

Leicestershire County Council

Strategic Needs Assessment (Older People) – Whole systems modelling project



Resume and findings from project – June 2007

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Executive Summary

Leicestershire County Council has achieved high levels of performance in a key national performance indicator over recent years, namely reducing the rate (per 1,000 population) of admissions to long term care. The Whole Systems Partnership were asked to explore factors that have contributed to this success in order to help the Authority evaluate the impact of service development models, for example in the provision of intensive home care packages and the development of innovative services such as the HART team.

This analysis is also designed to inform future strategic planning and strategic commissioning, for example in determining the sustainability and future trajectory of current performance, associated factors or consequences of these trends, as well as the potential impact of future service models, particularly the development of extra care housing.

The project was undertaken between January and June 2007. It involved engagement with a local team of senior managers and practitioners through a series of workshops and has produced a set of separate 'outputs' for each stage of the work, including presentation material. A simulation model underpinning the quantitative outputs from the work has also been made available to the Authority. This final report provides a resume of the key points emerging from the project.

The modelling work was built on careful analysis of local socio-demographic trends as well as historic data analysis (2004-2007), particularly in the area of care home admissions, intensive home care and intermediate care provision. It also considered available information in areas of increasing significance to the Local Authority in its strategic commissioning role such as the contribution of supported accommodation and the nature of the whole long term care market, including that for 'self funders'. The project was set clearly in the context of rising expectations of Local Authorities to undertake strategic commissioning in response to policy (national and local) that is driving toward an increasingly localised and individualised care system.

The project has identified a number of key findings, including:

- The significant impact that shifts in home ownership is and will have over the medium term in shifting the balance of the care home market increasingly toward responding to self funding clients – and the consequence on a performance indicator that only measures rates of admission to long term of Local Authority funded residents;
- The potential impact on both the rate of admission and the changing age profile of people in long term care due to increases in longevity and increases in the length of time people are expected to live with a limiting long term condition – the proportion of people in long term care who are over 85 is set to increase significantly as a result of these types of changes;
- The evidence that despite increased absolute numbers of older people, that both socio-demographic factors and service development initiatives have enabled overall capacity and therefore costs associated with this sector to be managed;
- That whilst socio-demographic changes, increased ability and willingness to support people at home and the development of intermediate care have all contributed to the recent performance in reducing rates of admission to long term care, that that latter makes the most significant contribution – albeit with an acknowledgement that intermediate responses that are

more closely aligned or integrated with health partners would further enhance the contribution of this sector;

- The sensitivity in modelling future long term care capacity requirements to 'length of stay' and particularly the possibility that increased life expectancy for over 85 year olds with limiting long term illness could significantly increase capacity requirements in this sector, and potentially therefore costs to the Local Authority;
- The forecast of a continued downward trajectory in rates of Local Authority funded long term care on the basis of established socio-demographic trends and continued delivery of intensive home care and intermediate care service models;
- The potential to further enhance the network of provision and support for people in the community and therefore provide genuine alternatives to long term care through the development of extra care housing as part of a local network of support.

The work has answered some significant questions for local strategic commissioners of long term care services for the people of Leicestershire. It has also, however, highlighted the challenges facing the Authority in developing key aspects of the market for long care provision, and in exerting its influence as strategic commissioner and market shaper.

Key benefits and ongoing work emerging from this project have included the development of clearer service models and capacity requirements surrounding extra care housing and the initiation of work to understand the way in which current fee rate structures for long term care contribute to or hinder the development of the necessary service model and market of care provision.

1 Introduction

1.1 Background

This project was commissioned to help Leicestershire County Council develop a more robust 'evidence base' for commissioning services for older people, and in particular to address the key question:

"How should we understand the current reducing rates of access to long term care and how might we expect this trend to continue with and/or without 'intervention'."

The development and use of a 'dynamic modelling' tool that has built on available data, but added value by exploring inter-relationships and system behaviour, has enabled those involved in the stakeholder workshops to take ownership of the project. Key issues that have been explored include:

- Recent trends in residential care (downward) and particularly the implications and sustainability of this trend;
- The links (evidence based and/or assumed) between these and the provision of home care;
- The impact that strategy and service development will have, for example rehabilitation and extra care, and their possible contribution to the above;
- Anticipated future demand and how services might need to change to meet this, particularly the balance between residential and nursing care provision on the one hand and rehabilitation and home care on the other.

The approach has sought to reflect the responsibility of the County Council to plan strategically for the whole population as well as to commission services directly for those that they have a financial responsibility for. The project has therefore explored a wide range of socio-demographic and socio-economic factors within the local population, albeit at a relatively 'high level' of aggregation.

1.2 Performance

Relevant performance indicators suggest that Leicestershire has been, and continues to perform well compared to other County Authorities:

- In 2005/06, the proportion of service users supported intensively through home care as opposed to residential or nursing care (PAF B11) was 29% and in the top band of performance. This was higher than the average of similar authorities (26%) and has increased further in 2006/07 to 31%. Furthermore, performance against the national PSA indicator which measures this statistic for older people only is 40%, which is significantly higher than the national target of 34% by March 2008;
- In 2005/06 older people helped to live at home (PAF C32) was 69 per 1,000 >65 and in PAF band 2. However, the national banding thresholds are such that three-quarters of authorities similar to Leicestershire are also in band 2.

Both of these will have a bearing on the rate at which people are admitted to a permanent long term care placement in a care home (PAF C72). In 2005/06, a rate in Leicestershire of 85 per 1,000 population aged 65+ was in the top PAF band of performance and in line with other similar authorities (83 per 1,000 popn. aged 65+). In 2006/07 performance improved and the Leicestershire rate was well within the top band at 82 admissions per 1000 popn. aged 65+.

It is clear from this that performance had been improving in both absolute and relative terms compared to similar Council areas. The objective of this project was partly to determine reasons and sustainability of this trend.

1.3 Approach

The approach adopted has involved:

1. Initial analysis of available information on need and service uptake to inform the process and identify/enable discussion of key questions.
2. A series of one-to-one discussions at an early stage of the project with key individuals to inform and help identify any critical issues from either a particular organisational or professional perspective.
3. Three half-day stakeholder workshops at key stages of the project to engage participants in a confirm and challenge process:
 - a. Defining the boundaries and key questions to be addressed, developing a map of the proposed model;
 - b. Validating a prototype model;
 - c. Testing a quantified simulation model to reflect current and alternative scenarios.
4. Developing a simulation modelling tool to analyse and communicate the key issues, including the analysis of alternative futures.

The work has been undertaken between January and May 2007.

1.4 Project outputs

The project has provided 'interim' outputs in the form of reports from the first two workshops and presentation material that has summarised progress at these stages. This report provides a resume of the final workshop but also describes the rationale and components of the modelling tool, a range of 'answers' to the key question (dependant on assumptions and future scenarios) and a pointer toward the implications for the Department in relation to its strategic commissioning role.

This is not a 'technical' report with regard to the model itself. It remains an option to develop local expertise in both the modelling techniques and the use and adaptation of the model developed during the project. At present the modelling approach, and the model itself, has provided a vehicle to support learning and to communicate the emerging findings from the project.

1.5 'Outstanding' issues

Throughout the project we have sought to remain focussed on the key areas of investigation and to balance our analysis and considerations to ensure they serve the primary objective for the project. However, there remain, as would be expected, some areas of analysis and investigation that may help in further refining both our understanding of the local system and potentially therefore of how the model reflects this in its simulations, for example the purpose and outcomes from temporary admissions to care homes and developing a better understanding of the self funder group in terms of length of stay and financial position.

In addition it was recognised during the project that exploring the supported accommodation sector as it might influence the rate of admissions to long term care would be of some benefit and therefore a separate but related element of the project was initiated. This process has enabled us to ask questions specifically of those

involved in this sector as to the contributory factors that inform people's decisions at key points in their 'care pathway'. It has also resulted in the collection of snap-shot information about supported accommodation tenancies and the linking of this to home care needs.

This area of project development will inform strategies being explored for the development of extra care housing schemes across the County as outlined in the report to Cabinet (5th March 2007).

Finally, whilst undertaking the project the Care Services Efficiency Delivery (CSED) Programme released Version 1.0 of its POPPI tool (Projecting Older People Population Information). The work has therefore undertaken an initial comparison of the content and outputs of this tool alongside the approach and outputs of this project.

2 Model description

2.1 Overview

An overview of the model is provided in Figure 1. It identifies:

- An influence on the need for care (and particularly intensive care at home) from socio-demographic factors;
- The impact of service redesign on the nature and extent of service provision, and particularly intensive care at home;
- The potential contribution that extra care housing (ECH) could make as an alternative to permanent admissions to a care home;
- An extended intensive home support 'sector' where extra care units operate in a hub and spoke model to support significantly more people with intensive levels of care needs but who choose to remain in their own homes;
- The different routes into Local Authority funded long term care either direct from home, sometimes following a temporary admission, or via a period of 'self-funded' long term care.

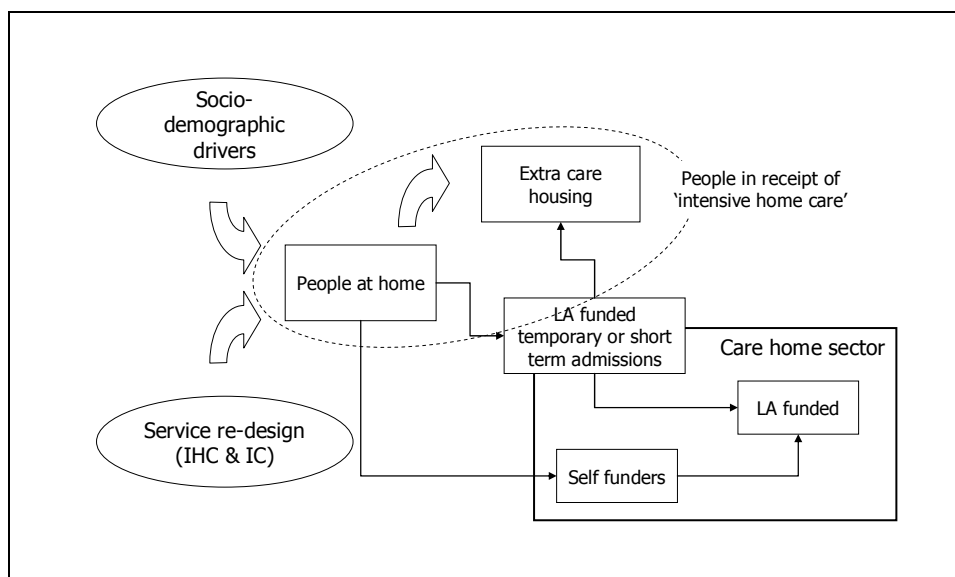


Figure 1 Schematic representation of 'concept' model

This 'schematic' of the model has been developed with the stakeholder group and represents a simple, high level view of what has subsequently been built using modelling software¹.

2.2 Socio-demographic factors

Traditional modelling approaches have represented the demographic impact on care needs through a simple extrapolation of rates per head of population in the light of changes in the population profile, i.e. increased numbers of older people. This project, however, has considered a number of other important elements of the socio-demographic context, namely:

- The demographic profile for 65-74, 75-84 and >85 year old age bands and specific age-related need and rates of access to care;
- Changes in life expectancy and particularly 'healthy' life expectancy;
- Numbers of people living alone and the availability of family support;
- Housing tenure and the potential impact this has on routes into Local Authority funded long term care.

A more detailed set of information is available in the presentation material developed for the third stakeholder workshop. The key 'evidence' incorporated into the model from these considerations, however, can be summarised as:

- An increase in life expectancy but also a proportionate increase in life expectancy with a limiting long term illness (for example at a national level between 1991 and 2001 life expectancy for a man at 65 increased overall by 1.8 years to 81.1 years, however, 'healthy' life expectancy at 65 only increased by 1 year to 74 meaning that a proportion of the extended life years would be spent with potentially significant care needs). This has been factored into the model by reducing rates of need amongst 65 to 74 year olds to reflect the extended healthy life expectancy at 65 but increasing rates of need for over 85 year olds in the light of the extended life expectancy with limiting long term illness;
- The number of people living alone in old age varies by age group. For the under 85's there has been little change in Leicestershire over the last 10 years. For the over 85's the rate, and therefore number, of people living alone has fallen slightly for males (37% to 36%) but increased for females (51% to 54%). Half of the overall increase in the numbers of older people living alone is accounted for by the over 85 age group despite the relatively small overall proportion that this group contributes to the whole. However, in addition the proportion of over 85 year olds with two or more surviving children is set to increase from 50% in 1995 to 75% in 2015, suggesting a larger pool of potential family carers. This has been factored into the model through the development of a 'family support index' that modifies the rate at which people present for care needs;
- The proportion of older people who own their own homes is steadily increasing, meaning that at the point of considering long term care consideration to 'asset management' is likely to be given, for example between 2001 and 2011 it is expected that home ownership amongst the >85 year old age group could increase from 47% to 53%. In the model this has the effect of modifying the pathway to long term care to increase the rate of self-funders comparative to those seeking Local Authority funding, with a 'downstream' impact on Local Authority funding for those in long term care whose assets become exhausted.

¹ The project uses 'ithink' software.

These factors are illustrated in Figure 2, which demonstrates the way in which they work together to affect the eventual call on care services and particularly potential for admission to Local Authority funded long term care.

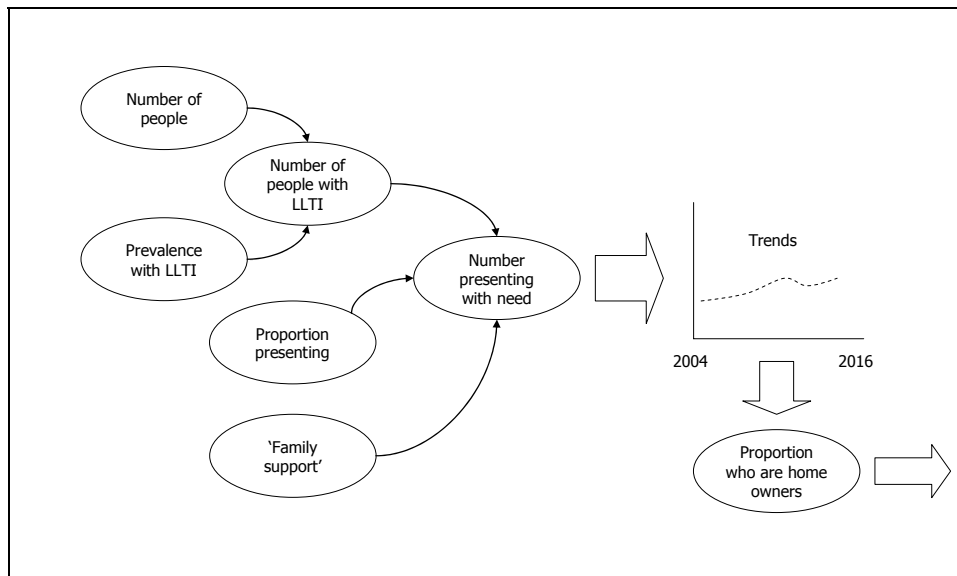


Figure 2 Overview of socio-demographic influences on 'presenting need'

The model outputs generated from this sector, i.e. the socio-demographic 'driver' for potential long term care needs, provides a useful profile over time by age group. Key elements of this profile are:

- That in absolute numbers the need for new care amongst the 65 to 74 age group has fallen in the last few years and increases only slowly from now up to 2016. However, the rate per 1,000 65-74 year olds likely to require Local Authority funded long term care, continues to fall throughout the modelling period (i.e. 2004 to 2016), largely due to improved healthy life expectancy and increased home ownership within this age group;
- That in absolute numbers the need for new care amongst the 75 to 84 age group has remained static in the last few years and increases only slowly from 2009 up to 2016. However, the rate per 1,000 75-84 year olds likely to require Local Authority funded long term care, continues to fall throughout the modelling period (i.e. 2004 to 2016), largely due to anticipated increased home ownership;
- That in absolute numbers the need for new care amongst the 85 plus age group increases gradually (approximately 0.8% p.a.) over the modelling period. However, the rate per 1,000 over 85 year olds likely to require Local Authority funded long term care continues to fall throughout the modelling period (i.e. 2004 to 2016), due to increased home ownership despite increased life expectancy with a limiting long term illness;
- As a consequence of the above any increase in absolute numbers of people presenting for new care needs will be largely accounted for by people who will own their own homes and therefore who, if progressing to need long term care, would be self-funders.

Figure 3 illustrates the profile for changes in the rate at which each of the three age groups present for new care needs (per thousand of the over 65 population) as a consequence of the combined factors described above – i.e. the socio-demographic driver for new care needs at the 'front-end' of the model.

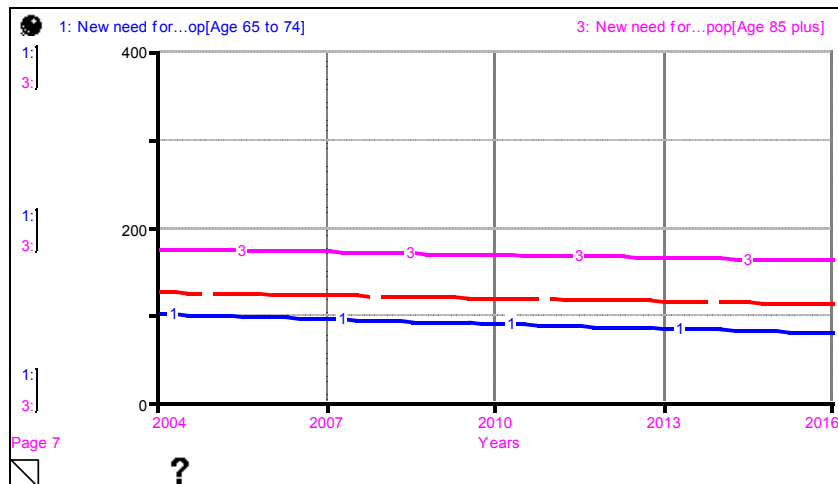


Figure 3 Rate of new need per thousand >65 population by age band (2004 to 2016)

3 Exploring the impact of service changes

3.1 Introduction

The preceding section has outlined the approach to developing the socio-demographic driver for new care needs at the 'front-end' of the system. The model has been developed to translate this, with or without service developments, into outputs representing the key performance indicators, as reflected in Figure 1.

Figure 4 reflects the potential rate of admissions to Local Authority funded long term care in the light of population changes only, i.e. extrapolation of current rates of access not taking into account wider socio-demographic factors (profile 1). The rise between 2004 and 2007 is a reflection of the significant increase in over 85 year olds over this period which moderates over the medium term (up to 2013) with further rises expected by the mid-2010's. In profile 1 rates of admission would have risen from 98 in 2004 to c.104 by 2007 and would remain above 100 over the modelling period.

Profile 2 modifies this by using the socio-demographic drivers described above and suggests a 'reduced rate of increase' over recent years. This does not, however, explain the actual reductions in this headline performance indicator as outlined in section 1.2 of this report, for which explanations need to be sought in the changes in service that have been developed in recent years.

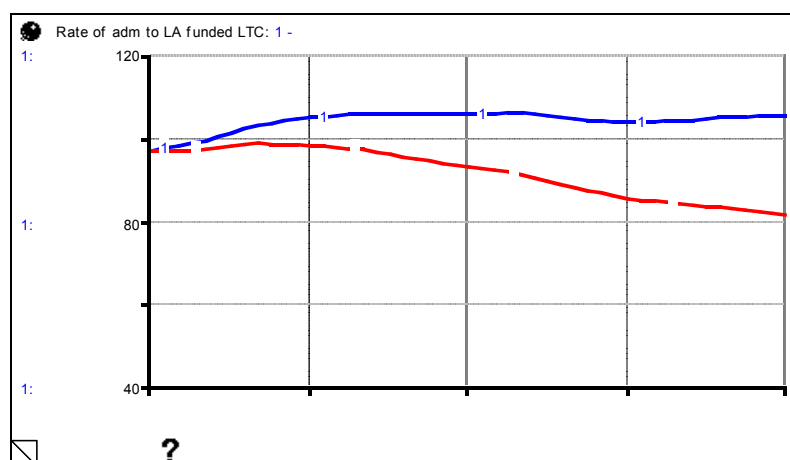


Figure 4 Rate of admission to long term care (reflecting PAF C72) using raw population data (profile 1) and with the influence of socio-demographic changes included (profile 2).

3.2 Home care

Between April 2004 and March 2005 3,202 new packages of care were commenced at home of which 17% were for over 10 hours a week (i.e. intensive packages) and 54% were for people over the age of 85. Over a similar period two years later (the most recent available data) the number of new packages had increased to 4,144 with 20% being for over 10 hours a week and 44% being for people over the age of 85.

This suggests a significant increase in the number of intensive home care packages being provided, although there appears to be a disproportionate increase for people under the age of 85. Figure 5 illustrates this trend. The significant increase in the younger age groups is illustrated further by the contents of Table 1, which identifies a doubling in the rate per 1,000 in both 65 to 74 and 75 to 84 age bands but only an increase of 7.5% for the over 85's. Further analysis has suggested that these increases are accounted for largely by the more intensive packages of more than 20 hours a week for people who are over 75 years of age (see appendix).

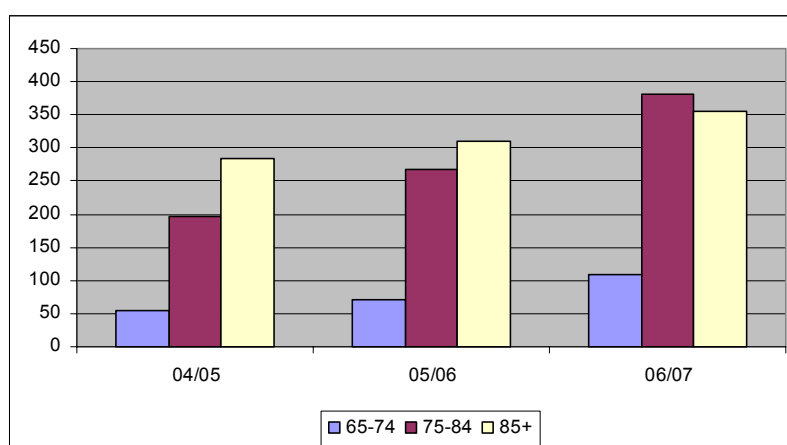


Figure 5 New home care packages of >10hr a week commenced by age group

Year	65-74	75-84	85+
2004	1.0	5.5	26.5
2005	1.3	7.4	27.0
2006	2.0	10.4	28.5

Table 1 Rate of new >10hr a week packages per 1000 population

In terms of modelling these changes it is necessary to make an assumption about the 'substitution' effect for long term care that the provision of intensive home care can have either in the short or medium term. Whilst the delivery of a package of intensive home care may not avert a care home admission at the time that the package starts, it is fair to assume that it will delay or avert an admission in a proportion of cases over the period that the support is being provided. In the model we have assumed that this is different for each age band (greater substitution in the older age band), and that overall the substitution effect, as described here, is in the order of 1/3 of cases².

² As with a range of other modelling assumptions these can be modified to explore the impact of alternative assumptions based on evidence if available or differences in 'opinion' and interpretation of the substitution effect.

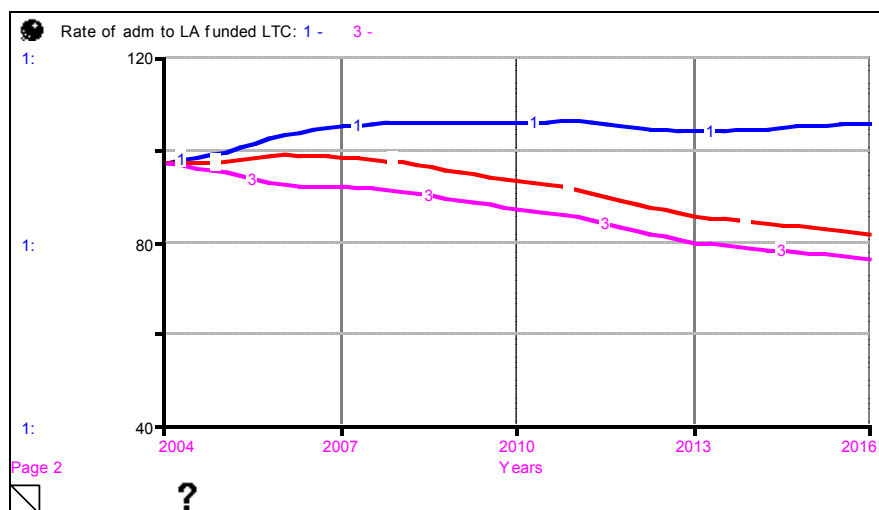


Figure 6 Rate of admission to long term care (reflecting PAF C72) with profile 3 reflecting additional impact of increases in packages of intensive home care between 2004 and 2007.

When these changes are applied to the model to reflect actual historic trends (04/05 to 06/07) the profile for the rate of admission to long term care is further modified as illustrated in Figure 6. It can be seen from this additional profile that the rate of admissions had fallen but remains above the performance actually witnessed in 2006/07 and therefore cannot in itself provide an explanation for the recent reductions.

3.3 Intermediate Care

Intermediate care services have been developed in recent years by the Local Authority as well as in the health sector. For the Local Authority key elements of this service development has been in the establishment and growing effectiveness and capacity in the Home Assessment and Rehabilitation Team (HART). This team provides an initial 8 week period of intensive rehabilitation at the start of each new package of home care with a view to enhancing independence and reducing the potential call on services.

Evidence suggests that there is, on average, a reduction in care input of 25% compared with that initially intended. This means that a significant number of people who benefit from the HART service can no longer be classified as being in receipt of 'intensive home care', thus reducing or delaying the downstream likelihood of them entering long term care.

Residential intermediate care has also been developed with a focus on both dementia and physical rehabilitation. Whilst a significant element of this service is used to facilitate discharge from the acute sector there remains an important role in reducing the likelihood of admission to long term care, particularly for those with dementia.

The modelling has sought to reflect the impact of intermediate care over the last couple of years through both direct 'substitution', i.e. an element of the residential element of intermediate care, and by increasing independence and therefore reducing the likely 'downstream' rate of admissions to long term care. The combined effect of this is illustrated in Figure 7 (with cumulative effect building on previous elements described above).

It can be seen that the rate of admission to Local Authority Funded Long Term Care has now reduced to approximately the level experienced, i.e. mid-80's. The model has therefore been able to 'simulate' the different contributions to the recent

reductions in admission rates to long term. What is now necessary is a discussion of additional potential actions and the sustainability of these trends.

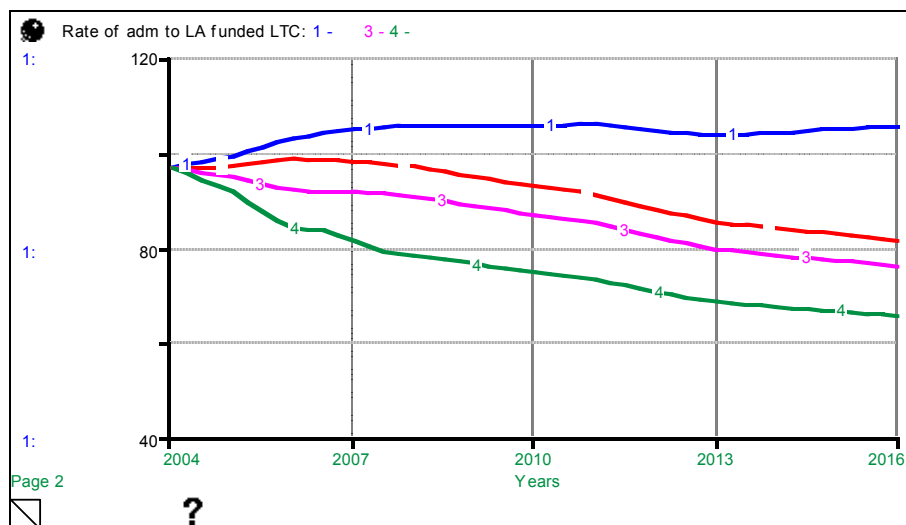


Figure 7 Rate of admission to long term care (reflecting PAF C72) with profile 4 reflecting additional impact of intermediate care developments

3.4 Extra Care Housing

At present there are four schemes with a total of 139 tenancies for extra care housing. The model has been developed to explore the potential additional impact of further development in this area, albeit based on an assumption (which can be modified in the model) that there is currently an 8% substitution effect of new extra care housing capacity for residential care, rising to 33% by 2016. Figures 8 and 9 illustrate this effect if a target of 500 units (8) and, alternatively 1000 units (9) of Extra Care Housing were developed.

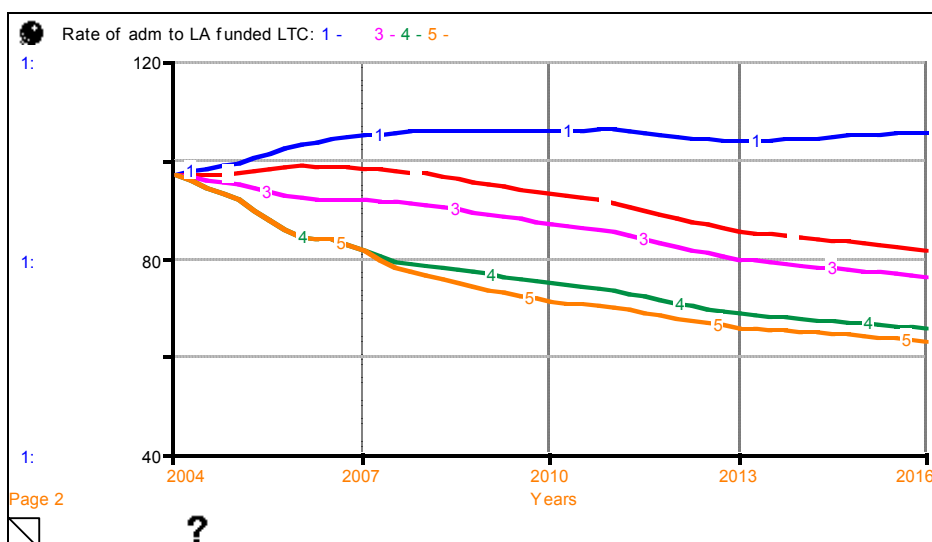


Figure 8 Rate of admission to long term care (reflecting PAF C72) with profile 5 reflecting the development of 500 units of extra care housing

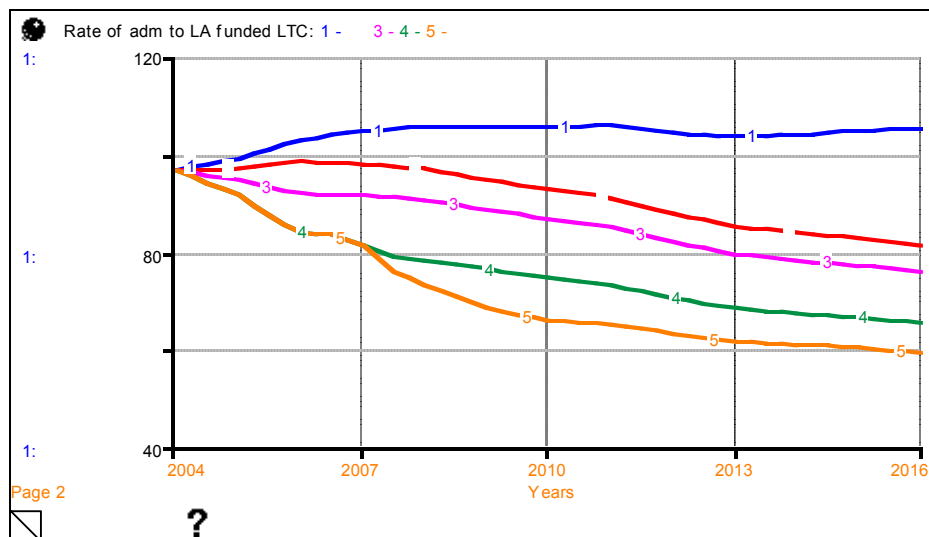


Figure 9 Rate of admission to long term care (reflecting PAF C72) with profile 5 reflecting the development of 1000 units of extra care housing

3.5 Extra Care Housing Hub and Spoke Model

The provision of 'Intensive Home Care' can be augmented by the emerging model of ECH as part of a local system of enhanced support for people, both in these ECH units and for people remaining at home. The simulation model has been developed so that as new ECH units are implemented there is a proportionate increase in the provision of Intensive Home Care, by a factor of 20%. Figure 10 (profile 5) shows the added effect of including this assumption of increased provision of Intensive Home Care.

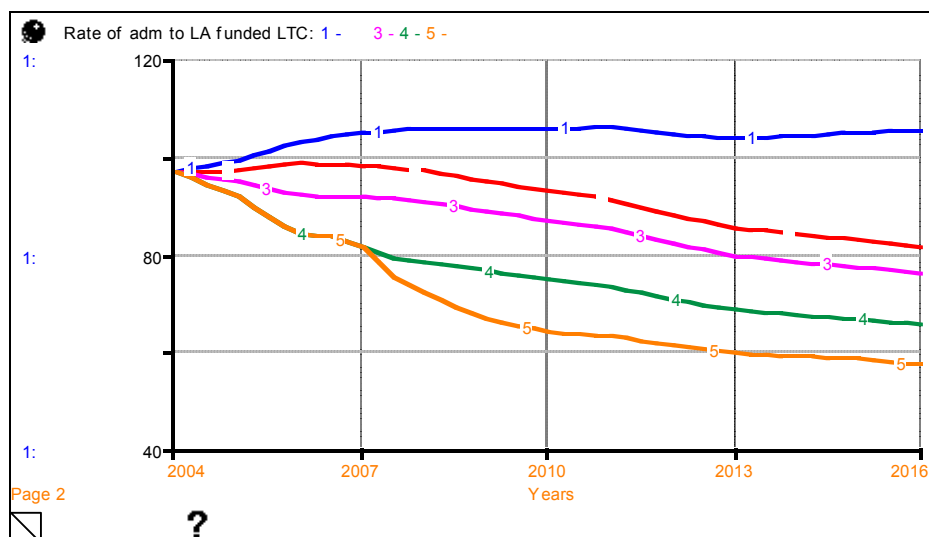


Figure 10 Rate of admission to long term care (reflecting PAF C72) with profile 6 reflecting the development of 1000 units of extra care housing and the staff at these units augmenting the provision of IHC.

This scenario suggest the potential to achieve rates of admission to Local Authority funded long term care approaching 60 per 1,000 >65 population over the medium term. However, the cost to the Local Authority for these clients is determined by how many people are in long term care at a point in time and is therefore sensitive to people's anticipated 'length of stay' in a care home. Equally the size of the care

home market is also affected by 'length of stay' as well as the number of self-funders (see section 3.7 below).

3.6 Over 85 population in long term care

The simulation model has been designed to enable a range of outputs to be generated in both graphical and tabular format. An additional output that has significance for both commissioners and providers of long term care is the shift, already inferred in the socio-demographic analysis, toward greater numbers of >85 year olds likely to be in long term care.

Figure 11 shows the percentage of long term care residents who will be over 85 in the following 5 scenarios:

1. Population effects only;
2. Added in socio-demographic impacts;
3. Plus shift in IHC capacity;
4. Plus changes to intermediate care;
5. Plus implementing an extra 1000 ECH units and, the hub and spoke model impacting IHC.

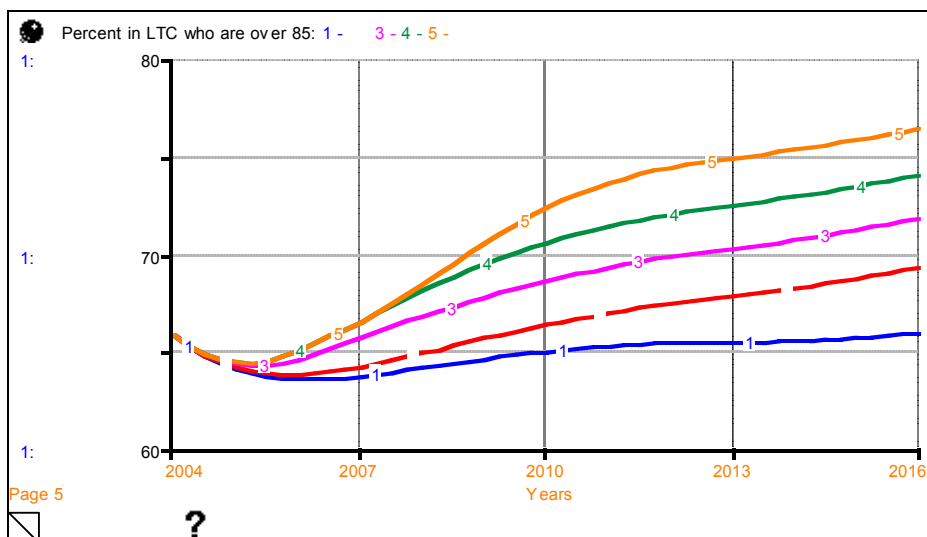


Figure 11 Percentage of long term care residents who are over 85 in the 5 scenarios described in this section³

The model outputs suggest a rise under all scenarios from the current (2007) 64% to between 66% and 76% - with clear implications for the complexity and nature of the care support required when both physical and organic mental health needs is taken into account for this client group.

3.7 The long term care market

A final output illustrated here is the overall capacity requirement in the long term care sector. In addition to changes in admission rates described and simulated above there will be an impact on the capacity requirement in the sector as a result of differences in length of stay by age group and over time.

³ Profile 5 assumes 1000 extra units of Extra Care Housing

Average lengths of stay have been estimated for each age group through analysis of actual episodes in care homes between 2005 and 2007 and trends established. The model enables the user to assume either static or trending lengths of stay as alternative scenarios. Outputs in this section of the report are based on static average lengths of stay. The differences in length of stay between age groups is factored into Figure 12. The five scenarios listed in Section 3.6 are again tested here.

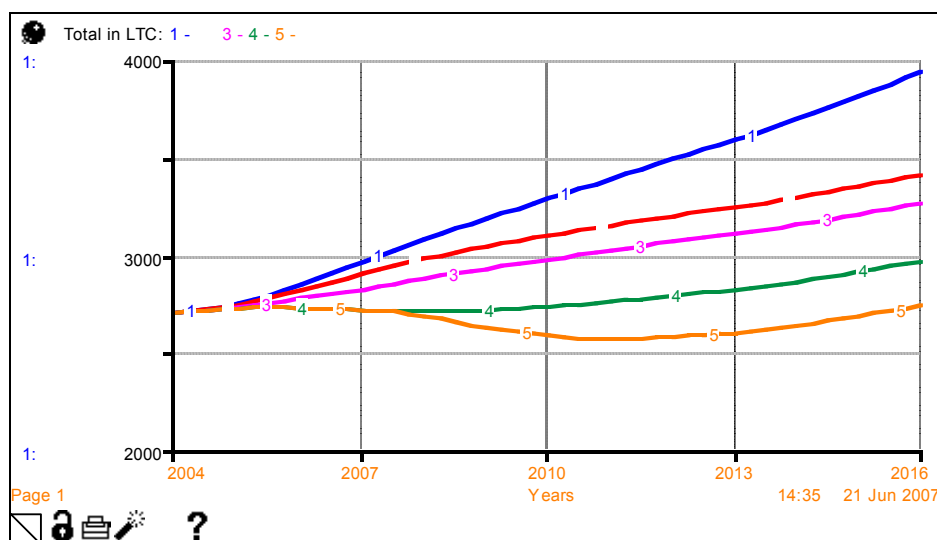


Figure 12 Capacity requirement in the long term care sector in line with the descriptions and scenarios developed in this section⁴

The output demonstrates an overall reduction in sector capacity requirements up to about 2010 but then a gradual increase. This will be due in part to the shifting demography of those in long term care, i.e. more over 85 year olds, who at present stay longer in care homes than the 75 to 84 age group. Analysis of the average lengths of stay are referenced in the Appendix. The application of these trends in the model significantly increases the possible capacity requirement in long term care. However, there remains some uncertainty in how reliable or sustainable the recent trends identified in the analysis would be.

3.8 'Futures'

Model outputs described above reflect futures taking into account socio-demographic changes and policies relating to extra care housing and the linked ongoing development of capacity to provide intensive support at home. It does not, however, factor in other potential areas of development such as:

- Increased capacity and capability, particularly in the context of increased partnership working with health, of the intermediate care sector;
- Changes in the nature of the market itself in response to changing needs and the potential for increased capacity in the short stay or specialist care home sectors.

Whilst simple projections can be developed using the model a key issue emerging out of the stakeholder workshop process has been to recognise both the changing expectations of citizens in relation to the services they need/want and the radical changes in the 'mechanisms' through which such a future will emerge, particularly the localisation agenda and development of individual budgets.

⁴ Profile 5 assumes 1000 extra units of Extra Care Housing

3.9 Summary

The results of these tests on the rates of access to LA funded long term care are summarised in Table 2.

	2004	2007	2010	2013	2016
Population effects only	97	105	106	104	106
Socio-demographic impacts	97	98	93	85	82
Shift in IHC capacity	97	92	87	80	76
Changes to intermediate care	97	81	75	68	65
Extra 1000 ECH units	97	81	66	62	59
Extra 1000 ECH units and, the hub and spoke model impacting IHC	97	81	64	60	57

Table 2 Showing ‘admissions per year’ into Local Authority funded long term care. Each initiative is incremental on the previous ones⁵.

4 Wider learning

4.1 Stakeholder workshop insights

At the third stakeholder workshop participants were asked to identify:

- The most significant ways in which the model had thrown light on the question of understanding changes in the rate of admission to long term care?
- The most significant uncertainties or gaps in our understanding – i.e. the development priorities?
- Key elements of the market, as people expect it to develop, over the next 5 years.

The ‘raw’ response to these questions is summarised in Table 3.

Insights	Development priorities	The future market
Throwing light on the nature and scale of impact from service changes to long term care admissions. Potential for exploring cost-benefit of service developments. Ability to see the ‘whole’ system in one model. Can inform the development of end of life care. Enhanced ability to explore investment/dis-investment options – i.e. market shaping. Building of engagement and trust between stakeholders.	Impact of adaptations, equipment and assistive technology to the future shape of the market. Contribution of health services and benefits of joint or integrated working (commissioning or provision) are not factored in. Some assumptions may need exploring, refining, evidencing. How would service users and care input to developing the model have affected it?	Self directed care will have significant impact. Retirement villages. Impact of changing health services on Local Authority commissioning. Buying power of individualised budgets.

Table 3 Key issues identified by stakeholder workshop participants

⁵ A 2004 admission rate of 97 has been factored into the model as being a ‘realistic’ ball-park figure. The actual admission rate at 2004 is being calculated at the time of writing this report.

4.2 The Commissioning Challenge

Older people as purchasers and consumers of services will continue to reflect the values of their upbringing and cultural experiences. These generational differences, and the influences of their 'families', have the power to significantly influence the range and nature of the 'market' available to support their care needs as they grow older. This will be reflected not only in differing views of the nature, type and delivery of personal support but also of family expectations of how those decisions, including the purchasing ones, are made. Ensuring that those most vulnerable and less economically independent are positively able to assert the same rights and with the same expectations will be fundamental to ensuring a single high quality market.

The final workshop began the process of exploring the nature and ambiguities inherent in the above. The challenges below begin to scope their nature:

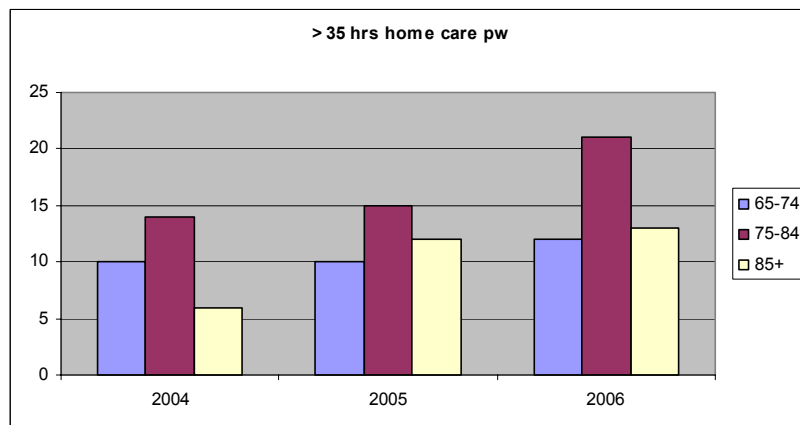
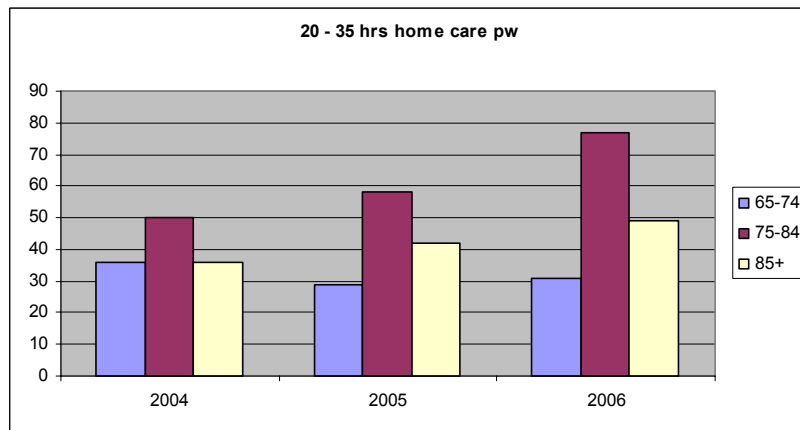
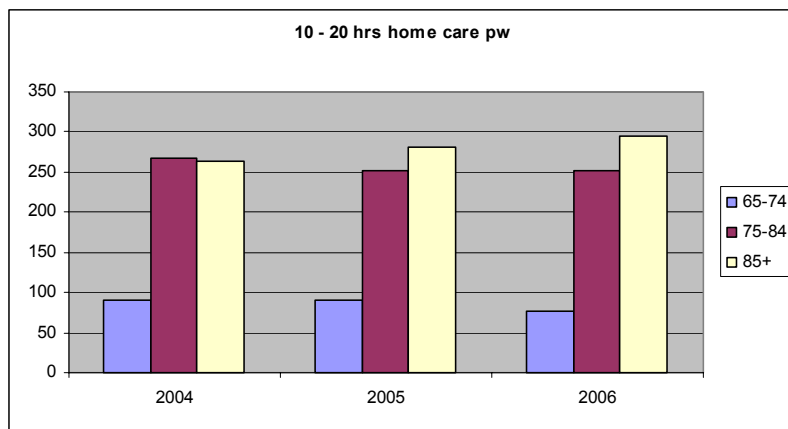
1. To clearly identify the 'values' that should drive the commissioning process, both informing the 'place shaping' Local Authority function and the models of organisational delivery that commissioners wish to support.
2. Whilst acknowledging that individual purchasing power for those with assets will pre-determine a proportion of the supply side, the promotion of choice and the maintenance of the highest level of independence and civic engagement for the most vulnerable is a key responsibility of the commissioners. To achieve this requires a distinct 'shape' of a future market to be developed and promoted, as the supply side will not necessarily naturally achieve this.
3. That an integrated and single commissioning process for the most vulnerable conducted with health commissioners is a pre-requisite of 'shaping' a comprehensive service profile. Achieving 'joint' benefit as organisations would also be paralleled by consumer benefit. End of life care would be an excellent example of this approach.
4. With the acceleration of personalisation policies and the development of resource allocations and processes to support joint commissioning, commissioners need to act to locally regulate and commission for outcomes and standards to legitimately protect individual consumers from low quality, poor outcome providers. This role will become increasingly important.
5. The commissioning function will need to address the principle of delivery and therefore workforce development, needing to be more flexible and mobile in supporting individuals as their needs change and become greater and more intensive in order to ensure continuity of environment. More rapid and tiered approaches to extra care housing would require adoption of this principle.

Appendix – further analysis

During the development of the model a number of areas were explored that could throw light on future developments in the model, and therefore in our understanding of the system behaviour being explored. These have not been reflected in the current version of the model but are provided here for information.

Rates of new Intensive Home Care by age group and levels of support

The following graphs illustrate the changes in the number of new packages of 'intensive home care' by age group over the three years of analysis but split into 10-20hrs, 20-35hrs and over 35hrs. This analysis would enable a more focussed approach to developed in understanding the nature and trends within the intensive home care sector. They add to the commentary provided at section 3.2 of the main report illustrating the increases in larger packages especially for the over 75s.



Temporary and respite admissions

This table shows admissions to care homes, supported by the Local Authority, since April 2005. It compares temporary with permanent admissions together with their relevant average lengths of stay (AVLOS). We have used this information to calculate the occupied days (OBDs) for each category, for comparison. This comparison provides a sense of the relative shares of this resource between the two groups of people.

	Admissions	AVLOS	OBDs	OBDs %
Permanent	2325	156.24	363258	78%
Temporary	6868	14.69	100891	22%
Total	9193		464149	100%