FIRST REPORT FOR THE RANGE AND CAPACITY REVIEW: PROJECTIONS OF COMMUNITY CARE SERVICE USERS, WORKFORCE AND COSTS

16 JULY 2004

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Chapter 1 – Introduction to the report

This is the first report of the Scottish Executive Health Department's Range and Capacity Review of Community Care Services for Older People in Scotland. The report contains projections of the numbers of community care service users, along with the associated workforce and costs, at national level up to 2019. **These projections are based on a number of assumptions and do not provide a conclusive evaluation of what might happen in the future.**

The report focuses on key community care services – the services included are not an exhaustive list of the community care services that are available to older people. It is also acknowledged that there will be an impact on community care services from initiatives in areas such as acute services and chronic disease management, which have not been included in this report.

This is the first report of the review – a second report will be published which will build on and develop the work described in this report. Our intention is continuously to review and develop the model, which will enable changes, such as in service provision and the use of new technology, to be incorporated. The underlying data will also be updated when new figures become available. It is intended that the model will provide the most up-to-date picture of the current balance of care.

Many local authorities or partnerships are currently engaged in local capacity planning work in their own areas. The projections in this report are at a national level only, and will not be wholly applicable to all local circumstances. Our intention, however, is to develop the model so that it can be used at the local level and make it available shortly after the publication of this report to local authorities to enable them, if they choose, to use it as part of their local capacity planning.

The remainder of this introduction briefly outlines the content of the report.

Chapter 2 introduces the background to the range and capacity review, and the reasoning behind it.

Chapter 3 describes the background to the model.

Chapter 4 discusses some of the services and subjects that could not be included in the report.

Chapter 5 looks at the baseline data, and describes how it was collected. This section includes details of the data sources used and explains the assumptions which were made when compiling the baseline.

Chapter 6 contains the population projections which underpin all the projections produced in this report.

The subsequent seven chapters look at the projections produced when different scenarios are considered. The purpose of this is to show the extent to which the projections differ when the underlying assumptions are changed. **None of the scenarios considered in this report should be interpreted as indicative of what is expected to happen in the future; nor are**

they proposals for new policies. They have been chosen purely to demonstrate the effect on the projections of applying different assumptions to the model.

Chapter 7 gives details of the base model, where population projections are the main driver. This section explains the assumptions made and presents projections of the numbers of recipients, workforce and costs over the next 5,10 and 15 years. This model is called the base model as the other scenarios build on its assumptions. **The base model projections show what could happen if everything were to remain as it is today and are not intended to show what is thought to be most likely to happen.**

Chapter 8 looks at what could happen if people in an NHS bed or care home, and classified as being of low or moderate dependency, live at home and are given LA-provided home care and community nursing as an alternative.

Chapter 9 gives projections assuming that those in an NHS bed, and classified as being of low or moderate dependency, can be accommodated in a care home.

Chapter 10 assumes that people receiving 20 or more hours a week of LA home care are moved to a care home.

Chapter 11 considers what could happen if formal care is offered as a substitute to a proportion of people receiving informal care.

Chapter 12 shows how the expenditure projections can vary by changing the annual increase applied to the unit costs.

Chapter 13 incorporates recommendations from the Joint Future Agenda into the base model.

The final section, chapter 14, discusses the possible future work of the range and capacity review.

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Chapter 2 – Background to the range and capacity review

In August 2001, the Minister for Health and Community Care asked the Head of the Scottish Executive Health Department to consider the problem of delayed discharges in Scotland and to report on both the short- and longer-term actions needed to resolve this problem. This resulted in the publication of the Delayed Discharge Action Plan in March 2002, which suggested a number of actions to tackle the problem, one of which involved a range and capacity review of community care services for older people.

A number of issues had been raised at the time, including the need to help stimulate the development required of the whole systems approach to contribute both to reducing the incidence of delayed discharge and to achieving the required shift in the balance of care from institutional to home-based settings. Other problems highlighted in the past have included the fact that as there is no overall strategy for developing the care home market the provision is patchy across the country. In some places it is very near its capacity, while in other places it is as yet undeveloped. There is a range of care options available, which the review considers.

From the NHS perspective, with advances in medical treatment, the health sector has been moving towards shorter periods of treatment and shorter lengths of stay in hospital. With a more intensive use of beds and more rapid turnover, more people are being treated in hospital, but for shorter periods of time. There has also been a reduction in the number of continuing care beds and a move to care in the community.

Local authority models of community care have also been changing, with a move away from care in care homes to more support for people in the community to help them live as independent a life as possible in their own homes for as long as possible. There are some concerns, however, that these changes in the pattern of care have developed unevenly and have resulted in a gap in provision for some people between NHS hospital care and care at home or in a care home. There is a need for new models of care to be developed to recognise this, with more intermediate rehabilitation taking place to maximise the independence of the older people involved.

The range and capacity review being carried out by the Scottish Executive, in conjunction with health and local authority representatives and members of the independent sector, is seeking to address some of these issues and assist the short- and long-term planning of local partnerships by looking at the levels of community care services for older people over the next 5,10 and 15 years, as a means of identifying the most effective way of developing and managing the market to meet future needs.

Chapter 3 – Background to the model

The model looks at the demand for, and financing of, key community care services for older people in Scotland. It projects the numbers of community care service users, along with the associated workforce and costs, at national level for each year up to 2019.

A baseline of the numbers of recipients, staff and unit costs was collected to give the most recent figures available. (Chapter 4 describes the baseline data in more detail.) Where possible, data were collected by age (65-74, 75-84 and 85+) and gender, dividing the older population into six sub-groups. The base model assumptions, described in chapter 5, were used to update the baseline data to 2004, which is the starting point for the projections. (Projected figures relate to financial years but calendar years are referred to in this report for presentational reasons. For example, 2004 refers to the financial year 2004/5.)

The projections are estimates based on the most recent data available, the latest population projections and various assumptions. They cannot be assumed to be predicting what will happen in the future with complete certainty.

Chapter 4 – Services and subjects not included in the main report

The report focuses on key community care services. These are not an exhaustive list of the community care services available to older people. In particular, there are a number of services and subjects which had been identified as being relevant to the review but which could not be included in the report. These areas are discussed below.

Health and dependency levels

Changes in health and dependency levels have not been taken into account in the projections, because of the lack of firm evidence to suggest what might happen in the future. One scenario might be that people remain healthier for longer and require fewer, and less intensive, community care services. Another scenario, however, might suggest that advances in technology and treatments are such that people who might otherwise have died are now being better supported and living longer, albeit possibly in ill-health and therefore requiring community care services. The future may be one on which people still require services, but at a later age and for longer periods of time. However, in the absence of firm evidence, health and dependency levels have been assumed to remain constant over time.

Ethnicity

Ethnicity has not been included in the projections produced in this report as no suitable data are available. The Government Actuary's Department does not produce population projections by ethnic group and as the ethnic minority population has increased by 62.3% since the 1991 Census, compared with a total population increase of 1.3%, assuming constant proportions over time from the 2001 Census is likely to produce inaccurate results.

The following table uses data from the Census of Population 2001 to give the number of people living in Scotland by ethnic group on Census day.

Table 1: Population of Scotland by ethnic group, 2001

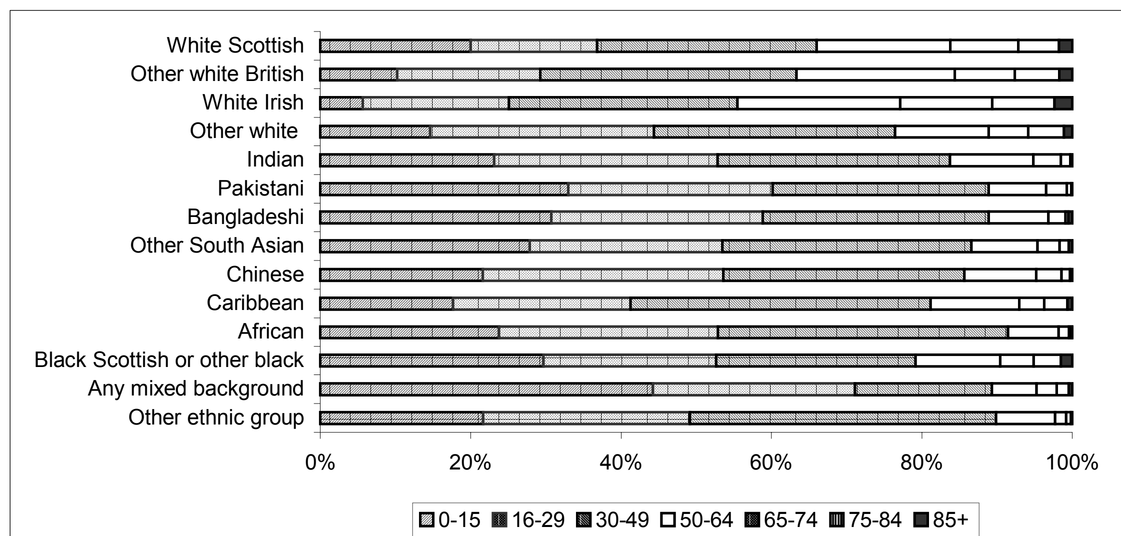
	Number	% of total population
White Scottish	4,459,071	88.09%
Other white British	373,685	7.38%
White Irish	49,428	0.98%
Any other white background	78,150	1.54%
Indian	15,037	0.30%
Pakistani	31,793	0.63%
Bangladeshi	1,981	0.04%
Chinese	16,310	0.32%
Other South Asian	6,196	0.12%
Caribbean	1,778	0.04%
African	5,118	0.10%
Black Scottish or any other black background	1,129	0.02%
Any mixed background	12,764	0.25%
Any other background	9,571	0.19%
Total	5,062,011	100.00%

In 2001, the size of the ethnic minority population was just over 100,000, and formed 2% of the total population of Scotland. Pakistani was the largest ethnic minority group, followed by

Chinese, Indian and then people from a mixed ethnic background.

Chart 1 shows the age profile of Scotland's population by ethnic group on Census day.

Chart 1: Age profile of Scotland's population by ethnic group, 2001



The white groups have an older age profile, with 16% of the combined white population aged 65 or over. With the exception of the black Scottish and other black group (10% of which is aged over 65), the proportion of each ethnic minority group aged 65 or over ranges from 2% to 7%.

Dementia prevalence

There exist some data on the number of people with dementia who receive certain community care services but, due to quality concerns, the data have not been included in the main projections. However, dementia is looked at briefly in this section to give an indication of the numbers of older people who may have dementia now and in the future.

The EURODEM study[1] has developed dementia prevalence rates for Europe by age and gender, based on a number of studies dating from 1980 to 1990. Table 2 shows the prevalence rates by age and gender.

Table 2: Dementia prevalence rates (EURODEM)

Males						Females					
65-69	70-74	75-79	80-84	85-89	90+	65-69	70-74	75-79	80-84	85-89	90+
0.0217	0.0461	0.0504	0.1209	0.1845	0.32	0.011	0.0386	0.0667	0.135	0.2276	0.3282

[1] 'The prevalence of dementia in Europe: a collaborative study of 1980-1990 findings', Hofman, Rocca, Brayne et al; International Journal of Epidemiology; 20:736-748, from Alzheimer Scotland's website: www.alzscot.org/info/stats.html

Table 3 applies the dementia prevalence rates to population projections, assuming the age/gender prevalence rates remain constant over time, to estimate the number of people with dementia up to 2019. Some of these people will be cared for in a hospital or care home, whilst others will be living in the community, either in their own homes or in sheltered accommodation. Those living in the community could be receiving a range of services, for example LA home care, informal care and day care.

Table 3: Projected number of people with dementia (thousands)

	2004	2009	2014	2018	2004 - 2019
65-74	12.7	13.2 (4%)	14.3 (8%)	15.9 (11%)	26%
75-84	25.5	26.1 (2%)	28.2 (8%)	30.6 (8%)	20%
85+	21.9	25.6 (17%)	29.8 (16%)	34.8 (17%)	59%
65+	60.1	64.8 (8%)	72.2 (11%)	81.3 (13%)	35%

Using the EURODEM prevalence rates, it is estimated that 7% of the population aged 65+ has dementia. This increases to 26% for the population aged 85+.

Rehabilitative services and intermediate care

Rehabilitative services and intermediate care are important services which can help prevent admissions to, and enable rapid discharges from, hospitals or care homes. As these services enable more people to be cared for in the community, they also need to be considered in conjunction with services such as community nursing and LA home care.

As there are no known data for rehabilitative services or intermediate care, these services have not been included in the projections.

Length of stay information

The length of time people spend in a particular service has not been incorporated into the model, and it is assumed that an individual receiving a particular service will do so permanently. While the population requiring long-term care is dynamic, and there is movement between and among services, it has not been possible to reflect this in the base model. The scenarios in chapters 8 to 13, which look at how the base model can vary by changing the base assumptions, assume some movement between services but once a move has been made then again that individual is assumed to be permanently using that service.

NHS psychiatry of old age beds

Data are available on the number of patients under the specialty ‘psychiatry of old age’, but long-stay patients cannot be identified from the short-stay or respite patients. Therefore, as the review is currently interested in long-stay patients only, projections for the numbers of psychiatry of old age patients have not been included.

Continuing care

The next phase of the review will look at how continuing care is used, and what alternatives are available in respect of community and rehabilitative services.

See also the discussion in this chapter under ‘Rehabilitative services and intermediate care’.

Care homes

Although figures for care homes with/without nursing will replace the current projections for private nursing homes and residential care homes, at the time of writing, the relevant dataset was undergoing quality checks and baseline data could not therefore be included.

The projections for residential care home and private nursing home residents are for long-stay residents only.

Private nursing homes

As data are not available on the charges made by individual private nursing homes, the charge suggested by the National Review Group has been used in the cost projections for private nursing homes. As the suggested charge is not applicable to privately funded residents, who can be charged any amount, figures on charges from the SE Residential Care Homes Census continue to be used in the cost projections for residential care homes, as it was considered they would produce more accurate projections. See chapter 5 for more details.

Care standards

While it is conceivable that the need to comply with care home standards may lead to a reduction in care home capacity, at a time when there is a need to increase capacity, this is not known with any certainty. The possible effect on care homes of the introduction of care standards will be considered in subsequent work following the publication of this report.

Sheltered housing

As with any dataset, there are quality issues concerning both the Elderly Accommodation Council (EAC) and Scottish Executive (SE) census data. Whilst it is not suggested that the quality of the SE data is necessarily higher than that of the EAC data, it was decided that it is possibly easier to assess and understand the limitations of the SE data. Therefore, although the SE data do not cover all sectors, it was decided that it should be used in the range and capacity review. It was also decided that, as the EAC data definitions are not strictly compatible with the SE data definitions, the EAC data would not be used for the sectors not covered by the SE census.

Respite care

No substantial information on respite care is included in the report (although see the joint future model in chapter 13). Respite care may be considered in subsequent work.

Equipment and adaptations

Equipment and adaptations are significant in helping people to stay at home for longer, and their provision is an important community care service. However, the report 'Equipped for Inclusion: Report of the Strategy Forum: Equipment and Adaptations'[2] found that there are no suitable figures available. For example, it is not known how many people use or require equipment and adaptations, how many items are currently being used or the annual expenditure on this service. An added difficulty when collecting information is that not all items are provided by the same organisation. For example, healthcare items are provided by the NHS, while social care items are provided by local authority social work services.

Although some local authorities do collect information on equipment and adaptations, at present this is not common throughout Scotland and data are not collected centrally. Equipment and adaptations have not therefore been included in the projections.

Housing with care schemes, and other technology

SMART technology is a care package which allows people to live independently in their own home. It may include a number of features, such as flood detectors, extreme heat detectors, fall detectors, automatic door and window openers etc, and can also be used centrally to discreetly monitor people's behaviour patterns, for example sleeping and moving around, to ensure their safety. The SMART technology package individuals receive depends on their assessed level of need, and will be a combination of the features available.

Housing with care uses SMART technology in combination with supported accommodation, personal care services provided by health and social work staff and other support services to enable people to live in the community.

West Lothian's capacity planning report[3] envisages that housing with care is suitable for people with up to moderate dependency levels, or even for short periods of high dependency, for example after an acute illness. It can also be used to provide respite breaks for informal carers.

A number of local authorities are developing these services and using them extensively in their own areas, whereas others have not progressed so far. A national dataset covering these types of services does not exist, and they have not therefore been included in the projections.

Workforce

This is an area which could be considered in the work which will directly follow the publication of this report, which will build on and take forward the work completed here.

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[2] 'Equipped for Inclusion: Report of the Strategy Forum: Equipment and Adaptations', Scottish Executive, 2003.
[3] 'Capacity Planning for Older People in West Lothian', Lardner and Muirhead, 2003.

Costs

At the time of writing, because the care homes dataset is unavailable, it has not been possible to split the projected costs to show free personal and nursing care expenditure and 'hotel' costs separately. When the data are available, free personal/nursing care expenditure and 'hotel' costs will be included in the model, as part of its continuing development.

Chapter 5 - Baseline data

The baseline was collected from Scottish Executive censuses, the Information and Statistics Division (ISD) of NHS Scotland and the Scottish Household Survey (SHS). The population projections are the Government Actuary's Department's 2002-based projections.

Service recipients

Unless otherwise stated, the data are available by age (65-74, 75-84, 85+) and gender.

- NHS bed
  - Source: ISD Scotland's SMR50 patient-based return.
  - Date: 1 April 2003.
  - Description: Patients aged 65+ in geriatric medicine and GP other than obstetrics in a long-stay unit for care of the elderly.

- Private nursing home
  - Source: ISD(S)34 return.
  - Date: 31 March 2002.
  - Description: Long-stay residents aged 65+ living in a private nursing home.
  - The ISD(S)34 return does not contain information on the number of long-stay residents by age and gender. Approximately 96% of all residents are long-stay, and this figure has been applied to the information on all residents, to estimate the number of long-stay residents by age and gender.

- Residential care home
  - Source: Scottish Executive Health Department's (SEHD) R1 return.
  - Date: 31 March 2002.
  - Description: Long-stay residents aged 65+ living in a residential care home.

- Sheltered housing
  - Source: SE Development Department's S1B return.
  - Date: 31 March 2002.
  - Description: People aged 65+ living in sheltered housing accommodation.
  - The S1B return covers dwellings and not occupants. There is no known information on sheltered housing tenants and so it has been assumed that there is a 95% occupancy rate of people aged 65+, of which 90% are singles and 10% are couples.
  - The S1B return covers dwellings provided by Public Agencies and Housing Associations only.

- LA home care
  - Source: SEHD H1 return.
  - Date: Week ended 31 March 2003.
  - Description: People aged 65+ receiving LA home care.
  - LA home care is defined here as being home care provided to people at home (excluding those in residential care) purchased by a local authority, even if it is provided by another LA or by the private or voluntary sectors.
  - Intensive home care clients are defined here as receiving 10 or more hours of care a week.

  - The model uses individual-based information on the numbers of hours of care received, which has been derived from a dataset covering 69% of all LA home care clients. The figures have been grossed to estimate total numbers, controlling for known age/gender sub-totals.

- Informal care
  - Source: The Scottish Household Survey.
  - Date: Financial year 2002/3.
  - Description: People aged 65+ receiving informal care.
  - Respondents were assumed to receive informal care if they receive regular help or care from a household member, relative, friend or neighbour.

- Private care
  - Source: The Scottish Household Survey.
  - Date: Financial year 2002/3.
  - Description: People aged 65+ receiving private care.
  - Respondents were assumed to receive private care if they have a home help who has been hired privately.

- Day care
  - Source: SEHD D1-B return.
  - Date: Week ended 31 March 2003.
  - Description: People aged 65+ attending a day care service.
  - Day care is defined here as being all day services that are provided or commissioned by an LA, as well as all other registered day services.

- Community nursing
  - Source: ISD(S)29/30 return.
  - Date: Year ended 31 March 2003.
  - Description: People aged 65+ seen by a district nurse or health visitor.
  - The data are not available by gender, and the age bands are 65-74 and 75+.
  - **The baseline data are not of National Statistics' standards and have not been published. Projections will therefore need to be treated with caution.** It is, however, thought that the data will produce more reliable projections than if less recently published data were used.

- NHS Chiropody
  - Source: ISD(S)8 return.
  - Date: Year ended 31 December 2002.
  - Description: People aged 65+ receiving NHS chiropody services.
  - The data are not available by age or gender, and are really for ‘pensioners’, i.e. males aged 65+ and females aged 60+.
  - The figures exclude the hospital service.

Workforce

The baseline workforce figures (excluding informal carers) are for the number of whole-time equivalent staff in post plus vacancies.

Where vacancy data were not available, workforce vacancy rates have been calculated to be 3% of total posts (i.e. filled posts + vacant posts) required.

- NHS bed
    - NHS workforce projections have not been included in the model, as national workforce planning is led by the National Workforce Committee, with a new group, the Workforce Numbers Group, leading on the workforce numbers and modelling across all staff groups. Further information can be obtained in the Scottish Health Workforce Plan 2004 baseline at www.scotland.gov.uk/publications.

- Private nursing home
    - Source: ISD(S)34 return.
    - Date: 31 March 2002.
    - Description: Nursing staff in post, including nursing auxiliaries, assistants and bank staff, and vacancies.
    - Agency staff have been excluded.

- Residential care home
    - Source: SEHD R1 return.
    - Date: 31 March 2002.
    - Description: Care and 'other' staff in post, plus vacancies (estimated).

- Sheltered housing
    - Sheltered housing workforce projections have not been included in the model as no data are available.

- LA home care
    - Source: SEHD H1 return.
    - Date: 31 March 2003.
    - Description: Staff in post employed to provide home care services directly to clients, plus vacancies (estimated).
    - Managers, organisers and other purely supervisory staff, and administrative staff have been excluded.
    - The H1 return only includes staff in post directly employed by the LA, and so staff providing home care purchased from outside each LA are excluded. The total number of staff required has been calculated by multiplying the number of directly employed staff per directly delivered hour of care by the total number of home care hours provided or purchased.

- Informal care inside household
    - Source: The Scottish Household Survey.
    - Date: Financial year 2002/3.
    - Description: People providing informal care to a person aged 65+ living inside the same household.
    - Informal care inside and outside the household has been calculated separately to avoid double-counting carers.

- Informal care outside household
    - Source: The Scottish Household Survey.

  - Date: Financial year 2002/3.
  - Description: People providing informal care to a person aged 65+ living outside the household.
  - Respondents were assumed to give informal care outside the household if they provide regular help or care for any sick, disabled or elderly person not living with them.
  - Informal care inside and outside the household has been calculated separately to avoid double-counting carers.

- Day care
  - Source: SEHD H1 return.
  - Date: 31 March 2003.
  - Description: Management, care and other staff in post, plus vacancies (estimated).

- District nurse
  - Source: ISD Scotland.
  - Date: 31 March 2003.
  - Description: District nurses in post, post under review and vacancies.
  - Posts under review are defined here as 'posts which are vacant as at 31 March 2003 because they are under review or held open to cover for peak workload or staff on courses, maternity leave or sick leave'.

- Health visitor
  - Source: ISD Scotland.
  - Date: 31 March 2003.
  - Description: Health visitors in post, post under review and vacancies.
  - Posts under review are defined here as 'posts which are vacant as at 31 March 2003 because they are under review or held open to cover for peak workload or staff on courses, maternity leave or sick leave'.

- NHS podiatrist
  - Source: ISD Scotland.
  - Date: 31 March 2003.
  - Description: Qualified NHS podiatrists and unqualified podiatry/foot care assistants in post, post under review and vacancies.
  - Posts under review are defined here as 'posts which are vacant as at 31 March 2003 because they are under review or held open to cover for peak workload or staff on courses, maternity leave or sick leave'.
  - Projections for chiropody patients exclude the health service, but the baseline data for podiatrists cover all those employed by the NHS. Therefore, projections will need to be treated with caution as they may overestimate the number of podiatrists required.

Unit costs

Where applicable, unit costs have been uprated to 2004/5 prices using the Treasury's GDP deflator series. (The deflator series used in the model is the series published following the Office for National Statistics' Quarterly National Accounts First Release on 26 March 2004.) All unit costs are given as gross figures.

- NHS bed
  - Source: Scottish Health Service Costs 2002/3 Report 40LS.
  - Date: 2002/3.
  - Baseline unit cost: £997 per inpatient week.
  - Unit cost at 2004/5: £1,048 per inpatient week.
  - Source of funding: 100% NHS funded.
  - The dataset contains two outliers, which have been removed to give the baseline unit cost. The original dataset gives a unit cost of £1,003 (£1,055 in 2004).

- Private nursing home
  - Source: National Review Group (NRG).
  - Date: 2004/5.
  - Baseline unit cost: N/A.
  - Unit cost at 2004/5: £417 per resident week.
  - Source of funding: NHS/LA/Privately funded, using data from the ISD(S)34 return, although no age/gender breakdown is available.
  - The ISD(S)34 return does not include information on fees charged by individual private nursing homes. Therefore, the fee suggested by the NRG has been applied to all private nursing home residents. It is important to note that the fee applies to publicly funded residents only, and residents who are privately funded can be charged any amount.
  - Background to the NRG: The NRG was established in September 2001 to conduct a review of the costs associated with providing nursing and residential care homes for older people in Scotland, and to determine a framework for appropriate fee levels for application from 1 April 2002. These fee levels apply to publicly funded residents only. The suggested fee level at 1 April 2004 for care homes with nursing has been set at £417.37. Although at the time of this report the figure has not yet been agreed, it is considered to be very likely that it will be, and fees will be backdated to 1 April 2004 from the date of agreement.

- Residential care home
  - Source: SEHD R1 return.
  - Date: 31 March 2002.
  - Baseline unit cost: Varies from £297 to £2,141 per resident week, depending on the home's sector and type.
  - Unit cost at 2004/5: Varies from £319 to £2,328 per resident week, depending on the home's sector and type.
  - Source of funding: NHS/LA/Privately funded, using data from the R1 return.
  - Background to the cost calculations: As charges differ between the different sectors and types of residential care home, the homes were grouped according to their sector and type (e.g. private home for people with mental health problems) and average charges calculated for each group. The projections for residential care home residents were then split according to the proportions in each group of homes in the base year, and the group charges were applied to their respective projections. The figures were then summed to give a national cost. This method was used to ensure that a group's fee would only contribute to the national figure in direct proportion to the number of residents in each

group. Therefore, a group with relatively few residents would not disproportionately affect the national cost.

- Sheltered housing
  - Sheltered housing cost projections have not been included in the model as data are not available.

- LA home care
  - Source: 'With Respect to Old Age – A Report by the Royal Commission on Long Term Care, Research Volume 1'.
  - Date: 1995/6.
  - Baseline unit cost: £8.50 per hour.
  - Unit cost at 2004/5: £10.70 per hour.
  - Source of funding: Assumed to be 100% LA-funded. There is no known information on sources of funding for LA home care services and so 100% LA funding has been assumed, although private sources also contribute.
  - There are no known data on unit costs of LA home care. The Royal Commission Report on Long Term Care used a UK-wide figure of £8.50 per hour, in 1995/6 prices.

- Private care
  - Source: The average cost per client week is the same as LA home care.
  - Date: N/A.
  - Baseline unit cost: N/A.
  - Unit cost at 2004/5: Approximately £68 per client week.
  - Source of funding: 100% private funding.
  - There are no known data on the average cost of home care which is provided privately, or suitable data on the number of hours of private care received. Therefore, it has been assumed that private home care clients receive the same number of hours per week, charged at the same hourly rate, as LA-provided home care. Averaged across the age/gender groups, this equates to just under six and a half hours of care received each week, at a charge of £10.70 per hour. However, the cost projections are calculated separately by age and gender to take into account the different numbers of hours of care received by each group.

- Day care
  - Source: 'With Respect to Old Age – A Report by the Royal Commission on Long Term Care, Research Volume 1'.
  - Date: 1995/6.
  - Baseline unit cost: £28 per attendance.
  - Unit cost at 2004/5: £35 per attendance.
  - Source of funding: Assumed to be 100% LA funded.
  - There are no known data on unit costs of day care. The Royal Commission Report on Long Term Care used a UK-wide figure of £28 per attendance, in 1995/6 prices.
  - There is no known information on sources of funding for day care services and so 100% LA funding has been assumed, although it is acknowledged that other sources of funding for day care do exist.

- District nurse
    - Source: ISD data – SFR 8.3.
    - Date: 2002/3.
    - Baseline unit cost: £27 per visit.
    - Unit cost at 2004/5: £28 per visit.
    - Source of funding: 100% NHS funded.

- Health visitor
    - Source: ISD data – SFR 8.3.
    - Date: 2002/3.
    - Baseline unit cost: £32 per visit.
    - Unit cost at 2004/5: £34 per visit.
    - Source of funding: 100% NHS funded.

- NHS chiropody
    - Source: ISD data – SFR 8.3.
    - Date: 2002/3.
    - Baseline unit cost: £19 per treatment.
    - Unit cost at 2004/5: £20 per treatment.
    - Source of funding: 100% NHS funded.

The model and scenarios

The model is sensitive to changes made to the underlying assumptions, and the following sections discuss the population projections used in the model, and describe seven scenarios which illustrate how using different assumptions can affect the projections. Tables give the relevant figures for service recipients, workforce and costs in five-year intervals. The percentage change between each five-year interval is shown in brackets, and the overall percentage change from 2004 to 2019 is shown in the final column.

Scenario 1 describes the base model, where population projections are the main driver.

Scenario 2 looks at what could happen if people in an NHS bed or care home, and classified as being of low or moderate dependency, live at home and are given LA home care and community nursing as an alternative.

Scenario 3 gives projections assuming that those in an NHS bed, and classified as being of low or moderate dependency, can be accommodated in a care home.

Scenario 4 looks at the projections produced by assuming that people receiving 20 or more hours a week of LA-provided home care are moved to a care home.

Scenario 5 considers what could happen if formal care is offered as a substitute to a proportion of people receiving informal care.

Scenario 6 shows how the expenditure projections can vary if the annual increase applied to the unit costs changes.

Scenario 7 incorporates recommendations from the Joint Future Agenda into the base model.

Chapter 6 – Population projections

The base model, described in the following chapter, uses population projections as the main driver. The scenarios considered in chapters 7 to 13 build on the base model, but all incorporate the population projections in their estimates.

The population projections used in this report are the Government Actuary's Department's 2002-based projections. The following table presents these projections by age and gender. It includes the six age/gender groups described in chapter 3 (male, female, 65-74, 75-84, 85+) as these are the groups into which the older population has been divided in the model. The table also includes population projections for the age group 16-64 to represent the potential workforce, although this group will include people such as students, who are not part of the workforce. Finally, the table also includes projections for the whole of Scotland, to provide a comparison for the older population.

Table 4: Population projections (thousands)

		2004	2009	2014	2019	2004 - 2019
65-74	Male	205.8	216.6 (5%)	244.7 (13%)	261.8 (7%)	27%
	Female	247.5	252.0 (2%)	277.0 (10%)	294.0 (6%)	19%
	All	453.4	468.6 (3%)	521.8 (11%)	555.8 (7%)	23%
75-84	Male	110.8	119.4 (8%)	133.8 (12%)	147.5 (10%)	33%
	Female	174.6	175.1 (0%)	184.1 (5%)	194.8 (6%)	12%
	All	285.4	294.4 (3%)	317.9 (8%)	342.3 (8%)	20%
85+	Male	23.0	31.3 (36%)	39.0 (24%)	48.3 (24%)	110%
	Female	62.4	71.8 (15%)	78.8 (10%)	89.1 (13%)	43%
	All	85.4	103.2 (21%)	117.8 (14%)	137.4 (17%)	61%
16-64	Male	1,610.5	1,604.0 (0%)	1,561.4 (-3%)	1,509.9 (-3%)	-6%
	Female	1,676.2	1,677.7 (0%)	1,644.9 (-2%)	1,602.9 (-3%)	-4%
	All	3,286.7	3,281.6 (0%)	3,206.3 (-2%)	3,112.8 (-3%)	-5%
65+	Male	339.7	367.3 (8%)	417.6 (14%)	457.6 (10%)	35%
	Female	484.6	498.9 (3%)	540.0 (8%)	578.0 (7%)	19%
	All	824.2	866.2 (5%)	957.5 (11%)	1,035.6 (8%)	26%
Total pop	Male	2,424.3	2,405.6 (-1%)	2,385.9 (-1%)	2,364.2 (-1%)	-2%
	Female	2,613.6	2,593.4 (-1%)	2,577.1 (-1%)	2,563.6 (-1%)	-2%
	All	5,037.8	4,999.0 (-1%)	4,963.0 (-1%)	4,927.8 (-1%)	-2%

The population as a whole is projected to decrease by 2% by 2019. The population aged 16-64 is also projected to decrease over the period, this time by 5%. As a comparison, the population aged 65+ is projected to increase by 26% by 2019, with the largest relative increase being for males aged 85+.

Chapter 7 – Scenario 1

Scenario 1 – Base model: Demography led projections

The base model (so called because the other scenarios build on its assumptions) takes the current picture of community care services and projects using population projections as the main driver. As with all the models considered in this report, the base model is concerned with projecting demand only. However, the supply of community care services will have an impact on the projections if it does not equal or exceed demand. In particular, the workforce projections show significant percentage increases over the period, and it is acknowledged that many areas are currently facing difficulties recruiting and retaining community care staff. The issues surrounding supply and demand will be considered in due course.

The base model projections show what could happen if everything were to remain as it is today. They are not intended to show what is thought most likely to happen.

Projections of numbers receiving each community care service were produced using the patterns of care seen from the baseline and applied to the population projections. Therefore, proportions of each age/gender group receiving an individual service were kept constant over time.

The required workforce was estimated by calculating the number of whole-time equivalent staff, including vacancies, per client, then applying this figure to the client projections. Where applicable, for example when calculating workforce figures for home care or community nursing, the number of hours or visits received replaced the number of clients in the calculation.

Unit costs were collected from a number of sources and uprated to 2004 prices using the Treasury's GDP deflator series. They were assumed to experience a 2% year-on-year increase above inflation from 2004. The unit costs were applied to the client projections to produce figures of the cost of each service for each year up to 2019. The cost projections are in 2004 prices and do not include inflation. As with the workforce projections, where applicable the number of hours or visits received replaced the number of clients in the calculation.

The cost projections are affected by population projections and the annual 2% increase applied to the unit costs. Therefore, the cost projections will increase over the period by a greater proportion than the user and workforce projections, which are affected by population projections only.

It is important to note that the cost projections are just the cost of providing a particular service. They do not include, for example, the cost of building new care homes for additional residents, the cost of providing homes for the increasing numbers of people remaining in the community or the cost of providing benefit payments.

Base model assumptions

- Proportions in each age/gender group receiving a service remain fixed over time

It is thought that people's preference to stay at home and improved technology will see a shift in more people receiving care at home and fewer living in care homes. However, there is no firm evidence to support this and so it is assumed that proportions receiving each community care service will remain fixed over time.

- The staff:client ratio remains fixed over time

It is not thought there will be a significant increase in staff productivity, or that improvements to care homes will result in a requirement for fewer staff. Therefore, a fixed staff:client ratio is assumed. It is also assumed that staff are working at maximum capacity and additional clients would therefore require further staff to be employed.

- Unit costs experience a 2% year-on-year increase above inflation from 2004 onwards

The Care Development Group, in the Fair Care for Older People report, assumed a 2% real-terms growth in unit costs. It decided that 2% reflects the long-term growth assumptions for GDP, and asserted that, as the economy continues to become wealthier, the cost of providing appropriate care will continue to rise. The range and capacity review reference group agreed that a 2% real terms growth in unit costs would be a realistic assumption to make for this model also.

Table 5: Projected numbers of service recipients (thousands)

	2004	2009	2014	2019	2004 - 2019
NHS bed	3.2	3.6 (12%)	4.0 (11%)	4.5 (12%)	40%
Private nursing home	20.2	22.3 (10%)	24.7 (11%)	27.5 (12%)	36%
Residential care home	13.2	14.7 (11%)	16.3 (11%)	18.3 (12%)	38%
Sheltered housing	100.1	105.2 (5%)	116.3 (11%)	125.8 (8%)	26%
Very sheltered	2.2	2.3 (5%)	2.5 (11%)	2.7 (8%)	26%
Sheltered without wheelchair	36.5	38.4 (5%)	42.5 (11%)	45.9 (8%)	26%
Sheltered with wheelchair	1.6	1.7 (5%)	1.8 (11%)	2.0 (8%)	26%
Amenity	17.3	18.1 (5%)	20.1 (11%)	21.7 (8%)	26%
Other with alarms	42.6	44.8 (5%)	49.5 (11%)	53.5 (8%)	26%
LA home care	56.0	60.7 (8%)	67.0 (10%)	74.0 (11%)	32%
Intensive	12.0	13.1 (9%)	14.5 (10%)	16.1 (11%)	34%
Non-intensive	44.0	47.6 (8%)	52.5 (10%)	57.9 (10%)	32%
Hours per week	363.1	394.9 (9%)	435.9 (10%)	482.2 (11%)	33%
Informal care	99.0	104.7 (6%)	115.6 (10%)	125.6 (9%)	27%
Private care	45.7	48.4 (6%)	53.0 (10%)	57.9 (9%)	27%
Day care	12.1	13.1 (8%)	14.5 (10%)	16.0 (10%)	32%
Attendances per week	26.0	28.2 (8%)	31.2 (10%)	34.4 (10%)	32%
District nurse	163.0	173.0 (6%)	190.4 (10%)	207.8 (9%)	28%
Visits per year	3,121.4	3,316.3 (6%)	3,648.7 (10%)	3,985.0 (9%)	28%
Health visitor	52.9	56.3 (7%)	61.9 (10%)	67.7 (9%)	28%
Visits per year	169.2	180.1 (6%)	198.0 (10%)	216.6 (9%)	28%
Chiropody	339.0	356.3 (5%)	393.8 (11%)	426.0 (8%)	26%
Treatments per year	1,188.1	1,248.6 (5%)	1,380.2 (11%)	1,492.8 (8%)	26%

Note: Components may not sum to totals due to rounding.

Under the base model, by 2019 the numbers of recipients of each service are projected to increase by between 26% and 40%.

Table 6: Projected workforce numbers (thousands)

	2004	2009	2014	2019	2004 - 2019
NHS bed	-	-	-	-	-
Private nursing home	14.0	15.5 (10%)	17.1 (11%)	19.1 (12%)	36%
Residential care home	14.4	16.0 (11%)	17.8 (11%)	19.9 (12%)	38%
Sheltered housing	-	-	-	-	-
LA home care	12.5	13.6 (9%)	15.0 (10%)	16.5 (11%)	33%
Informal care inside household	57.1	60.2 (5%)	66.6 (11%)	72.1 (8%)	26%
Informal care outside household	281.9	298.2 (6%)	328.4 (10%)	357.6 (9%)	27%
Day care	2.1	2.3 (8%)	2.5 (10%)	2.8 (10%)	32%
District nurse	1.4	1.4 (6%)	1.6 (10%)	1.7 (9%)	28%
Health visitor	0.22	0.23 (6%)	0.26 (10%)	0.28 (9%)	28%
NHS podiatrist	0.61	0.64 (5%)	0.70 (11%)	0.76 (8%)	26%

Note: Workforce figures for NHS beds and sheltered housing have not been included in the model. Please see p14 for details.

The number of staff required is projected to increase by between 26% and 38%.

Table 7: Projected costs (£m)

	2004	2009	2014	2019	2004 - 2019
NHS bed	173	214 (24%)	264 (23%)	327 (24%)	89%
Private nursing home	438	534 (22%)	652 (22%)	803 (23%)	83%
Residential care home	261	320 (22%)	392 (22%)	484 (23%)	85%
Sheltered housing	-	-	-	-	-
LA home care	202	243 (20%)	296 (22%)	361 (22%)	79%
Private care	162	190 (17%)	231 (21%)	278 (21%)	71%
Day care	47	57 (20%)	69 (22%)	84 (22%)	78%
District nurse	87	103 (17%)	125 (21%)	150 (21%)	72%
Health visitor	5.8	6.8 (18%)	8.2 (21%)	9.9 (21%)	72%
NHS chiropody	24	28 (16%)	34 (22%)	40 (19%)	69%
NHS expenditure	318	385 (21%)	472 (22%)	579 (23%)	82%
LA expenditure	765	928 (21%)	1,134 (22%)	1,392 (23%)	82%
Private expenditure	318	382 (20%)	464 (22%)	567 (22%)	78%
Total expenditure	1,402	1,695 (21%)	2,070 (22%)	2,538 (23%)	81%

Notes:

1. Projected costs for sheltered housing have not been included in the model. Please see p17 for details.

2. The cost projections include just the cost of providing a particular service.

3. Components may not sum to totals due to rounding.

The base model projects that the increase in costs for each service will vary by between 69% and 89%. Total expenditure has been projected to increase over the period by 81%, to £2,538m.

Chapter 8 – Scenario 2

Scenario 2 – Low/moderate dependency people in an NHS bed or care home are given LA home care and community nursing care

These projections take the base model assumptions, but assume that people in an NHS bed or care home, and classified as being of low or moderate dependency, live at home and are given LA-provided home care as an alternative. It is also assumed that the NHS bed patients and private nursing home residents who are removed (i.e. those more likely to require nursing care) receive the average number of community nursing visits for their age/gender group.

This scenario was chosen to illustrate what could happen to the projections if the number of people being cared for in a residential setting were to decrease. Removing the residents classified as being of low or moderate dependency produces this decrease, but should not be interpreted as being a recommendation for how to provide the best care for these people.

The Scottish Health Resource Utilisation Groups (SHRUGS) and Scottish Care Resource Utilisation Groups (SCRUGS) data have been used to determine dependency levels.

The SHRUGS and SCRUGS classifications are shown below. For the purposes of the model, patients in an NHS bed in SHRUGS A have been assumed to be of low dependency, and those in group C as being of moderate dependency. Residents in care homes classified as being in SCRUGS A have been assumed to be of low dependency, and those in groups C or E as being of moderate dependency. People with behavioural difficulties or special care needs have not been included in groups that could be offered home care as an alternative.

It is acknowledged that the SHRUGS/SCRUGS data lack sensitivity for some mental health and social issues, and that a proportion of people with apparently low or moderate dependency are appropriately placed for a number of reasons, including palliative care. Also, moving low or moderate dependency people accommodated for social reasons to the community could leave them socially isolated and an additional package of care, including a range of services to cater for their social needs, would be required. However, as noted above, this scenario should not be interpreted as being a recommendation for how to provide the best care for low or moderate dependency people living in a hospital or care home. Removing these residents is used merely to shift the balance of care, and to show the resulting effect on the projections.

The latest available SHRUGS data were collected over the year ended 31 March 2003 and cover approximately 90% of geriatric medicine patients in long-stay care of the elderly hospital wards. The SCRUGS data were collected over the period November 2001 to January 2003 and cover seven Health Boards and approximately 27% of residents in care homes. The data are reasonably representative within Health Boards, with coverage of approximately 80% of care homes within each Health Board.

SHRUGS group – For patients in hospital

A – Low dependency; no behavioural difficulties
B – Low dependency; with behavioural difficulties
C – Moderate dependency; no needs for special care or clinically complex treatments
D – Moderate dependency; with needs for special care and/or clinically complex treatments *or* High dependency; no needs for special care or clinically complex treatments
E – High dependency; with needs for special care and/or clinically complex treatments

SCRUGS group – For residents in care homes

A – Low dependency; neither behaviour nor special care needs
B – Low dependency; either behaviour or special care needs
C – Low to moderate dependency; neither behaviour nor special care needs
D – Low to moderate dependency; either behaviour or special care needs
E – Moderate dependency; neither behaviour nor special care needs
F – Moderate dependency; either behaviour or special care needs *or* High dependency; neither behaviour nor special care needs
G – Moderate dependency; both behaviour and special care needs *or* High dependency; either behaviour or special care needs
H – High dependency; both behaviour and special care needs

The following three tables give current estimates of numbers in each dependency category by applying the SHRUGS/SCRUGS percentages to the base model projections for 2004.

Table 8: Estimates of NHS bed patients in each SHRUGS dependency category, 2004

	A	B	C	D	E	Total
M 65-74	29	2	36	55	69	192
M 75-84	45	5	141	118	124	433
M 85+	45	5	125	128	72	375
F 65-74	27	3	40	57	57	184
F 75-84	62	10	198	224	207	701
F 85+	108	12	393	449	336	1,297
Total	316	37	933	1,031	865	3,182

Table 9: Estimates of private nursing home residents in each SCRUGS dependency category, 2004

	A	B	C	D	E	F	G	H	Total
M 65-74	206	83	143	110	261	216	163	23	1,205
M 75-84	502	160	239	215	521	478	246	29	2,390
M 85+	331	117	278	145	410	336	126	27	1,768
F 65-74	235	81	128	110	349	301	184	37	1,425
F 75-84	915	314	645	348	1,437	1,280	606	67	5,613
F 85+	1,334	289	1,256	367	2,122	1,685	679	70	7,801
Total	3,523	1,044	2,690	1,294	5,101	4,295	2,003	253	20,202

Table 10: Estimates of residential care home residents in each SCRUGS dependency category, 2004

	A	B	C	D	E	F	G	H	Total
M 65-74	583	85	95	20	45	30	5	0	862
M 75-84	912	108	139	56	74	56	26	0	1,371
M 85+	744	58	164	82	106	106	19	0	1,279
F 65-74	567	110	100	72	48	58	10	0	965
F 75-84	1,742	277	435	161	274	277	55	0	3,221
F 85+	2,865	305	798	283	709	471	111	0	5,541
Total	7,413	942	1,730	674	1,256	998	226	0	13,240

The remainder of this chapter looks at how the projections are affected under this scenario. It is important to note that the cost projections are just the cost of providing a particular service. They do not take into account, for example, any 'hotel costs' or changes in benefit payments which may occur when moving people to the community. It is also acknowledged that, if people are moved to the community, there will need to be significant investment in social housing, both in terms of conversions using SMART technology and also new builds, which has not been included in the projections. It is also important to note that removing people from an NHS bed or care home will not have such a direct impact on costs as the projections are showing, as there are still running costs involved with empty places.

The following tables give the projections produced under this scenario. As the workforce and cost projections are affected by the number of hours of home care each new client receives, projections have been produced assuming different amounts of home care are received, ranging from each new client's receiving 20 hours of home care each week up to 80 hours.

For the purposes of estimating costs, the proportion of care home residents remaining in each of the different sectors and types of home is assumed to be the same as in the base model. The base model proportions are also applied to the different sources of funding.

Table 11: Projected service recipients and workforce if low dependency people are moved to the community

	HC hrs	2004	2009	2014	2019	'04 – '19
Service recipients ('000s)						
NHS bed	-	3.2	3.2 (1%)	3.6 (11%)	4.0 (12%)	26%
Private nursing home	-	20.2	18.4 (-9%)	20.4 (11%)	22.7 (11%)	12%
Residential care home	-	13.2	6.5 (-51%)	7.2 (11%)	8.0 (12%)	-39%
LA home care	-	56.0	73.2 (31%)	80.8 (10%)	89.5 (11%)	60%
Hours	20	363.1	644.6 (78%)	713.2 (11%)	792.3 (11%)	118%
	30	363.1	769.5 (112%)	851.8 (11%)	947.3 (11%)	161%
	40	363.1	894.3 (146%)	990.5 (11%)	1,102.3 (11%)	204%
	50	363.1	1,019.2 (181%)	1,129.1 (11%)	1,257.3 (11%)	246%
	60	363.1	1,144.0 (215%)	1,267.8 (11%)	1,412.4 (11%)	289%
	70	363.1	1,268.8 (249%)	1,406.4 (11%)	1,567.4 (11%)	332%
	80	363.1	1,393.7 (284%)	1,545.1 (11%)	1,722.4 (11%)	374%
District nurse	-	163.0	177.3 (9%)	195.1 (10%)	213.1 (9%)	31%
Visits per year	-	3,121.4	3,399.1 (9%)	3,740.6 (10%)	4,087.8 (9%)	31%
Health visitor	-	52.9	60.6 (15%)	66.6 (10%)	73.0 (10%)	38%
Visits per year	-	169.2	193.7 (14%)	213.0 (10%)	233.4 (10%)	38%
Workforce ('000s)						
NHS bed	-	-	-	-	-	-
Private nursing home	-	14.0	12.8 (-9%)	14.1 (11%)	15.7 (11%)	12%
Residential care home	-	14.4	7.1 (-51%)	7.8 (11%)	8.7 (12%)	-39%
LA home care	20	12.5	22.1 (78%)	24.5 (11%)	27.2 (11%)	118%
	30	12.5	26.4 (112%)	29.2 (11%)	32.5 (11%)	161%
	40	12.5	30.7 (146%)	34.0 (11%)	37.8 (11%)	204%
	50	12.5	35.0 (181%)	38.7 (11%)	43.1 (11%)	246%
	60	12.5	39.3 (215%)	43.5 (11%)	48.5 (11%)	289%
	70	12.5	43.5 (249%)	48.3 (11%)	53.8 (11%)	332%
	80	12.5	47.8 (284%)	53.0 (11%)	59.1 (11%)	374%
District nurse	-	1.4	1.5 (9%)	1.6 (10%)	1.8 (9%)	31%
Health visitor	-	0.22	0.25 (14%)	0.28 (10%)	0.30 (10%)	38%

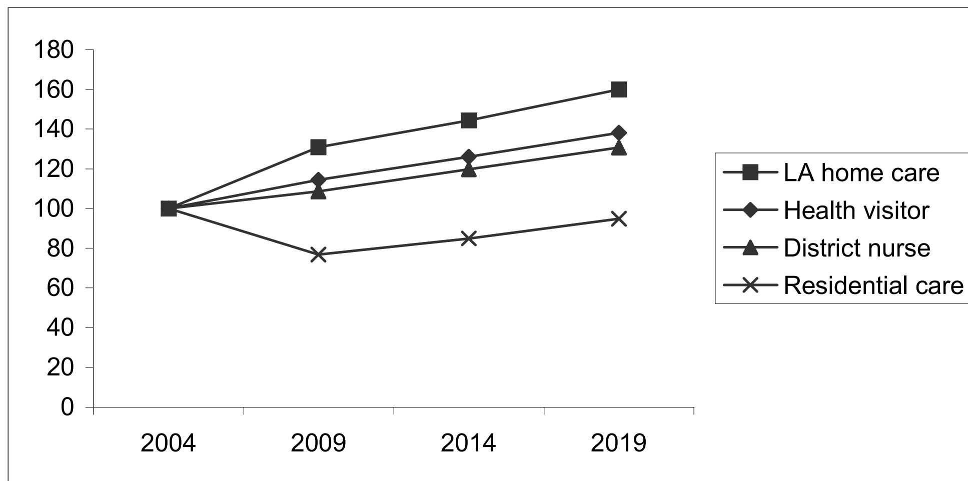
Notes:
1. Workforce figures for NHS beds have not been included in the model. Please see p14 for details.

Table 12: Projected costs if low dependency people are moved to the community

	HC hrs	2004	2009		2014		2019		'04 – '19
Costs (£m)									
NHS bed	-	173	193	(11%)	237	(23%)	294	(24%)	70%
Private nursing home	-	438	441	(1%)	538	(22%)	662	(23%)	51%
Residential care home	-	261	140	(-46%)	172	(22%)	212	(23%)	-19%
LA home care	20	202	396	(96%)	484	(22%)	593	(23%)	194%
	30	202	473	(134%)	578	(22%)	709	(23%)	251%
	40	202	549	(172%)	672	(22%)	825	(23%)	309%
	50	202	626	(210%)	766	(22%)	942	(23%)	366%
	60	202	703	(248%)	860	(22%)	1,058	(23%)	424%
	70	202	779	(286%)	954	(22%)	1,174	(23%)	481%
	80	202	856	(324%)	1,048	(22%)	1,290	(23%)	538%
District nurse	-	87	105	(20%)	128	(22%)	154	(21%)	76%
Health visitor	-	5.8	7.3	(26%)	8.8	(21%)	10.7	(21%)	86%
Total costs (£m)									
NHS expenditure	-	318	361	(13%)	442	(22%)	542	(23%)	70%
LA expenditure	20	765	877	(15%)	1,071	(22%)	1,316	(23%)	72%
	30	765	954	(25%)	1,165	(22%)	1,432	(23%)	87%
	40	765	1,030	(35%)	1,259	(22%)	1,548	(23%)	102%
	50	765	1,107	(45%)	1,353	(22%)	1,664	(23%)	117%
	60	765	1,184	(55%)	1,447	(22%)	1,780	(23%)	133%
	70	765	1,261	(65%)	1,541	(22%)	1,896	(23%)	148%
	80	765	1,337	(75%)	1,635	(22%)	2,012	(23%)	163%
Private expenditure	-	318	319	(0%)	388	(22%)	472	(22%)	48%
Total expenditure (£m)									
	20	1,402	1,557	(11%)	1,901	(22%)	2,329	(23%)	66%
	30	1,402	1,634	(17%)	1,995	(22%)	2,445	(23%)	74%
	40	1,402	1,711	(22%)	2,089	(22%)	2,561	(23%)	83%
	50	1,402	1,787	(27%)	2,183	(22%)	2,677	(23%)	91%
	60	1,402	1,864	(33%)	2,277	(22%)	2,793	(23%)	99%
	70	1,402	1,941	(38%)	2,371	(22%)	2,910	(23%)	108%
	80	1,402	2,017	(44%)	2,465	(22%)	3,026	(23%)	116%

Notes:
1. Total costs include the costs of providing all community care services considered in this report, not just those affected by the scenario.
2. Total costs exclude sheltered housing. Please see p17 for details.
3. Individual cost projections include just the cost of providing a particular service.
4. Removing people from an NHS bed or care home will not have such a direct impact on costs as the projections are showing, as there are still running costs involved with empty places.
5. Components may not sum to totals due to rounding.

Chart 2: Projected recipients under low dependency model, indexed at 2004=100



By 2019 the number of people in an NHS bed or care home is projected to decrease by 5%, as opposed to increasing by 37% under the base model. There will be 15,500 more people receiving LA home care, and 5,300 more people receiving care from a district nurse and health visitor.

If the additional home care clients are assumed to receive 20 hours of home care a week then the number of LA home care staff is projected to increase by 118% by 2019, as opposed to by 33% under the base model. The total expenditure will increase over the period by 66% to £2,329m, instead of by 81% to £2,538m.

If the additional home care clients are assumed to receive 80 hours of home care a week, then the number of LA home care staff is projected to increase by 374% by 2019. The total expenditure will increase over the period by 116% to £3,026m.

Table 13: Projected service recipients and workforce if low and moderate dependency people are moved to the community

	HC hrs	2004	2009	2014	2019	'04 – '19
Service recipients ('000s)						
NHS bed	-	3.2	2.2 (-32%)	2.4 (11%)	2.7 (12%)	-16%
Private nursing home	-	20.2	9.8 (-52%)	10.8 (11%)	12.0 (11%)	-41%
Residential care home	-	13.2	3.1 (-76%)	3.5 (11%)	3.9 (12%)	-71%
LA home care	-	56.0	86.2 (54%)	95.2 (10%)	105.7 (11%)	89%
Hours	20	363.1	905.3 (149%)	1,001.8 (11%)	1,115.4 (11%)	207%
	30	363.1	1,160.5 (220%)	1,284.7 (11%)	1,432.0 (11%)	294%
	40	363.1	1,415.6 (290%)	1,567.6 (11%)	1,748.5 (12%)	382%
	50	363.1	1,670.8 (360%)	1,850.5 (11%)	2,065.1 (12%)	469%
	60	363.1	1926 (430%)	2,133.5 (11%)	2,381.7 (12%)	556%
	70	363.1	2,181.2 (501%)	2,416.4 (11%)	2,698.3 (12%)	643%
	80	363.1	2,436.3 (571%)	2,699.3 (11%)	3,014.8 (12%)	730%
District nurse	-	163.0	187.0 (15%)	205.9 (10%)	225.1 (9%)	38%
Visits per year	-	3,121.4	3,588.2 (15%)	3,949.9 (10%)	4,322.1 (9%)	38%
Health visitor	-	52.9	70.3 (33%)	77.3 (10%)	85.0 (10%)	61%
Visits per year	-	169.2	224.4 (33%)	247.0 (10%)	271.4 (10%)	60%
Workforce ('000s)						
NHS bed	-	-	-	-	-	-
Private nursing home	-	14.0	6.8 (-52%)	7.5 (11%)	8.3 (11%)	-41%
Residential care home	-	14.4	3.4 (-76%)	3.8 (11%)	4.2 (12%)	-71%
LA home care	20	12.5	31.1 (149%)	34.4 (11%)	38.3 (11%)	207%
	30	12.5	39.8 (220%)	44.1 (11%)	49.1 (11%)	294%
	40	12.5	48.6 (290%)	53.8 (11%)	60 (12%)	382%
	50	12.5	57.3 (360%)	63.5 (11%)	70.9 (12%)	469%
	60	12.5	66.1 (430%)	73.2 (11%)	81.7 (12%)	556%
	70	12.5	74.8 (501%)	82.9 (11%)	92.6 (12%)	643%
	80	12.5	83.6 (571%)	92.6 (11%)	103.4 (12%)	730%
District nurse	-	1.4	1.6 (15%)	1.7 (10%)	1.9 (9%)	38%
Health visitor	-	0.22	0.29 (33%)	0.32 (10%)	0.35 (10%)	60%

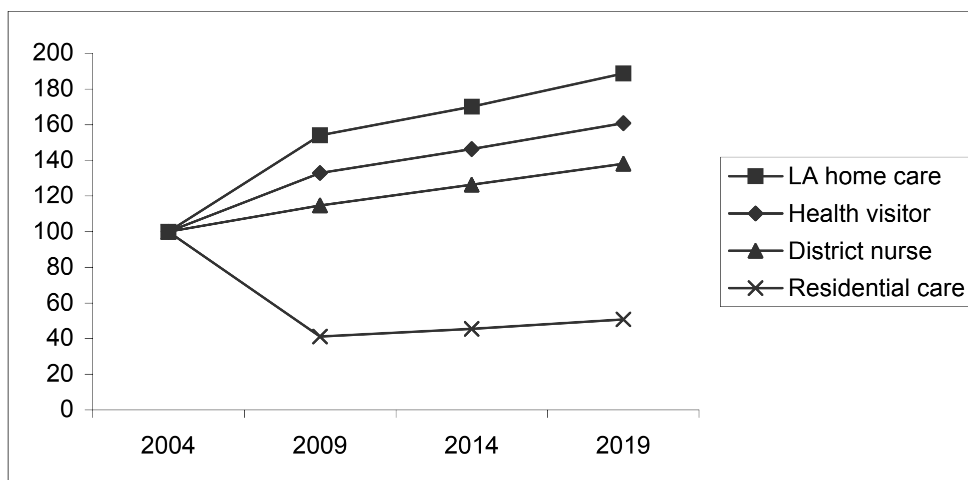
Notes:
1. Workforce figures for NHS beds have not been included in the model. Please see p14 for details.

Table 14: Projected costs if low and moderate dependency people are moved to the community

	HC hrs	2004	2009	2014	2019	'04 – '19
Costs (£m)						
NHS bed	-	173	130 (-25%)	159 (23%)	197 (24%)	14%
Private nursing home	-	438	234 (-47%)	285 (22%)	350 (23%)	-20%
Residential care home	-	261	68 (-74%)	84 (22%)	103 (23%)	-61%
LA home care	20	202	556 (175%)	679 (22%)	835 (23%)	313%
	30	202	713 (253%)	871 (22%)	1,072 (23%)	431%
	40	202	870 (330%)	1,063 (22%)	1,309 (23%)	548%
	50	202	1,026 (408%)	1,255 (22%)	1,546 (23%)	665%
	60	202	1,183 (486%)	1,447 (22%)	1,783 (23%)	783%
	70	202	1,340 (563%)	1,639 (22%)	2,021 (23%)	900%
	80	202	1,497 (641%)	1,831 (22%)	2,258 (23%)	1017%
District nurse	-	87	111 (27%)	135 (22%)	163 (21%)	86%
Health visitor	-	5.8	8.4 (46%)	10.2 (22%)	12.4 (21%)	116%
Total costs (£m)						
NHS expenditure	-	318	292 (-8%)	356 (22%)	435 (22%)	37%
LA expenditure	20	765	834 (9%)	1,018 (22%)	1,250 (23%)	63%
	30	765	990 (29%)	1,210 (22%)	1,488 (23%)	94%
	40	765	1,147 (50%)	1,402 (22%)	1,725 (23%)	125%
	50	765	1,304 (70%)	1,594 (22%)	1,962 (23%)	156%
	60	765	1,461 (91%)	1,786 (22%)	2,199 (23%)	187%
	70	765	1,617 (111%)	1,977 (22%)	2,436 (23%)	218%
	80	765	1,774 (132%)	2,169 (22%)	2,673 (23%)	249%
Private expenditure	-	318	257 (-19%)	312 (21%)	378 (21%)	19%
Total expenditure (£m)						
	20	1,402	1,382 (-1%)	1,686 (22%)	2,064 (22%)	47%
	30	1,402	1,539 (10%)	1,878 (22%)	2,301 (23%)	64%
	40	1,402	1,696 (21%)	2,070 (22%)	2,538 (23%)	81%
	50	1,402	1,852 (32%)	2,262 (22%)	2,775 (23%)	98%
	60	1,402	2,009 (43%)	2,454 (22%)	3,012 (23%)	115%
	70	1,402	2,166 (55%)	2,646 (22%)	3,249 (23%)	132%
	80	1,402	2,323 (66%)	2,838 (22%)	3,486 (23%)	149%

Notes:
1. Total costs include the costs of providing all community care services considered in this report, not just those affected by the scenario.
2. Total costs exclude sheltered housing. Please see p17 for details.
3. Individual cost projections include just the cost of providing a particular service.
4. Removing people from an NHS bed or care home will not have such a direct impact on costs as the projections are showing, as there are still running costs involved with empty places.
5. Components may not sum to totals due to rounding.

Chart 3: Projected recipients under low and moderate dependency model, indexed at 2004=100

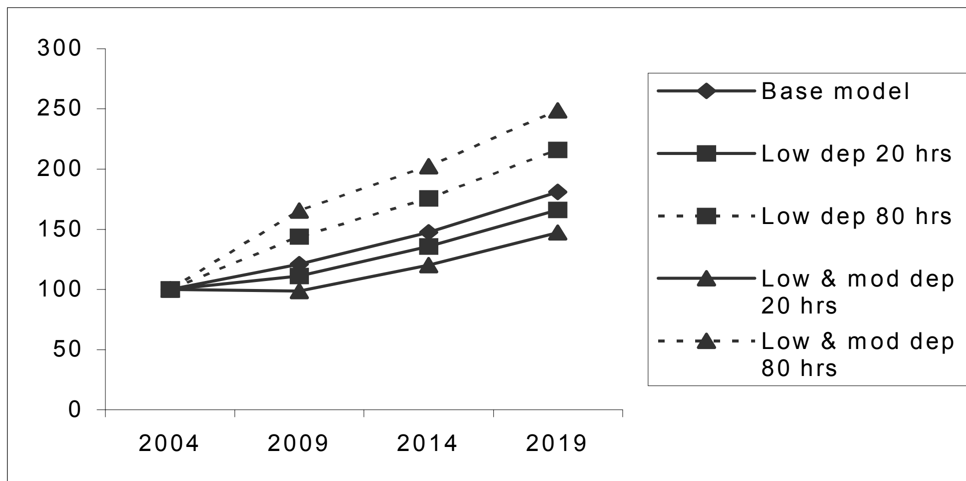


By 2019 the number of people in an NHS bed or care home is projected to decrease by 49%, as opposed to increasing by 37% under the base model. There will be 31,700 more people receiving LA home care, and 17,300 more people receiving care from a district nurse and health visitor.

If the additional home care clients are assumed to receive 20 hours of home care a week then the number of LA home care staff is projected to increase by 207% by 2019, as opposed to by 33% under the base model. The total expenditure will increase over the period to £2,064m, £474m less than under the base model and £265m less than if just low dependency people are moved.

If the additional home care clients are assumed to receive 80 hours of home care a week, then the number of LA home care staff is projected to increase by 730% by 2019. The total expenditure will increase over the period to £3,486m, £948m more than under the base model and £460m more than if just low dependency people are moved.

Chart 4: Projected total expenditure, indexed at 2004=100



Notes:
1. Total costs include the costs of providing all community care services considered in this report, not just those affected by the scenario.
2. Total costs exclude sheltered housing. Please see p17 for details.
3. Individual cost projections include just the cost of providing a particular service.
4. Removing people from an NHS bed or care home will not have such a direct impact on costs as the projections are showing, as there are still running costs involved with empty places.

Chapter 9 – Scenario 3

Scenario 3 – Low and moderate dependency people in an NHS bed can be accommodated in a care home

This scenario is based on the scenario in the previous chapter. Instead of removing low and moderate dependency people in all 'institutional' care (i.e. NHS bed or care home) and accommodating them in their own homes, this scenario looks at removing only those in an NHS bed with low or moderate dependency and accommodating them in a care home.

For the purposes of this scenario, the low dependency people in an NHS bed identified in the previous chapter using SHRUGS/SCRUGS data are accommodated in a residential care home. The moderate dependency people are moved to a private nursing home.

Again, this is not a policy suggestion or a prediction of future trends but simply another example of how the projections can change when different assumptions are used.

As noted in the previous chapter, removing all low or moderate dependency NHS patients to a care home may not be the right solution for those patients who are in an appropriate care setting for their needs. It is important to note that the cost projections include just the cost of providing a particular service. They do not include the cost of building new care homes for additional residents, nor do they take into account any changes in benefit payments which may occur when moving people from hospital to a care home. It is also important to note that removing people from an NHS bed will not have such a direct impact on costs as the projections are showing, as there are still running costs involved with empty places.

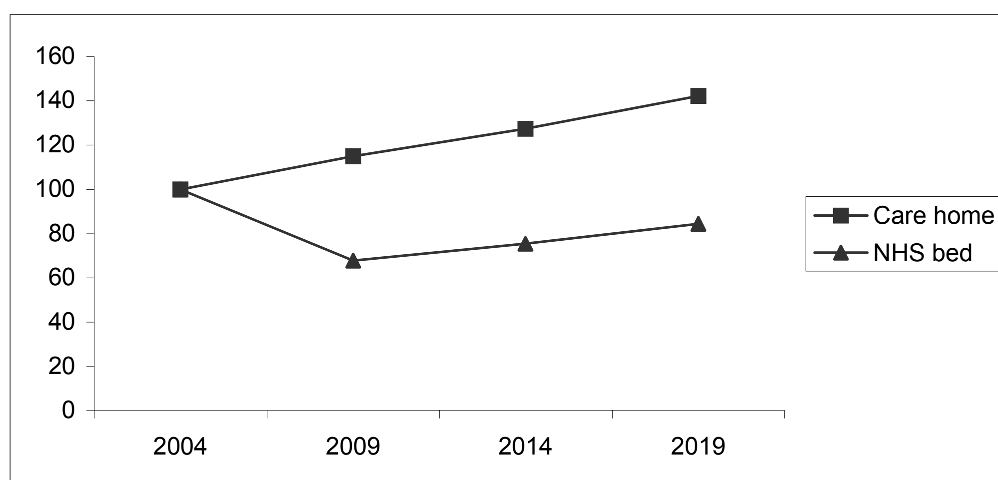
To estimate costs, the people moved to a care home are assumed to move to each of the different sectors and types of home so that the proportions are the same as in the base model. The base model proportions are also applied to the different sources of funding.

Table 15: Projected numbers if low and moderate dependency people in an NHS bed are moved to a care home

	2004	2009	2014	2019	2004 - 2019
Service recipients ('000s)					
NHS bed	3.2	2.2 (-32%)	2.4 (11%)	2.7 (12%)	-16%
Private nursing home	20.2	23.4 (16%)	25.8 (11%)	28.8 (12%)	43%
Residential care home	13.2	15.1 (14%)	16.7 (11%)	18.7 (12%)	41%
Workforce ('000s)					
NHS bed	-	-	-	-	-
Private nursing home	14.0	16.2 (16%)	17.9 (11%)	20.0 (12%)	43%
Residential care home	14.4	16.4 (14%)	18.2 (11%)	20.4 (12%)	41%
Costs (£m)					
NHS bed	173	130 (-25%)	159 (23%)	197 (24%)	14%
Private nursing home	438	559 (28%)	683 (22%)	842 (23%)	92%
Residential care home	261	328 (25%)	402 (22%)	496 (23%)	90%
Total costs (£m)					
NHS expenditure	318	302 (-5%)	369 (22%)	451 (22%)	42%
LA expenditure	765	952 (24%)	1,163 (22%)	1,429 (23%)	87%
Private expenditure	318	389 (22%)	473 (22%)	578 (22%)	82%
Total expenditure (£m)	1,402	1,644 (17%)	2,006 (22%)	2,459 (23%)	75%

Notes:
1. Workforce figures for NHS beds have not been included in the model. *Please see p14 for details.*
2. Total costs include the costs of providing all community care services considered in this report, not just those affected by the scenario.
3. Total costs exclude sheltered housing. *Please see p17 for details.*
4. Individual cost projections include just the cost of providing a particular service.
5. Removing people from an NHS bed will not have such a direct impact on costs as the projections are showing, as there are still running costs involved with empty places.
6. Components may not sum to totals due to rounding.

Chart 5: Projected recipients, indexed at 2004=100



Under these assumptions, by 2019 the number of people in an NHS bed is projected to decrease by 16% and the number in a care home is projected to increase by 42%, as opposed to increasing by 40% and 37% respectively under the base model. NHS expenditure is

projected to increase by 42% to £451m, £128m less than under the base model. This large decrease is partly balanced by an increase in LA and private expenditure, although the total expenditure is projected to increase to £2,459m, £79m less than under the base model.

Chapter 10 – Scenario 4

Scenario 4 – People receiving 20+ hours of LA home care are accommodated in a residential care home

Scenario 4 considers what could happen if a proportion of people being supported in the community are moved to a care home. This scenario takes the base model assumptions, but assumes that people receiving 20 hours or more of LA home care a week are moved to a residential care home.

This scenario looks at what could happen to the projections if the balance of care shifts towards more residential care being offered. It is not a proposal for a new policy to be implemented.

To estimate the numbers of hours of LA home care received by those remaining in the community, the average number of hours of care a week for each age/gender group has been revised in this scenario, and has been calculated by removing those receiving 20+ hours of care a week.

To estimate costs, the people moved to a residential care home are assumed to move to each of the different sectors and types of home so that the proportions are the same as in the base model. The base model proportions are also applied to the different sources of funding.

It is important to note that the cost projections are just the cost of providing a particular service. They do not include the cost of building new care homes for additional residents, nor do they take into account any changes in benefit payments which may occur when people move from the community to a care home.

In the absence of data, the model assumes that those receiving 20 or more hours of LA home care do not receive any other community care services. In reality, moving a proportion of people receiving LA home care to a care home would also have an effect on the numbers of users of other community care services, for example community nursing.

Table 16: Projected numbers if people receiving 20+ hours of LA home care are accommodated in a residential care home

	2004	2009	2014	2019	2004-2019
Service recipients ('000s)					
Residential care home	13.2	17.3 (31%)	19.2 (11%)	21.5 (12%)	62%
LA home care	56.0	58.1 (4%)	64.0 (10%)	70.8 (11%)	26%
Hours	363.1	311.4 (-14%)	343.6 (10%)	380.5 (11%)	5%
Workforce ('000s)					
Residential care home	14.4	18.9 (31%)	20.9 (11%)	23.4 (12%)	62%
LA home care	12.5	10.7 (-14%)	11.8 (10%)	13.1 (11%)	5%
Costs (£m)					
Residential care home	261	379 (45%)	463 (22%)	570 (23%)	118%
LA home care	202	191 (-5%)	233 (22%)	285 (22%)	41%
Total costs (£m)					
NHS expenditure	318	385 (21%)	472 (22%)	579 (23%)	82%
LA expenditure	765	922 (21%)	1,126 (22%)	1,383 (23%)	81%
Private expenditure	318	395 (24%)	480 (22%)	586 (22%)	84%
Total expenditure (£m)	1,402	1,702 (21%)	2,079 (22%)	2,548 (23%)	82%

Notes:
1. Total costs include the costs of providing all community care services considered in this report, not just those affected by the scenario.
2. Total costs exclude sheltered housing. Please see p17 for details.
3. Individual cost projections include just the cost of providing a particular service.
4. Components may not sum to totals due to rounding.

Under this scenario, by 2019 the number of residential care home residents is projected to increase by 62% and LA home care clients by 26%. This compares with increases of 38% and 32% respectively under the base model. The number of home care hours received in a typical week in 2019 is projected to increase to 380,500, 101,700 fewer than under the base model.

Chapter 11 – Scenario 5

Scenario 5 – A proportion of people receiving informal care receive formal care

It is not known with any certainty what is likely to happen to the supply of or demand for informal care, but this scenario considers how the projections could vary if there were a shift from informal to formal care.

Scenario 5 assumes that the proportion of people receiving informal care decreases by 1% each year. 63% of the people projected as requiring informal care under the base model but not receiving it under this model are given LA-provided home care as a substitute. The remainder are accommodated in a residential care home.

It is acknowledged that, if the supply of informal care were to decrease, then people who would otherwise receive informal care could choose to purchase home care privately, rather than receive LA-provided home care or move to a care home.

As mentioned above, it is not known what will happen to the supply or demand of informal care and so 1% is an arbitrarily chosen figure.

It is also not known how many informal care recipients could feasibly be offered home care as an alternative, as it is acknowledged that removing the informal care component from what could be a complex package of care could result in informal care recipients requiring residential care. As there is no suitable information on the number of hours of care received per recipient, the 63% figure is derived from the Census of Population, and is the proportion of informal carers (not recipients) who give 1-19 hours of informal care a week,

In the absence of data, the model assumes that those now receiving LA home care did not do so previously and so will be additional clients, and will receive the average number of hours of care for their age/gender group as those already receiving home care. It is also assumed that all informal care recipients live in the community, although people could provide informal care to someone living in a care home or hospital.

To estimate costs, the people moved to a residential care home are assumed to move to each of the different sectors and types of home so that the proportions are the same as in the base model. The base model proportions are also applied to the different sources of funding.

Table 17: Projected numbers if the proportion of people receiving informal care decreases

	2004	2009	2014	2019	2004 - 2019
Service recipients ('000s)					
Residential care home	13.2	16.6 (26%)	20.4 (23%)	24.8 (22%)	88%
LA home care	56.0	64.0 (14%)	73.9 (15%)	85.1 (15%)	52%
Hours per week	363.1	416.1 (15%)	481.6 (16%)	554.9 (15%)	53%
Informal care	99.0	99.5 (1%)	104.5 (5%)	108.1 (3%)	9%
Workforce ('000s)					
Residential care home	14.4	18.1 (26%)	22.2 (23%)	27.0 (22%)	88%
LA home care	12.5	14.3 (14%)	16.5 (15%)	19.0 (15%)	52%
Costs (£m)					
Residential care home	261	364 (39%)	496 (36%)	666 (34%)	155%
LA home care	202	256 (27%)	327 (28%)	416 (27%)	106%
Total costs (£m)					
NHS expenditure	318	385 (21%)	472 (23%)	579 (23%)	82%
LA expenditure	765	976 (28%)	1,248 (28%)	1,592 (28%)	108%
Private expenditure	318	390 (23%)	485 (24%)	603 (24%)	90%
Total expenditure (£m)	1,402	1,752 (25%)	2,205 (26%)	2,774 (26%)	98%

Notes:
1. Total costs include the costs of providing all community care services considered in this report, not just those affected by the scenario.
2. Total costs exclude sheltered housing. Please see p17 for details.
3. Individual cost projections include just the cost of providing a particular service.
4. Components may not sum to totals due to rounding.

Under these assumptions, the number of residential care home residents is projected to increase to 24,800, 6,500 more than under the base model. The number of LA home care clients is projected to increase to 85,100, 11,100 more than under the base model. Informal care recipients are projected to increase by 9% to 108,100, as opposed to by 27% to 125,600.

The following table and charts illustrate how the projections can vary if a different proportional change is assumed. The charts show numbers of people if the proportion receiving informal care remains fixed as in the base model or decreases by up to 4% each year.

These proportional changes may seem small, but as they accumulate over the period they can produce significant changes. For example, a decrease of 4% each year could result in a 199% increase in residential care home residents, a 97% increase in LA home care clients and a 31% decrease in informal care recipients by 2019, as opposed to 38%, 32% and 27% increases respectively under the base model.

Table 18: Projected numbers of residential care home residents, LA home care clients and informal care recipients, under different assumptions of change in proportion of informal care recipients (thousands)

	2004	2009	2014	2019	2004 - 2019
Residential care home					
0% (Base model)	13.2	14.7 (11%)	16.3 (11%)	18.3 (12%)	38%
-1%	13.2	16.6 (25%)	20.4 (23%)	24.8 (21%)	87%
-2%	13.2	18.4 (39%)	24.1 (31%)	30.4 (26%)	130%
-3%	13.2	20.2 (52%)	27.6 (36%)	35.3 (28%)	167%
-4%	13.2	21.9 (65%)	30.7 (40%)	39.5 (29%)	199%
LA home care					
0% (Base model)	56.0	60.7 (8%)	67.0 (10%)	74.0 (11%)	32%
-1%	56.0	64.0 (14%)	73.9 (16%)	85.1 (15%)	52%
-2%	56.0	67.1 (20%)	80.3 (20%)	94.7 (18%)	69%
-3%	56.0	70.0 (25%)	86.1 (23%)	103.0 (20%)	84%
-4%	56.0	72.9 (30%)	91.4 (25%)	110.2 (21%)	97%
Informal care					
0% (Base model)	99.0	104.7 (6%)	115.6 (10%)	125.6 (9%)	27%
-1%	99.0	99.5 (1%)	104.5 (5%)	108.1 (3%)	9%
-2%	99.0	94.6 (-4%)	94.4 (-0%)	92.8 (-2%)	-6%
-3%	99.0	89.9 (-9%)	85.2 (-5%)	79.6 (-7%)	-20%
-4%	99.0	85.3 (-14%)	76.8 (-10%)	68.1 (-11%)	-31%

Chart 6: Projected numbers of residential care home residents, under different assumptions of change in proportion of informal care recipients, indexed at 2004=100

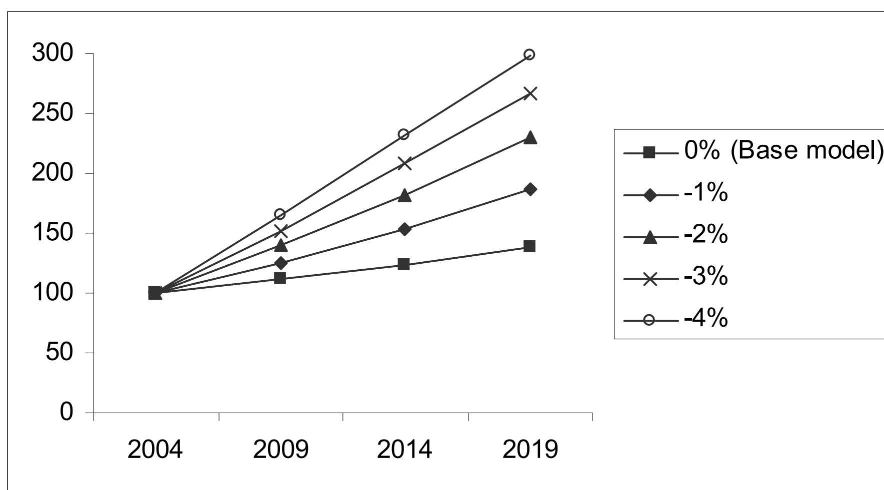


Chart 7: Projected numbers of LA home care clients, under different assumptions of change in proportion of informal care recipients, indexed at 2004=100

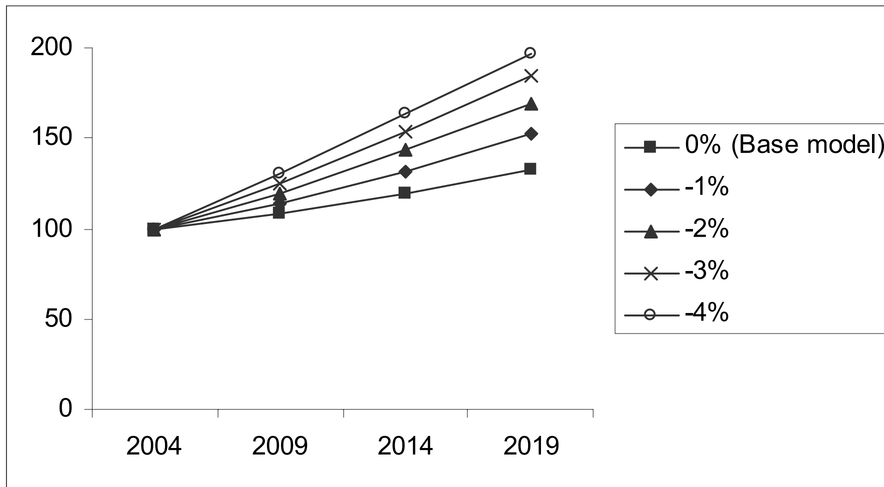
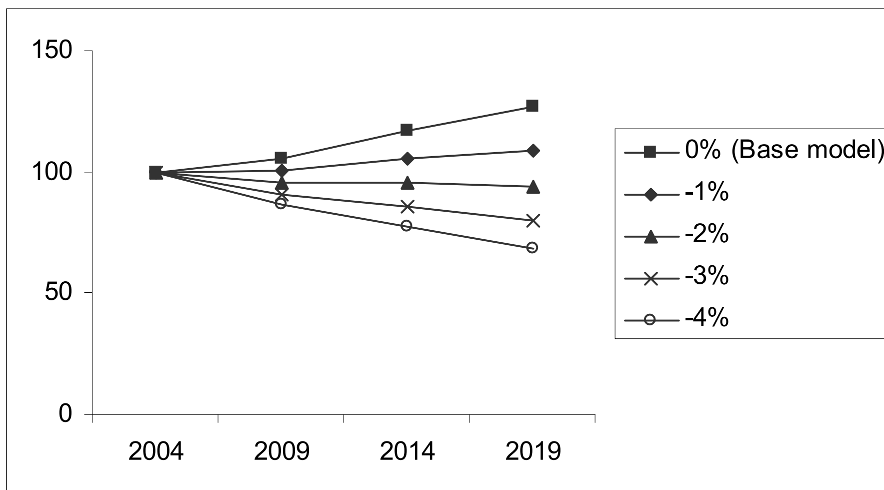


Chart 8: Projected numbers of informal care recipients, under different assumptions of change in proportion of informal care recipients, indexed at 2004=100



Chapter 12 – Scenario 6

Scenario 6 – Changing the increase in unit costs

The base model and all subsequent scenarios assume that the unit costs experience a 2% year-on-year increase above inflation from 2004 onwards. As noted in chapter 7, this figure was chosen to reflect the long-term growth assumptions for GDP. It also supports the belief of the reference group that, as the economy becomes wealthier, the cost of providing appropriate care will continue to rise.

If the 2% figure is changed, this could have a large impact on the cost projections, and it is important to realise the sensitivity of the model to this assumption and understand the extent to which the projections will vary as this assumption varies.

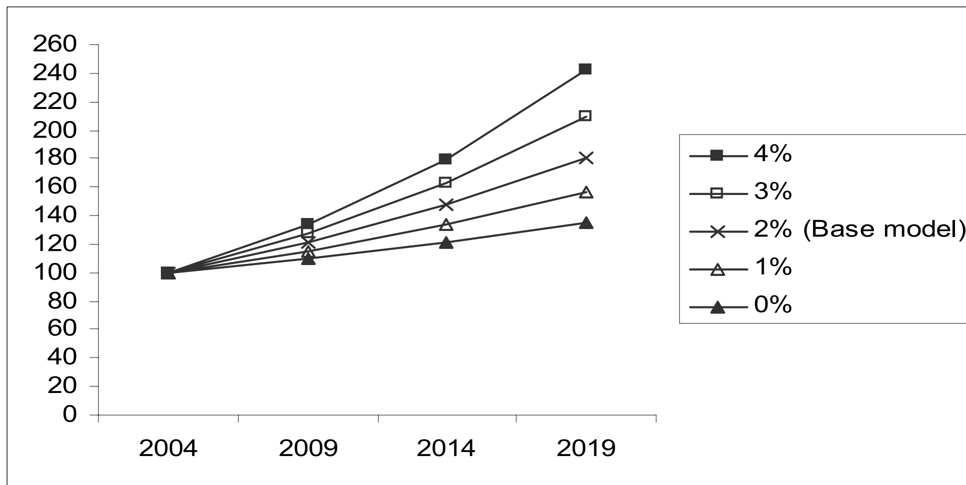
Table 19 shows projected expenditure when the unit costs are assumed to experience an annual increase of 0% (i.e. the costs rise in line with inflation), 1%, 2% (the figure used in the base model), 3% and 4%.

Table 19: Projected expenditure, under different assumptions of change in unit costs (£m)

	2004	2009	2014	2019	2004 - 2019
NHS					
0%	318	349 (10%)	387 (11%)	430 (11%)	35%
+1%	318	367 (15%)	428 (17%)	499 (17%)	57%
+2% (Base model)	318	385 (21%)	472 (22%)	579 (23%)	82%
+3%	318	405 (27%)	520 (29%)	670 (29%)	110%
+4%	318	425 (33%)	573 (35%)	775 (35%)	143%
LA					
0%	765	841 (10%)	930 (11%)	1,035 (11%)	35%
+1%	765	884 (16%)	1,027 (16%)	1,201 (17%)	57%
+2% (Base model)	765	928 (21%)	1,134 (22%)	1,392 (23%)	82%
+3%	765	975 (27%)	1,250 (28%)	1,612 (29%)	111%
+4%	765	1,023 (34%)	1,377 (35%)	1,863 (35%)	144%
Private					
0%	318	346 (9%)	381 (10%)	421 (11%)	32%
+1%	318	363 (14%)	421 (16%)	489 (16%)	54%
+2% (Base model)	318	382 (20%)	464 (22%)	567 (22%)	78%
+3%	318	401 (26%)	512 (28%)	656 (28%)	106%
+4%	318	420 (32%)	564 (34%)	758 (34%)	138%
Total					
0%	1,402	1,535 (10%)	1,698 (11%)	1,886 (11%)	35%
+1%	1,402	1,614 (15%)	1,876 (16%)	2,189 (17%)	56%
+2% (Base model)	1,402	1,695 (21%)	2,070 (22%)	2,538 (23%)	81%
+3%	1,402	1,780 (27%)	2,282 (28%)	2,938 (29%)	110%
+4%	1,402	1,868 (33%)	2,514 (35%)	3,396 (35%)	142%

Notes:
1. Total costs exclude sheltered housing. Please see p17 for details.
2. Components may not sum to totals due to rounding.

Chart 9: Projected total expenditure, under different assumptions of change in unit costs, indexed at 2004=100



Note: Total costs exclude sheltered housing. Please see p17 for details.

If the unit costs are assumed to increase in line with inflation, this could result in total expenditure increasing by 2019 by 35% to £1,886m, as opposed to by 81% to £2,538m in the base model. If the unit costs are assumed to increase by 1% above inflation each year, then this could produce an increase in costs of 56% to £2,189m. An annual increase of 3% could result in an 110% increase in costs, to £2,938m, and a 4% annual increase could see projected costs rising by 142% to £3,396m.

Chapter 13 – Scenario 7

Scenario 7 – The joint future model

The paper 'National User and Carer Outcomes and Local Improvement Targets for the Joint Future Agenda'
(http://www.scotland.gov.uk/about/HD/CCD2/00017673/OutcomesPaperMarch04.pdf)
sets out the Health and Community Care Ministerial Steering Group's intention that local partnerships should focus on improved outcomes for individuals and their carers, as part of the 'Re-invigorating the Joint Future Agenda'.

This scenario looks at the projections produced when the joint future recommendations set out in the paper are incorporated.

Of the 14 local improvement targets recommended in the paper, only three could be incorporated into a model, due to relevance and data availability. These are:

- Supporting more people at home, as an alternative to residential and nursing care – increased numbers of people receiving intensive home care or care at home packages;
- Supporting more people at home, as an alternative to residential and nursing care – proportion of older people over 65 in residential/nursing care in relation to those being supported at home; and
- Better involvement of carers – more carers accessing respite care.

The first recommendation has been incorporated into the model by moving to the community the low dependency people living in a care home (i.e. those in SCRUGS group A – see chapter 8 for a discussion of the SCRUGS data), who are then given 10 hours of LA home care a week. This shift in the balance of care occurs in 2005 only.

The second recommendation comes into effect in the following year, 2006. The proportion in each age/gender band in 2005 living in a care home in relation to those receiving LA home care is reduced by 1% each year. The care home residents removed as a result of reducing the proportions are given the average number of hours of LA home care a week by age and gender as those already receiving intensive home care (i.e. more than 10 hours a week).

It is also assumed that the private nursing home residents who are removed receive the average number of community nursing visits for their age/gender group.

The third recommendation assumes that 63% of people receiving informal care receive 10 hours of LA home care a week, for 4 weeks each year, and the remainder receive 4 weeks each year of respite care in a residential care home.

As discussed in scenarios 2 and 3, it is acknowledged that some low dependency care home residents are appropriately placed, and moving them to the community would not in reality be an option.

As discussed in scenario 5, as there is no suitable information on the number of hours of care received per recipient, the 63% figure is derived from the Census of Population, and is the proportion of informal carers (not recipients) who give 1-19 hours of informal care a week,

To calculate the projected numbers of staff required, it has been assumed that the numbers of informal care recipients receiving respite care are spread evenly across the year.

To calculate costs, the unit cost for a residential care home for older people has been used for the informal care recipients who receive 4 weeks of residential care a year. The respite care given to the informal care recipients has been assumed to be LA-funded.

Table 20: Projected numbers under the joint futures model

	2004	2009	2014	2019	'04 – '19
Service recipients ('000s)					
Private nursing home	20.2	15.8 (-22%)	16.8 (6%)	18.0 (7%)	-11%
Residential care home	13.2	8.2 (-38%)	8.4 (3%)	8.7 (4%)	-34%
Residential care home - respite	0.0	3.0 (N/A)	3.3 (10%)	3.6 (9%)	N/A
LA home care	56.0	73.8 (32%)	82.8 (12%)	93.1 (12%)	66%
Intensive	12.0	26.2 (118%)	30.3 (16%)	35.1 (16%)	192%
Non-intensive	44.0	47.6 (8%)	52.5 (10%)	57.9 (10%)	32%
Hours per week	363.1	618.9 (70%)	706.5 (14%)	807.6 (14%)	122%
LA home care - respite	0.0	5.1 (N/A)	5.6 (10%)	6.1 (9%)	N/A
Hours per week	0.0	50.7 (N/A)	56 (10%)	60.9 (9%)	N/A
District nurse	163.0	179.6 (10%)	198.3 (10%)	217.4 (10%)	33%
Visits per year	3,121.4	3,443.8 (10%)	3,802.8 (10%)	4,170.7 (10%)	34%
Health visitor	52.9	62.9 (19%)	69.8 (11%)	77.3 (11%)	46%
Visits per year	169.2	201.0 (19%)	223.3 (11%)	247 (11%)	46%
Workforce ('000s)					
Private nursing home	14.0	10.9 (-22%)	11.6 (6%)	12.5 (7%)	-11%
Residential care home	14.4	12.1 (-16%)	12.7 (5%)	13.4 (5%)	-7%
LA home care	12.5	23.0 (84%)	26.2 (14%)	29.8 (14%)	139%
District nurse	1.4	1.5 (10%)	1.7 (10%)	1.8 (10%)	34%
Health visitor	0.22	0.26 (19%)	0.29 (11%)	0.32 (11%)	46%
Costs (£m)					
Private nursing home	438	377 (-14%)	443 (17%)	525 (18%)	20%
Residential care home	261	177 (-32%)	201 (14%)	230 (14%)	-12%
Respite	0	73 (N/A)	89 (22%)	107 (20%)	N/A
LA home care	202	380 (88%)	479 (26%)	605 (26%)	199%
Respite	0	31 (N/A)	38 (22%)	46 (20%)	N/A
District nurse	87	106 (22%)	130 (22%)	157 (21%)	80%
Health visitor	5.8	7.5 (31%)	9.3 (23%)	11.3 (22%)	96%
Total costs (£m)					
NHS expenditure	318	380 (19%)	465 (22%)	569 (23%)	79%
LA expenditure	765	948 (24%)	1,148 (21%)	1,395 (22%)	82%
Private expenditure	318	314 (-1%)	374 (19%)	447 (19%)	40%
Total expenditure (£m)	1,402	1,642 (17%)	1,987 (21%)	2,411 (21%)	72%

Notes:
1. A percentage change cannot be calculated where the starting figure is zero.
2. The numbers of people receiving respite care, and respite home care hours, are for an average week, and assume that the numbers are spread evenly across the year.
3. Total costs include the costs of providing all community care services considered in this report, not just those affected by the scenario.
4. Total costs exclude sheltered housing. Please see p17 for details.
5. Individual cost projections include just the cost of providing a particular service.
6. Removing people from a care home will not have such a direct impact on costs as the projections are showing, as there are still running costs involved with empty places.
7. Components may not sum to totals due to rounding.

Incorporating the joint future recommendations into the base model results in long-stay care home residents decreasing by 20% by 2019, as opposed to increasing by 37% under the base model. The number of LA home care clients (excluding informal care

recipients receiving respite home care) is projected to increase to 93,100, 19,100 more than under the base model.

Providing respite care to informal care recipients under these assumptions is estimated to result in 6,100 people receiving LA home care and 3,600 people receiving residential care in a typical week in 2019.

Total expenditure is projected to increase by 72% over the period to £2,411m, £127m less than under the base model.

Chapter 14 – Future work of the range and capacity review

As discussed in the introduction, the model will be continuously reviewed and developed to take into account changes in data and new information relating to the balance of care. The model will also be used to investigate the possible implications of new policy developments.

In the short term, it is also intended that the model will be developed at the local level and be made available to local authorities to enable them to use it as part of their local capacity planning.

The reference group for the review is presently in its second phase of work, which involves looking at the future provision of care services to older people. The group aims to deliver recommendations on effective methods of developing and managing provision to meet future needs, and also to investigate different models of care.

The group is expected to report to Ministers later this year.