Adult Social Care

Investment in services to tackle social inclusion and to support independent living for adults and older people is a major priority for councils and accounts for around a quarter of total council spend. Both council- run and council purchased services are included here. Expenditure has increased by 18% in real terms in this area between 2010/11 and 2020/21 (range: -5% to +49%). This includes a 1.6% increase in 2020/21 (range: -6% to +12%). The exceptional rate of inflation during 2020/21 should be noted when interpreting expenditure trends.

Even prior to the COVID-19 pandemic, social care is an area where councils and their partners faced growing demands due to an ageing population and the increasing complexity of needs experienced by older and disabled people. It is forecast that the percentage of the population aged 65 or over will increase by 8.4% by 2025 (and the over 75 population will increase by 14%).[28]

The impact of COVID-19 within health and social care has been significant and will continue across the coming period. Key areas affected include the fragility of the care home sector, a frontline workforce that has been under tremendous pressure to maintain the same level of care, increased demands on mental health and wellbeing services, pressure on unpaid carers and families who provide much needed support to some of our most vulnerable citizens; and the way that services such as adult day services have had to adapt and change.

In the face of these increasing demands, councils and their partners continue to modernise and transform social care provision to deliver better anticipatory and preventative care, provide a greater emphasis on community-based care, and enable increased choice and control in the way that people receive services. The partnership approach within Health and Social Care Partnerships (HSCPs) has been more important than ever as services continue to respond to the pandemic and work together to plan the route for recovery.

To reflect this major reform and to respond to the new challenges facing the sector from the COVID-19 pandemic, we continue to work with Social Work Scotland and Chief Officers of the Integration Authorities to agree benchmarking measures which will usefully support Integration Joint Boards fulfil their duties.

This is a period of significant change and reform in the social care landscape, and it will be essential that the LGBF evolves to reflect the challenges and opportunities which will be critical in supporting recovery from COVID-19. We will continue to work with Social Work Scotland and Chief Officers of the Integration Authorities to ensure developments in the LGBF reflect the key priorities, and are informed by the current reform of adult social care,[29] including proposals for the establishment of a National Care Service.

Care at home services

COVID-19 has heightened the challenges already faced by the home care sector and the following factors will be important in understanding the trends observed in home care provision during the first year of the pandemic: pressure on frontline services and staff as a result of increasing demand, staff absence, recruitment challenges and requirement for services to adapt and change; the increase in care and support provided informally by families (which may have been made possible through furlough or a necessity if care at home services were not offered during the pandemic or not accepted if clients were isolating); and access to care & support via care homes/hospitals. While these elements will have impacted across all local authority areas, the degree and timing may differ.

Council spend on care at home services has been standardised around care at home costs per hour for each council. This includes expenditure across all providers. Since 2010/11 there has been a real- terms increase of 10.0% in spending per hour on care at home for people over 65 across Scotland. This reflects an overall 24.3% increase in gross expenditure and 13.1% increase in the number of hours delivered during this period, although movement between years has fluctuated.[30]

28 https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-projections/population-projections-scotland/2020-based

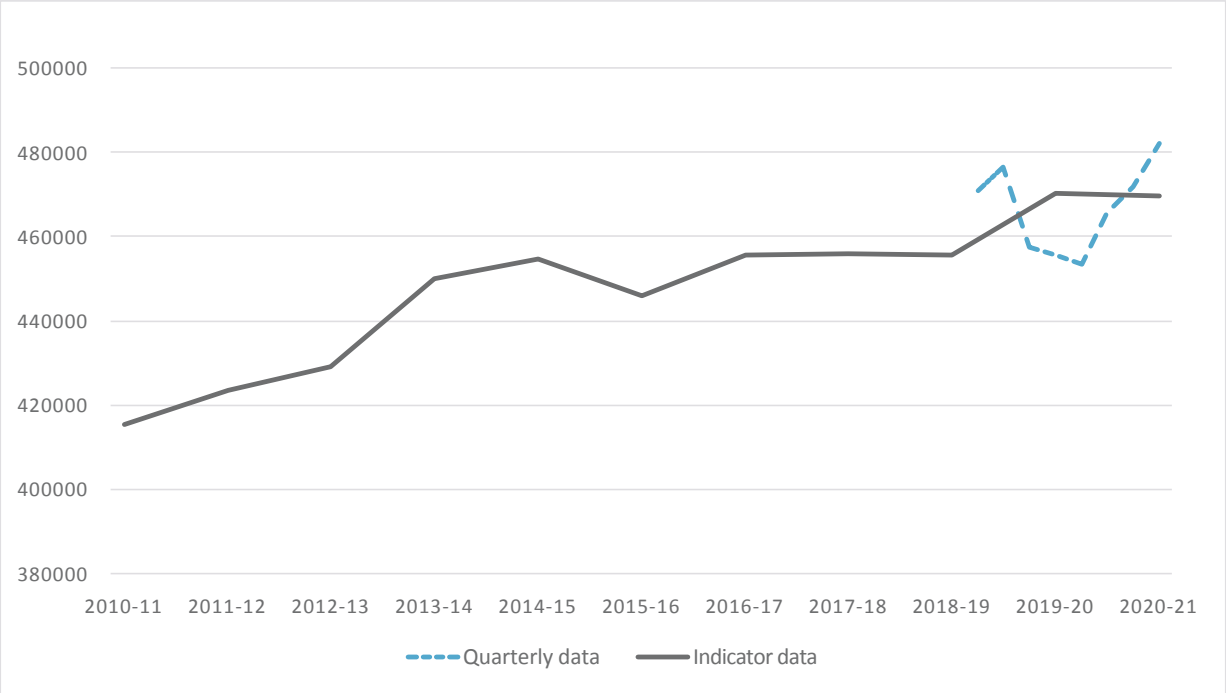
29 https://www.gov.scot/policies/social-care/reforming-adult-social-care/

30 These average care at home figures will differ from the soon to be published national statistics in the Free Personal and Nursing Care publication which reports solely on Quarter 4 statistics.

Table 26: Care at home costs per hour for people aged 65 or over

2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	% Change 2019-20 to 2020-21	% Change 2010-11 to 2020-21
£25.15	£24.32	£24.68	£23.87	£23.59	£24.54	£25.64	£26.47	£26.98	£27.25	£27.65	1.5%	10.0%

Figure 49: Hours of care at home for clients aged 65+ - yearly and quarterly data



In 2020/21, spending per hour has increased by 1.5% from £27.25 to £27.65. This reflects a 1.3% increase in expenditure and a 0.1% decrease in hours delivered. While the hours delivered across the year decreased slightly, the quarterly data reveals a more accurate picture. The provision of care at home hours fell initially in the first quarter of 2020/21 during the first lockdown period, however then increased over the rest of the year to the highest rates observed since 2010/11. There was also significant variation across councils in relation to care at home provision in 2020/21, ranging from a 19% growth in hours delivered to a 16% reduction. Similarly, while most authorities saw their care at home spend increase, a third of councils spent less in 2020/21. This variation resulted in a mixed picture in relation to hourly costs, and while the average cost increased by 1.5%, almost half of councils reported reducing costs in 2020/21, counter to the national trend.

The increase in care at home expenditure in recent years will reflect in part the commitment from October 2016 to pay all social care workers the living wage. Going forward, some caution may be required in the interpretation of care hour figures as we move away from recording hours of care into more person-centred care with the ability to select direct payments or more inventive provision of care under self-directed support options. This will be reflected in the current reform of adult social care and we will continue to work with Social Work Scotland and Chief Officers of the Integration Authorities to develop more meaningful measures which accurately capture progress and drive improvement in this area.

As highlighted, there is significant variation across councils in spend per care at home hour, ranging from £14.05 to £74.62. The level of variation observed continues to widen and is greater than any preceding year. Costs are higher and faster growing in more deprived council areas, however the difference between most

and least deprived councils is no longer significant. Between 2010/11 and 2020/21, the average spend per hour for the most deprived councils increased by 37%, from £26.49 to £36.38. By comparison, spend in the least deprived councils increased by 15.3%, from £26.40 to £30.45.

While care at home costs remain higher for rural authorities, perhaps in part due to the longer travelling times involved in the delivery of care, the difference is no longer statistically significant due to variation within the family group. Rural authorities have also seen a faster cost increase over time compared to urban authorities. Average rural costs have increased by 20.4% from £30.98 to £37.29 while average urban costs have increased by 11.8% from £25.54 to £28.56. It is worth noting that island costs remain the highest of all councils.

Figure 50: Home care costs per hour for people aged 65 or over by family group - deprivation

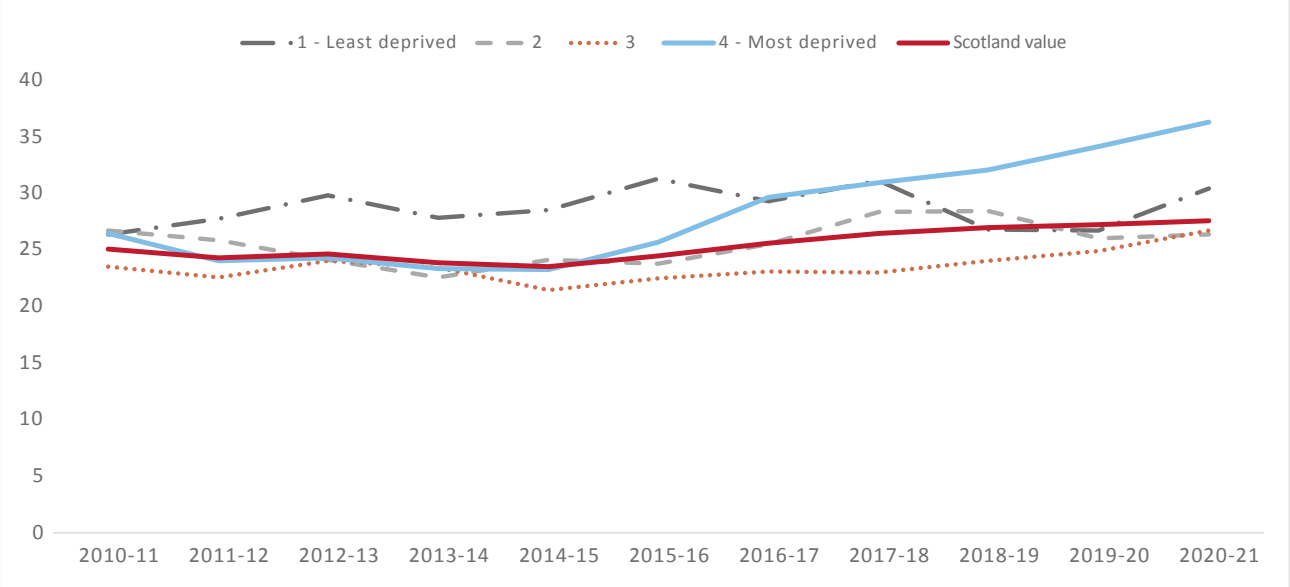


Figure 51: Home care costs per hour for people aged 65 or over by family group - geography

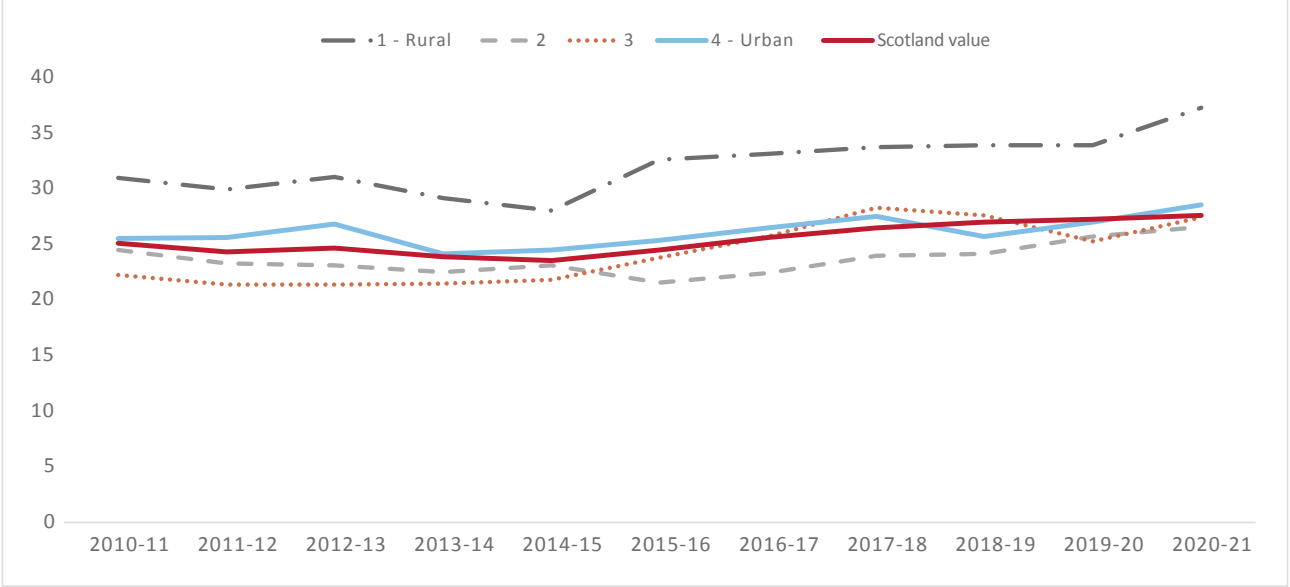
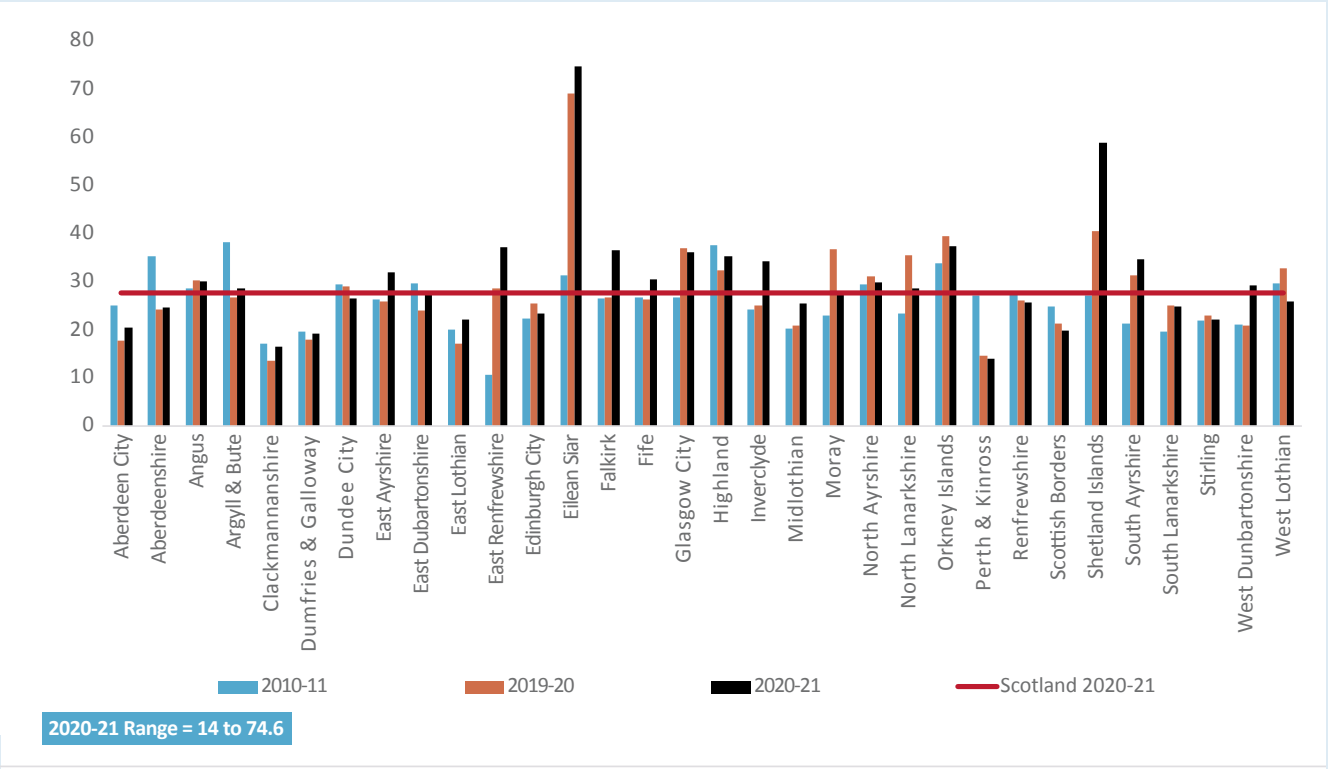


Fig 52: Older persons (over 65) home care costs per hour (£)



Source: Social Care Survey and Quarterly Survey, Scottish Government. Additional data sourced directly from councils to allow adjustment for any COVID-19 impact on provision in March 2019.

Local Variation – Older persons (over 65) care at home costs per hour

2020/21 Value

Scotland: £27.70; council range: £14.05 - £74.62. Widening variation in the most recent year. Higher costs in the most deprived councils compared to least deprived councils (£36.38 compared to £30.45, not statistically significant). Higher costs in rural councils compared to urban councils (£37.29 compared to £28.56, not statistically significant).

Change Over Time

In 2020/21: Scotland: +1.5%. councils: 18 increased and 14 decreased (range: -24.4% to +45.1%)

Since 2010/11: Scotland: +10%; councils: 20 increased and 12 decreased (range: -48.2% to +249.8%)

Balance of care

Balance of care is captured by the percentage of adults over 65 with long term care needs receiving care at home. This remains an area of growing importance in an effort to care for more people in their own home rather than institutional setting such as hospitals. The effective design and delivery of home care services is central to independent living, citizenship, participation in society and in supporting a fulfilling life. Services can help prevent those most at risk of unplanned hospital admissions from entering the hospital sector unnecessarily. For those who do enter hospital, it can also help prevent delayed discharges.

COVID-19 has had significant implications for access to care and support via home care, care homes and hospitals during this period. While the full impact of this is yet to be fully understood, it will be important to consider these factors when interpreting the patterns emerging in the balance of care data.

The balance of care has shifted in line with policy objectives between 2010/11 and 2020/21, with a growth in care at home hours provided (13.1%) and a relative decline in residential places (-8.6%). The percentage of people with long- term needs who are now receiving personal care at home has increased from 58.9% in 2010/11 to 61.7% in 2020/21.[31] This includes an increase of 1pp in 2020/21. As importantly, the number of people receiving care at home has decreased over time and the hours of care they receive on average has increased, i.e. in shifting the balance of care, a greater resource has become targeted on a smaller number of people with higher needs. The reducing number of care at home service users, alongside the size of the package delivered reflects the agreed eligibility criteria now in place to ensure the fair allocation of care.

There is variation beneath this national trend however. While the national balance of care continues to improve, the range in movement across councils is -14 percentage points to +13 percentage points since 2010/11, with a third of councils reporting a decrease counter to the national trend. This mixed picture remains true in the most recent year, with a quarter of councils reporting a decrease, counter to the national trend.

Table 27: Percentage of people aged 65 or over with long-term care needs receiving care at home

2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	Value Change 2019-20 to 2020-21	Value Change 2010-11 to 2020-21
58.9	59.2	59.8	59.8	60.0	60.7	60.1	61.7	61.0	60.7	61.7	1.0	2.8

In 2020/21, there remains significant variation across councils in relation to the balance of care, ranging from 52.4% to 76.1% across Scotland. The level of variation has widened slightly in 2020/21. Smaller councils continue to record a higher balance of care at home than areas with larger populations (71% compared to 59%), although this difference is no longer significant Those councils serving areas with higher levels of deprivation also tend to report higher rates (67.1% compared to 59.3%) and have seen a faster growth over the 10-year period.

31 Current data incorporates a Scottish Government modeled estimate for Hospital Based Complex Clinical Care (HBCCC) patients which is based on compound annual growth calculations. This is due to suspended HBCCC data collection in 2019/20 and 2020/21 due to COVID-19, and the estimate does not account for any impact COVID-19 may have had on patients receiving HBCCC.

Fig 53: Percentage of people aged 65 or over with long-term care needs receiving care at home by family group - deprivation

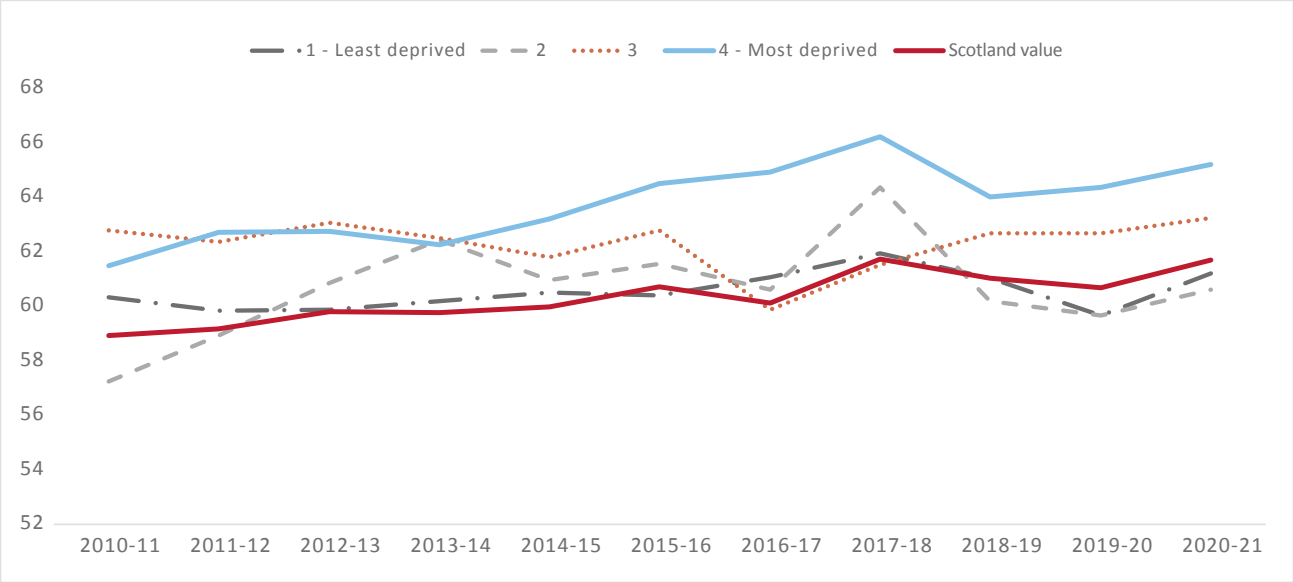
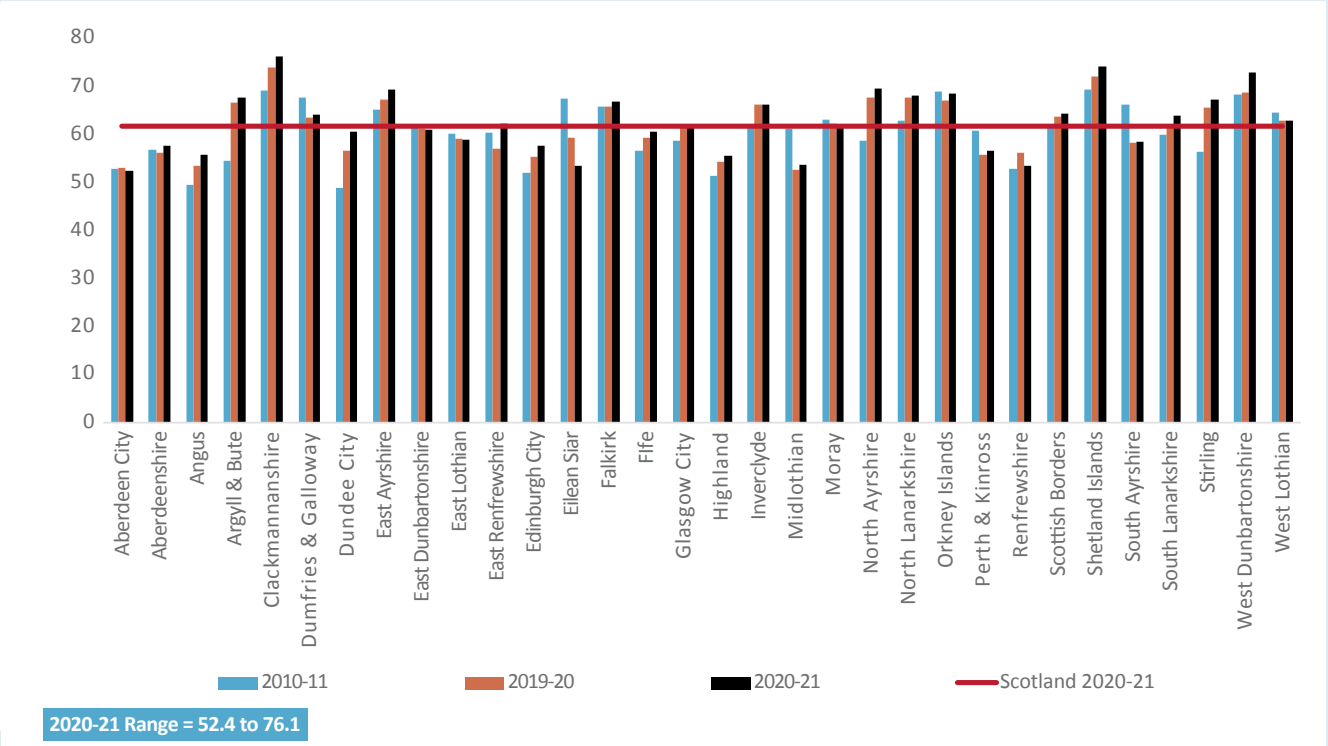


Fig 54: Percentage of people aged 65 or over with long-term care needs who are receiving personal care at home



Source: Social Care Survey and Quarterly Survey, Scottish Government. Additional data sourced directly from councils to allow adjustment for any COVID-19 impact on provision in March 2019.

Local Variation – Percentage of people aged 65 and over with long-term care needs receiving personal care at home

2020/21 Value

Scotland: 61.7%; council range: 52.4% - 76.1%. Widening variation in the most recent year. Higher rates in most deprived councils compared to least deprived councils (67.1% compared to 59.3%, not statistically significant). Higher rates in smaller councils compared to bigger councils (71% compared to 59%, not statistically significant).

Change Over Time

In 2020/21: Scotland: +1 pp. councils: 24 increased and 8 decreased (range: -5.9pp to +5.1pp)

Since 2010/11: Scotland: +2.8pp; councils: 21 increased and 11 decreased (range: -13.9 to +13.1pp)

Readmission to hospital

The readmission rate reflects several key elements of an integrated health and care service, including discharge arrangements and co-ordination of follow up care underpinned by good communication between partners.

This measure captures the rate of readmission to hospital within 28 days per 1,000 discharges. The 28-day follow-up is selected as this is the time that the initial support on leaving hospital, including medicines safety, could have a negative impact and result in readmission. A longer period of follow up would be more likely to include admissions that are unrelated to the initial one, whereas a shorter period (e.g. 7 days) is more likely to only pick up immediate issues linked to the hospital care.

The volume and focus of hospital activity have been impacted significantly by measures put in place due to COVID-19. During 2020/21, there has been a significant reduction in total discharges, largely due to cancelled or delayed elective activity during the COVID pandemic. This will be an important factor in interpreting the trends in relation to hospital readmissions.

Since 2010/11, the rate of readmissions to hospital within 28 days (per 1,000 discharges) has increased year on year, from 89.7 to 120.0, a 33.8% increase. 2020/21 saw the sharpest increase to date, with rates rising by 14.7%.

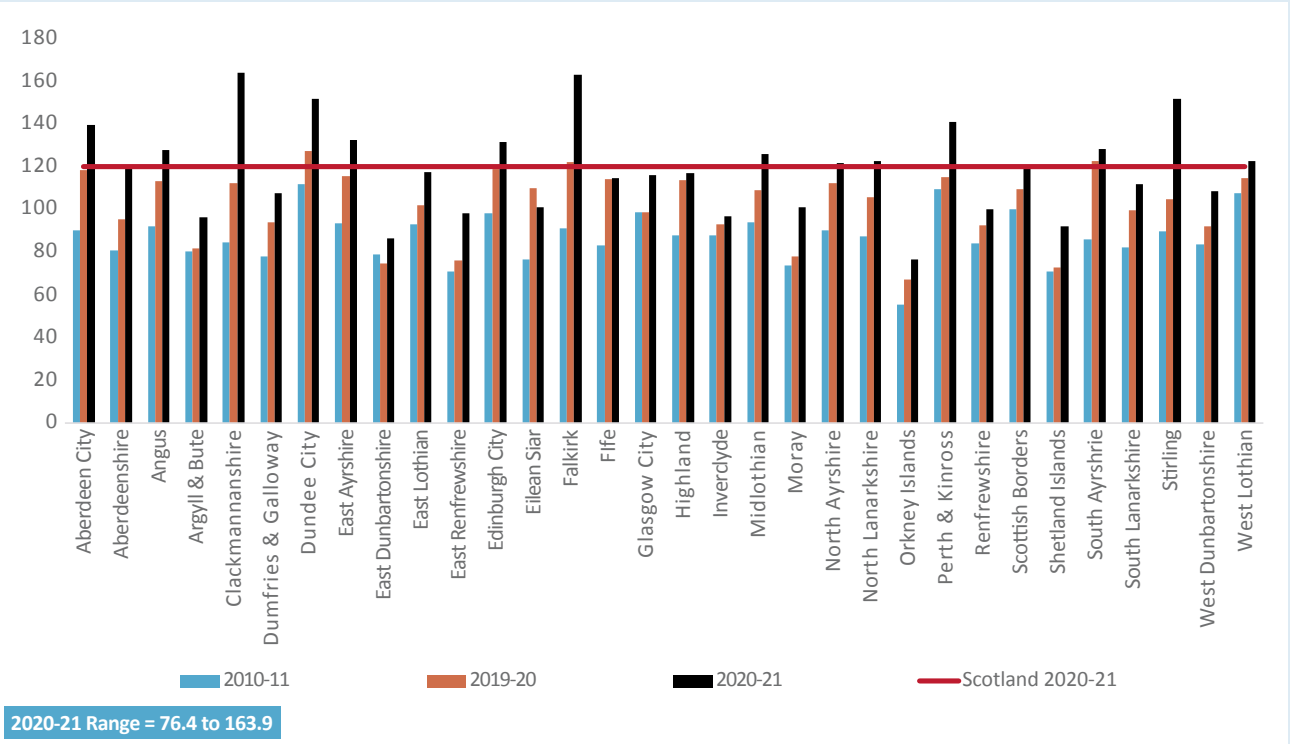
In 2020/21 the actual number of emergency readmissions within 28 days decreased. However, a greater reduction (proportionally) in the number of total discharges (-25%) than in the number of emergency readmissions (-17%) has led to an increase in the rate observed. As highlighted previously, discharges include both elective and non-elective activity and have reduced, largely due to cancelled or delayed elective activity during the COVID pandemic.

The increasing trend is evident for all 32 councils since 2010/11, although one authority reported a decrease in the most recent year. In 2020/21, rates across authorities ranged from 76.4 to 163.9, with variation widening significantly in this most recent year. Historically, readmission rates were significantly lower in the least deprived authorities compared to the most deprived authorities. While this pattern can still be observed (110 compared to 119), the relationship is no longer significant in the 2020/21 data due to faster increases for the least deprived councils during the most recent year.

Table 28: Rate of readmission to hospital within 28 days per 1,000 discharges

2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	% Change 2019-20 to 2020-21	% Change 2010-11 to 2020-21
89.7	92.5	93.5	95.3	97.2	98.1	101.0	102.7	103.0	104.7	120.0	14.7%	33.8%

Fig 55: Rate of readmission to hospital within 28 days per 1,000 discharges



Source: PHS

Local Variation – Rate of readmission to hospital within 28 days per 1,000 discharges

2020/21 Value

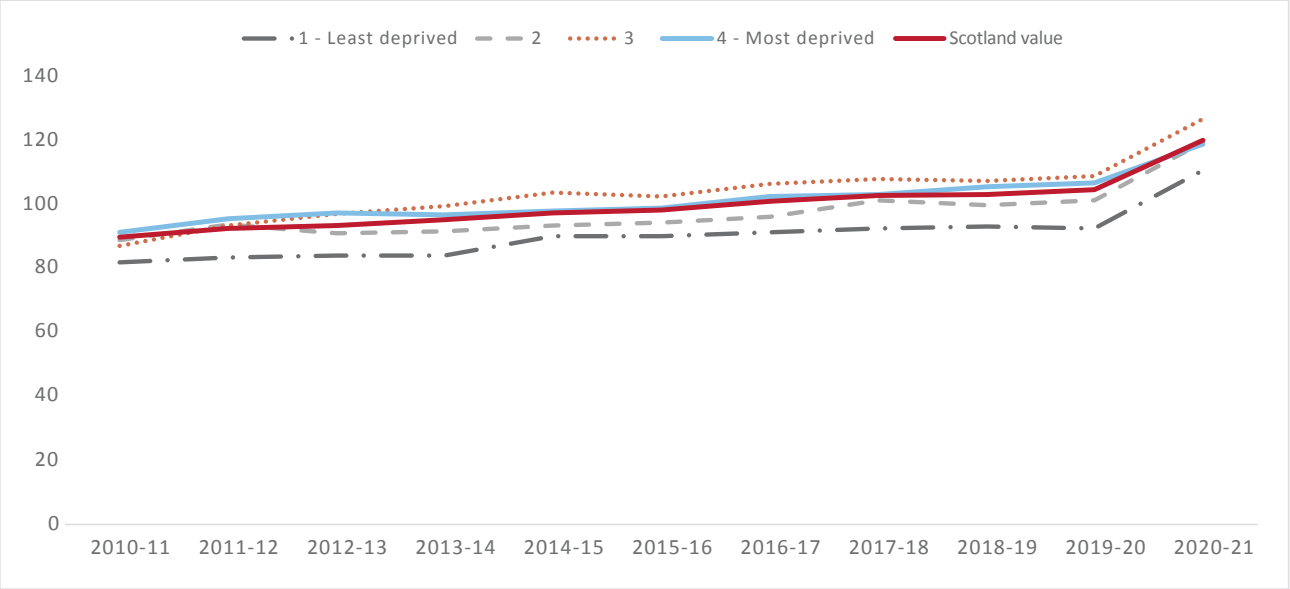
Scotland: 120.0; council range: 76.4 to 163.9. Widening variation in most recent year. Historically, admission rates were significantly lower in the least deprived authorities compared to the most deprived authorities, however this is no longer significant (110 compared to 119) due to faster increases for the least deprived councils during the most recent year.

Change Over Time

In 2020/21: Scotland: +14.7%; councils: 1 increased and 31 decreased (range: -8.4% to +46%)

Since 2010/11: Scotland: 33.8% increase. All 32 councils increased (range: +9% to +94%)

Fig 56: Rate of readmission to hospital within 28 days per 1,000 discharges – family group - deprivation



As we have seen, hospital readmission data from the initial COVID-19 period in 2020/21 has been shaped by the reduction in hospital discharges largely due to cancelled or delayed elective activity during the pandemic. Data from 2021/22 onwards will be vital in understanding the medium to long term impact of COVID-19 on hospital readmission rates, in particular in relation to issues such as increasing complexity of need and frailty in an ageing population, co-ordination, delivery and capacity in relation to follow-up support, and decision making in relation to discharge or readmission.

Delayed discharges

Health and Social Care services strive to ensure that people do not have to wait unnecessarily for more appropriate care to be provided after treatment in hospital. Waiting unnecessarily in hospital is a poor outcome for the individual and is particularly bad for the health and independence of older patients. It is an ineffective use of scarce resource potentially denying an NHS bed for someone else who might need it.

This indicator presents the number of days over 75s spend in hospital when they are ready to be discharged. The indicator on its own does not tell us about the outcomes, as people need to be discharged to an appropriate setting that is best for their reablement. Focusing on discharging patients quickly at the expense of this is not desirable, and improvements need to be achieved by better joint working and use of resources.

The level of delayed discharges has been significantly impacted by the response to the COVID-19 pandemic, which is evidenced in data from 2020/21. The overall significant reductions in non-COVID-19 related hospital admissions during this period, along with concerted efforts to move patients out of hospital to free up hospital capacity and create a better outcome for individuals at risk of acquiring infection in hospital both contributed to the marked fall in delayed discharges observed in 2020/21.

In 2020/21, reduction in delayed transfers from hospital was significantly greater than observed in previous years, with the number of days reducing from 774 to 484, a reduction of 37.4%. While this pattern is true for the majority of council areas, 4 authorities reported an increase during this period counter to the national trend.

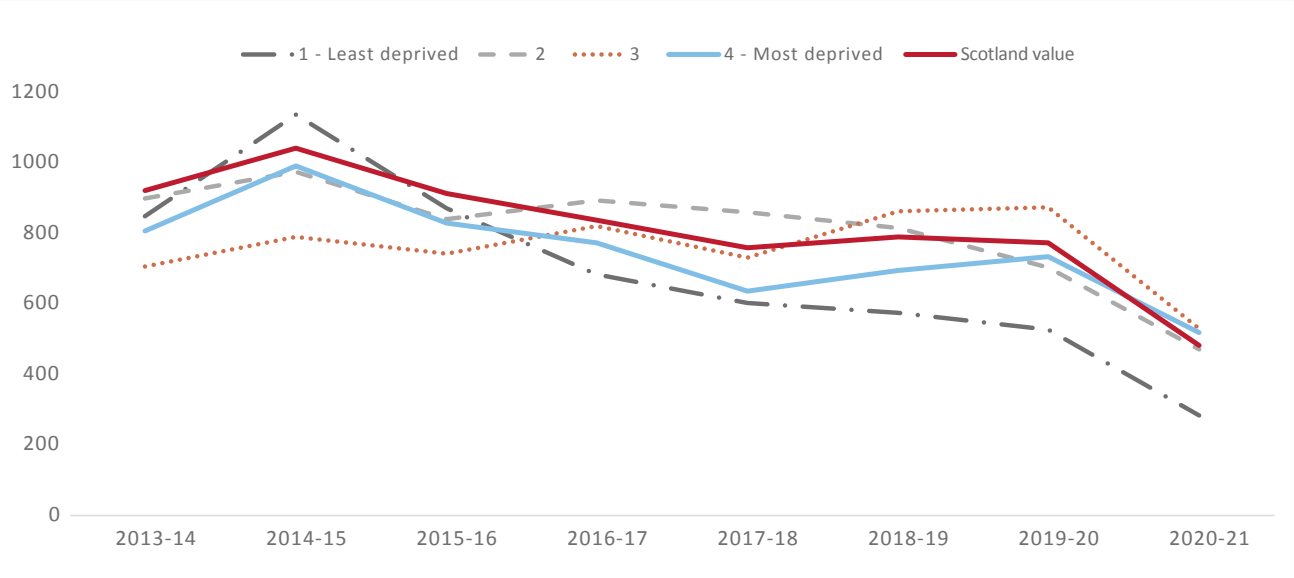
In contrast, prior to COVID-19, between 2016/17 and 2019/20, there was a 7.9% reduction in the number of days over 75s spend in hospital when they are ready to be discharged. This reduced from 840 to 774 days per 1,000 population. The reducing trend was not however universal, with significant variation in trend across the country and with over a third of council areas reporting increasing delayed discharges counter to the national trend.

Table 29: Number of days people spend in hospital when they are ready to be discharged, per 1,000 population (75+)

2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	% Change 2019-20 to 2020-21	% Change 2013-14 to 2020-21
922	1044	915	840	762	793	774	484	-37.4%	-47.5%

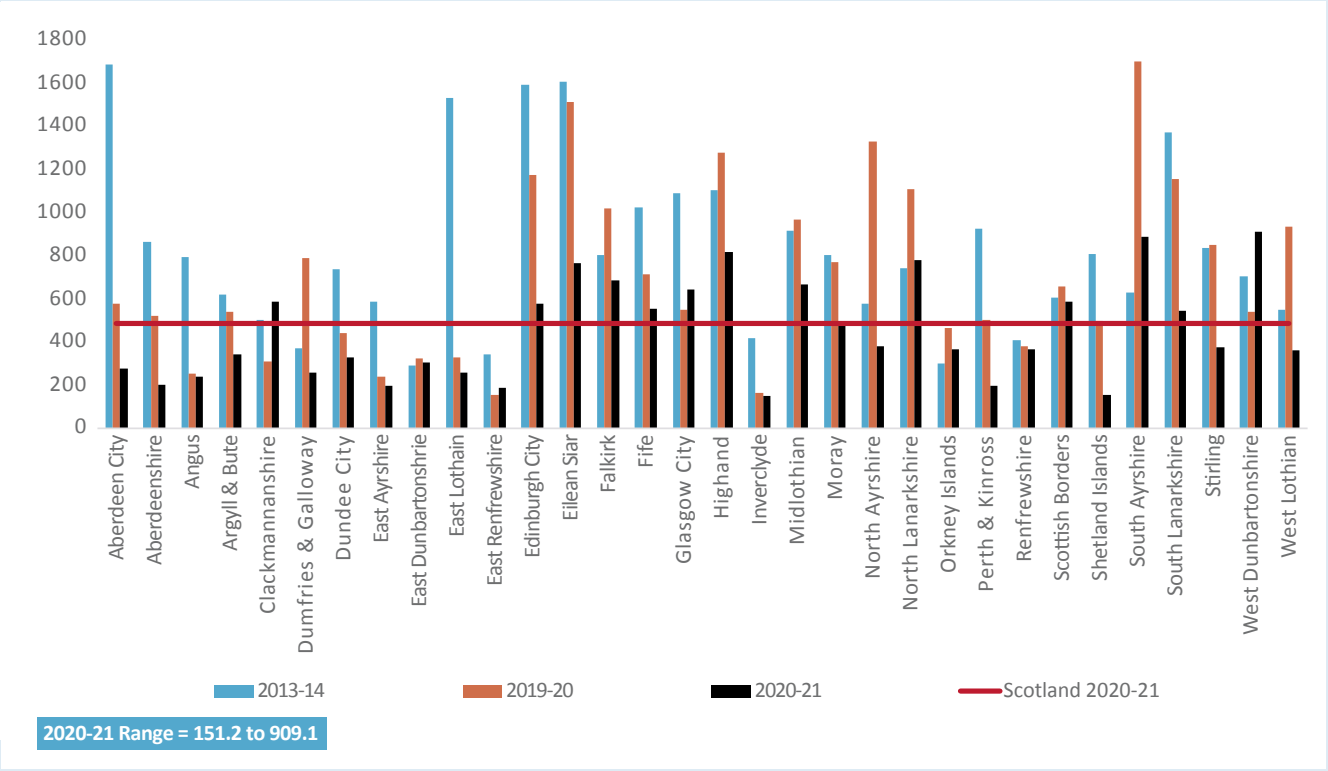
In 2020/21, while there remains significant variation across authorities in terms of the number of days people spend in hospital when they are ready to be discharged, with rates per 1000 ranging from 151 to 909, the level of variation has narrowed markedly. Council areas with lower levels of deprivation report fewer numbers of days delayed in hospital than the most deprived councils, and a faster rate of reduction in recent years. The relationship with deprivation however is not significant due to variation within the family group.

Fig 57: Number of days people spend in hospital when they are ready to be discharged, per 1,000 population (75+) by family group - deprivation



This has been an area of significant and sustained focus for authorities and has shown some improvement across the longer period. The impact of COVID-19 has had a significant effect on recent trends which although will require careful interpretation, also undoubtedly proved to be a stimulus to make significant reductions. The response to the outbreak has removed some of the historic barriers as well as providing the enablers and incentive for progress. Following the sharp reduction in rates during 2020/21, increases revealed in more recent data are a matter of concern, and further exploration will be necessary to understand what lessons can be learned from the initial response and what the long-term impact of the pandemic will be on this area.

Fig 58: Number of days people spend in hospital when they are ready to be discharged, per 1,000 population (75+)



Source: PHS

Local Variation – Number of days people spend in hospital when they are ready to be discharged, per 1,000 population (75+)

2020/21 Value

Scotland: 484; council range: 151 to 909. Narrowing variation in most recent year. Council areas with lower levels of deprivation report fewer days delayed in hospital (284 for least deprived, and 519 for most deprived).

Change Over Time

In 2020/21: Scotland: -37.4%; councils: 4 increased and 28 decreased (range: -71.3% to +89.4%). Least deprived councils report larger decrease than most deprived councils (-46% compared to -29%).

Since 2013/14: Scotland: -47.5%; councils: 6 increased and 26 decreased (range: -83% to +40.8%). Least deprived councils report larger decrease than most deprived councils (67% compared to 36%).

Direct Payments and Personalised Managed Budgets

From 1st April 2014, self-directed support introduced a new approach which gives people who require social care support more choice and control over how their support is delivered. Social work services continue to drive forward changes to ensure people's outcomes are being met, rather than a person fitting in to a service.

The Self-Directed Support Act 2013 puts a duty on local authorities to be transparent about the resources available to provide support and offer a choice as to how that support is managed/ delivered/ organised through the following four options:

1. Direct Payment (a cash payment)
2. Personalised Managed Budget (PMB) where the budget is allocated to a provider the person chooses (sometimes called an individual service fund, where the council holds the budget but the person is in charge of how it is spent)
3. The local authority arranges the support
4. A mix of the above.

In May 2020, the Scottish Government introduced COVID-19 SDS Guidance directing local authorities to allow people who receive Self Directed Support Options 1 or 2 to use their direct payments in a more flexible way (e.g. to purchase alternative support if their usual support has been unavailable or if services have been reduced or closed).

The LGBF indicator refers to the percentage of total social work spend allocated via direct payments (DP) or Personalised Managed Budgets (PMB).[32] This data will provide important insight into the implementation of Options 1 and 2 during the pandemic, and the progress made to deliver flexibly.

Since 2010/11, the proportion of total social work spend allocated via DP and PMB has grown steadily from 1.6% to 8.2%. All 32 authorities have reported growth during this period. Glasgow and North Lanarkshire account for a significant proportion of this growth, where expenditure via DP and PMB has grown from £5.5 million to £131.3 million. Excluding Glasgow and North Lanarkshire, the spend on direct payments and PMB as a percentage of total social work spend increased from 2.2% to 5.7% across the same period, with direct payments accounting for 67% of this spend (down from 74%).

In 2020/21, the proportion of spend via DP and PMB rose from 7.8% to 8.2% (although reduced from 6.2% to 5.7% excluding Glasgow and North Lanarkshire). The pattern across authorities is not universal, with 16 authorities reporting a small decline in the past year and 16 reporting an increase.

Table 30: Spend on direct payments and personalised managed budgets as a percentage of total social work spend on adults 18+

2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	Value Change 2019-20 to 2020-21	Value Change 2010-11 to 2020-21
1.6	2.9	6.0	6.4	6.9	6.7	6.4	6.8	7.2	7.8	8.2	0.4	6.6

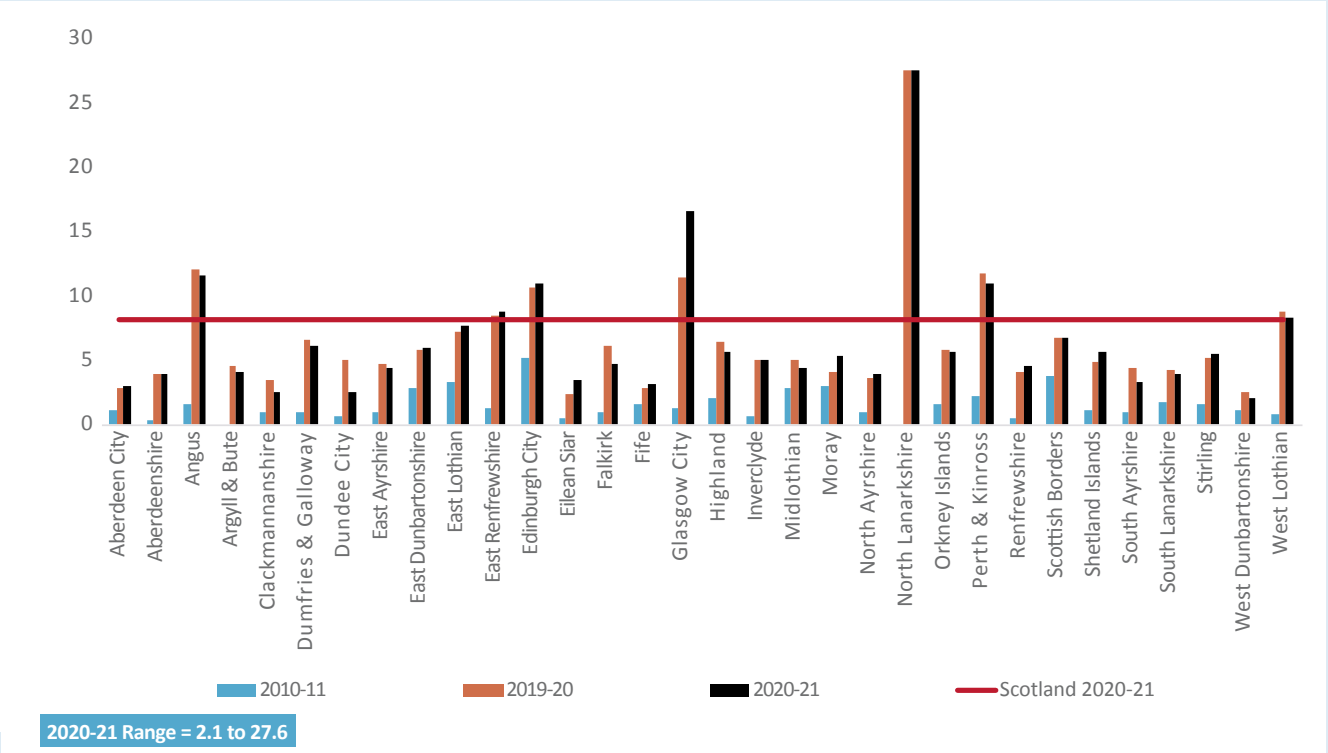
32 The PMB breakdown was included in councils return to the Improvement service for 13/14 - 20/21, and includes only residual expenditure from the personalised budget where it is unknown what support was purchased, i.e. where the council used a third party to arrange services. It does not include where the budget has been used to purchase known services from either the authority or another provider. Analysis of the data however indicates some variation in relation to what is included currently.

In 2020/21 the range in spend across councils was 2.1% to 27.6% (2.1% to 11.5% excluding outliers). Variation has widened over the past three years.

The data suggests a relationship between deprivation and the uptake of DP and PMB. Those councils with lower levels of deprivation have a higher uptake of direct payments (4.4% compared to 2.2% in the most deprived areas). Councils with higher levels of deprivation have a higher uptake of PMB, (9.7% compared to 1.6% in the least deprived areas). These relationships are however no longer statistically significant, due to variation within the Family Group.

Analysis of the LGBF data reveals rurality is also important in understanding the variation between councils, with supported people in urban authorities more likely to opt for personalised managed budgets (statistically significant). Historically, supported people in rural authorities were more likely to opt for direct payments, however this is no longer true in the most recent data.

Fig 59: Spend on direct payments and personalised managed budgets as a percentage of total social work spend on adults 18+



Source: council supplied expenditure figures

Note: Missing values reflect no data returned for that year

Local Variation – Direct payments and managed personalised budgets spend on adults 18+ as a % of total social work spend on adults 18+

2020/21 Value

Scotland: 8.2%; council range: 2.1% - 27.6% (2.1% - 11.5% excluding outliers). Widened variation in past 3 years. Higher uptake of direct payments in least deprived councils compared to most deprived councils (4.4% compared to 2.2%, no longer statistically significant). Higher update of PMB in most deprived councils compared to least deprived councils (9.7% compared to 1.6%, no longer statistically significant).

Supported people in urban councils more likely to opt for PMB (statistically significant). Historically, supported people in rural councils were more likely to opt for direct payments, however this is no longer true in the most recent data.

Change Over Time

In 2020/21: Scotland: +0.4pp; councils: 15 increased and 16 decreased (range: -2.4pp to +5.2pp (-2.4pp to +1.2pp excluding outliers))

Since 2010/11: Scotland: +6.6pp. All 32 councils increased (range: +0.9pp to +27.6pp)

Care homes

Care homes and their residents have been acutely affected by COVID-19. Residents of care homes for older people experienced a particularly high rate of COVID-19 related deaths. In addition, public health measures to restrict visitors created particular challenges for care home residents, their families and the staff that look after them.

A number of other factors influenced care home provision during this time. This includes the transfer of patients from hospitals into care homes; the closure of care homes to new residents; many of those at home remaining at home (with family often providing care and support on an informal basis); and finally staffing absence and recruitment issues. These factors will be vital when considering the emerging data on care home provision. While these elements will be important across all local authority areas, there will be differences in timing and degree.

The cost of care home services is reflected in the framework by a standardised measure using net costs per week per resident for people over the age of 65.

Between 2012/13 and 2020/21, there has been a 1.6% reduction in unit costs from £446 to £439. This has been driven by an 7.8% reduction in net expenditure and a reduction in the number of adults supported in residential care homes of 6.2%. It is important to note that the figures for 2012/13 to 2020/21 have in agreement with the Local Government Directors of Finance excluded a support cost component which was included in 2010/11 and 2011/12, and therefore a direct comparison with costs from earlier years is not possible.

Although the national trend shows a 1.6% reduction in unit costs, the range in movement across councils was -40% to +51%, with 13 authorities reporting increased costs since 2012/13, counter to the national trend.

Gross expenditure levels have remained steady over this period therefore the reduction in net expenditure indicates an increase in the income received by councils rather than a reduction in expenditure. The growth in the number of privately or self-funded clients as a proportion of all long stay residents over this period would support this trend (an increase from 28% to 33% between 2010/11 and 2020/21).[33]

In 2020/21, the average cost per week per resident fell by 2.2% from £449 to £439. This reflects a 7.9% decrease in net expenditure and 5.8% decrease in the number of residents. While the average cost reduced in the past 12 months, almost half of councils reported increasing costs counter to the national trend.

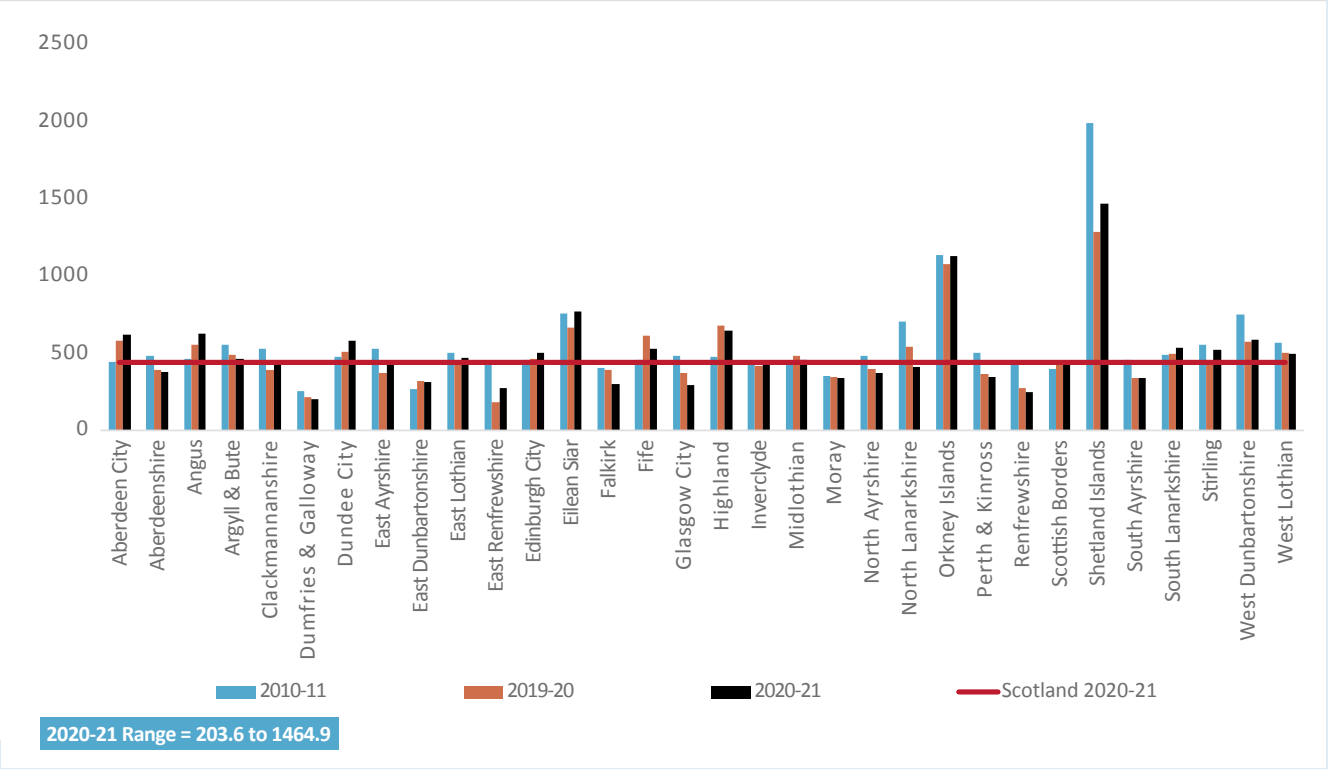
Table 31: Care home costs per week for people over 65

2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	% Change 2019-20 to 2020-21	% Change 2010-11 to 2020-21
£485	£490	£446	£427	£432	£422	£422	£415	£423	£449	£439	-2.2%	-9.5%

There is a considerable level of variation in care home costs across councils, ranging from £203 to £1,465 in 2020/21. Island authorities on average report significantly higher costs (£1,120 on average compared to Scottish average of £439). When island councils are excluded, costs range from £203 to £643. The level of variation has widened in the most recent year.

33 https://publichealthscotland.scot/publications/care-home-census-for-adults-in-scotland/care-home-census-for-adults-in-scotland-statistics-for-2011-to-2021-full-release/

Fig 60: Older persons (over 65s) residential care costs per week per resident (£)



Source: Social Care Survey and Quarterly Survey, with additional data sourced directly from councils to allow adjustment for any COVID-19 impact on provision in March 2019., Scottish Government; council supplied expenditure figures

Local Variation – Older persons (over 65s) residential care costs per week per resident (£)

2020/21 Value

Scotland: £439; council range: £204 - £1465 (£203 to £643 excluding outliers). Variation among councils widened this year and is at its widest since 2011/12. Costs are higher for island councils (£1,120 on average compared to Scottish average of £439).

Change Over Time

In 2020/21: Scotland: -2.2%; councils: 15 increased and 17 decreased (range: -24% to +50%)

Since 2012/13: Scotland: -1.6% ; councils: 13 increased and 19 decreased (range: -40% to +51%)

Up to and including 2020/21, the National Care Home Contract (NCHC) for residential care for older people will, to a large extent, have standardised costs. However, it is important to note that the net cost per resident will not equate to the NCHC rate, as care home residents will pay a proportion of their care home fees. The NCHC rate only applies to LA-funded residents who are in private and voluntary run care homes. Residential care costs however include net expenditure on:

- The net cost of any LA-funded residents (paying the NCHC rate)

- The cost of paying free personal care and free nursing care payments to self-funders (there are around 10,000 self-funders receiving Free Personal Care payments; around two-thirds also receive the Free Nursing Care payment)[34]

- The net cost of running any LA care homes (this will be gross cost less charges to residents). These will not equate to the NCHC rate and not all LAs run their own care homes so this may be something to explore further when examining differences across councils.

Therefore, if we compare net expenditure with all long-stay care home residents (private/ voluntary and local authority) we would expect the average rate to be lower than the NCHC rate.

Based on the above, variation in net costs between councils will be largely influenced by the balance of LA funded/self-funded residents within each area, and the scale of LA care home provision and associated running costs. There may be value in reviewing whether further breakdowns in this measure could provide further insight around the variation between areas.

Satisfaction with care services

The LGBF includes a suite of 'satisfaction' measures to capture progress made in relation to improving personal outcomes, promoting enablement, increasing choice and control, and supporting carers. These measures are taken from the HSC Core Suite of integration Indicators[35] with data drawn from the bi- annual Health and Care Experience Survey. The latest data available from this survey covers 2019/20 and therefore does not cover the COVID-19 period.

The Health and Care Experience Survey provides a more locally robust sample than is available from the Scottish Household Survey in relation to social care. The experience survey is part of the GP survey and asks about experience of 'care'. The data cannot be related to a specific element of social care and may reflect users experience across a mixture of health care, social care, and district nursing for example.

Across the suite of measures, there have been year on year reductions in satisfaction across each element. Since 2013/14,

- the percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life has fallen from 85% to 80%. The range in movement across councils was -18 percentage points to +8 percentage points, with 5 councils showing improvement counter to the national trend.

- the percentage of adults supported at home who agree that they are supported to live as independently as possible has fallen from 83% down to 81%. The range in movement across councils was -12 percentage points to +19 percentage points, with 12 councils showing improvement counter to the national trend.

- the percentage of adults supported at home who agree that they had a say in how their help, care or support was provided has fallen from 83% down to 75%. The range in movement across councils was -18 percentage points to +12 percentage points, with 3 councils showing improvement counter to the national trend.

- the percentage of carers who feel supported to continue in their caring role has fallen from 43% down to 34%. The range in movement across councils was -15 percentage points to +4 percentage points, with 2 councils showing improvement counter to the national trend.

34 Free Personal and Nursing Care, Scottish Government, https://www.gov.scot/publications/free-personal-nursing-care-scotland-2017-18/

35 https://www2.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes/Indicators/Indicators

Table 32: Satisfaction with care services

	2013 -14	2015 -16	2017 -18	2019 -20	Value Change 2017-18 to 2019-20	Value Change 2013-14 to 2019-20
Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	85.0	84.0	80.0	80.0	0.1	-5.0
Percentage of adults supported at home who agree that they are supported to live as independently as possible	82.8	82.7	81.1	80.8	-0.4	-2.0
Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	83.1	78.8	75.6	75.4	-0.2	-7.7
Percentage of carers who feel supported to continue in their caring role	43.0	40.0	36.6	34.3	-2.3	-8.7

For all these elements, satisfaction levels vary considerably across councils. For those who agree services had a positive impact on quality of life, this ranges from 68% to 88%; for independence, satisfaction ranges from 71% to 98%; for control and choice, the range is 67% - 87%; and for Carers, satisfaction ranges from 29% to 50%. Rural authorities report significantly higher rates for Carers satisfaction (38% compared to 35%), and the least deprived authorities report higher satisfaction rates in relation to control and choice (79% compared to 76%). There are no systematic relationships with deprivation, rurality or council size for satisfaction with impact or independence.

Figure 61 – Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided by family group - deprivation

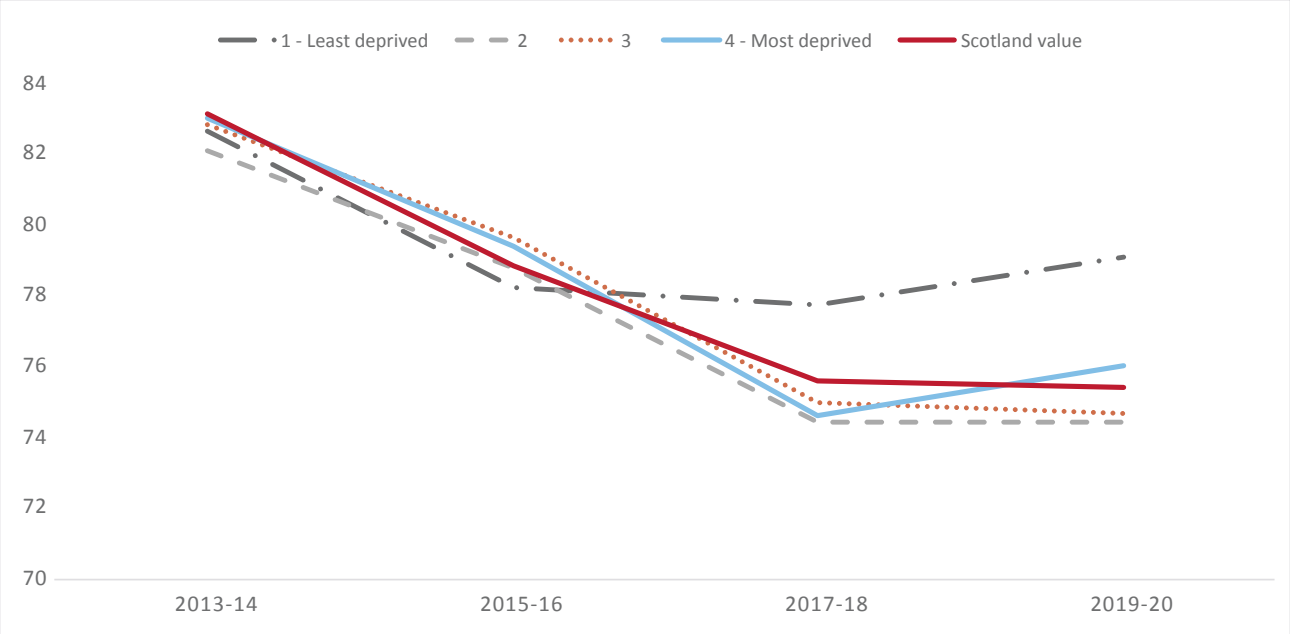


Figure 62 – Percentage of carers who feel supported to continue in their caring role by family group - rurality

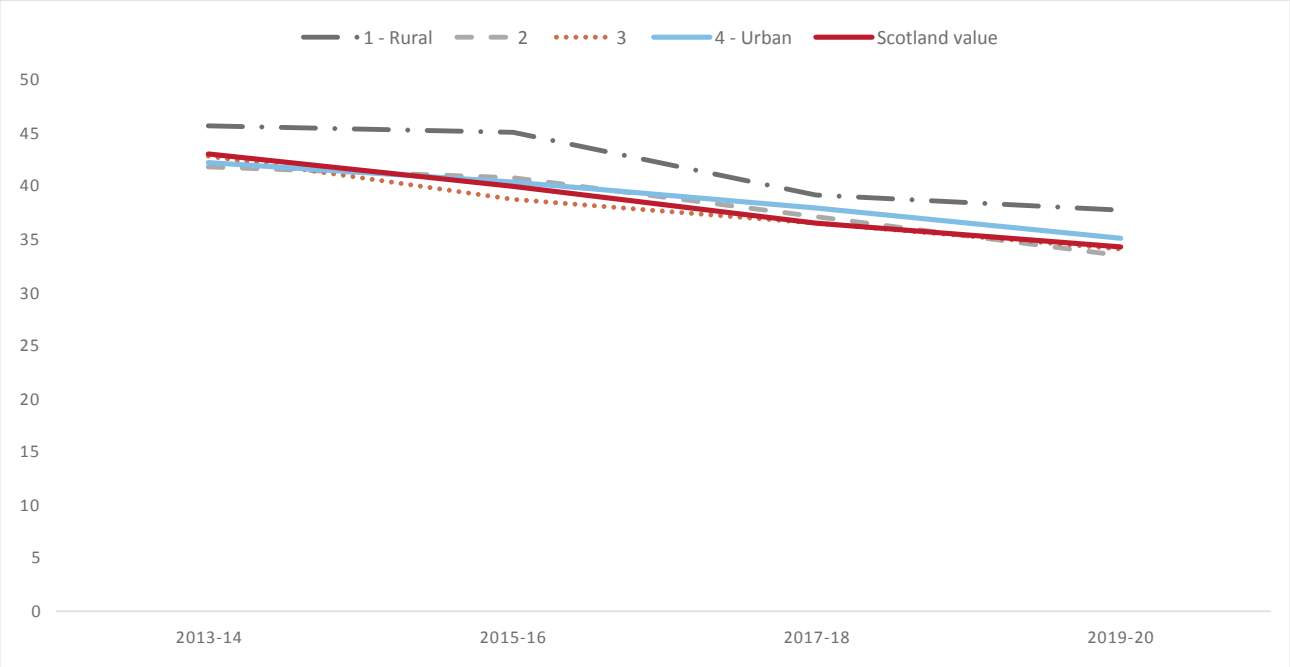
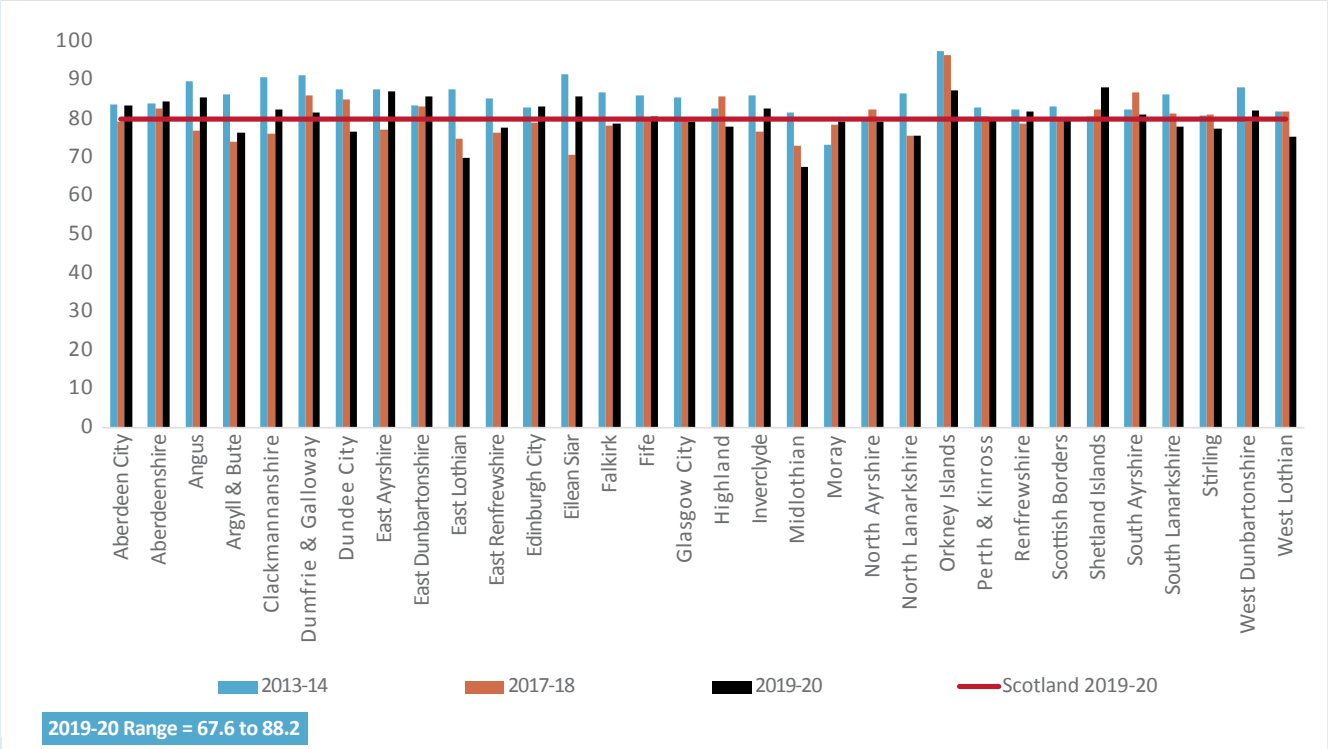
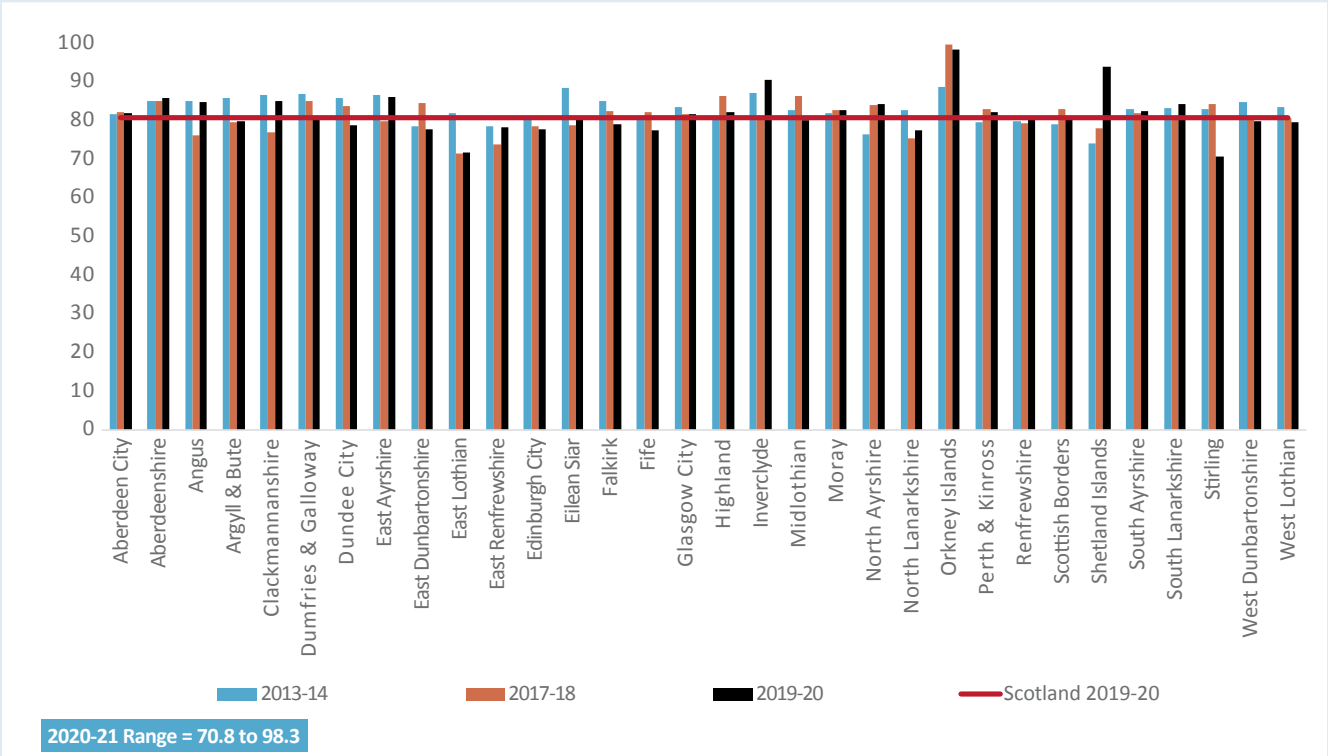


Fig 63: Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life



2019-20 Range = 67.6 to 88.2

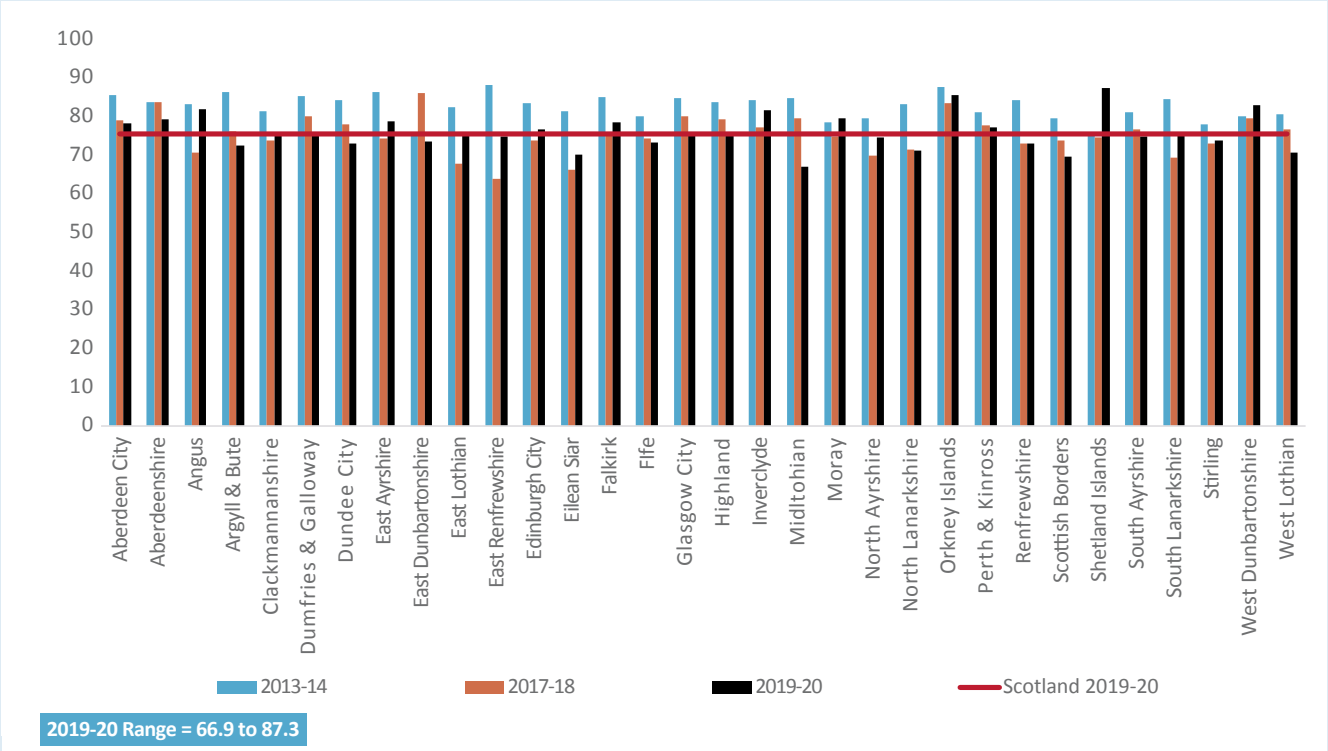
Fig 64: Percentage of adults supported at home who agree that they are supported to live as independently as possible



2020-21 Range = 70.8 to 98.3

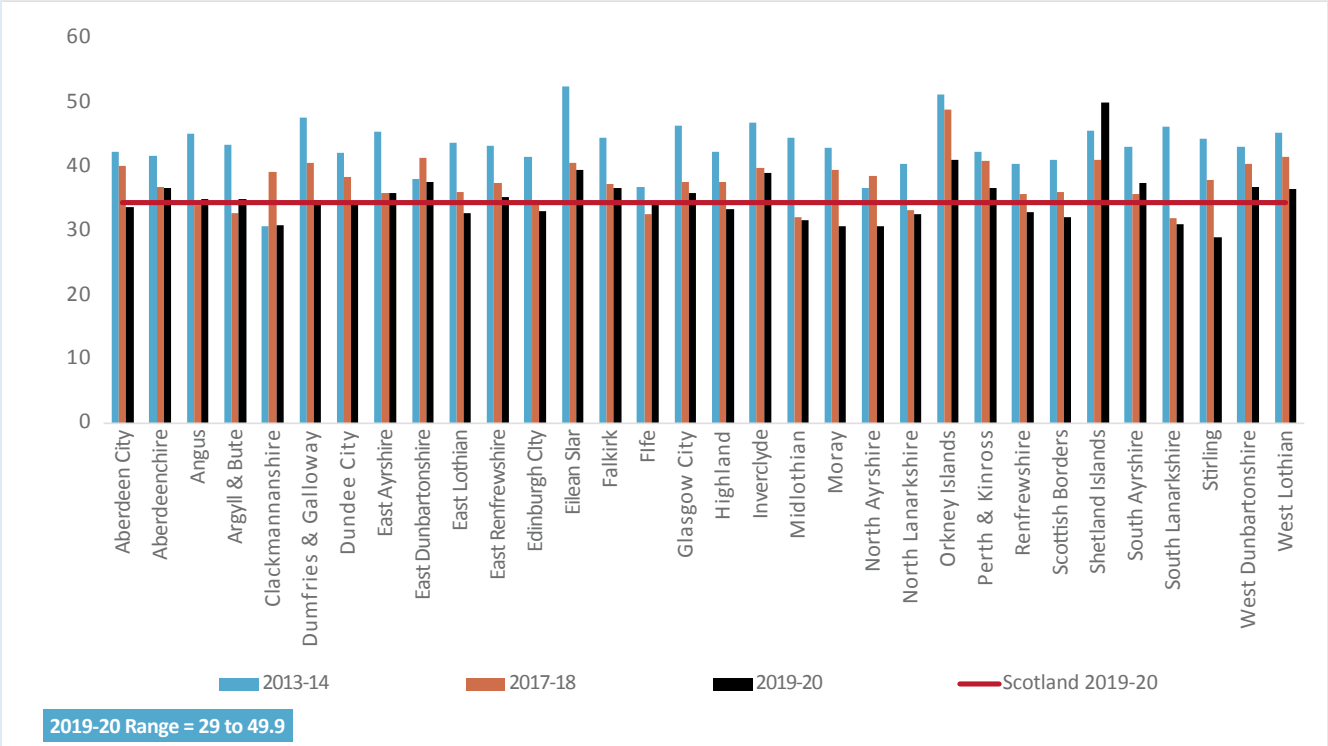
Source: Health and Care Experience Survey

Fig 65: Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided



2019-20 Range = 66.9 to 87.3

Fig 66: Percentage of carers who feel supported to continue in their caring



2019-20 Range = 29 to 49.9

Quality ratings of care services

This indicator provides a measure of assurance that adult care services meet a reasonable standard. This includes care provision provided by Local Authority, Health Board, Third Sector and Private Sector and includes the following care services:

- Care Homes for adults and older people
- Housing Support Services
- Support Services including Care at Home and adult Daycare
- Adult placements
- Nurse Agency

The Care Inspectorate grades care services on the following themes:

- Quality of Care and Support
- Quality of Environment (Care Homes only)
- Quality of Staffing
- Quality of Management and Leadership

New Health and Social Care Standards were published by the Scottish Government in June 2017.[36] These new standards are relevant across all health and social care provision. They are no longer focused only on regulated care settings, but are for use in social care, early learning and childcare, children's services, social work, health provision, and community justice.

In recent years, the Care Inspectorate changed the way it inspects the quality of care and support to reflect the new Health and Social Care Standards. In July 2018, a new framework for inspections of care homes for older people was introduced, drawing heavily on the new Health and Social Care Standards. Similar frameworks will be developed for other settings in due course. It will be important to consider the impact of these new standards and inspection frameworks when interpreting future data on care quality ratings.

In the 2020/21 inspection year, the number of inspections was greatly reduced due to COVID-19. The majority of services retained their grades from previous inspection. This should be considered when interpreting the data.

There has been an overall improvement in quality ratings since 2011/12, with the % of care services graded 'good' (4) or 'better' (5) increasing from 80.9% to 82.5%. The range in movement is -6.8pp to +19.1pp, with 11 councils declining counter to the national trend.

Until April 2018, the overall performance of care services was improving, with the proportion of good or better services growing and the maximum obtained grade rising. In the two inspection years prior to COVID-19, quality ratings declined. This was driven by a decrease in quality ratings for Care homes for Older People which coincided with the introduction of the new care standards. If removed, the Scotland average rating would have continued to improve for care services overall during these pre-COVID-19 years.

In the most recent year, ratings have increased from 81.8 to 82.5, counter to the trend observed in the previous 2 years. The increase in overall gradings observed in 2020/21 may reflect the significant change to

36 http://www.newcarestandards.scot

the Care Inspectorate's approach to inspection under COVID-19, and the recent in registration cancellations in services with grades `less than good'. The recent upward trend quality ratings is not universal, with a third of councils showing a reduction in gradings during 2020/21 counter to trend.

Table 33: Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections

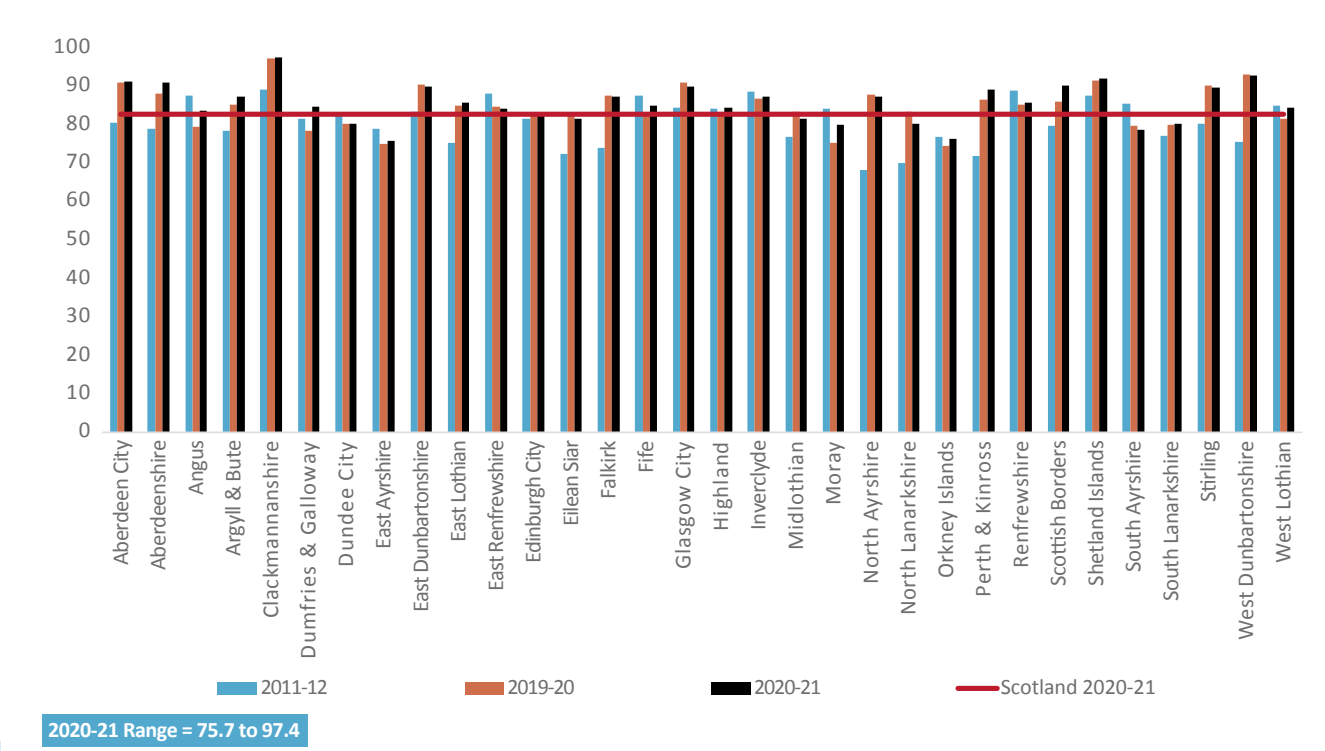
2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	Value Change 2019-20 to 2020-21	Value Change 2011-12 to 2020-21
80.9	80.2	80.2	80.5	82.9	83.8	85.4	82.2	81.8	82.5	0.7	1.6

There is significant variation between councils, with ratings in 2020/21 ranging from 75.7% to 97.4%. The level of variation has narrowed in the recent two years. Most deprived councils are more likely to have fewer services graded 'good' or better (84% compared to 89%) in the least deprived council areas.

Work within Family Groups has identified the following factors as important in understanding the local variation between authorities

- *Rurality: there is some connection between rurality and the cost of social care provision. Rural authorities have higher residential and home care costs, although this effect is not significant. Rural areas also tend to have higher satisfaction rates in the quality of the service and in relation to its impact on their outcomes, although again, this is not statistically significant. Councils with the largest populations have a significantly lower proportion of people cared for at home.*
- *Demographic variability: the number and proportion of over 75s within local populations will have a significant influence on the cost and balance of social care service provision locally.*
- *Proportion of self-funders locally and impact on residential care expenditure: variations in net expenditure between councils are systematically related to the percentage of self-funders within council areas.*
- *Local service design and workforce structure: local factors such as the service delivery balance between local authority provision and private/voluntary provision locally, along with variability in the resilience and capacity within local workforce and provider markets, will influence both costs and balance of care*

Fig 67: Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections



Source: Care Inspectorate

Local Variation – Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections

2020/21 Value

Scotland: 82.5%; council range: 75.7% - 97.4%. Narrowing variation in most recent year. Values are significantly lower in most deprived councils than least deprived councils (84% compared to 89%).

Change Over Time

In 2020/21: Scotland: +0.7pp; councils: 20 increased and 11 decreased (range: -3.2pp to + 6.0pp)

Since 2011/12: Scotland: +1.6pp; councils: 21 increased and 11 decreased (range: -6.8pp to +19.1pp).