. This is particularly the case as the fastest increases are likely to be seen in the oldest age-groups, those most likely to need social care.

Figure 1a (over-page) highlights the projected increases in the 65+ population across Demoshire. This shows a 17% increase in the number of people aged 65+, and an 18% increase in the number aged 85+, to 2015. The increases to 2030 are projected to be 57% and 127% respectively.

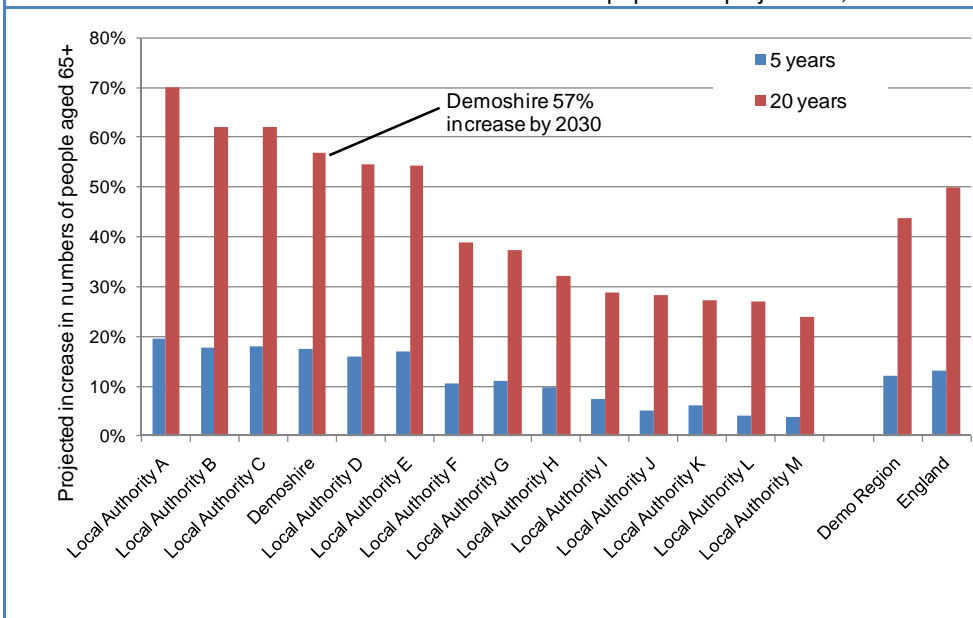
<sup>5</sup> ONS (2008) Sub-national population projections for 2009 to 2031.

<sup>6</sup> ONS (2008) Mid-Year Estimates 2001 to 2008 and ONS (2008) Sub-national population projections for 2009 to 2031.

Figure 1. Projected increase in 65+ population (a) increase for Demoshire; (b) 5 and 20-year increases for Demoshire and comparator areas



Source: ONS Sub-national population projections, 2006-2031



Source: ONS Sub-national population projections, 2006-2031

Compared with other Local Authorities across the Demo Region, Demoshire shows the fourth highest projected increase in the older population over the next 20 years (see Figure 1b).

Table 2 identifies the projected increases by age group, showing the faster increases over the 20-year period for the 75-84 and 85+ groups.

Table 2 Demographic profile for older people in Demoshire, based on ONS sub-national population projections

	2010		2015		2030	
	N		N	% increase from 2010	N	% increase from 2010
All people 65+	107,300		126,200	17%	168,300	57%
Women 65+	58,900		67,900	15%	90,100	53%
Men 65+	48,400		58,300	20%	78,200	62%
People aged 65-74	57,800		69,300	20%	75,200	30%
People aged 75-84	35,100		39,900	14%	60,300	72%
People aged 85+	14,400		17,000	18%	32,800	127%

The 20-year projected increase in Demoshire for the 65+ group (57%) compares to increases of 43% for the region and 50% for England.

Table 3 shows the projected increases for Demoshire and the Districts. At District level, District C shows the highest projected increases in the older population, with the population aged 65+ projected to increase by 70% between 2009 and 2030. By contrast, the population aged 65+ in District D is projected to increase more slowly, by 47% over the same period to 2030.

Table 3 Population projections for older people in Demoshire Districts, based on ONS sub-national population projections

All people 65+	2010	2015		2030	
	N	N	% increase from 2010	N	% inc from 2010
Demoshire	107,300	126,200	18%	168,300	57%
District A	18,400	21,200	15%	28,300	54%
District B	17,700	20,400	15%	26,900	52%
District C	11,800	14,500	23%	20,100	70%
District D	14,400	16,200	13%	21,100	47%
District E	24,800	29,400	19%	39,800	60%
District F	20,500	24,800	21%	32,000	56%
Demo Region	936,200	1,049,800	12%	1,346,000	44%
England	8,584,300	9,714,500	23%	12,879,600	50%

- The 'Lower' scenario (based on low levels of inward migration, small increases in life expectancy and low levels of fertility) projects a 51% increase in the 65+ population by 2030 (110% for the 85+ group).

## Key messages from this section

### *Current position*

The most recent estimates show the 2010 65+ population of Demoshire as 107,300 with 14,400 aged 85+. Compared with England, the profile of the 65+ population in Demoshire is very similar, with comparable proportions of older people aged 85+ (around 13%), 75-84 (around 33%) and 65-74 (around 53%).

### *Demographic projections*

The size of the 65+ population is projected to grow significantly in Demoshire over the next 20 years - an 18% increase in all 65+ groups to 2015 (18% also for 85+) and a 57% increase in 65+ to 2030 (127% for 85+). This projected increase is likely to drive increased demand for social care in the county. This is particularly the case as the fastest increases are seen in the oldest age-groups, those most likely to need social care

Compared with other Local Authorities across the Demo Region, Demoshire shows one of the highest levels of projected increase in the older population.

### *Impact of varying migration and life expectancy levels on the projected numbers of older people in Demoshire*

The population projection scenario used for the ONS sub-national population projections is based on a set of assumptions on how levels of in- and out-migration, life expectancy, and fertility will vary in future. Varying these assumptions through additional scenarios gives a range in projected increases of the older population in Demoshire, of 51% to 62% by 2030 for the numbers of people aged 65+, and from 110% to 145% by 2030 for the numbers aged 85+.

## Impact of varying migration and life expectancy levels on the projected numbers of older people in Demoshire

The population projection scenario used for the ONS sub-national population projections is based on a set of assumptions on how levels of in- and out-migration, life expectancy, and fertility will vary in future<sup>7</sup>.

As outlined in Appendix C, the Planning4care 'population projections' scenarios assess the impact of additional Government Actuary Department scenarios on the projected numbers of older people in Demoshire as follows:

- The standard 'Principal' scenario projects a 57% increase in the 65+ population by 2030 (128% for the 85+ group)
- The 'Higher' scenario (based on high levels of inward migration, large increases in life expectancy and high levels of fertility) projects a 62% increase in the 65+ population by 2030 (145% for the 85+ group);

<sup>7</sup> Government Actuary's Department (2008), *2006-based Population projections*. From [www.gad.gov.uk/Demography%20Data/](http://www.gad.gov.uk/Demography%20Data/)

## 5 Current and projected levels of social care need for older people in Demoshire

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### Introduction

In this section we identify the current and projected levels of social care need for older people in Demoshire, based on the Planning4care analysis and government population projections. We also explore how future levels of social care need in Demoshire would vary under the alternative scenarios of: changes to life expectancy and migration, changes to Healthy Life Expectancy, and the impact of effective preventative care initiatives.

### Classification of social care needs

The Wanless Social Care review<sup>8</sup> set out a classification for older people's levels of social care need, along with estimates of the size of these groups at national level:

- *No care needs*: People able to perform personal care and domestic care tasks without difficulty or need for help;
- *Low need*: People able to manage personal care tasks, but who have difficulty in performing domestic care tasks and/or have difficulty with bathing;
- *Moderate need*: People who have difficulty with one or more other personal care tasks;
- *High need*: People who are unable to perform one personal care task without help;
- *Very high need*: People who are unable to perform two or more personal care tasks without help.
- *Very high need, Physical*: people for whom need for support is due primarily to physical impairment
- *Very high need, Cognitive*: People for whom need for support is due primarily (or equally) to cognitive impairment.

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<sup>8</sup> Wanless D (2006), *Securing Good Care for Older people – Taking a Long-Term View*, Kings Fund.

See Appendix B for details of the personal care and domestic care tasks used in the needs classification.

At local level, Planning4care<sup>9</sup> uses this same needs classification, and provides locally sensitive estimates of social care need at small area level, based on local populations (by age, gender and receipt of attendance allowance) and additional 'risk' factors (including measures of local income and deprivation levels).

We have used this data to estimate the level of social care need in Demoshire and to project how levels of social care need may change in the future based on the different projections of how older groups are increasing over time. In the following sections we link this level of need to typical social care packages to estimate likely service requirements (both total and publicly funded) and cost implications.

### Older people with social care needs in Demoshire – current estimates

#### *Estimates of numbers aged 65+ with different levels of social care need*

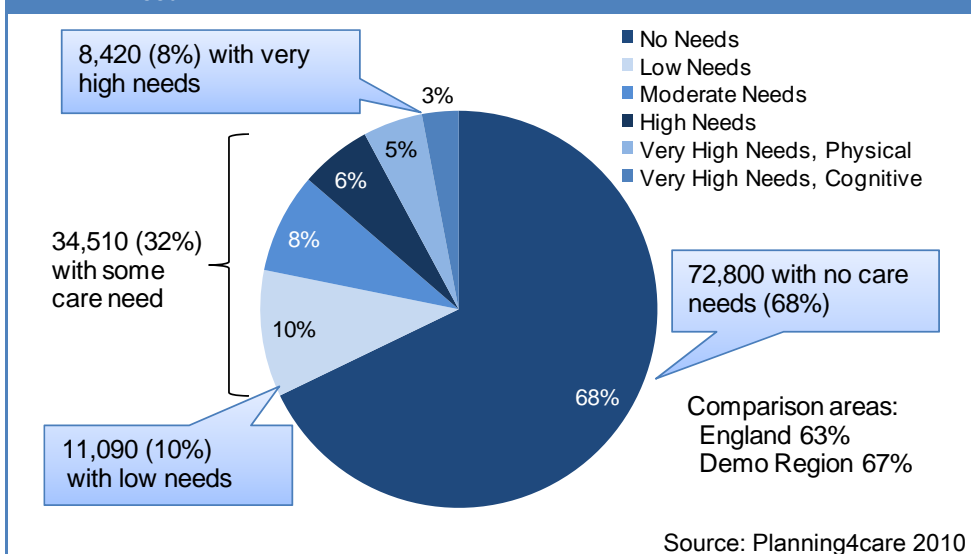
Of the total number of people in Demoshire aged 65+, 34,500 (32%) are estimated to have some level of social care need, with 23,400 having 'moderate' to 'very high' needs, and 8,400 (8%) having 'very high' needs<sup>10</sup>, as shown in Figure 2.

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<sup>9</sup> For more details see Appendices A, B

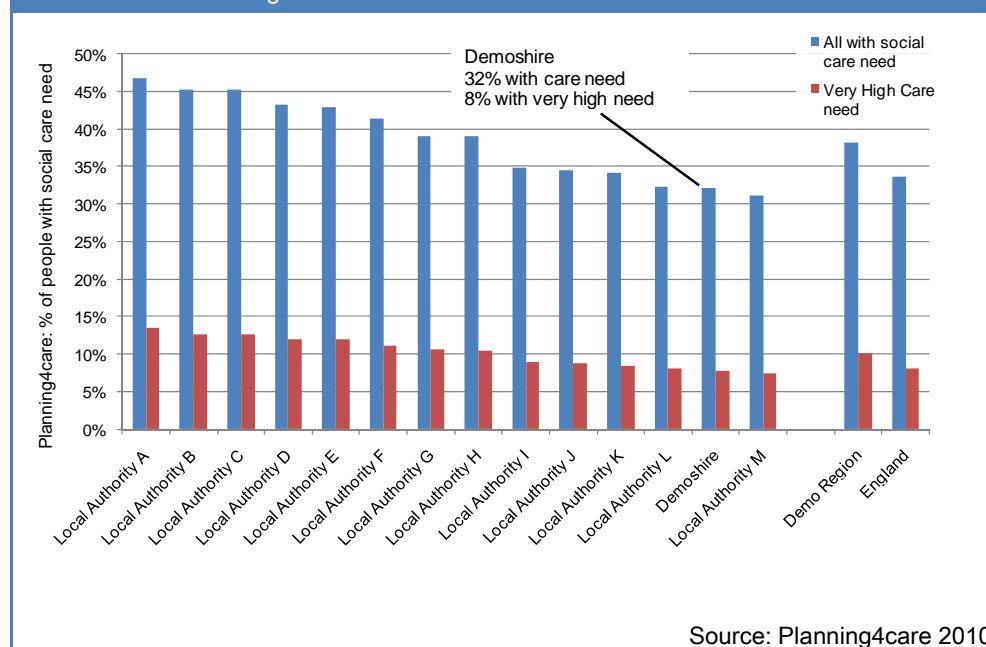
<sup>10</sup> The population denominator for the social care needs groups is not identical to ONS Mid Year Estimates, due to the way we have counted those in residential care. Not all those in residential care will be originally from the local area, and people may be in residential care located outside the LA which is paying for that care.

Figure 2. Planning4care estimates of proportion of people in Demshire with social care need



Social care need increases significantly with age. Table 4 shows that of those aged 65+ across the County, only 13% are aged 85+ but this age-group accounts for 23% of all people with moderate levels and above of social care needs in Demshire.

Figure 3. Percentage of people 65+ with social care needs, Demshire compared to other LAs in the region



Of the total 'very high needs group', 3,200 are estimated to have severe functional disability resulting from a high level of cognitive impairment (primarily dementia).

### Social care need by age

Table 4 Estimated levels of social care need by age

Age-group	All people aged 65+ in Demshire (2010)		People aged 65+ with moderate or above levels of social care need	
	N	% of people aged 65+	N	% of people aged 65+ with needs at moderate level and above
People aged 65+	107,300	100%	34,510	100%
People aged 65-74	57,800	54%	12,450	36%
People aged 75-84	35,100	33%	14,050	41%
People aged 85+	14,400	13%	8,000	23%

Figure 3 above shows the level of social care need in Demshire, compared to other LAs across the region. The proportion of older people across the county with any level of social care need (32%) is below the regional average (37%).

## Distribution across Districts

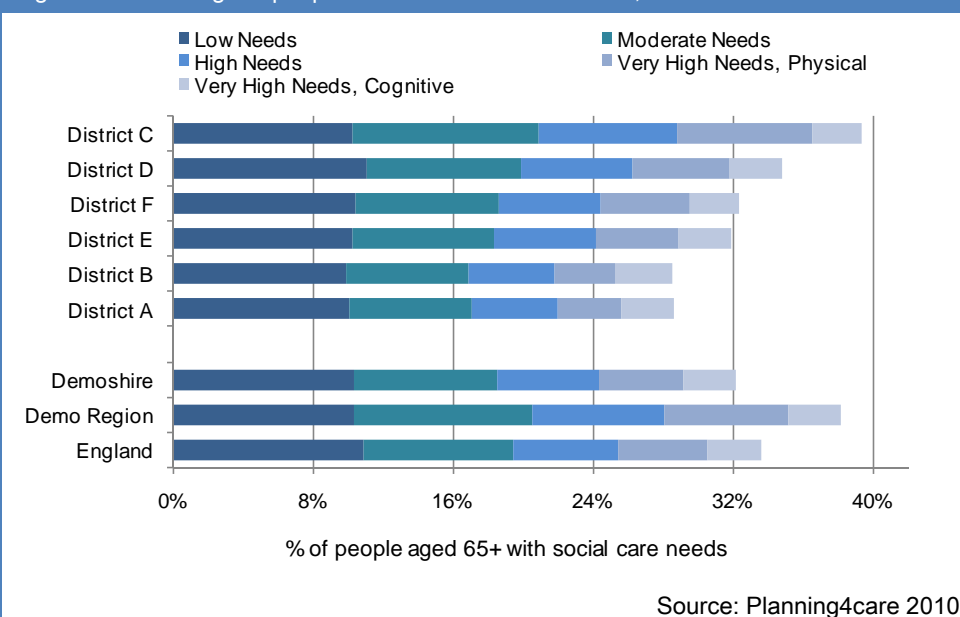
Table 5 Estimated levels of social care need across Demoshire and Districts

District Name	People aged 65+ with social care need (2010)		People aged 65+ with moderate or above levels of social care need (2010)	
	N	% of total population aged 65+	N	% of total population aged 65+
Demoshire	34,500	32%	23,410	22%
District A	5,260	29%	3,400	18%
District B	5,040	28%	3,290	19%
District C	4,640	39%	3,440	29%
District D	5,000	35%	3,400	24%
District E	7,920	32%	5,380	22%
District F	6,630	32%	4,490	22%
Demo Region	356,940	37%	260,250	27%
England	2,881,740	33%	1,946,140	22%

Table 5 shows the estimated levels of social care need across Demoshire and the Districts. At District level, District C has the highest proportion of people aged 65+ with social care need: 39% of all older people have some level of social care need, and 29% have moderate or above levels of social care need. By contrast, in District B only 28% of people aged 65+ have some level of social care needs (with 19% having moderate or above levels).

Figure 4 shows the proportions of those aged 65+ with different levels of social care need.

Figure 4. Percentage of people 65+ with social care needs, Demoshire and Districts



## Estimated numbers in Demoshire with different forms of support

Table 6 Summary of the current support (2010) in Demoshire

	Total number	Number supported by informal care	Number requiring formal care – supported by council	Number requiring formal care – potential self funders
Low needs	11,090	2,730	0	8,350
Moderate needs	8,750	1,450	260	7,040
High needs	6,250	1,100	1,390	3,750
Very high needs	8,420	780	2,700	4,930

Of all those with social care needs in Demoshire, Planning4care estimates suggest that:

- 28,420 are potentially in need of formal care, whilst 6,060 are estimated to be well supported by informal care;<sup>11</sup>
- Of those in need of formal care, 20,070 are estimated to have needs at moderate level and above;
- 4,360 of those with moderate to very high need receive care funded by the Local Authority<sup>12</sup>; 2,700 of these are estimated to have ‘very high’ needs<sup>13</sup>;
- 15,720 of all those with moderate to very high need are estimated to be either unsupported or funding their own care; this includes 4,930 with ‘very high’ needs.

### Projections for how social care need in Demoshire is likely to change over time

Based on ONS published data on projected increases in the numbers of people aged 65+, the number aged 65+ with any level of social care needs in

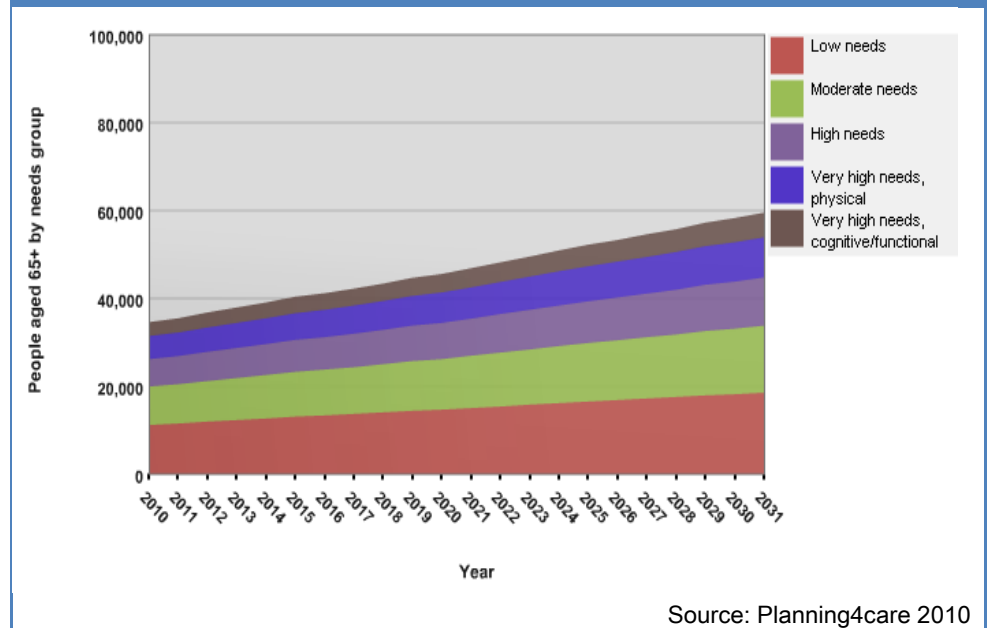
<sup>11</sup> People are considered in need of formal care if they are not well supported by informal care. An individual is regarded as not well supported by informal care if they have no effective informal social support for main functional disablement problem, or receive support from a carer who does not live in the same household. The estimates of informal care levels are calculated using the 2001 General Household Survey (GHS). These are applied to the population who are *not* living alone, which is estimated from a combination of GHS and census indicators.

<sup>12</sup> Publicly-funded levels based on NASCIS 2008/09 data. Calculated as the sum of those supported in residential and nursing home care, plus those receiving home care.

<sup>13</sup> We have assumed that people with ‘low’ level needs are unlikely to receive publicly funded care; the Planning4care methodology assumes that all people supported in residential and nursing home care are in the ‘very high’ needs category; the distribution of home care between the needs groups assumes that those receiving less than 2 hours a week are in the ‘moderate’ needs group, those receiving between 2 and 10 hours are in the high needs group, and those receiving 10 hours and above are in the ‘very high’ needs group. It is further assumed that older people in receipt of day care are a subset of those receiving publicly funded home care.

Demoshire is projected to rise by 68% over the next 20 years (above the regional rise of 50% and the national rise of 54%). The number in Demoshire with very high social care needs is expected to rise by 71% between 2010 and 2030.

Figure 5. Projected needs in Demoshire



The total number of people with dementia is projected to rise over the 20-year period by 91% (97% for those with the ‘very high needs’ level of ‘severe cognitive impairment and functional disability’). This is significantly above the regional (69%) and England (69%) comparative increases for total numbers with dementia.

The table below identifies the Planning4care five-year and twenty-year projections for the number of older people with social care needs in Demoshire and districts. The highest predicted rate of increase is in District C and the lowest in District D.

Table 7 Planning4care five-year and twenty-year projections for the number of older people with social care needs in county, district and comparator areas

Areas	People aged 65+ with some level of social care need					
	2010		2015		2030	
	N	N	% increase	N	% increase	
Demoshire	34,500	40,240	17%	58,110	68%	
District A	5,260	6,050	15%	8,620	64%	
District B	5,040	5,780	15%	8,330	65%	
District C	4,650	5,570	20%	8,470	82%	
District D	5,000	5,550	11%	7,640	53%	
District E	7,920	9,310	18%	13,710	73%	
District F	6,630	7,960	20%	11,340	71%	
Demo Region	356,940	396,980	11%	533,870	50%	
England	2,881,740	3,228,060	12%	4,445,060	54%	

### Alternative scenarios: The impact of changes to healthy life expectancy and preventative initiatives on future social care needs in Demoshire

Planning4care includes a set of alternative scenarios to explore the impact on future numbers with social care needs of a range of 'different futures', including variations in population projections, Healthy Life Expectancy, and the impact of early prevention strategies<sup>14</sup>.

Tables 8 and 9 below show the Planning4care projected levels of social care need in Demoshire (Table 8 is *all* people with social care need; Table 9 is those with *very high* need) under a selection of alternative scenarios. The tables show the impact of the '1-in-10' and '2-in-10' Healthy Life Expectancy scenarios, the 'Higher' and 'Lower' population projection scenarios, and the 'Preventative care 10%' scenario.

<sup>14</sup> See Appendix C for details of the Planning4care scenarios.

Table 8 Planning4care projections for older people in Demoshire with *any* level of social care need under a range of alternative scenarios

Scenarios	Older people in Demoshire with some level of social care need			
	2015		2030	
	N	% increase	N	% increase
Planning4care 'Base'	40,240	17	58,110	68
'1-in-10' increases in HLE	39,250	14	53,390	55
'2-in-10' increases in HLE	38,280	12	48,860	43
'Higher' population projection	40,650	17	60,730	75
'Lower' population projection	39,820	16	55,470	61
'Preventative care 10%'	40,240	17	58,110	68

(Note that the preventative care scenario is based on successfully stopping a proportion of people with moderate needs progressing to high needs, and people with high needs progressing to very high needs. The overall number of people with social care need in Table 8 is therefore the same for both the base case and 'Preventative care 10%' scenario).

Table 9 Planning4care projections for older people in Demoshire with *very high* social care need under a range of alternative scenarios

Scenarios	Older people in Demoshire with very high social care need			
	2015		2030	
	N	% increase	N	% increase
Planning4care 'Base'	9,800	16	14,420	71
'1-in-10' increases in HLE	9,560	14	13,270	58
'2-in-10' increases in HLE	9,330	12	12,160	46
'Higher' population projection	9,904	17	15,101	79
'Lower' population projection	9,690	16	13,730	64
'Preventative care 10%'	8,820	16	12,980	71

The Planning4care estimates for levels of need in 2010 are for 34,500 people aged 65+ to have some level of social care need, increasing to 40,240 by

2015. The impact of improvements in Healthy Life Expectancy and effective preventative care interventions is significant:

- The optimistic '2-in-10' scenario results in 1,960 fewer people having any form of social care need by 2015 (500 fewer with very high social care need), and 9,250 fewer people by 2030 (2,260 fewer with very high social care need)
- The 'Preventative care 10%' scenario results in no change to numbers with any level of social care need, but a significant decrease of 1,000 people with very high needs by 2015, and 1,440 by 2030.

## Key messages from this section

### *Social care needs classification*

The social care needs classification set out in the Wanless Social Care review<sup>15</sup> takes a five point scale from 'no care needs' to 'very high care needs'.

We have used Planning4care estimates of social care need, based on local populations (by age, gender and receipt of attendance allowance) and additional 'risk' factors (including measures of local income and deprivation levels) to estimate the level of social care need in Demoshire and to project how levels of social care need may change in the future based on alternative scenarios.

### *Current numbers of older people with social care needs in Demoshire*

Of the total population aged 65+ in Demoshire (2010), 34,500 (32%) are estimated to have some level of social care needs; of these 23,420 are estimated to have 'moderate' to 'very high' needs, and 8,420 (8%) to have 'very high' needs. 28,420 are potentially in need of formal care, whilst 6,060 are estimated to be well supported by informal care.

4,360 of those with moderate to very high need receive care funded by the Local Authority<sup>16</sup> (2,700 of these are estimated to have 'very high' needs).

15,720 of those with moderate to very high need are estimated to be either unsupported or funding their own care (including 4,930 with 'very high' needs).

Of the total 'very high needs group', 3,190 are estimated to have severe functional disability resulting from a high level of cognitive impairment (primarily dementia).

The proportion of older people across Demoshire estimated to have some level of social care need (32%) is below the regional average (37%). By district, this ranges from 28% in District B to 39% in District C.

### *Projections of social care need*

Based on Planning4care estimates and ONS published data on projected increases in the numbers of people aged 65+, the number aged 65+ with some level of social care need in Demoshire is projected to rise by 68% over the next 20 years (above both the regional rise of 50% and the national rise of 54%). The number of people in Demoshire with very high social care needs is expected to rise by 71% over the same period.

### *The impact of changes to healthy life expectancy and preventative initiatives on future social care needs in Demoshire*

The potential impact of improvements in Healthy Life Expectancy and effective preventative care interventions on projected numbers with social care need is significant:

- The optimistic '2-in-10' scenario results in 1,960 fewer people having any form of social care need by 2015 (500 fewer with very high social care need) compared to the 'base' projection, and 9,250 fewer people by 2030 (2,060 fewer with very high social care need)
- The 'Preventative care 10%' scenario results in no change to numbers with any level of social care need, but a decrease of 1,000 people with very high needs by 2015 compared to the base projection, and 1,240 by 2030.

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<sup>15</sup> Wanless D (2006), *Securing Good Care for Older people – Taking a Long-Term View*, Kings Fund.

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<sup>16</sup> Publicly-funded levels based on NASCIS 2008/09 data. Calculated as the sum of those supported in residential and nursing home care, plus those receiving home care.

## 6 Likely future service requirements and costs for supporting older people with social care needs in Demoshire

### Introduction

In this section, we identify Planning4care estimates of the likely requirements for services to support older people with social care needs<sup>17</sup>. The analysis is based on the levels of social care needs identified in the previous sections, and the continuation of current patterns of service delivery. Our analysis is framed around the following questions:

- What are the service requirements for supporting older people with social care needs, *based on current patterns of care?*
- What are the projected increases in service requirements, *based on demographic projections and future scenarios?*

### What are the service requirements for supporting older people with social care needs, *based on current patterns of care?*

Current patterns of publicly funded service delivery across Demoshire are taken from the National Adult Social Care Intelligence System (NASIS) data for 2008/09<sup>18</sup>. These patterns are applied to the Planning4care local estimates of the numbers of people with different levels of social care needs.

The total number in residential care is based on the relative size of the very high needs group, and national data on the total residential care population. The estimated proportion of this group with very high needs resulting from severe cognitive impairment is taken from PSSRU research<sup>19</sup>. The local rate of LA-supported residential care is taken from Demoshire 2008/09 NASIS data.

<sup>17</sup> For more details on Planning4care, see Appendices A-C and [www.planning4care.org.uk](http://www.planning4care.org.uk).

<sup>18</sup> See <http://www.drfoosterintelligence.co.uk/registration/kigstool/default.aspx>.

<sup>19</sup> Comas-Herrera et al, 2003, *Cognitive impairment in older people: its implications for future demand for services and costs*, PSSRU Discussion Paper 1728

For those supported in the community, “representative” home care hours by needs group are calculated using the NASIS data<sup>20</sup>.

The proportion of older people receiving home care who also receive day care (assumed high and very high needs groups only) is also calculated from the NASIS data. These local representative care packages are shown in Table 10.

Table 10 Typical community-based care packages for Demoshire and England

	Home care (hours per week)	Home care (hours per week)
	Demoshire	England
Moderate needs	1.0	1.0
High needs	6.0	5.7
Very high needs (physical and cognitive)	17.9	19.9
% of those with high and very high needs receiving home care who also receive day care	36.8%	34%

### *What is the projected requirement for residential care, home care and day care commissioned by the local authority?*

Based on current patterns of services in Demoshire, and assuming that the same proportions of people with different levels of need continue to be supported in the future in residential and community-based services

<sup>20</sup> Local representative values for ‘typical’ sizes of home care packages against needs level are calculated on the assumption that people receiving less than 2 hours of home care a week have moderate levels of need, those receiving between 2 and 10 hours have high levels of need, and those receiving 10 hours and above have very high needs.

respectively, Table 11 shows the change in requirement for local authority commissioned home care hours, day care placements and residential care placements over the next 5 and 20 years. This represents an increase of 71% in LA commissioned home care hours, day care placements and residential care placements between 2010 and 2030, compared to regional increases of 50% and national increases of 54% over the same period.

Table 11 Projected LA-commissioned service requirements based on current patterns of provision in Demoshire

	2010	2015	2030
Home care (hours per week)	24,110	28,080	41,310
Day care (placements)	830	970	1,420
Residential care (supported placements)	1,840	2,140	3,150

### *What is the total population projected requirement for residential care, home care and day care?*

Table 12 shows the total requirement for the provision of residential care, home care and day care (assuming current service patterns) for all people in Demoshire with social care needs at moderate level and above who are in need of formal care. This represents an increase of 71% in the whole population requirement for home care hours, day care placements and residential care placements between 2010 and 2030, compared to regional increases of 50% and national increases of 54%.

Demoshire is currently commissioning 29% of the estimated total 65+ population requirement for home care and day care provision, and supporting 36% of the estimated total requirement for residential placements.

Table 12: Projected total population service requirements based on current patterns of provision in Demoshire

	2010	2015	2030
Home care (hours per week)	84,300	98,170	144,390
Day care (placements)	2,840	3,310	4,870
Residential care (placements)	5,050	5,880	8,650

### *What is the projected cost of local authority commissioned care in Demoshire?*

Table 13 shows the projected costs of providing LA-commissioned residential care, home care and day care services, using local unit costs and following current patterns of service provision.

Table 13: Projected costs per week of providing LA-commissioned residential care, home care and day care services following current patterns of provision in Demoshire

Costs per week (£)	2010	2015	2030	% increase 2010 to 2030
Moderate need	3,610	4,200	6,160	71%
High need	139,140	162,020	238,400	71%
Very high need	1,077,200	1,254,320	1,845,690	71%
Total costs per week (£)	1,219,950	1,420,540	2,090,250	71%

### *What is the projected total care cost in Demoshire?*

Table 14 shows the total projected costs of providing residential care, home care and day care services for all people with social care needs at levels moderate and above, using local unit costs and following current patterns of service provision.

Table 14: Projected whole population costs per week of providing residential care, home care and day care services following current patterns of provision in Demoshire

Costs per week (£)	2010	2015	2030	% increase 2010 to 2030
Moderate need	102,120	118,960	174,280	71%
High need	513,640	598,110	880,080	71%
Very high need, physical	1,668,220	1,942,520	2,858,350	71%
Very high need, cognitive	1,346,620	1,568,040	2,307,310	71%
Total costs per week (£)	3,630,600	4,227,620	6,220,020	71%

## What are the projected costs for supporting older people with care needs, based on alternative future scenarios?

The Planning4care 'base' projection model indicates expected increases of 71% in the levels of services required and cost implications, both for publicly funded/ LA commissioned services and for total service requirements – in response to the projected demographic change and assuming continuation of current patterns of service provision. Tables 15 and 16 show the variation in service and cost increases predicted under the range of alternative scenarios.

The application of alternative scenarios can have a significant effect on these projections. The optimistic '2-in-10' Healthy Life Expectancy scenario reduces the projected increase to 46%, while the 'higher population' projection increases it to 79%.

Table 15: Projected costs of providing LA-commissioned residential care, home care and day care services under a range of alternative future scenarios

	2010	2015	2030	% increase 2010 to 2030
Planning4care 'Base' (£)	1,219,950	1,420,540	2,090,250	71%
'1-in-10' increases in HLE (£)	1,215,040	1,386,310	1,923,480	58%
'2-in-10' increases in HLE (£)	1,210,140	1,352,460	1,762,870	46%
'Higher' population projection (£)	1,221,540	1,431,630	2,182,860	79%
'Lower' population projection (£)	1,218,430	1,409,460	1,996,970	64%
'Informal care reduction' 2% (£)	1,221,950	1,433,870	2,149,660	76%
'Residential shift 10%' (£)	1,209,140	1,407,960	2,071,730	71%
'Preventative care 10%' (£)	1,117,310	1,301,040	1,914,400	71%

A distinction needs to be made between the year-on-year incremental scenarios (Healthy Life Expectancy, higher and lower population projections), and those modelled on instantaneous shifts (changes in level of informal care, shifts in use of residential care, changes resulting from preventative care). The latter do not show a change in the rate of increase, but effect an immediate change in the base year value (and the same proportionate change in subsequent years).

For instance, the 'preventative care 10%' scenario in which an effective prevention strategy results in 10% of people with very high needs shifting to high needs, and 10% with high needs shifting to moderate needs, results in an overall 8% reduction in estimated costs.

Table 16: Projected costs of providing whole population residential care, home care and day care services under a range of alternative future scenarios

	2010	2015	2030	% increase 2010 to 2030
Planning4care 'Base' (£)	3,630,600	4,227,620	6,220,020	71%
'1-in-10' increases in HLE (£)	3,615,990	4,125,720	5,723,720	58%
'2-in-10' increases in HLE (£)	3,601,410	4,024,970	5,245,740	46%
'Higher' population projection (£)	3,646,070	4,273,190	6,514,730	79%
'Lower' population projection (£)	3,614,300	4,181,010	5,923,230	64%
'Informal care reduction' 2% (£)	3,637,370	4,272,600	6,420,430	77%
'Residential shift 10%' (£)	3,600,890	4,193,030	6,169,120	71%
'Preventative care 10%' (£)	3,354,240	3,905,820	5,746,510	71%

## Key messages from this section

### *Projected service requirements*

This section gives estimates of likely service requirements and costs – both for publicly funded services provided or commissioned by the council, and for whole population requirements. These are based on the estimates in the previous section of the projected numbers of people in Demoshire with different levels of social care needs, together with information on current patterns of service delivery.

It is estimated that Demoshire is currently commissioning 29% of the estimated total (65+) population requirement for home care and day care provision, and supporting 36% of the total estimated requirement for residential placements.

Assuming continuation of current patterns of care, the number of LA-commissioned home care hours would expect to increase from 24,100 to 41,300 per week between 2010 and 2030, day care placements from 830 to 1,420, and supported residential placements from 1,840 to 3,150.

The total population requirement for home care would increase from 84,300 to 144,400 hours per week, day care placements from 2,840 to 4,870 and residential placements from 5,050 to 8,650.

In line with the demographic projections, all of these represent a projected increase of 71%, compared to 50% at regional level and 54% nationally.

### *Projected costs*

Costs (derived from the application of local unit costs) would similarly mirror a projected zero-inflation increase of 71%.

### *Impact of alternative population projections, changes to healthy life expectancy, preventative initiatives and alternative service patterns*

The application of alternative scenarios can have a significant effect on these projections. The optimistic '2-in-10' Healthy Life Expectancy scenario reduces the projected increase to 46%, while the 'higher population' projection increases it to 79%. The 'preventative care 10%' scenario predicts an 8% reduction in overall costs. A shift from residential to community-based care

indicates some reduction in cost but relatively little, given the likely high intensity of community care required for people in this group<sup>21</sup>.

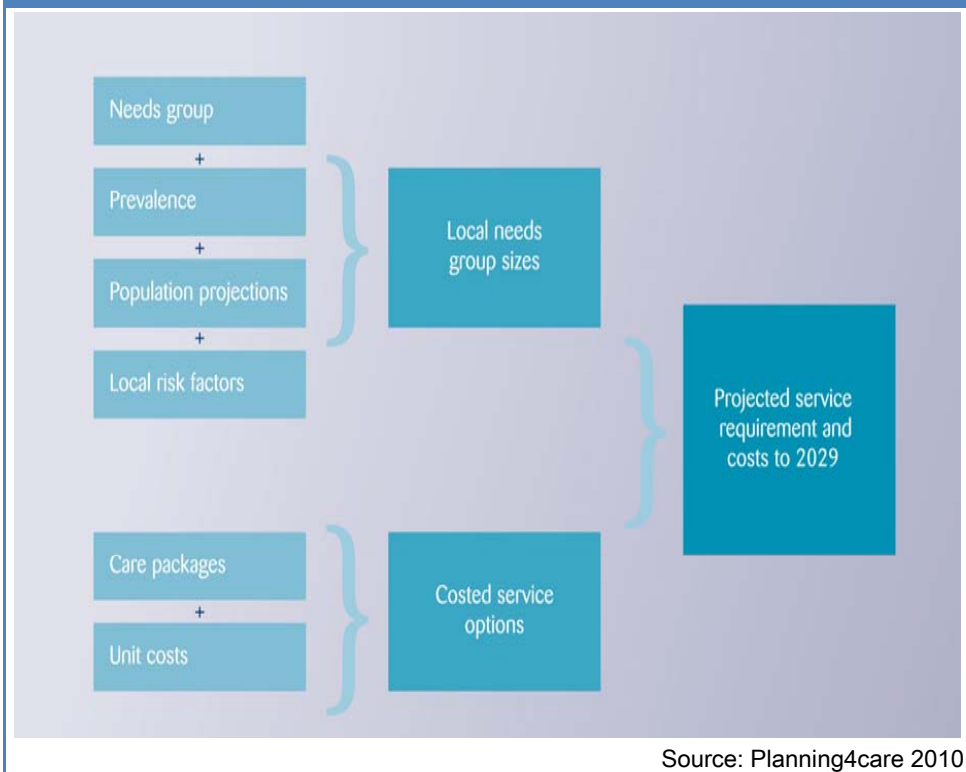
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<sup>21</sup> The model assumes that people supported in the community who would otherwise have been in residential care are likely to be at the higher end of the 'very high needs' spectrum, and therefore increases the typical very high needs care package by 50% for this group.

# Appendix A: Key definitions and assumptions

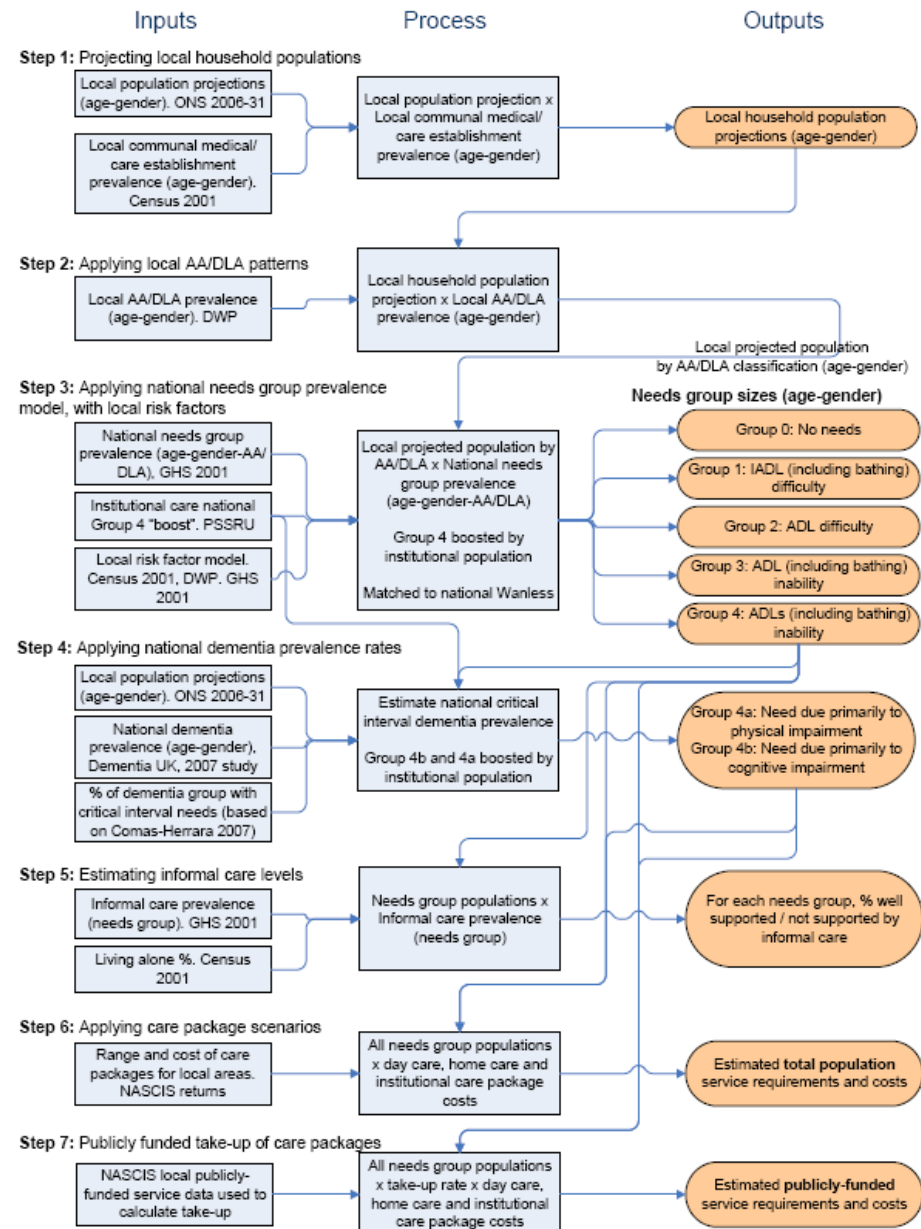
## How does Planning4care work?

Figure 6. Planning4care overview



Source: Planning4care 2010

The Planning4care model follows the PSSRU/Wanless national projection methodology, in adopting a set of clearly identified levels of need for social care support, and then estimating the current and projected proportions of the total over-65 population expected to fall into each of these groups. See Appendix B for the needs group definitions.



### *Care needs and dementia prevalence*

Prevalence rates by age-groups (65-74, 75-84, 85+) and gender for each of the needs classification groups are derived from analysis of the General Household Survey 2001. The GHS survey was based on a large national random population sample and asked detailed questions about self-care ability of people aged 65+.

Prevalence rates for dementia by age-group (5-year bands up to 84, 85+) are taken from the Dementia UK report<sup>22</sup>, with estimates of those with severe combined cognitive impairment and functional disability taken from Comas-Herrera et al 2007<sup>23</sup>.

Prevalence of informal care support is derived from the General Household Survey 2001 and the 2001 Census.

### *Population projections*

Data for comparator areas is based on sub-national population projections by age and gender taken from Office for National Statistics (ONS) sub-national projections. Source: GAD 2006 for 2006 – 2031. The model is updated with the most recent ONS projections as these come on line. Locally produced population projections can be put into the model on request.

### *Local risk factors*

The model incorporates local socio-economic indicators, or risk factors, that were identified as having an impact on prevalence of the needs classification groups (using ordinal logistic regression analysis of the GHS). These factors were used to refine prevalence rates at local level. These include, at individual level, take-up of Attendance Allowance/ Disability Living Allowance [AA/DLA] and, at area level, data on the proportion of households with no car, the proportion of rented housing, the proportion of people aged 65 or over, and the proportion of employed people with routine or manual occupations.

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<sup>22</sup> *Dementia UK: The full report*. Available from

[http://www.alzheimers.org/downloads/Dementia\\_UK\\_Full\\_Report.pdf](http://www.alzheimers.org/downloads/Dementia_UK_Full_Report.pdf)

<sup>23</sup> *Comas-Herrera et al 2007, International Journal of Geriatric Psychiatry, 22, 1037*

### *Local needs group sizes*

The analysis provides a whole population estimate of people aged 65+ by needs group. It also separates out people who are well supported by informal care, people receiving publicly funded social care services and people who are either unsupported or funding their own care.

### *Care packages*

Having calculated the numbers of older people projected to be in each needs group, the tool then calculates "typical" local-based levels and types of care for each needs group, in order to calculate projections of total (and publicly funded) resource requirements and costs.

The methodology follows the Wanless review in focusing on the three principal current components of long-term care – residential and nursing home care, home care, and day care. Given that the nature of services is expected to change - especially the replacement of residential care with extra care housing, and the replacement of day care with other forms of community-based support - the above three components are regarded as representative of broader categories of service, referred to in the Wanless review as "care with housing", "community based services" and "other community services" respectively.

### *Unit costs*

Local unit costs are applied to the different components of care packages to produce costed service options.

### **Key assumptions**

- The number of people by age and gender (65+) changes in line with the latest Government Actuary Department (GAD) population projections.
- Prevalence of disability by age and gender remain unchanged, as reported in the 2001-02 General Household Survey (GHS). (Scenarios can be set up which vary this assumption.)
- Local risk factors affecting prevalence of needs groups remain constant over time.

- The proportion of people receiving informal care remains constant over time for each subgroup by age, disability and other needs related characteristics. (Scenarios can be set up which vary this assumption.)
- The total local population 65+ in residential and nursing home care has been modelled to reflect the national rate of institutional care per population 65+ with high needs, in order to take account of cross boundary flows. The publicly funded residential population is based on actual take-up in each council.
- People in residential and nursing homes are assumed to be in the 'very high' needs group.
- Publicly funded care packages are assumed to be not available for people in the 'low' needs group; they are also not included in the whole

population care requirement calculations. (However, volumes and cost of services targeted specifically at this group could be modelled, based on local strategies).

- In the standard scenario, the proportions of older people receiving formal community and residential or nursing home services remain constant over time for each subgroup by age, disability and other needs related characteristics.

Details of the variations adopted for the different scenarios are given at Appendix C.

Further details on the methodology are included in the methodology section on the web page, see [www.planning4care.org.uk](http://www.planning4care.org.uk).

## Appendix B: Needs groups used in Planning4care

### Needs group definitions

Planning4care uses the classification for older people's levels of social care need set out in the Wanless Social Care review<sup>24</sup>, based on Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), see table below.

No care needs	People able to perform ADL (personal care) tasks and IADL (domestic care) tasks without difficulty or need for help
Low need	People who have difficulty in performing IADL tasks and/or have difficulty with bathing, showering or washing all over but not with other ADL tasks
Moderate need	People who have difficulty with one or more other ADL tasks
High need	People who are unable to perform one ADL task without help
Very high need	<p>People who are unable to perform two or more ADL tasks without help.</p> <p>A: people for whom need for support is due primarily to physical impairment</p> <p>B: people for whom need for support is due primarily (or equally) to cognitive impairment</p>

### Activities of Daily Living and Instrumental Activities of Daily Living

The *Activities of Daily Living* used in the needs classification are:

- Transfer: get in and out of bed (or chair)
- Use toilet
- Get dressed and undressed
- Feed self
- Bath, shower or wash all over. Note: 'Bath, shower or wash all over' is treated as a special case in that difficulty with this task is grouped with IADL tasks (group 1), while inability is treated as any other ADL.

<sup>24</sup> Wanless D (2006), *Securing Good Care for Older people – Taking a Long-Term View*, Kings Fund

The Instrumental Activities of Daily Living (IADL) used in the needs classification are:

- Shopping
- Laundry
- Vacuuming
- Cooking a main meal
- Managing personal affairs.

The "*Very high needs (B), Severe cognitive impairment and functional disability*" group includes people who show symptoms consistent with diagnosis of dementia. ICD-10 Diagnostic Guidelines for Dementia states that each of the following symptoms should be present for a diagnosis of dementia:

- A decline in memory to an extent that interferes with everyday activities, or makes independent living either difficult or impossible
- A decline in thinking, planning and organising day-to-day things, again to the above extent.
- Initially, preserved awareness of the environment, including orientation in space and time.
- A decline in emotional control or motivation, or a change in social behaviour, as shown in one or more of the following: emotional lability, irritability, apathy or coarsening of social behaviour, as in eating, dressing and interacting with others.<sup>25</sup>

<sup>25</sup> Henderson AS and Jorm AF (2000) Definition and Epidemiology of Dementia: A Review. In Maj M and Sartorius N (eds.), *Dementia*. WPA Series: Evidence and Experience in Psychiatry, Wiley, Chichester.

## Appendix C: Planning4care future scenarios

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Predicting the future is an inherently risky business, and should not be based on a single view of what is likely to happen. Planning4care v2.0 explores the impact on future social care needs through a range of alternative future scenarios:

- *Population projections*: the impact of varying migration and life expectancy levels on the projected numbers of older people.
- *Increases in Healthy Life Expectancy*: the impact of people getting healthier on projected levels of social care need.
- *Impact of low-level preventative care*: Based on evidence of the impact of low-level preventative work (eg from the POPPs projects), and impact of re-ablement on subsequent use of services, Planning4care now estimates plausible changes in demand for residential care and other services resulting from the impact of successful preventative care at local level.
- *Trends in publicly funded service provision*: the impact of shifts away from residential care.
- *Changes to informal care levels*: Planning4care estimates the impact of informal care levels on the need for services at local level. Additional scenarios enable users to explore likely impact on service requirements and costs from changes to informal care levels over time.

### Population projections: the impact of varying migration and life expectancy levels on the projected numbers of older people

The 'Principal' population projection scenario used for the sub-national population projections is based on a set of assumptions on how levels of in- and out-migration, life expectancy, and fertility will vary in future<sup>26</sup>. In addition to this 'Principal' scenario, the Government Actuary Department publishes population projection data at national level based on a series of additional

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<sup>26</sup> Government Actuary's Department (2008), *2006-based Population projections*. From [www.gad.gov.uk/Demography%20Data/](http://www.gad.gov.uk/Demography%20Data/)

scenarios, exploring varying levels of in- and out-migration, increases in life expectancy, and changes in fertility<sup>27</sup>.

The Planning4care 'population projections' scenarios assess the impact of two alternative Government Actuary Department scenarios on the projected numbers of older people<sup>28</sup>:

- 'Higher' scenario: Based on high levels of inward migration, large increases in life expectancy, and high levels of fertility;
- 'Lower' scenario: Based on low levels of inward migration, small increases in life expectancy, and low levels of fertility.

### Healthy Life Expectancy: the impact of people getting healthier on projected levels of social care need

Healthy Life Expectancy (HLE) is an indicator of how many years a person can expect to live without disability. The Planning4care Base scenario pessimistically assumes that Healthy Life Expectancy will not change over time. For example, an 80 year-old in 2029 is assumed equally likely to need social care as an 80 year-old today. This is unlikely to be the case, for example over the period 2000-2002 to 2004-2006 HLE at birth has increased from 67.1 to 68.5 for males and 70.1 to 70.7 for females, and HLE aged 65 has increased from 12.0 to 12.9 for males and 14.2 to 14.7.

Based on alternative scenarios set out in research carried out for the national Ageing Strategy<sup>29</sup>, we have assessed additional scenarios to explore the

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<sup>27</sup> Government Actuary's Department (2008), *2006-based Variant projections*. From [www.gad.gov.uk/Demography%20Data/Population/index.aspx?y=2006&v=Variant](http://www.gad.gov.uk/Demography%20Data/Population/index.aspx?y=2006&v=Variant)

<sup>28</sup> Based on the differences in projected population sizes (by 5-year age band and gender) between the 'Principal', 'Higher' and 'Lower' population projection scenarios at national level, we have adjusted the sub-national population projection numbers to create 'Higher' and 'Lower' scenarios at Local Authority level.

impact of HLE increases on the projected numbers of older people with social care need:

- '1-in-10' scenario: Healthy Life Expectancy increases by *one* year every ten years;
- '2-in-10' scenario: Healthy Life Expectancy increases by *two* years every ten years;
- Planning4care 'Base' scenario: Healthy Life Expectancy does not increase over time.

## Impact of low-level preventative care

There is growing evidence that prevention and early intervention services have a positive impact, particularly with respect to the care of older people. For example:

- Impacts of prevention services within the POPP projects include reduction in hospital admissions and service users reporting improvements in quality of life. Both are factors that may delay or prevent entry to residential care.
- There is clear evidence that people at higher levels of need can and do benefit significantly from home care re-ablement services.
- Qualitative evaluations of telecare schemes have described benefits as improved quality of life by increasing choice and control, increased safety and independence, supporting carers and giving 'peace of mind' to both service users and carers. Again these are factors that may delay or prevent entry to residential care.

Based on evidence of the potential impact of preventative care initiatives, we have developed scenarios to identify changes to social care need, and residential care need, resulting from the impact of successful preventative care strategies:

- 'Preventative care 1%' scenario: Effective early care programmes result in successfully stopping a proportion of people with moderate needs progressing to high needs, and people with high needs progressing to

very high needs. The net result is a shift of 1% of the high needs group to the moderate needs group, and a shift of 1% of the very high needs group to the high needs group.

- Preventative care 5%, 10%, 15% and 20%: Taking the same methodology as the 1% shift, these four scenarios result in 5%, 10%, 15% and 20% respectively shifting from high to moderate, and very high to high, needs. For illustration, we have shown data for the 'Preventative care 10%' scenario.

## Trends in publicly funded service provision: the impact of shifts away from residential care

Local areas are seeing changes in the take-up of services, resulting from both policy initiatives, and individual user choice. For example in many areas, there is an ongoing shift towards community care, and away from residential care. Planning4care now incorporates future scenarios incorporating likely shifts, including a relative reduction in use of residential care, and the impact on likely future demand for residential care at local level.

Nationally, KIGS and NASCIS data for 2001/2 to 2008/9 identifies a consistent fall in take-up of LA-supported residential care places, from 25.1 places per 1,000 65+ population in 2001/2 to 21.07 in 2007/8. Planning4care now incorporates additional scenarios exploring the shift from residential to community care:

- Residential care shift 5% scenario: Likely future trends in service provision will see a decrease in the numbers of people with high need taking-up residential care provision. The Planning4care Residential care shift 5% scenario reduces the numbers of people estimated to need residential care by 5%, with a corresponding increase in those taking up community care packages.
- People shifting from residential care to community care packages are likely to be at the upper end of the 'very high needs' care packages spectrum. The scenario therefore incorporates an increased level of community care for this group, with a 50% increased level of home-care hours, and 50% more likely to use daycare, for this group compared with the typical local 'very high needs' care package.

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<sup>29</sup> Mayhew, L. (2009) Increasing longevity and the economic value of healthy ageing and working longer. *Cass Business School, City University*, part of the 'Building a Society for All Ages' strategy's evidence base.

- Residential care shift 10%, 15% and 20%: Taking the same methodology as the 5% shift, these three scenarios result in 10%, 15% and 20% respectively shifting from residential care to community care services

## Changes to informal care levels

Planning4care estimates the impact of informal care levels on the need for services at local level. Additional scenarios enable users to explore likely impact on service requirements and costs from changes to informal care levels over time:

- Informal care -1% (or -2%) scenarios: The proportion of people well-supported by informal care *falls* by 1% (or 2%) per year, resulting in an *increase* in the need for care services (this might happen as a result of continuing trends where older people are more likely to live alone in future).
- Informal care +1% (or +2%) scenarios: The proportion of people well-supported by informal care *increases* by 1% (or 2%) per year, resulting in a *decrease* in the need for care services (this might happen as a result of increased support for those providing informal care).

## Appendix D: Data Sources

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Inputs used in the Planning4care tool include the following sources on "need":

- [Projections of age-gender populations](#) (Office for National Statistics / Government Actuary Department). Data included is the 2006-based long term Subnational Population Projections for England (SNPP), published on 12 June 2008
- [Medical and care establishment populations](#) (Census 2001 Standard Table 126)
- [Provision of care by levels of need](#) (Personal Social Services Research Unit / Wanless Social Care Review)
- [Attendance Allowance / Disability Living Allowance claimant levels by age-gender](#) (Department for Work and Pensions)
- [Needs group prevalence analysis](#) (General Household Survey, 2001)
- [Dementia UK: The full report](#). (Dementia UK report, commissioned from Personal Social Services Research Unit, LSE)

- Estimates of those with severe cognitive impairment and functional disability. Comas-Herrera et al (2007), International Journal of Geriatric Psychiatry, 22, 1037.
- Informal care levels ([General Household Survey](#); [Census 2001](#), [Census Access Table 02](#))
- Local risk factors ([General Household Survey](#); [Census 2001](#); [Department for Work and Pensions](#))

The following data on "resources" are also used as inputs to the tool:

- [Local take-up rates for publicly funded care \(National Adult Social Care Intelligence Service, NASCIS\)](#). As of January 2010, the data included is from the latest published 2008/9 returns.
- [Local unit costs \(National Adult Social Care Intelligence Service, NASCIS\)](#). As of January 2010, the data included is from the latest published 2008/9 returns.

## Appendix E: How to use Planning4care to improve commissioning

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### Introduction

Planning4care provides critical analysis for commissioners and providers to improve service planning and delivery. This section gives some practical advice on how to make best use of this analysis.

### Why Strategic Needs Assessment?

"Assessing and understanding the needs of individuals, as well as of the population as a whole, is integral to helping them achieve good outcomes. This allows local partners to identify common priorities (for particular groups, services and areas) and to decide how best to work together to meet those needs" *DH 2007, Commissioning framework for health and well-being*<sup>30</sup>

The scale of demographic changes coupled with changing aspirations and a focus on outcomes means that local authorities and primary care trusts must now embrace the longer term in planning and market development. The importance of predicting demand and developing strategic (i.e. long-term) commissioning plans has been heavily emphasised in recent policy initiatives in social care.

### *Renewed focus on commissioning*

The White Paper *Our health, our care, our say*<sup>31</sup> sets out the outcomes for future health and social care services, and sees commissioning as the key activity to deliver these outcomes. This theme is further developed in the *Commissioning framework for health and well-being*<sup>32</sup>, which provides the guidance for implementing the White Paper vision, and in *World class*

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<sup>30</sup> Department of Health (2007), *Commissioning framework for health and well-being*

<sup>31</sup> Department of Health (2006), *Our health, our care, our say: a new direction for community services*

<sup>32</sup> Department of Health (2007), *Commissioning framework for health and well-being*

*commissioning: the vision*<sup>33</sup> which aims to raise ambitions for a new form of commissioning to be implemented across the NHS.

A wide range of guidance materials have been produced since 2007 much of which is available at the DH care networks website [www.dhcarenetworks.org.uk](http://www.dhcarenetworks.org.uk), and the linked Care Services Efficiency Delivery (CSED) website [www.dhcarenetworks.org.uk/csed](http://www.dhcarenetworks.org.uk/csed). These include, for example, guidance on commissioning for personalisation<sup>34</sup>[http://op.planning4care.org.uk/using/\\_ftn4](http://op.planning4care.org.uk/using/_ftn4), outcome based commissioning<sup>35</sup>, commissioning tools<sup>36</sup>, and commissioning strategies<sup>37</sup>.

### *Joint strategic needs assessment*

Central to the development of commissioning is the requirement for *Joint Strategic Needs Assessment (JSNA)*<sup>38</sup>. Since April 2008 there has been a statutory duty on all upper tier local authorities and PCTs to produce a JSNA. The idea behind JSNA is that all key decision makers in a local area work together to produce a wide-ranging needs assessment that deals with the whole population and identifies the health and well-being needs and inequalities that exist within that population.

The purpose is to enable local services to plan ahead for the next 10 to 15 years and to support the development of the wider health and social care market - including services for those who have the ability to pay for social care

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<sup>33</sup> Department of Health (2008), *World class commissioning: the Vision*

<sup>34</sup> Department of Health (2008), *Commissioning for personalisation a framework for local authority commissioners*

<sup>35</sup> Department of Health, CSED (2007), *Configuring Future Services; Developing a Structured Approach to Delivering Better outcomes for Older People*

<sup>36</sup> CSED (2008), *Putting People First Commissioning toolkit*

<sup>37</sup> Care Services Improvement Partnership (2008), *Key activities in commissioning social care: Lessons from Care Services Improvement Partnership Commissioning Exemplar Project*

<sup>38</sup> Department of Health (2008), *Guidance on joint strategic needs assessment*

themselves. Guidance on core data sets for JSNA was published in 2008<sup>39</sup>; some of this data is now available on the National Adult Social Care Intelligence Service (NASIS).

A review by the IDeA in 2009<sup>40</sup> found that developing the data set has proved to be demanding with two kind of difficulties emerging ; firstly, for some sub-domains there is too much data and too little translation of it into usable information, and secondly, for other sub-domains the data is incomplete. However there is some evidence that the process has brought partners more closely together and that there has been a sense of rigour about the use of evidence and information that was often missing from previous joint planning.

### *Shifting the balance towards prevention*

Evidence that prevention and re-ablement works is providing incentives for commissioners to invest in early intervention. The final evaluation report of the Partnerships for Older People Projects (POPPS), across 29 English council areas has proved that investment in preventative services more than pays for itself in savings<sup>41</sup>. Further CSED Interim reports on the effects of homecare re-ablement reveal significant overall short term improvements in social care outcomes and in perceived health and quality of life benefits for service users. Assessing need and costs of preventative services and modelling impact is a key part of strategic needs consideration.

### How can I use Planning4care?

We have designed Planning4care specifically to support the development of longer-term commissioning strategies. The strength of Planning4care lies in its needs-based perspective and in its analytic capacity to bring together, synthesise and make sense of a wide range of quantitative local area data. This provides the backdrop against which existing and possible future patterns of need, services and costs can emerge more clearly. Planning4care version 2 now incorporates a range of scenarios that enables the exploration of possible futures.

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<sup>39</sup> Department of Health / APHO (2008), *The JSNA core dataset*

<sup>40</sup> IDeA (2009), *JSNA so far*

<sup>41</sup> PSSRU / DH (2010), *National Evaluation of Partnerships for Older People Projects: final report*

The Planning4care analysis is of course only part of a more detailed canvas of needs assessment and strategic options which should aim to include local knowledge of service user aspirations, what is effective in achieving outcomes, political imperatives and financial constraints, and data on supply of services and market trends. It is also important to recognise that not all questions that commissioners may ask can be answered, and that commissioning strategies need to acknowledge what is not known as well as what is known. There will always be an element of planning for uncertainty.

The Care Services Improvement Partnership publication *Key activities in commissioning social care*<sup>42</sup> provided guidance on commissioning for social care based on the lessons learnt from the experience of authorities involved in the Commissioning Exemplar Project. The guidance emphasised the development and implementation of comprehensive longer-term (ideally ten year) *commissioning strategies* as the vital component of effective commissioning.

These strategies should in turn drive contracting arrangements, with systems to ensure strategies are implemented, and with the effective use of monitoring to assess and evaluate progress. Longer term strategies help commissioners move from a focus on minor re-configurations of current service provision towards long-term goals and aspirations, and a genuine attempt to understand need and supply and the relationship between the two. Starting from this guidance, we outline below how commissioners can use Planning4care to progress some of the essential steps required to set in place robust strategies. We have also briefly indicated what other information gathering and analysis this would need to link in with.

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<sup>42</sup> Care Services Improvement Partnership (2008), *Key activities in commissioning social care: Lessons from Care Services Improvement Partnership Commissioning Exemplar Project*

## Understanding the present

### Understanding present need

Examples of what you need to consider	<ul style="list-style-type: none"> <li>• How many people have social care needs and at what level?</li> <li>• How many people are likely to need very high levels of care?</li> <li>• Who might be the target groups for preventative services?</li> <li>• Where are the areas of highest concentration of people with social care need?</li> </ul>
How you can use Planning4care	<ul style="list-style-type: none"> <li>• Planning4care helps you understand needs of <i>whole</i> local populations, not just needs of those currently receiving LA-funded services.</li> <li>• Using prevalence rates adjusted for local risk factors, Planning4care calculates robust local estimates of numbers in each needs group as a baseline for forward planning. This helps you quantify potential target populations for different levels and types of social care and enables a more proactive approach to service planning.</li> <li>• Planning4 care shows how social care needs are affected by socio-economic factors and can map local geographic pattern. Maps showing how people with social care needs are distributed geographically will help you assess whether services are located to optimise access, or where particular programmes may be targeted</li> <li>• The Planning4care social care needs classification provides a framework for segmenting the total 65+ population into groups of people with different levels of social care need, from those requiring high levels of support to people who may benefit from early intervention programmes.</li> </ul>
What else do you need to do?	<ul style="list-style-type: none"> <li>• Monitor and analyse trends in demand</li> <li>• Collate and analyse local evidence of unmet need</li> </ul>

### Understanding present support and costs

Examples of what you need to consider	<ul style="list-style-type: none"> <li>• How many people with social care needs are well supported by informal care?</li> <li>• How many are likely to need formal care?</li> <li>• What is the take-up rate/ strike rate for LA funded care?</li> <li>• Who are the current target groups for publicly funded care?</li> <li>• How many people are estimated to be funding their own care?</li> <li>• What is the average cost of care for people with different levels of need</li> </ul>
How you can use Planning4care	<ul style="list-style-type: none"> <li>• Planning4care provides analysis on how care needs are met locally. By comparing the picture of whole population need with the numbers of people supported in different ways, you can begin to quantify potential gaps in support as a baseline for forward planning. For example, how does support provision for carers compare with numbers of carers potentially in need of support? What are the gaps and potential gaps in publicly funded services for different levels of client need? What might be the impact on costs of changing eligibility criteria?</li> </ul>
What else do you need to do?	<ul style="list-style-type: none"> <li>• Collate and analyse information on market provision - to assess gaps in service provision against need (whole population)</li> <li>• Use social services activity information to get a full picture of the profile of current clients, trends in demand for services, and service response (see below)</li> </ul>

## Service user profiling

<p>Examples of what you need to consider</p>	<ul style="list-style-type: none"> <li>• Trends in service take-up</li> <li>• Trends in demand for publicly funded services and how this breaks down into eligible, not eligible need</li> <li>• Profile of service users by level of need</li> <li>• Service user feedback</li> </ul>
<p>How you can use Planning4care</p>	<ul style="list-style-type: none"> <li>• Planning4care uses local authorities' published statistical returns on service provision to calculate the current 'strike-rate', i.e. the proportion of people at different levels of need who are currently receiving local authority services, and the level and type of care they receive. Understanding these patterns is the starting point for considering options for a different balance of provision in the future.</li> <li>• Planning4care can show you geographical spread of service users by mapping current service user populations to the base map of all people with social care needs if post-code information on current clients is made available</li> </ul>
<p>What else do you need to do?</p>	<ul style="list-style-type: none"> <li>• Most authorities have a wealth of data about service users, yet often this is in a format where extracting and analysing that data in order to help plan future commissioning is very difficult. We suggest that, to optimise the use of Planning4care population analysis, you should consider how you may map the current client population to the social care needs classification. For example, our pilot work and recent work by the PSSRU has shown a strong overall correlation between the ADL based needs groups used in planning4care and FAC levels.</li> <li>• Another priority area would be systematic monitoring of demand by needs level, including people falling outside eligibility criteria (as an indication of unmet need).</li> </ul>

## Anticipating and planning for the future

*Projecting forward current need and the implications for future social care (examples)*

Examples of what you need to consider	<ul style="list-style-type: none"> <li>• How the number of people with social care needs is likely to change (as a result of changing demographics)?</li> <li>• What does this mean for likely future service requirements and costs (based on current baseline patterns)?</li> </ul>
How you can use Planning4care	<ul style="list-style-type: none"> <li>• Planning4care calculates the numbers of people falling into each needs group for each year over the next 20 years and the effect this may be expected to have on requirements for services and on overall costs. This is your essential starting point for financial planning and for considering strategic options for the future.</li> </ul>
What else do you need to do?	<ul style="list-style-type: none"> <li>• Share this picture with all your stakeholders to promote a common starting point in early consultations about the commissioning strategy.</li> <li>• Sharing the financial overview with elected members will be a crucial part of negotiations for a strategic budget framework</li> </ul>

*Anticipating changes in needs and aspirations, and implications for services and costs*

Examples of what you need to consider	<ul style="list-style-type: none"> <li>• What are potential future service requirements and costs (based on alternative service patterns) ?</li> <li>• How would this change under different scenarios relating to             <ul style="list-style-type: none"> <li>○ Population growth</li> <li>○ Healthy life expectancy</li> <li>○ Change in informal care</li> <li>○ Impact of more effective prevention</li> </ul> </li> <li>• How may future expectations on services change amongst relevant groups</li> </ul>
How you can use Planning4care	<ul style="list-style-type: none"> <li>• Planning4care version 2 provides you with the facility to look at impact of population trends and a range of future scenarios             <ul style="list-style-type: none"> <li>○ Changes in 'typical' care packages</li> <li>○ Impact of shifts in residential care</li> <li>○ 'What-if' analyses based on impact of potential changes in patterns of informal care, health status, investment in prevention, unit costs</li> </ul> </li> <li>• You can use these scenarios to explore what changes might happen, or be planned, and with what impact, either short term (3+ years) e.g. for LAAs, longer term for strategic planning</li> </ul>
What else do you need to do?	<ul style="list-style-type: none"> <li>• There is also a need to develop a more qualitative picture of what services people may aspire to in the future, for example using the methodology developed by CSED, <i>Anticipating Future Needs Toolkit</i><sup>43</sup>, or a methodology was constructed and tested as part of the <i>Commissioning Exemplar Project</i><sup>44</sup> - see 'Back to the future - Planning into old age'</li> </ul>

<sup>43</sup> Department of Health / CSED (2007), *Anticipating Future Needs Toolkit*

<sup>44</sup> Care Services Improvement Partnership (2007), *Key activities in commissioning social care: Lessons from Care Services Improvement Partnership Commissioning*

## Planning for service re-configuration

### *Cost-benefit analysis*

Examples of what you need to consider	<ul style="list-style-type: none"> <li>• Forming a judgement of relative costs against relative gains or outcomes of changes in provision of care.</li> </ul>
How you can use Planning4care	<ul style="list-style-type: none"> <li>• Planning4care can provide some high level analyses based on 'what-if' scenarios, which may be used to 'justify' alternative investment, though it should be remembered that these can only be broad brush calculations. For example,</li> <li>• You could use the informal care scenarios to predict the potential costs of reduced levels of informal care, or explore what level of increase in the rate of informal care (e.g. through reduction in carer breakdown) would be required to offset a given level of expenditure on increased support to carers.</li> <li>• You could explore potential savings from investments in preventative services by calculating the reduction in costs of a reduced number of people requiring very high levels of care over, say, a ten year period.</li> <li>• You could explore potential impact on costs by reduced levels of residential care substituted by community packages.</li> <li>• With the introduction of personal budgets and resource allocation formula (RAS), there is potential to map the RAS to Planning4care needs groups and model potential overall costs on this basis.</li> </ul>
What else do you need to do?	<ul style="list-style-type: none"> <li>• Measure and monitor impact of investment in preventative services against the hoped-for benefits.</li> </ul>

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*Exemplar Project, Second edition, Appendix 2: 'Back to the future - Planning into old age*