LONDON BOROUGH OF
RICHMOND UPON THAMES

London Borough of Richmond upon Thames

Adult Social Care
Market Position Statement 2014

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Foreword

Cathy Kerr
Director of Adult and Community Services, London Borough of Richmond Upon Thames

As the Director of Adult Social Care in the Borough, I am keenly aware that we are working in a period of significant change. This change creates uncertainty for all stakeholders from ourselves as the commissioners, to you the providers and perhaps most acutely by the people of Richmond who need access to care and support on a day to day basis. The tests that we face together over the next decade are enormous; the growth in the ageing population (16.8% over 5 years for the over 75s); the resultant increase in people with one or more complex long term conditions (50% increase over the next 10 years); the introduction and impact of the Care Bill and all in the context of significant public sector financial pressures.

I am clear that in order for us to meet these head on, we must change the way we commission services, we must change the way services are provided, and above all we must change the outcomes for the people of Richmond for the better.

As a council, we need to commission differently and we have to engage with providers and service users with meaningful dialogue from the start to ensure service users' outcomes are met. Traditionally the market within Richmond for Adult Social Care has been reactionary, by that I mean waiting for the Council to commission a designed service; this has to change. As providers of services you are best placed to identify problems within services, you are best placed to understand the day to day needs of service users and develop solutions to meet those needs.

I fundamentally believe that by developing the providers, we will be best placed to meet those needs by working together in partnership. Slow incremental change will not produce the transformations the people of Richmond are going to need. As providers we want you to work together to look at this whole pathway of care. Whether you are the first, middle or last contact in the care pathway you are indirectly working together (if not directly already) and you can see the changes in need and activity levels that will help future planning and improve service user outcomes along the care pathway.

It is by working together and developing care pathways around the service user that we will enable better care, better delivery and above all better outcomes for the people of Richmond.

Introduction

What is a Market Positioning Statement?

This Market Positioning Statement (MPS) is primarily aimed at adult social care and health care providers, but will be of interest to a much wider range of stakeholders, and particularly those who use services. Richmond needs to develop a far more diverse market for care, one that offers people choice from a wide range of personalised community based services that are delivered in the way individuals want them and when they want them. The MPS provides information on current supply and demand, planned changes and emerging trends that should prove useful to existing providers in the borough and those considering starting a new business or extending their operations in to Richmond. A small selection of tables and charts has been included in the MPS to illustrate key issues but much more information is available on the website (www.richmond.gov.uk) and this will be regularly updated.

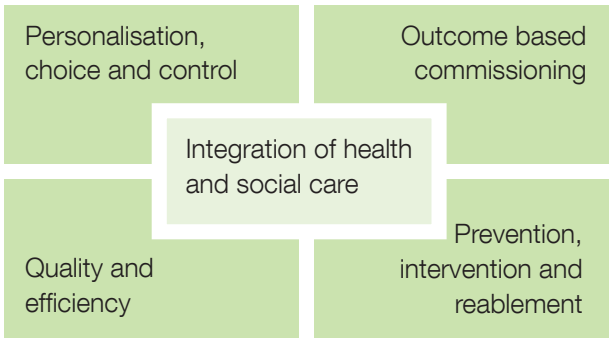
The MPS is intended to act as a starting point for focussed discussions between commissioners and providers on the challenges of delivering high quality personalised services at affordable costs. The local authority must not only plan to meet the needs and wishes of those people it has traditionally funded but must develop a market that also responds to the needs and preferences of those able to fund their own care. The MPS highlights both the challenges and opportunities arising from demographic changes and policy initiatives, which will be built on in future versions of the MPS.

The foundation of Richmond's MPS is the development of high quality and efficient personalised services within strong local communities that are responsive to individuals and put them in control of their care. This means moving away from traditional service provision and an over reliance on residential and nursing care to flexible personal care focussed on promoting independence, enablement and rehabilitation within the individual's own community and home. By focussing on outcomes for the individual rather than outputs we will reduce dependency, improve individuals' health and support people and communities to help themselves.

As one of the first steps in achieving these ambitious aims, Richmond has established a Joint Commissioning Collaborative between the Council and Richmond Clinical Commissioning Group (CCG) to ensure a coordinated approach to the strategic commissioning of services that delivers better services more efficiently. The commissioning intentions of the CCG and the Council have been aligned and are reflected within the strategic priorities in the MPS.

Strategic Priorities

We have identified the five strategic priorities below to help us work with providers and other stakeholders to develop the market to effectively and efficiently meet the needs of the people of Richmond over the next five years. These priorities are highly interdependent and reflect the increasingly complex nature of service provision and the need for a synchronised, integrated and holistic approach to commissioning and market development:



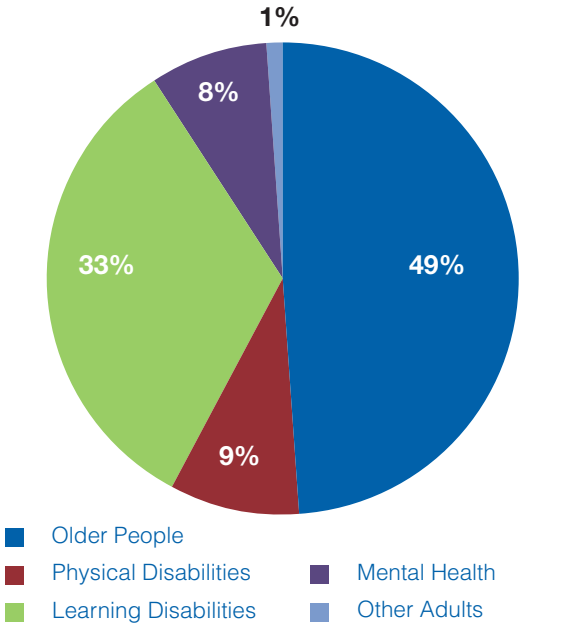
Funding For The Future

National measures to reduce the UK budget deficit continue to cause uncertainty around future local government funding, whilst demand for local services continues to grow. It is expected that there will be continued reductions to public spending going forward, which will undoubtedly impact on the Council's funding. The financial context for the Council is, therefore, one of on-going resource reductions and there will be a greater need to work with our commissioned providers to find ways of reducing costs, whilst maintaining essential services to residents and service quality. Adult Social Care represents a large proportion of the Council's overall budget, 37%, and therefore will be required to make efficiencies going forward. The Council seeks to work with providers to explore ways of achieving efficiency in the way services are delivered.

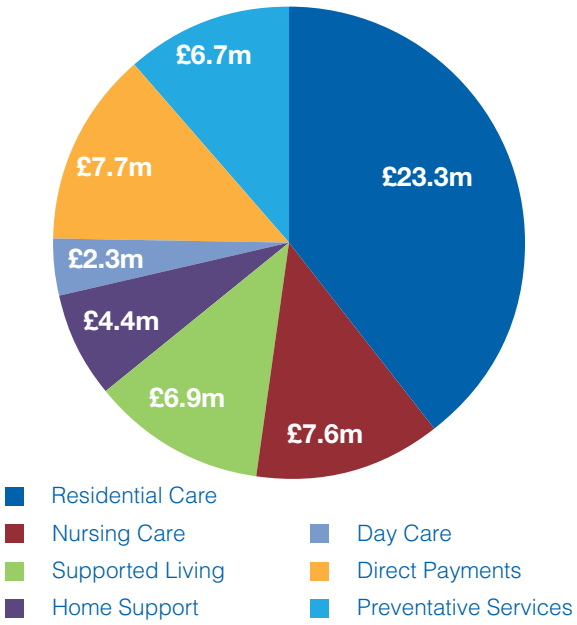
There is a particular focus on developing services that prevent, reduce or delay the need for people requiring care services e.g. through self-help, early intervention, reablement and rehabilitation. At the same time, it remains a local priority to develop integrated health and social care services so that our residents receive properly co-ordinated health and care services so that they remain healthy and remain living independently. Local examples of services in Richmond upon Thames include the Richmond Response and Rehabilitation Team, which integrates the Council's Reablement Service with NHS Intermediate Care to provide a joint solution to reduce unplanned hospital admissions and to prevent people needing care services.

The Council will continue to develop and commission integrated health and social care services in the coming years and plans are being developed with Richmond CCG to provide integrated services from the Better Care Fund, a pooled fund which brings together existing council and NHS funds to provide integrated services.

The Council spends approximately £60m on adult social care services to older people and people with disabilities as follows:



The budget is spent on commissioned care services shown below:



Care Bill

The Care Bill currently progressing through Parliament consolidates existing legislation on care and support to adults and carers, and is due to be implemented in two phases; April 2015 for the majority of changes and April 2016 when funding reforms come into force.

The Bill is a huge change for Adult Social Care and is wide ranging covering most aspects of social care; the key areas that impact on providers are highlighted below:

- The Bill places a Duty on councils to support and arrange care for the whole population; not just those financially eligible for support.
- There will be a cap on care costs for people requiring social care and councils will set up independent personal budgets and care accounts for those people arranging their own care. The local authority will therefore be in contact with a lot more people requiring social care and if required will support them to find appropriate care.
- When the 'cap' on care costs is reached the Council will then fund the care. We expect that from the 2019/20 financial year more people will be funded by the council as they reach the 'cap'.
- The Bill requires that councils provide better information to residents about social care and specifically about the range and types of services available locally and the quality of those services. As a result the Council will develop an accreditation scheme and will expect all providers to sign up to the standards in the scheme.
- Carers will for the first time have the same legal rights as service users and will have their own eligibility criteria and will be eligible for a personal budget and a support plan. Carers' services will need to be developed to meet this new demand from carers.

These changes create opportunities for providers as we expect that there will be a significant increase in demand for services.

Key Messages

Providers and commissioners need to disinvest in residential and nursing care and re-invest in innovative and responsive personalised services for people living at home.

Providers need to realign business models and systems to meet the needs of Self-Funders and the ever increasing use of Direct Payments.

Commissioners and providers need to develop flexible procurement solutions that ensure quality and service user outcomes are at the core of delivery.

Providers need to focus on delivering individual outcomes that increase independence and make creative use of universal services.

Commissioners and providers need to work together to reduce hospital admissions and avoid admissions to care homes from hospital.

Providers need to develop a range of reablement and intensive care at home services to help people remain at, or return to home. This needs to include better quality end of life care.

The integration of health and social care is a national and local priority, it is essential to improve people's experience of care and to deliver essential efficiencies across the sector.

Providers will also need to consider the benefits of greater integration and how they might adapt, develop partnerships, join consortia or merge with other organisations to deliver a holistic and more effective approach to service provision.

Commissioners will work with service users and providers to develop a quality accreditation scheme that provides useful information and reassurance to actual and potential service users about the standard and cost of provision. The scheme will incorporate user and carer feedback to ensure it reflects the experience of the customer.

Navigation

There are two main sections to the MPS, the first provides information in respect of each of the strategic priorities in turn, providing more detail and highlighting the key implications and challenges for providers as well as some ideas for potential business development. The second section provides detailed demographic information on the population of Richmond and on the following key service areas:

1. Older People

2. Mental Health

3. Learning Disability

The MPS will be regularly reviewed and it is likely that these areas will be expanded on and new ones added as we develop the MPS; for example, information on specific health conditions, public health initiatives and examples of innovative developments by providers.

Strategic Priorities

Integration of Health and Social Care

A key element within the 2012 Health and Social Care Act is the integration of health and social care. The Act contains a number of provisions to encourage the NHS, local government and other sectors to improve outcomes for people through far more effective co-ordinated working. Improving the quality of health and social care is one of the main objectives of integration, however a key driver for reform is the need to address the ever increasing cost of care.

The development of a Joint Collaborative Commissioning Team between the Council and the CCG in 2013 was a significant step towards increasing integration of health and social care within Richmond. The next step is the development of services based on functional integration, where service delivery encompasses health, social care and the 3rd sector which meets the needs of the population. The Better Care Fund (BCF) is the catalyst to ensure commissioners drive through the changes and have integration at the forefront of service development.

Challenges & Benefits

The existing organisation of health and social care across the country tends to be fragmented and confusing for those that use services. In addition there is an increasing demand for services due to an ageing population and the growth in the number of people with complex and multiple conditions.

The key outcomes of integration must be:

- A seamless service for people who need services, that is easy to access and ensures people get the services they require quickly.
- The efficient use of resources with integrated assessment, care planning and service delivery across health and social care, and the voluntary and independent sectors.

Case Study – Community Rehabilitation and Rapid Response Service

The London Borough of Richmond upon Thames and Richmond Clinical Commissioning Group has commissioned an integrated hospital discharge, community rehabilitation and rapid response service for Richmond residents.

Securing the best outcomes for people sits at the heart of the Community Rehabilitation service. People, not service providers or systems, should hold the choice and control about their care. Care is a uniquely personal service, it supports people at their most vulnerable and often covers the most intimate and private aspects of their lives.

When people develop care and support needs, the first priority should be to restore an individual's independence and confidence. The community rehabilitation service facilitates the development of effective and realistic outcomes-focussed independence and support plans driven by their individual needs, wishes and circumstances.

People should be empowered to set goals for themselves that include the acquiring of new skills, or regaining skills that may have been lost. With choice and control, people's dignity and freedom is protected and the quality of their life is enhanced. The vision for the community rehabilitation service is to make sure everyone can get the person-centred support they deserve to emerge from their period of crisis the most independent they can be.

Aims

The community rehabilitation service will build on the best aspects of the current reablement and intermediate care services. It will offer people a clear care pathway for hospital discharge and the opportunity to receive the level and intensity of rehabilitation services at the time and for the duration they need it, from appropriate highly skilled workers.

The new service will stretch investment to provide a wider and more effective rehabilitation and rapid response offer for residents through:

- Improving the transition from acute to community services through facilitating safe and timely discharge from hospital.
- Providing a rapid response, urgent care assessment, observation and support for people whose health needs would otherwise lead to an admission to hospital or an extended stay in hospital.
- A range of short-term interventions, which help people recover their skills and confidence after an episode of poor health, admission to hospital, or sudden deterioration of their functionality.
- Providing short-term intensive support to people to regain independence and wellbeing.
- A person-centred package of support to people in their own homes, in hospital or in a care home setting which is jointly delivered by health and social care professionals.
- Ensuring an effective referral process to district nursing and other specialist teams as appropriate.
- Maintaining an effective communication with GPs and other referrers to the service.
- Supporting people in care homes and preventing unnecessary emergency calls and hospital admissions.

Implications for Providers

To fully realise the benefits of integration for people who buy and use services it is essential that providers become more integrated; internally, with commissioners and their requirements and with other providers.

Providers who can deliver holistic services across health and social care that deliver the required outcomes will do better in an integrated system. Providers will need to consider:

- Extending the range and type of services they provide rather than focussing on niche areas.
- How to make it easy for the customer to know what you are offering and be clear about the cost, provide a menu to facilitate choice.
- Developing partnerships, consortia or subcontracting relationships to deliver desired skill mix to suit the lifestyle of each individual.
- Working jointly with other health and social care providers as well as linking with mainstream activities to increase choice and enhance the quality of an individual's life.
- Developing their workforce to meet the challenges of personalisation and the need for responsive flexible services.

Provider Opportunities

- Develop further the independent brokerage and financial advocacy service to support people to navigate through the health and social care market, and to access mainstream services to make the most of their personal budgets.
- Develop integrated services to meet the needs of people with complex and multiple needs throughout their lives.
- Follow the development of integration within the health and social care community in Richmond to pick up on changes and new developments to help anticipate and respond to new demand. www.richmond.gov.uk/adult_commissioning

Personalisation, Choice and Control

Providers will need to offer people as much choice and control as possible over the type of support available as well as the way it is delivered and when it is provided. Providers will need to be flexible and responsive, adapting the service provided, the frequency and time to suit the lifestyle of the person.

Personal Budgets are available to all people with eligible adult social care support needs, and they promote independence and choice by informing people about how much money they need to meet the cost of their support. In addition from 1st April 2014 personal budgets will be introduced in phases within health services, starting with continuing healthcare.

People can choose to let the Council arrange and manage their support or to arrange their own support, with or without assistance, using a Direct Payment.

The Council plans to make Direct Payments more accessible by implementing Pre-Paid cards in early 2014 to make it easier for people to access and use them. Currently 35% of council funded service users have a Direct Payment and we expect this to rise to 60% by 2016/17.

Dignity & Respect

We expect all providers to respect each person's dignity and provide services that meet their needs and preferences, both in the types of services provided and in the way they are delivered to suit each individual.

Personalisation is not just about personal budgets and Direct Payments. Providers need to offer services in a person centred way regardless of the way payment is provided.

Richmond Council has already confirmed its intention to become a commissioning council rather than its current commissioning and providing role. As such it will facilitate the relationship between people who need support and organisations that can provide good quality flexible services efficiently. When the Care Bill is introduced this will include services for people who are able to fund their own support and who represent a significant proportion of the population accessing care services. To do this we will:

- Review the range of preventative and 'universal services' which are available to all residents outside of eligibility criteria.
- Make Direct Payments more accessible and increase the number of people using them by implementing Pre-Paid cards.
- Implement a resource directory of local service providers alongside a quality accreditation scheme to give individuals looking to purchase services better information to inform their decisions, so they know what they can expect from providers and what to do if they are dissatisfied.
- Facilitate user feedback on quality of provider service and publish the results.

Implications for Providers

Providers will need to:

- Engage with and involve the people who use your services.
- Change their business model to accommodate higher numbers of Direct Payments and Self-Funders.
- Develop systems and processes to accommodate prepayment cards, e-purchasing and on-line booking.
- Provide clear information and advice including cost, quality and a menu of options that enable people to tailor support to meet their needs.
- Develop a flexible skilled workforce with positive customer service skills.
- Provide budget management options for those who don't want to manage their own budget or who lack capacity.
- Develop integrated services to ensure continuity of care within a seamless service.

Provider Opportunities

- Develop independent support planning and brokerage services for increasing number of people with Direct Payments & Self-Funders.
- Develop services and systems to meet the needs of people with personal health budgets in the future.
- Develop personalised health and wellbeing services that use community venues and resources such as Gym Buddies.

Outcome Based Commissioning

The national agenda has changed in relation to how commissioners evaluate the quality and successful delivery of services to the residents of Richmond in both Health and Social Care, from a target based model to an outcome based model.

Commissioners will be working with providers to develop monitoring and evaluation processes that capture outcomes focussing on quality aspects of delivery in user centric format.

As stated previously in April 2013 Richmond Council and Richmond CCG set up a Joint Commissioning Collaborative (JCC) to ensure an integrated approach to commissioning health and social care services; this is a fundamental part of the council's vision to become a commissioning authority. This JCC removes the artificial barrier between the two organisations that inadvertently led to the development of services that sometimes worked at cross purposes.

The focus is on achieving positive agreed outcomes with service users that increase their independence and wellbeing. There will be less concern with outputs, and those that are monitored will be clearly linked to delivering better outcomes.

The focus on outcomes is designed to facilitate creativity and innovation whilst driving up quality and will be closely linked to a provider accreditation scheme. This will provide both opportunities and challenges for providers, with a clear expectation that they will provide higher quality personalised services at lower costs.

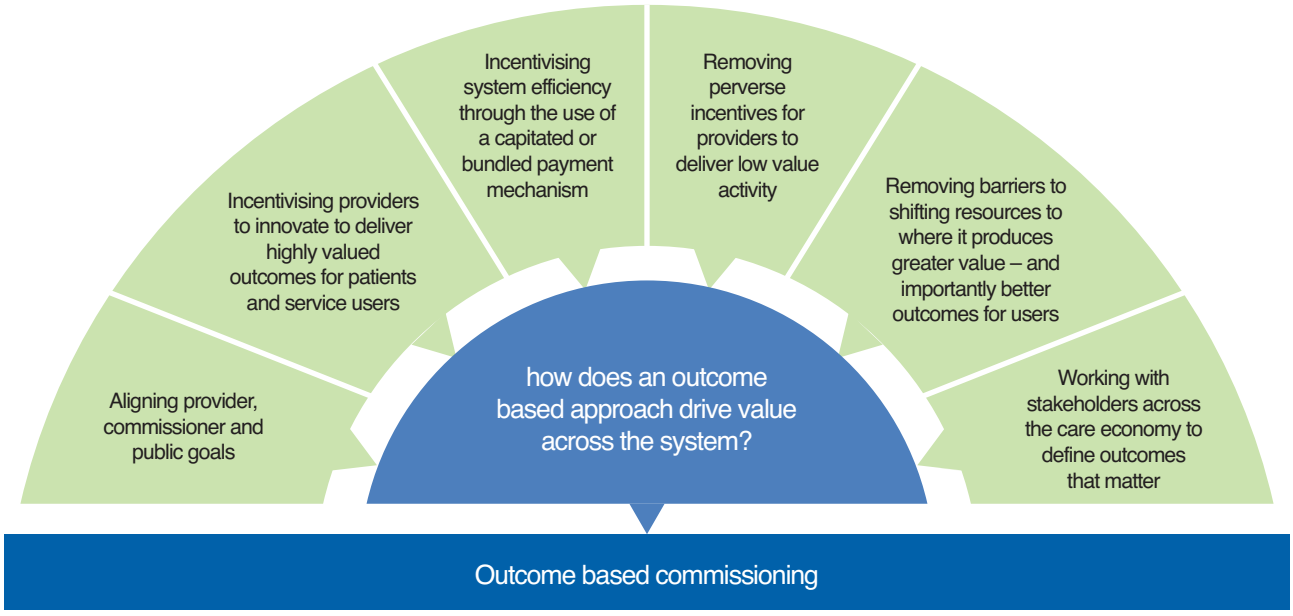
The commissioning intentions for the Council dovetail with those of Health and this synergy will be developed and enhanced through the Joint Commissioning Collaborative. This crossover can be seen in many of the council's key targets and ambitions, including:

- Greater emphasis on public health and prevention.
- Clear focus on outcomes and reducing the burden of contract monitoring whilst improving and assuring service quality.
- Integration within the provider (including voluntary) sector to deliver a holistic approach to service provision.
- Easier navigation and access to services particularly for individuals purchasing with Direct Payments and for Self-Funders.
- Reducing the number of people entering residential and nursing homes, particularly when discharged from hospital.
- Work with service users to set their own outcomes and commission services to meet them.
- Increasing options for people with dementia and complex/multiple conditions to reflect the personalisation agenda and meet increasing demand.

Aligning Commissioning Intentions

Richmond is also unique in not having an acute hospital, which means it commissions from a range of acute hospital trusts across west London as well as Hounslow & Richmond Community Health Care.

Richmond commissioning intentions reflect a shared health and social care agenda across the Borough through the development of a Joint Out of Hospital Care Strategy.



Implications for Providers

Providers will need to:

- Consider extending the range of services they provide.
- Widen their target customer base, either independently or in collaboration with other providers, to ensure continuity of care between social care and health.
- Plan for an ongoing reduction in demand for publicly funded residential and nursing care.
- Market themselves to the increasing number of Self-Funders and those with Direct Payments.
- Re-orientate themselves towards integrated service provision.
- Make the outcomes of services users the forefront of developing a customer centric culture within the workforce.
- Develop front facing electronic customer systems to facilitate choice and booking.
- Develop back office systems to accommodate customer choice and fast flexible responses to changes in individual plans.

Provider Opportunities

Imaginative and innovative providers will be able to increase the range of services they provide to attract new customers with greater expectations in terms of quality and choice.

A higher proportion of deaths occur in hospitals in Richmond compared to the England average while surveys suggest that people would prefer not to die in hospital. Providers should consider how they can provide support and choice to people at the end of their lives.

Increasing numbers of people with dementia are associated with small increases in nursing home placements but providers need to develop services to support people with dementia in their home using trained and competent staff.

Additional Information

- Both the Council and NHS providers deliver integrated out-of-hospital care.
- Preventing unnecessary emergency admissions with a focus on commissioning high quality local health services.
- The co-commissioning of services across Boroughs including councils and CCG footprints.
- Delivery of the Better Care Fund will bring challenges and opportunities for providers.
- Ensure best value for individual placements and continuing care.
- Focus on public health and prevention, moving away from a single disease model to a holistic approach to mitigate against the rise in co-morbidities and complex care needs.
- Redesign the model of care for community, mental health and elective outpatient services.
- Ensuring timely discharge from the hospital to community, including integrated health and social care access, discharge, rehabilitation and reablement services.

Providers must take in to account the economic position and therefore adapt service delivery to meet the needs of residents of Richmond. Providers need to look at designing flexibility in to their services, no longer expecting what they currently do to be sufficient to meet the needs of patients. There is a need to look at ‘modular’ service provision that allows for user specific pathways to be developed that are costed accordingly.

Providers will be expected to work together to look at the holistic needs of the service user in order to maximise the outcomes, as opposed to focussing on specific elements they deliver.

Prevention, Early Intervention and Reablement

Richmond Borough has one of the highest life expectancies in the country and year on year we are seeing this increase. The growth in the elderly population brings with it significant challenges from increasing demand of support services, growth in the numbers of patients with complex needs, to an increasing number of single occupier households.

We need to focus on people staying healthy and more independent for longer and we need to reduce the number of emergency admissions to hospital and long-term admissions to nursing and residential care. We need to provide information, advice and support to enable people to lead healthier life styles and remain as independent as possible. When people do become ill, and their mobility or functioning is reduced, then they should be supported to regain their health and independence as much as possible.

The average life expectancy in Richmond is higher than either the London or England average (see graph on page 18). By 2018 an estimated 30.2% of the population of Richmond will be aged 65 and over, with significant increases in those aged 75 and over. Although people in Richmond are generally living healthier as well as longer lives, there will inevitably be an increase in demand for services. The focus on prevention, early intervention and reablement improves the quality of life for older people and people with chronic and complex conditions, it also reduces the overall cost of services, which is essential in the context of an increasing older population and the current economic environment.

Helping people to stay at home for longer and stay safe

People need support to enable them to stay in their own homes and within their own community, and providers need to position themselves to deliver the key outcomes of:

- Independence
- Social Inclusion
- Wellbeing

Prevention services need to:
Encourage healthy lifestyles
Reduce risk factors for ill health before they develop
Encourage and support people to undergo health screening
Reduce social isolation

Early intervention needs to:
Respond quickly to referrals
Prevent avoidable deterioration
Effectively support people to regain confidence and independence
Maximise use of assistive technology

Reablement services need to provide:
Responsive rehabilitation interventions
Intermediate treatment
Extra care schemes
Assistive technology to meet individual need and maximise recovery and independence

Implications for Providers

- Need to offer whole range of services, they need to demonstrate improvement in individuals' independence, they therefore need to consider the evidence/data they collect.
- Need to align services with principles of prevention, early intervention and reablement.

Provider Opportunities

- Ageing affluent 'baby boomer' generation will need services with higher expectations than previous generations (see graph on page 17).
- Need to develop non-residential options for people discharged from hospital including intensive home support.

Quality and Efficiency

Richmond will take a realistic view about the cost of delivering quality services that deliver personalised care and good outcomes for individuals. However, we cannot ignore the current and future reductions in funding for adult health and social care despite ever increasing demand (www.richmond.gov.uk/jsna). It is therefore essential that we significantly improve efficiency in ways that do not impact on people negatively.

We will do this by:

- Taking a whole systems approach that does not simply shunt costs from one part of the system to another.
- Developing a quality accreditation system that incorporates user feedback and facilitates service improvement and customer choice.
- Focussing on individual outcomes that promote independence and reablement.
- Moving away from a narrow single model focussed on the disability to one based on the holistic needs and abilities of the individual.
- Facilitating access to universal services and developing community capital.

Implications for Providers

- Providers will need to be more involved in local communities, working with voluntary organisations, local groups and businesses to develop community assets.
- Providers will need to review their own operations and back office systems to make them more efficient. They will need to consider sharing facilities with local organisations.
- Smaller organisations may need to consider merging with others or becoming part of a consortium to reduce operating costs.

Provider Opportunities

- Work with other providers to develop shared training facilities and programmes, taking advantage of particular skills and knowledge within organisations to improve the quality of training whilst reducing the cost.
- Develop staff skills to ensure they can provide high quality care to people with dementia and other complex conditions.
- Develop a reputation for reducing costs by enabling people to become more independent and thereby facilitating further business.

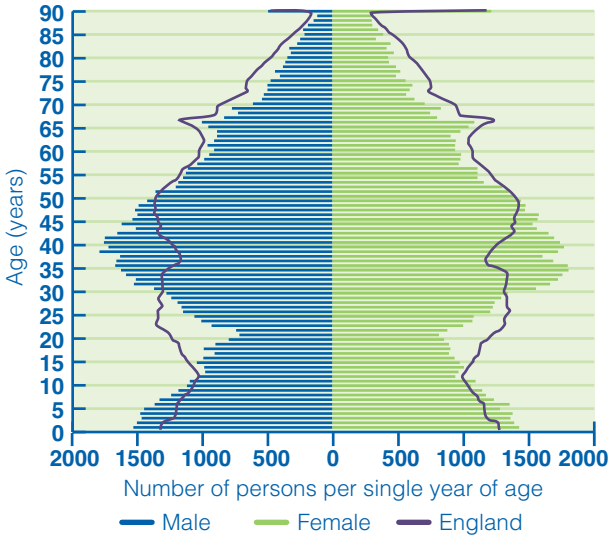
Demographics and Service Areas

Demographic Change

Population Growth

The population of Richmond in 2011 was 189,000 and is predicted to rise to 198,000 by 2016. The chart below shows the population of Richmond in 2013 by age and gender compared to the England average. While Richmond shows a similar pattern to England as a whole there are significantly more people between the ages of 30 and 50 and very young children.

Richmond 2013 population distribution



Source: SNPP at www.ons.gov.uk

Living in Richmond

The general picture of living in Richmond is a positive one, with low premature mortality rates, less crime, fewer accidents, more green space, better air quality, high educational attainment and high levels of volunteering within the community, compared with other London boroughs.

However, the overall picture masks some areas of deprivation and health inequalities, including:

- Almost 18,000 (9%) people in eleven small areas experience above average levels of deprivation for England.
- Life expectancy is approximately 6 years lower for men and four years lower for women in the most deprived areas compared to the least deprived areas.
- Reduced life expectancy in the most deprived areas is mainly due to coronary heart disease, chronic obstructive pulmonary disease and cancer.
- Population projections suggest that growth in the number of older people will be mainly in the wards with higher levels of deprivation.
- Around 29,000 adults in the Borough smoke, with 200 deaths per year attributable to smoking.
- National prevalence models estimate that 45,000 adults are drinking at potentially harmful levels and alcohol related hospital admissions are increasing, particularly in the older age groups.
- Screening coverage for breast and cervical cancers is significantly lower than the national average.
- The proportion of people with more than one long-term condition is expected to increase by 50% between 2008 and 2018.

Diversity & Migration

There is a marked contrast between Richmond and London, with 71% of residents in Richmond of white British origin compared to 45% across London.

Estimates of population change for 2013-2018 indicate a net increase for inward migration of around 1,000 people per year. However most of the people moving in will already be resident in England, the numbers of people moving into Richmond from other countries is much smaller and tends to be balanced by similar numbers leaving.

On the basis of these estimates it is unlikely that the current level of diversity will change significantly over the next five years.

Older People

By 2018 an estimated 14.5% of the population of Richmond will be aged 65 and over with significant increases in the number of people aged 70-74 and those aged 75 and over. The table shows the projected changes in population by age.

Increasing age generally correlates with an increasing need for health and social care, however advancing age does not necessarily mean incapacity, dependency or poverty. Just over three-quarters of older people in Richmond own their own home, which makes them potentially asset rich and more likely to be able to pay for their care. The development of more flexible and easily accessible high quality services will have significant appeal to Self-Funders and the development of a quality accreditation system will give them more information when choosing who should provide their care.

Furthermore, Richmond has a significantly higher proportion of people living alone than the national average.

With the introduction of the Care Bill in April 2016 there will be a cap of £72,000 on total Self-Funder care costs and an increase on the upper means test threshold to £188,000. This means that the Council will be supporting more Self-Funders. This is likely to have a significant impact on the local market within Richmond, presenting both opportunity and risk for providers.

Current and predicted population of Richmond aged 65 and over

Population in 1000s

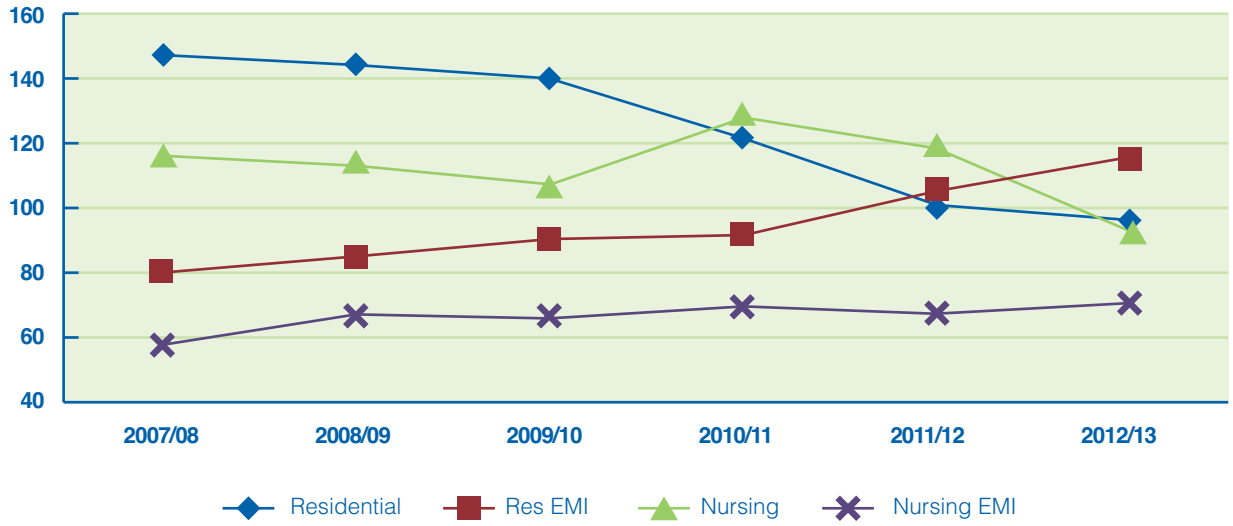
Age	2012	2014	2016	2018	2020
65-69	8.4	9	9.1	8.5	8.4
70-74	5.7	6.2	6.9	8.1	8.2
75-79	4.5	4.8	4.9	5.1	5.7
80-84	3.7	3.7	3.7	3.8	4
85-89	2.6	2.5	2.6	2.6	2.7
90 and over	1.7	1.8	2	2.1	2.2
Total population 65 and over	26.6	28	29.2	30.2	31.2

Older People

There was an overall reduction in the number of older people funded by the Council in residential and nursing homes from 413 in 2010/11 to 368 in December 2013 indicating a possible future trend for funded placements by the borough. Of these placements about 300 are funded within the Borough out of a total of 812 available care home beds.

The increasing focus on personalisation, reablement and independence should continue to reduce council funded care home placements over the next five years, particularly for those people requiring residential care. However demand for dementia placements (both residential and nursing) could rise. The development of new and more community based services may prove attractive to Self-Funders as well and could reduce demand for residential and nursing care further.

65 and over residential and nursing placements at March 2013



Self-Funders

A Self-Funder is someone who arranges and funds their own social care and support and we are aware that Richmond as the least deprived borough in London has a high proportion of Self-Funders compared to other local authorities.

As previously stated Richmond is a healthy borough with higher than average life expectancy, and local data shows that the average age of people starting to receive care funded by the Council is 84 for people receiving care at home, and 87 for people moving into a care home. We therefore expect that most Self-Funders would be in the 85+ age group which is a population of 4,300 people in the borough. Of this age group the council only provides care to about 850 people at any one time and we expect that many other people in this age bracket will be funding their own care.

Local data shows that 49% of older people age 65+ in care homes in the Borough are Self-Funders and about 400 people (across all age groups) fund their own care with local homecare providers.

With the introduction of changes with the Care Bill from 2016, whereby a cap will introduced on the amount people pay for their social care, we expect that the number of people funding their own care will increase.

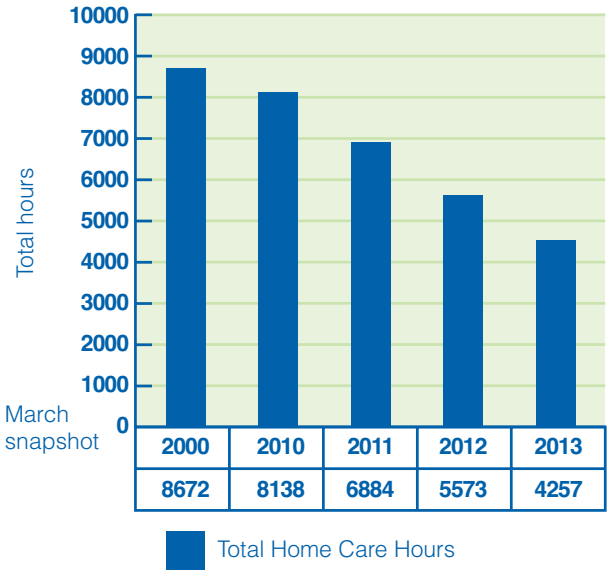
Since April 2013 all new and existing service users residing in the community are using personal budgets, which gives them greater choice and control.

Homecare

Nationally and locally there has been a reduction in the number of home care hours commissioned in both the independent sector and within councils. In Richmond home care hours reduced by almost half between 2009 and 2013, see chart below.

Whilst the actual numbers of people are much smaller those receiving a reablement service more than doubled in 2012/13 from 39 to 86. By focussing on promoting health and independence and targeting services more accurately, we will meet the needs of the population of Richmond more effectively and more efficiently.

Total homecare hours for service users aged 65 and over



Mental Health

The *ONS Adult Psychiatric Morbidity Survey* (2007) provides data on the prevalence of both treated and untreated psychiatric disorders in the English adult population (aged 16 and over). The survey showed that in 2007 nearly one person in four (23.0 per cent) in England had at least one psychiatric disorder and 7.2 per cent had two or more disorders. There are about 35 people with a common mental disorder for each person with psychosis. Though common mental health disorders are usually less disabling than major psychiatric disorders, such as psychosis, their greater prevalence means that the impact on the wellbeing of the population and available resources is very significant. In Richmond there are well over 20,000 people with a common mental health condition compared to just over 500 people with a psychotic disorder.

The chart below shows the estimated number of Richmond residents with different categories of common mental health disorders. About 50% of those with common mental health problems may require some form of treatment (Meltzer et al 2000).

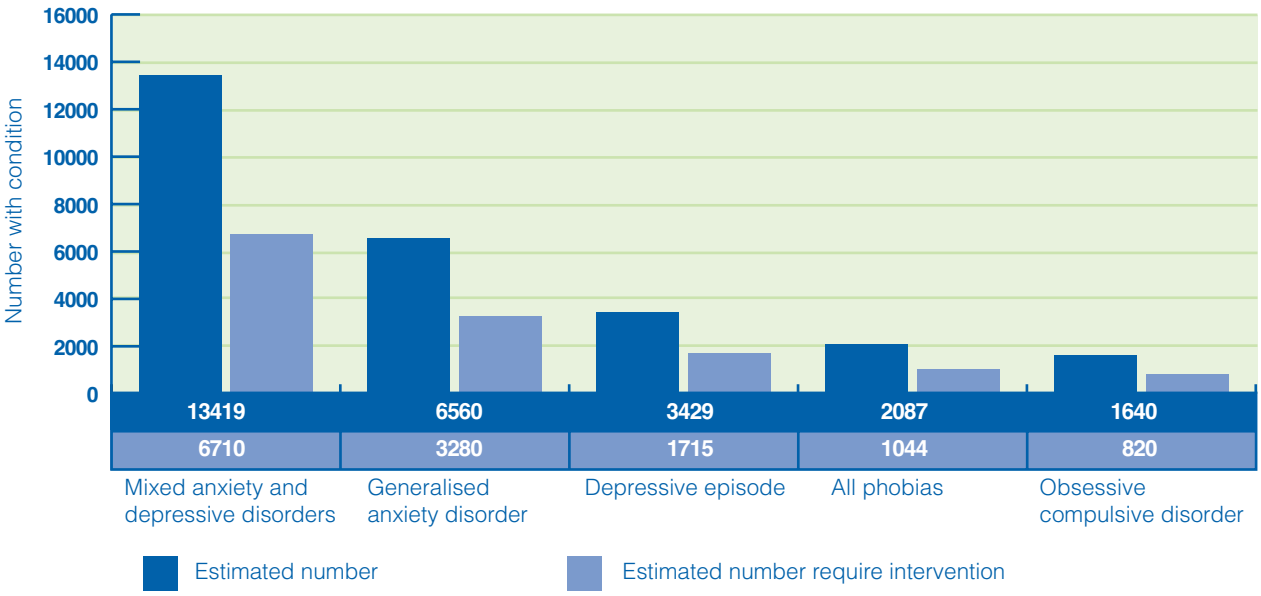
Older people suffer from a range of mental health conditions but are also far more prone to dementia as well. In Richmond in 2012 almost 3000 older people experienced depression or severe depression and about 2000 suffered from dementia.

The number of people with depression and severe depression is expected to increase by about 20% and the number of people with dementia is expected to rise by 18% by 2020.

Provider Implications & Opportunities:

Increasing demand will require commissioners and providers to work closely together to create more innovative and cost effective services that promote greater independence and thereby reduce demand.

Estimated number of Richmond population aged 18+ with common mental health problems, 2012



Learning Disability

The table below shows the prevalence estimates for people with a learning disability (LD) compared to those known to health and social care services. The number of people known to local health and social care services is substantially lower than estimates based on national research, which estimates that there are 770 adults with moderate or severe learning disability and therefore likely to be in receipt of services. This indicates a gap of around 470 adults who are not known to local services, but may in the future need services.

Around 40% of people with a learning disability who receive services funded by the local authority live in care homes with 60% living in the community with support. While the higher proportion of people living in the community is in line with local and national policy, the numbers in residential care are relatively high and will need to reduce significantly in the future. Providers need to work with commissioners to develop more community based services whilst disinvesting in residential care.

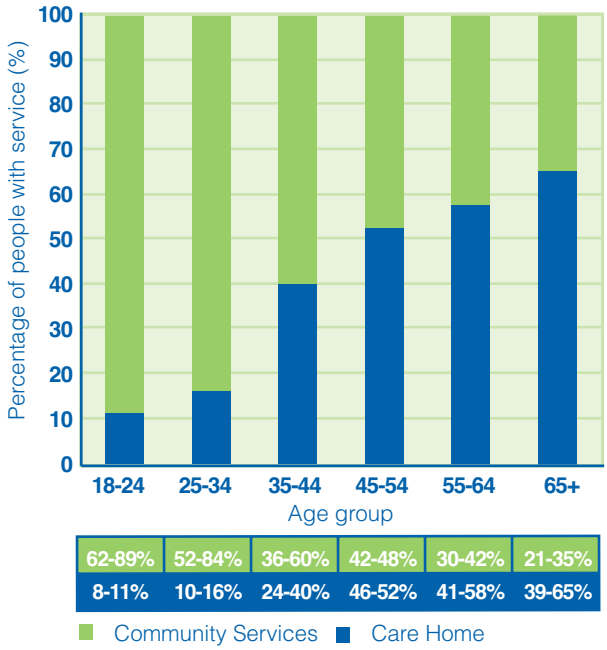
People with a learning disability, like the rest of the population, are living longer. However, they generally have more complex health needs, which inevitably increase as they get older. A key factor in accessing appropriate health care for people with a learning disability is an annual health check by their GP and, although funded by the NHS, less than half of the people in Richmond with a learning disability received an annual health check in 2012, which was below the England average of 48.64%. The highest rated London borough was Barnet with 84%, and Kingston was the highest rated south west London borough with 69%. The table below provides a breakdown of people with a learning disability in receipt of services by age.

The national and local trend is for people to live at home with family or as tenants with the support of community services designed to meet their individual needs. Younger people are far less likely to move into residential care and this is illustrated in the table on page 23, which compares the proportion of people receiving community services compared to those in care homes by age.

Service users by age group

Age group	18-24	25-34	35-44	45-54	55-64	65+
Number of service users	70 (17%)	62 (15%)	61 (15%)	88 (21%)	71 (17%)	60 (15%)

Service users by age group and type of service



Many of the people in the older age groups have lived in residential care for many years and the current high numbers reflect the Normansfield Hospital closure in 1997. However this is a diminishing number of people who will not be replaced by younger people coming through. The numbers in residential care will continue to drop at an increasing rate over the next five years while the overall population of people with a learning disability will increase by just over 1% per year. These changes in demography and demand will drive the development of more personalised community services and providers will need to respond both efficiently and flexibly to meet individual needs within available resources. London-wide projections for the number of people actually coming forward for services is much higher with estimates of an increase of 4.6% by 2015 and 11.4% by 2020.

Market Opportunity

76% of people aged 18-24 and 57% of those aged 25-34 use Direct Payments. These levels will increase over time, develop services to meet the growing demand for creative personalised community support.

Self-Funders

A Self-Funder is someone who arranges and funds their own care and support. Some local authorities have modest numbers of Self-Funders, but we are aware that Richmond as the least deprived borough in London has high numbers of Self-Funders. Self-Funders are often not significantly reflected in national statistics, and in local and national social care and health strategies and policies. This is mainly due to numbers and characteristics of the self-funding population being unknown.

Self-Funders in Care Homes

There are currently 19 care homes within the Borough for older people providing 812 beds. 768 beds are occupied and 393 are filled by Self-Funders. This represents 51% of the occupied beds in the borough. A full list of the homes in the borough and the funding of the beds can be found on page 27.

Between 2007 and 2013, there has been a significant decline in the number of council funded admissions (29% decrease) to care homes. During this period there has been a significant increase in the numbers of people for whom the Council has had to pick up the costs to pay for their care home placement, due to the resident's money running out.

Self-Funders Receiving Community Based Services

In the Borough, there are currently 23 providers of homecare services, 7 contracted to the Council and 16 registered within the Borough but not contracted to the Council. From surveying these home care providers we are aware that they provide support to approximately 370 Self-Funders. In the (2006) *Future demand for long-term care, 2002-2041: projections of demand for older people in England, PSSRU* report, it is estimated that 10.4% of people aged over 65 fund their own care in England. This means that there could be potentially 2,763 people who fund their own care in Richmond. However, as we do know that we have a higher proportion of Self-Funders, this could potentially be more.

Care Bill Implications

Care funding will significantly change with the introduction of the Care Bill; there will be a cap on care costs and people will only pay a maximum of £72,000 in their lifetime for their social care. The Council will pick up care costs when this cap is reached. This is likely to also mean an increase in people coming to the Council to fund their care, where they would have Self-Funded prior to the introduction of the Care Bill; however, demand is unclear at this time.

Number of Care Home Beds by Funding Stream

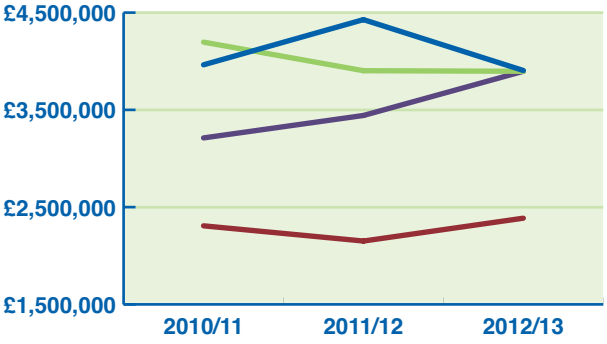
Home	Richmond Funded	Self-Funded	Other Councils	NHS Funded	Vacancies	Total
Abbeyfield	3	19	3	0	4	29
Alexander House	4	10	2	0	0	16
Brinsworth House	3	23	5	2	3	36
Cecil Court	14	23	7	1	0	45
Dalemead	8	30	3	0	5	46
Deer Lodge	3	8	0	0	3	14
Deer Park View	1	45	0	14	0	60
Greville House	54	5	0	0	0	59
Hampton Care	8	41	1	19	7	76
Homemead	6	12	6	0	2	26
Laurel Dene	75	24	0	0	0	99
Lynde House	2	54	0	19	1	76
Marling Court	5	25	0	0	7	37
Nightingale House	6	7	5	0	1	19
Orione	18	13	3	0	0	34
Redcotts	3	11	1	0	3	18
St Marys	2	17	3	0	2	24
Viera Gray	13	16	3	0	6	38
White Farm Lodge	50	10	0	0	0	60
Total	278	393	42	55	44	812
Total Percentage	34%	48%	5%	7%	5%	100%

Appendix

Spend

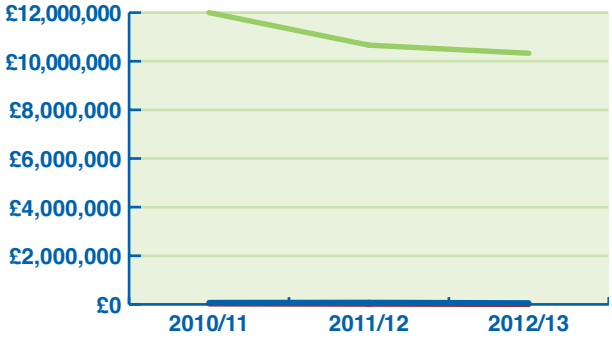
Shows spend on residential and nursing dementia beds against residential and nursing beds. Older People shows an increase in dementia spend offset by a reduction in residential and nursing spend.

Older People



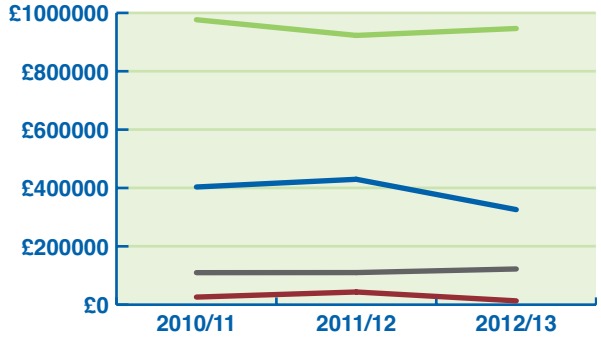
	2010/11	2011/12	2012/13
Nursing	£3,963,205	£4,427,761	£3,904,840
Nursing Dementia	£2,307,784	£2,151,304	£2,386,317
Residential	£4,196,381	£3,902,648	£3,896,695
Residential Dementia	£3,211,476	£3,442,433	£3,852,494

Learning Disabilities



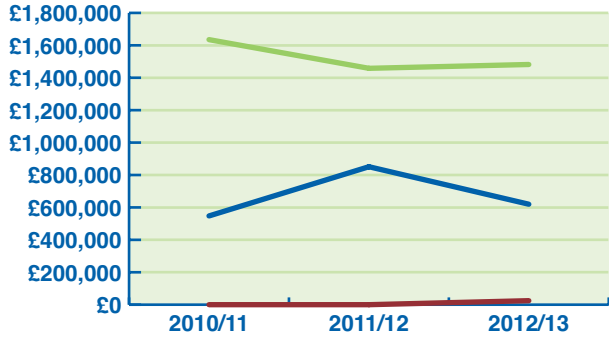
	2010/11	2011/12	2012/13
Nursing	£78,510	£84,053	£64,719
Nursing Dementia	£19,614	£10,371	
Residential	£12,022,125	£10,661,103	£10,327,462

Physical Disabilities



	2010/11	2011/12	2012/13
Nursing	£403,358	£429,750	£325,817
Nursing Dementia	£26,064	£43,517	£13,136
Residential	£976,570	£922,777	£946,541
Residential Dementia	£109,735	£110,036	£122,378

Mental Health



	2010/11	2011/12	2012/13
Nursing	£457,502	£851,045	£619,795
Nursing Dementia			£24,750
Residential	£1,635,035	£1,458,102	£1,481,737

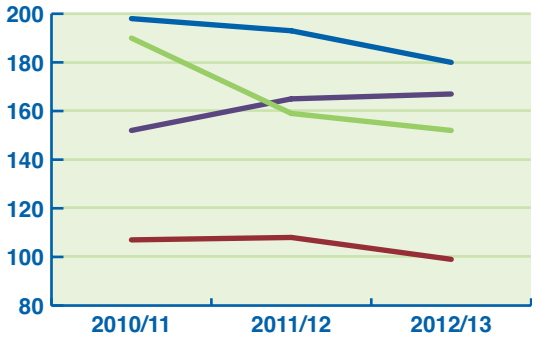
Key

Nursing
Residential
Nursing Dementia
Residential Dementia

Numbers

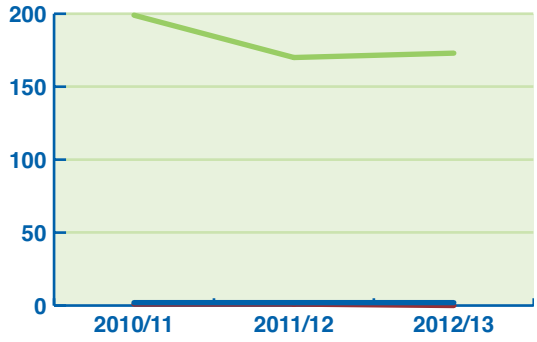
Shows numbers of people in residential and nursing dementia beds against residential and nursing beds. Older People shows a reduction in both nursing and nursing dementia numbers. Older People shows an increase in residential dementia numbers offset by a reduction in residential numbers.

Older People



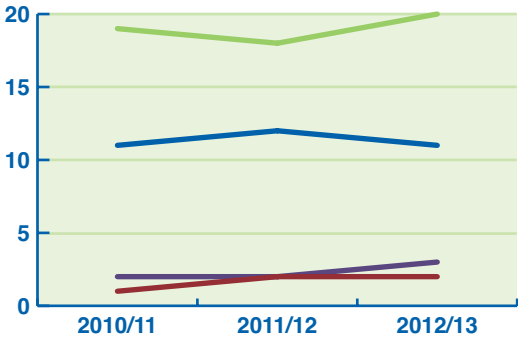
	2010/11	2011/12	2012/13
Nursing	198	193	180
Nursing Dementia	107	108	99
Residential	190	159	152
Residential Dementia	152	165	167

Learning Disabilities



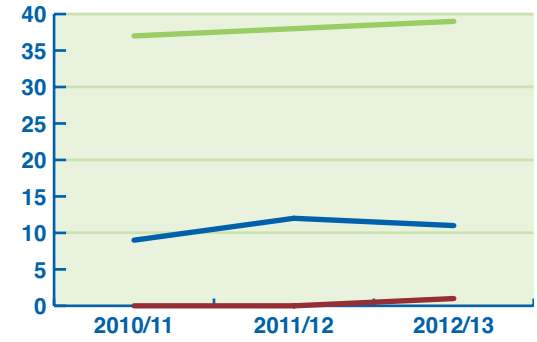
	2010/11	2011/12	2012/13
Nursing	2	2	2
Nursing Dementia	1	1	0
Residential	199	170	173

Physical Disabilities



	2010/11	2011/12	2012/13
Nursing	11	12	11
Nursing Dementia	1	2	2
Residential	19	18	20
Residential Dementia	2	2	3

Mental Health



	2010/11	2011/12	2012/13
Nursing	9	12	11
Nursing Dementia	0	0	1
Residential	37	38	39

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