HOME DELIVERY

A Profile of the Care at Home Sector in Scotland 2015

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About the authors

Barry McLeod is a research consultant who has undertaken research in the area of health and social care for nearly 20 years. He was the lead evaluator in one of the first attempts to integrate health and social care services in Scotland and together with Mari Mair, has subsequently provided health and social care research consultancy and support for the Scottish Government, COSLA, as well as numerous local authorities and NHS Health Boards.

Before her role as a research consultant, **Dr Mari Mair** was Technical Advisor to the Director of Finance in Glasgow City Council. Since 2002, she and Barry McLeod have provided research and consultancy support across a wide range of issues facing the public sector including their work in health and social care. This has included two national evaluations on behalf of the Scottish Government and a review of quality standards in Care Homes on behalf of COSLA.

About Scottish Care

Scottish Care is a membership organisation and the representative body for independent social care services in Scotland. Scottish Care represents the largest group of health and social care sector independent providers across Scotland delivering residential care, day care, care at home and housing support. 'Independent sector' in this context means both private and voluntary provider organisations. Our membership includes organisations of varying types and sizes, amongst them single providers, small and medium sized groups, national providers and not-for-profit voluntary organisations and associations. There is recognition of the merits for a strong single representative body in Scotland and our core strategy is to create the strongest possible alliance and collective voice to protect and promote the interests of all independent care sector providers in Scotland. Scottish Care speaks with a single unified voice for both members and the whole independent care sector. This includes those who use independent sector care services. Scottish Care is committed to supporting a quality orientated, independent sector that offers real choice and value for money. Our aim is to work with key partners and stakeholders to create an environment in which care providers can continue to deliver and develop the high quality care that communities require and deserve.

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Foreword

Delivering care and support to people in their own homes, helping them to retain their independence and community connectedness, and preventing unnecessary admission to hospital or long-term care, are central to the Scottish Government's strategy for Reshaping Care and improving outcomes for adults and older people with care needs. At the same time, we have lacked a coherent picture of this sector of provision. Good data, analysis, and narrative are crucial for effective Strategic Planning at both a national and local level. Accordingly, Scottish Care commissioned the authoritative collation, summary and review of existing data on care at home in Scotland, which forms the basis of this report. We hope it will focus attention on the sector, highlight key challenges, and stimulate discussion about future development. If care at home is to fulfil its full potential, there needs to be a collective commitment and nationally endorsed plan of action.

Ranald Mair
Chief Executive Officer
June 2015

Section One

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The voice of the independent care sector in Scotland

Introduction and Methodology

1.1 Introduction

1.1.1 This report was commissioned by Scottish Care in 2014 with the aim of providing a profile of the care at home sector in Scotland, focussing on provision for the over 65s. In particular, the research aims to map the size and scope of the care at home sector and to consider the opportunities and challenges facing the sector.

1.1.2 **The specific objectives of the research were as follows:**

- Source and analyse existing data on the care at home sector in Scotland;
- Analyse the Care Pound and how it is spent including a comparison of home care expenditure to that of other care provision such as residential care and hospital care;
- Provide a human narrative about the role home care plays in older people's lives;
- Consider issues related to the challenges and opportunities facing the sector

1.2 Summary of Research Findings

1.2.1 **The main findings from the research are summarised below:**

- The number of publicly funded clients receiving care at home has fallen across Scotland over the last decade
- The number of clients who receive public funding to meet their non-personal support needs (such as mopping and shopping) has dramatically reduced over the decade
- The number of hours of care at home provided publicly in Scotland has increased
- The number of publicly funded clients receiving 10 plus hours of care at home has increased
- Local authorities now contract out more than half *(60%)* of all care at home hours, having previously provided almost 70% of care at home hours through their own in-house services
- There is evidence to suggest that the commissioning process between purchasers and providers remains problematic
- Over the past decade, more hours of care at home have been provided by fewer staff
- The care at home workforce in Scotland remains predominately female, is older than the average of Scotland's working age population, and is largely employed on a part time basis
- Pay rates in the sector are below Scottish average pay rates
- Care at home expenditure has increased over recent years, while spend on residential care has been decreasing
- Expenditure on care at home, combined with expenditure on residential care, is less than what is spent nationally on emergency admissions into hospitals
- The cost of one average emergency admission for over 65s equates to caring for 27.7 care at home clients for one week or caring for an older person for 9.28 weeks in a residential care home
- In the quarter April to June 2014, delayed discharges accounted for 91,644 bed days. The expenditure associated with this could alternatively provide a year's care at home for 4,042 clients or a year's residential care for 1,354 clients
- Overall, client satisfaction levels with care at home services are high. However, studies demonstrate that many clients would like to receive more care at home services than they have currently been allocated
- Client satisfaction levels were lower in relation to the organisations delivering care at home services, with issues of communication and lack of flexibility being raised
- Many of the studies noted that care packages were lacking in adequate provision of what was termed 'mopping and shopping' services
- The research has identified a number of key challenges facing the care at home sector, highlighted at the end of the report, for consideration.

1.3 Background and Policy Context

1.3.1 This profile is set within an overall policy context that has sought over the past decade to achieve several objectives. An important development in the care at home sector was the introduction of Free Personal Care in Scotland in 2002. This provided free personal care at home to over 65s in Scotland, irrespective of income, but introduced a tight definition of what constitutes "personal care". The initiative was modelled on the Royal Commission Report, With Respect to Old Age, published on 1 March 1999 and the relevant Act was passed by the Scottish Parliament in 2002. This Act made Scotland distinct from the rest of the UK. Another important policy initiative over the period has been to shift the balance of care towards enabling people to live at home, healthy and independent, for as long as possible. This has been a key policy objective of the Scottish Government for a number of years. Reports such as Better Outcomes for Older People *(May 2005)* called for a significant shift forward in health and social care services in the community to support this overall policy by developing innovative health and social care services.

1.3.1 Around the same time, policies also sought to focus more upon the needs of individual clients. The provision of person-centred services were and still are believed to be paramount to ensuring individuals are able to obtain the support from services to enable them to remainin their own home for as long as possible. As noted in *Changing Lives in 2006*, the previous approach to providing services to individuals, which was primarily provider-led had to be changed to one where strategies are required to focus more upon the needs and preferences of individuals.

1.3.3 Recent legislation such as the Social Care *(Self-directed Support) (Scotland)* Act 2013 has sought to further increase the choice and control which individuals have over the care and support they receive. The Act requires local authorities to offer people four choices on how they can get their social care. The choices are:

The Act requires councils to offer people four choices on how they can get their social care. The choices are:

- A direct payment to the individual from the local authority
- The individual chooses a support organisation that they want to provide support and the local authority will arrange it *(known as Option 2)*
- The local authority selects who should provide support the individual and also arranges the support
- A mix of the above.

1.3.4 In order to facilitate both the need to shift care from a residential setting and also to aid better choices and control for individuals, successive governments have sought to achieve better integration between health and social care providers through a number of pieces of legislation and national initiatives. Over a decade ago, the Community Care and Health Act 2002, enabled local partners to delegate functions and pool budgets and the Joint Futures guidance reinforced this ethos with respect to the joint working between health and social work services. Despite this, further calls for better integration and streamlining of services were highlighted in the Commission on the future delivery of public services *(The Christie Commission)* which focused on better integration in order to achieve more positive outcomes for clients. Over the years, the Scottish Government has increasingly focused upon improving outcomes for individuals. This has been achieved through the introduction of a National Performance Framework, and Single Outcome Agreements between each Community Planning Partnership and the Scottish Government. These are underpinned by the Community Care Outcomes Framework *(Community Care Outcomes)*. These frameworks are intended to offer means to demonstrate how individuals' quality of life has improved as a consequence of receiving services or support.

1.3.5 The latest piece of legislation whose aim is to further improve the integration of healthand social care services is the Public Bodies *(Joint Working) (Scotland)* Act 2014. The legislation requires the fouteen area health boards and thirty-two local authorities to jointly submit an integration plan for each local authority area. There are two options for integration through which health boards and local authorities must establish new partnership arrangements. **These options are:**

- Delegation of functions and resources between health boards and local authorities, whereby one statutory body assumes responsibility for integrated arrangements (the Lead Agency model). The only partnership to adopt this model is Highland.
- Delegation of functions and resources by health boards and local authorities to a newly established body known as an Integrated Joint Board (the Body Corporate model). All partnership areas except Highland will be adopting the Body Corporate model.

1.3.6 It is hoped that such integration will further assist with the delivery of health and social care services in order that they are provided in a seamless manner and provide more positive outcomes for those using the services. Whichever format the new Health and Social Partnerships take, it is these partnerships that have responsibility for strategic planning at a local level and therefore will have to address and take forward the challenges facing the care at home sector in Scotland.

1.3.7 Whilst these new pieces of legislation have been introduced, the Scottish Government have also introduced a Reshaping Care for Older People Programme, covering the period 2011 to 2021. It "provides a long term and strategic approach to delivering that change so that we can achieve our vision for future care for older people in Scotland." *(p.3)*. The report concedes that care services in Scotland are under considerable strain as resources are squeezed and demographic changes increase. In light of this, a key focus of the programme is to reduce the number of bed days used as result of emergency admissions to hospital byolder people, a proportion of which can be avoided. As part of the programme the Scottish Government has made available approximately £370 million nationally, through the Change Fund, across the period 2011-12 to 2014-15. Each of the thirty-two councils has been allocated aproportion of the total fund to progress the reshaping agenda locally.

1.3.8 Councils have been using the additional money to reduce delayed discharge in hospitals by targeting money in providing additional residential care home places. It was expected that towards the end of the funding phase of the Change Fund *(which has now ceased)* that spending would be much more targeted upon anticipatory and preventative care to reduce inappropriate emergency admissions into hospitals. For example, in Glasgow City Council in the first year of the Change Fund allocation, 69% was allocated for hospitals and long term care home places while 5% was allocated to prevention and anticipatory care. By 2014 - 15 it is anticipated that only 29% will be allocated to hospitals and long term care home places with 21% allocated for prevention and anticipatory care[1].

1.3.9 South Lanarkshire has taken a different approach to Glasgow in utilising its Change Fund allocation. Their emphasis in the first year was on prevention and anticipatory care. with more funding allocated to hospitals and long term care in the second year. This difference merely reflects local priorities in terms of reshaping health and social care.

1.3.10 It is within this context that this report is set, that is, one where national policy and local planning have sought to achieve certain goals including shifting the balance of care, introducing more personalisation and more choice and control for clients as well as achieving better integration of service providers. The profile of the care at home sector provided within the report will consider the extent to which some of these policy objectives have been met as well as outlining the challenges faced by the sector in trying to meet them.

1 Reshaping Care for Older People Glasgow City Partnership Draft Joint Strategic Commissioning Plan 2013-16

1.4 Methodology

1.4.1 This research project is desk based and draws upon the analysis of secondary sources of data about the care at home sector. These include national data sets from a number of sources such as Information Services Division *(ISD)*, the Scottish Government, Scottish Social Services Council *(SSSC)*, the Office for National Statistics *(ONS/NOMIS)*, General Registrar's Office for Scotland *(GROs)*, etc. These sources were used for both profiling the sector and also analysing the Care Pound. In terms of the human narrative section, a review of research reports on the experiences of care at home clients was undertaken. This analysed primary research that had been previously undertaken in this area, allowing the views of older people to be heard.

1.4.2 In terms of the analysis of data on the Scottish care at home sector *(Section 2)*, data is presented over a number of years to provide some context on the care at home sector today. This includes geographical variations where the data allows. The purpose of this is to profile the sector in terms of the clients who receive a service and the workforce and organisations which provide these services. This data will be used to examine the extent towhich the current policy agenda, in particular shifting the balance of care to the community, is actually reflected in practice. As well as this, the data will be used to highlight workforce and procurement issues in the sector.

1.4.3 In terms of the analysis of the Care Pound provided in Section 3, as well as considering levels of expenditure on care at home, a modelling approach has been developed in order to demonstrate what social care services could be provided as an alternative to expenditure currently consumed by inappropriate emergency hospital admissions and delayed discharges.

1.4.4 Finally, the Human Narrative stage will review a wide range of health and social care research in the UK over recent years. Only projects based upon primary research were included in the review in order to provide insightful narratives about a range of aspects pertaining to care at home. These include client views on quality of care, quantity of care provided, perceptions of care providers, benefits of receiving care at home and areas for improvement.

Section Two

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Scottish Care at Home Data Profile

2.1 Introduction

2.1.1 Having highlighted the policy and legislative context in which care at home in Scotland operates and develops, this section will examine a range of information on care at home across Scotland for those aged 65 and over. The data is analysed at local authority and national levels across a decade, where the data allows.

2.1.2 Figure 1 below highlights the increase in population for those aged 65 and over across the last decade in Scotland. Over this period the population of this group has increased by 15.7%. Given this increase, one would expect the number of care at home clients aged 65 and over to increase at a similar rate *(assuming equivalent morbidity and mortality rates)*. However, as this section will demonstrate, this has not been the case.

2.2 Care at Home: Profile of Clients Across Scotland

2.2.1 This section examines the number of older persons who receive a care at home service and considers the way in which this has changed over the last decade.

2.2.2 The number of people aged 65 and over receiving care at home across Scotland in 2013 was 50,354 *(See Figure 2 overleaf)*. Across the last decade this figure has steadily declined by some 12.8%. These figures refer solely to those who received a service which was publicly funded. If we include privately funded clients, in 2013, the total number of care at home clients in Scotland was 63,000. That is, almost 13,000 or 20% of the total clients receiving a service were privately funded clients.

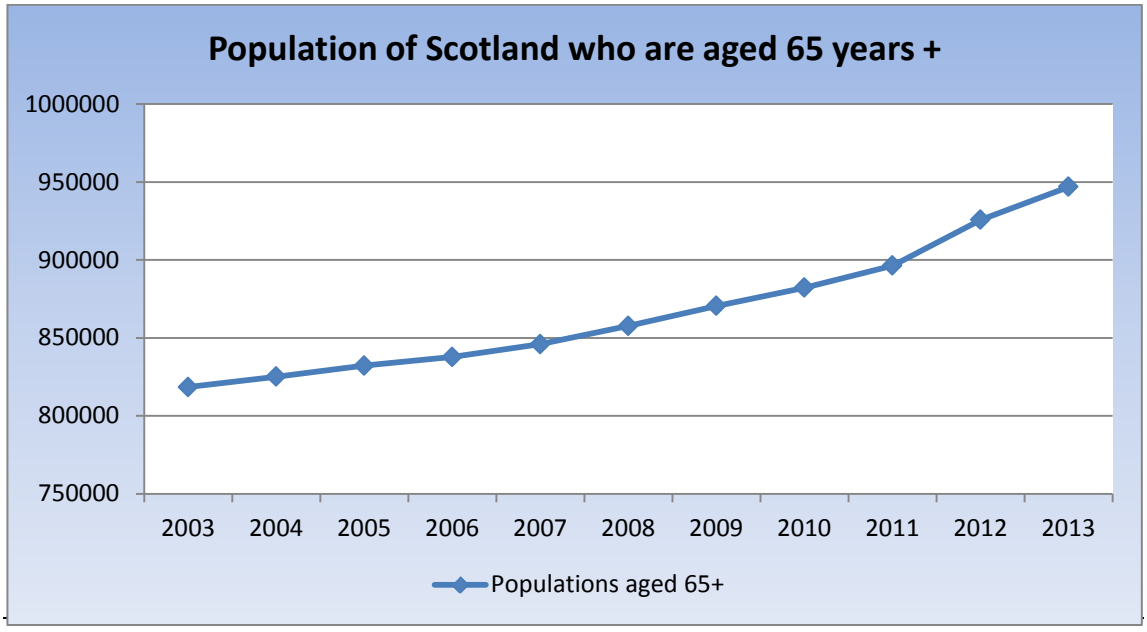


Fig 1.

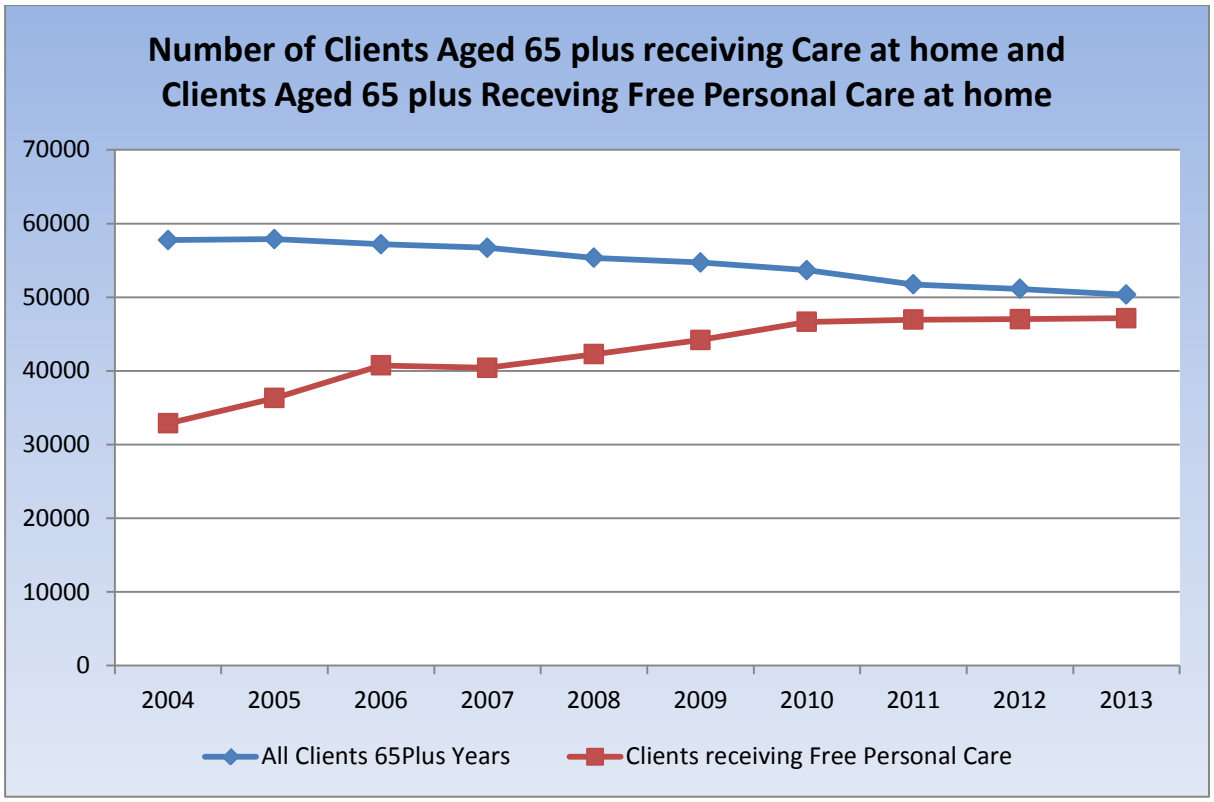


Fig 2.

2.2.3 However, the picture across local authorities in terms of people receiving care at home is a mixed one. While the number of older persons receiving this service has declined across Scotland as a whole, half of local authorities have shown an increase in the number of people aged 65 and over using a care at home service. For instance, there has been amarked decline *(by 40.6%)* in the number of older people receiving care at home in the Fife Council area over this period and a 37.6% decline in the number of older persons receiving care at home services in the Highland Council area. However, against the overall national trend of fewer clients using care at home across Scotland, South Ayrshire Council has seen the greatest increase amongst councils in terms of the number of older people using care at home services *(38.7%)*. Similarly, South Lanarkshire Council has also seen a substantial increase in numbers receiving care at home services *(36.8%)*.

2.2.4 The figure also shows the number of clients in receipt of free personal care *(FCP)*, since its introduction in 2003/4. As the figure shows, when FCP was introduced, clients in receipt of this accounted for 56.9% of all care at home clients over 65 years. In 2013, this has increased to 93.6%. This clearly demonstrates the changes to eligibility criteria for care at home which have occurred over the decade. Now, just over 5% of care at home clients who receive a service in Scotland have their support needs met out-with public funding. Therefore, there has been a dramatic fall in publicly funded clients who have their non-personal support needs met through their funded care package. In 2003/4, there were 24,892 clients with non-personal care needs such as domestic support, in 2013 the figure is now 3,204. This represents a dramatic reduction in the number of clients receiving publicly funded support for areas out-with the definition of 'personal care', such as 'mopping and shopping.' The lack of provision of this type of support for care at home clients raises issues around the prevention agenda. In other words, services that are deemed to assist older people to live at home for as long as possible, help reduce early admission into care homes and prevent inappropriate admissions into hospital, are now in short supply.

2.2.5 The following figure shows the increase in expenditure on FPC since 2003-04 *(an increase of 164%)*. As with the number of FPC clients shown in Figure 3, the level of expenditure increases at the start of the decade and levels out after 2010.

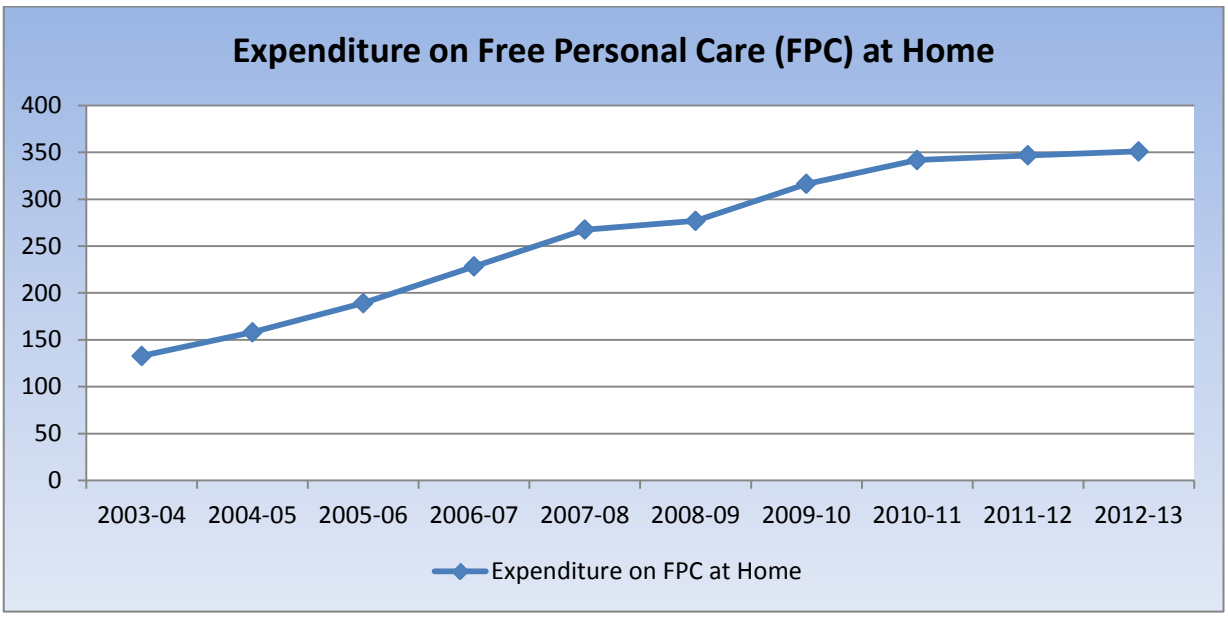


Fig 3.

2.2.6 Despite the reduction in the overall number of clients receiving a care at home service, the total number of hours of care at home being provided has increased markedly across Scotland by over a quarter *(27.3%)* since 2003.

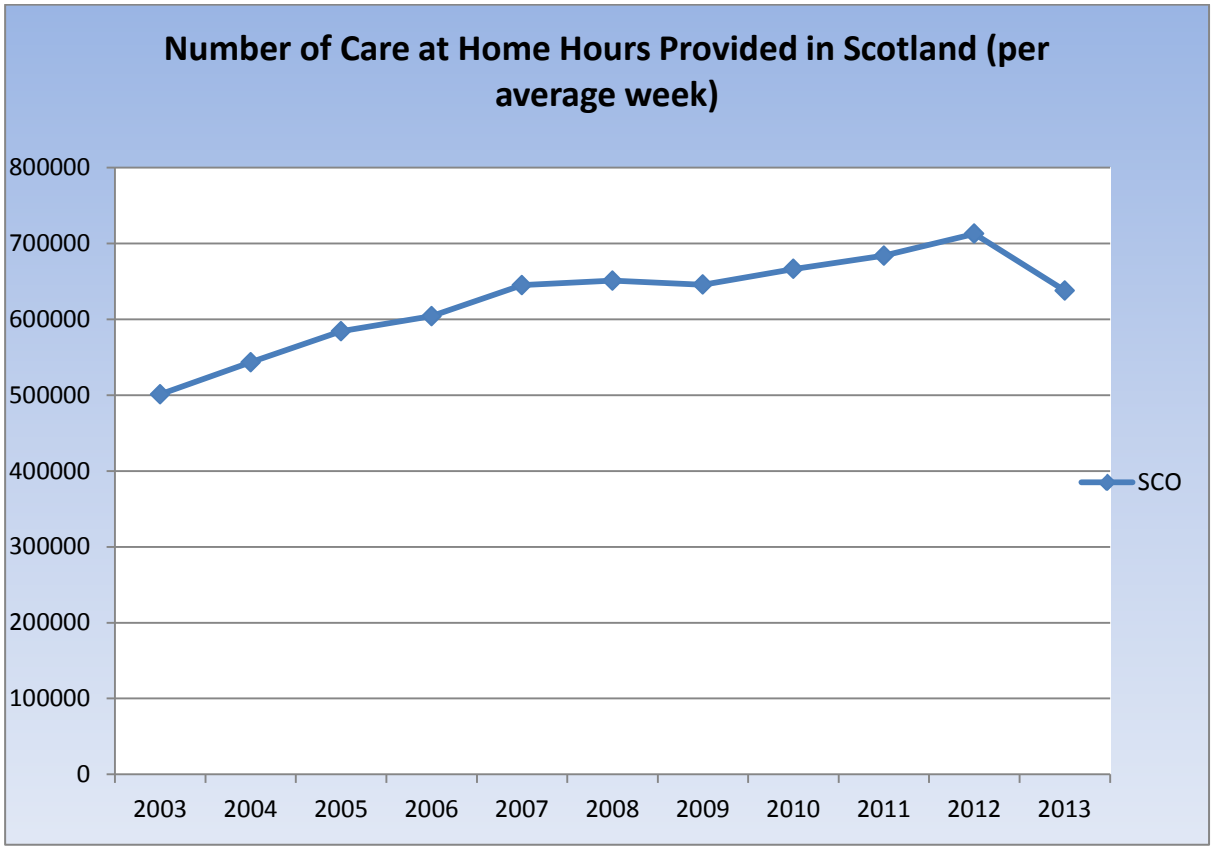


Fig 4.

1 Reshaping Care for Older People Glasgow City Partnership Draft Joint Strategic Commissioning Plan 2013-16

2.2.7 As before, the Scotland figure masks considerable variations in hours provided across the thirty-two councils. In fact, seven councils have shown an increase of over 100% in hours of care at home provided since 2003, with East Dunbartonshire Council having a 219.3% increase *(See Table 1 below and Appendix 1 for all councils)*. It should be noted that these hours relate to all care at home clients and not just those aged 65 and over.

% Increase in Hours Provided of Care at Home by Council (2003-2013)	
East Dunbartonshire	219.3%
East Lothian	195.8%
Stirling	158.8%
East Renfrewshire	118.4%
South Ayrshire	116.9%
South Lanarkshire	112.7%
North Ayrshire	108.1%

Table 1.

2.2.8 Despite the overall trend across Scotland of an increase in the number of care at home hours being provided, it should also be noted that ten councils in Scotland reduced the number of care at home hours they provided over this period. In particular, there have been considerable reductions in hours provided in North Lanarkshire *(-42.5%)*, Orkney *(-44%)* and in Glasgow City Council *(-35%)*. In real terms, these reductions would be even greater given the population growth of 15.6% for this age group over the same period.

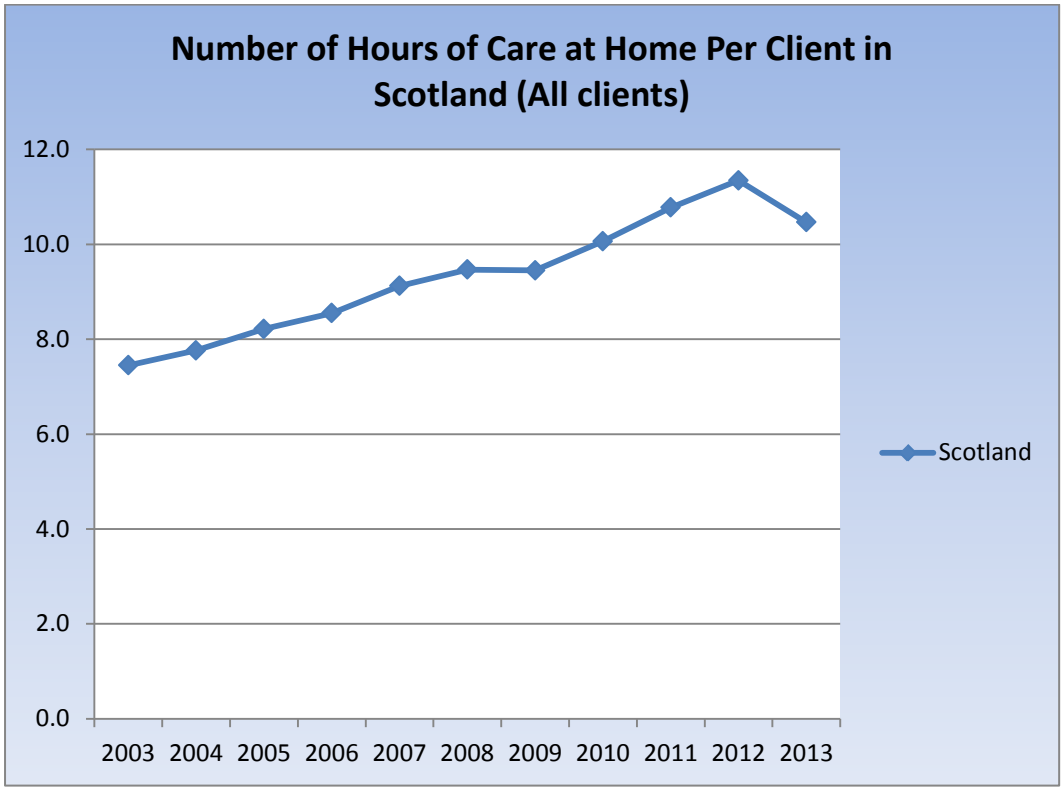


Fig 5

2.2.9 Given the national trend over the last ten years towards fewer care at home clients combined with more hours of care at home being provided, it is not surprising that Figure 5 below shows an increase in the number of hours per client. In fact, since 2003, the number of hours per client has increased substantially by 40.5% (from 7.4 hours per client in 2003 to 10.5 in 2013).

2.2.10 However, as before, the national trend masks considerable variation across Scotland's councils. Fife Council have increased their hours per client by 177.9% over this period with East Dunbartonshire increasing by 170.9% and Edinburgh City Council by 100.8%. While most councils have shown an increase in the hours provided per client overthe last 10 years, 4 councils have seen a reduction. These councils are Aberdeenshire who have reduced hours per client by 26.2% over this period, North Lanarkshire by 23.5%,Glasgow City Council by 5.5% and Renfrewshire by 3.5%.

2.2.11 The steady increase in the number of hours of care at home service provided per client is attributable to a large extent to the increase in the number of clients receiving 10 or more hours of care at home across Scotland *(See Figure 6 below)*.

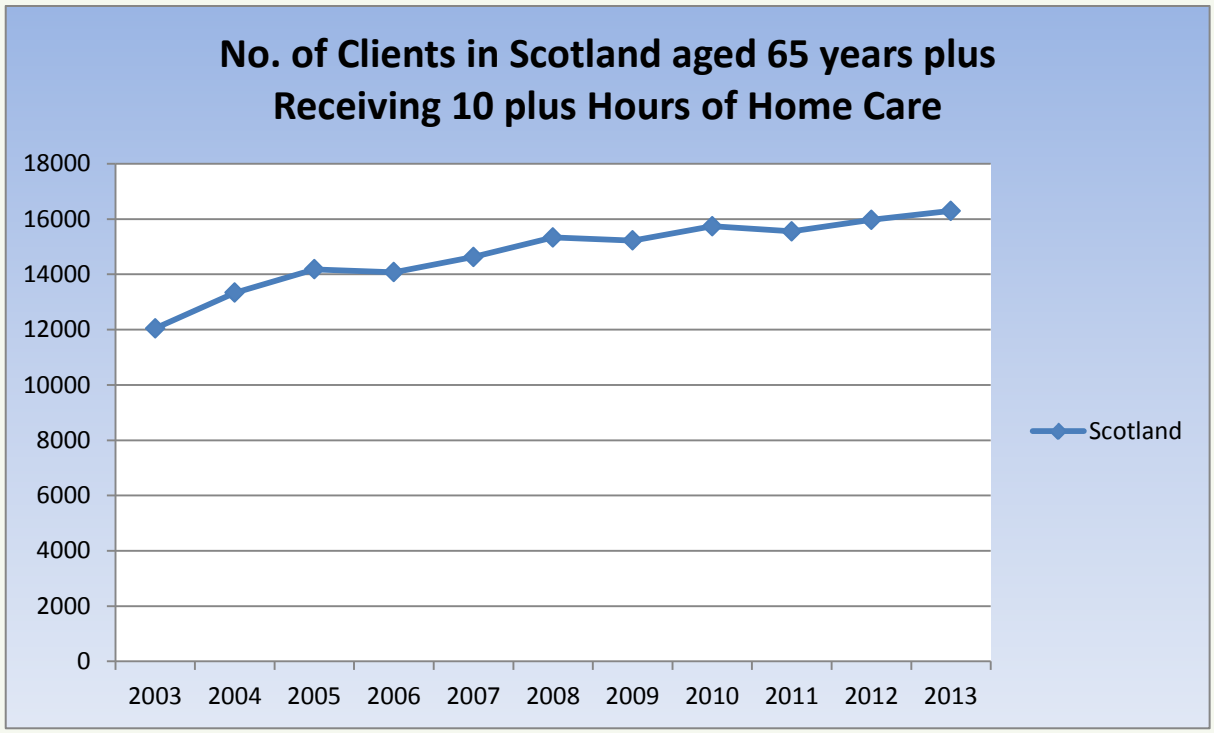


Fig 6.

2.2.12 While there has been an overall reduction in the number of care at home clients aged 65 and over across Scotland, there has been a considerable increase in the number of clients aged over 65 receiving 10 or more hours of care at home services. Figure 6 above shows that there has been a 35.3% increase in the number of older clients receiving 10 plus hours of home care. Since 2003, the number has increased from 12,047 to 16,297 clients. The figures show that while fewer older people in Scotland have received a care at home service in recent years, the numbers of those receiving a more intensive service at homehas increased.

2.2.13 While the overall increase in Scotland since 2003 is 35.3%, it is important to note that the number of older persons receiving 10 or more hours of care at home varies significantly across councils in Scotland. For instance, in Midlothian Council, since 2003, the service has increased in uptake by some 374.5% *(from 98 clients to 465)*. Similarly, in East Lothian there has also been a substantial increase in this service by 262.2%. However, six councils have seen a reduction in the number of clients using 10 or more hours of care at home, such as Orkney Council and Renfrewshire who have seen reductions of 26.9% and 28.4% respectively since 2003.

2.2.14 One of the targets within the Scottish Government's Community Care Outcome Framework is to shift the balance of care, in particular to increase the number of older people with intensive care needs *(10 plus hours)* who are receiving care and support at home. Figure 6 above and Figure 7 below shows that across Scotland, progress has been made in this area across the decade. In 2003, 14.7 over 65s with intensive care needs per 1,000 of the population aged over 65 years received their care at home. In 2013, this figure increased to 18.3 per 1,000.

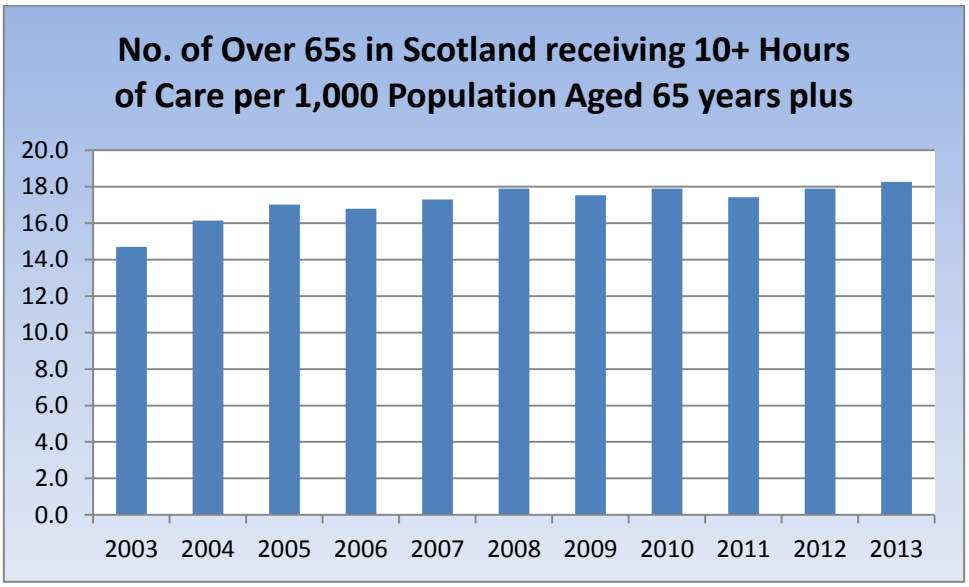


Fig 7.

2.2.15 As noted above, not all local authorities across Scotland have made the same progress across the decade towards improving the balance of care. Figure 8 below shows some of the extremes that exist across the local authorities and compares this to the national average. The rate of older people with intensive care needs receiving care at home has been consistently low in Angus, and well below the Scottish average. Across the decade, the rate has marginally increased in Angus from 4.1 per 1,000 to 4.7. This contrasts markedly to the rate in Glasgow City Council, where in 2003, 28 per 1,000 of the over 65 population with intensive care needs received care at home and over the decade this has increased to 30.7 per 1,000. One local authority which has seen a marked increase in the rate of over 65s with intensive needs receiving care at home is Midlothian Council. Over the decade, the council has increased it rate from 8 per 1,000 to 33.2 per 1,000.

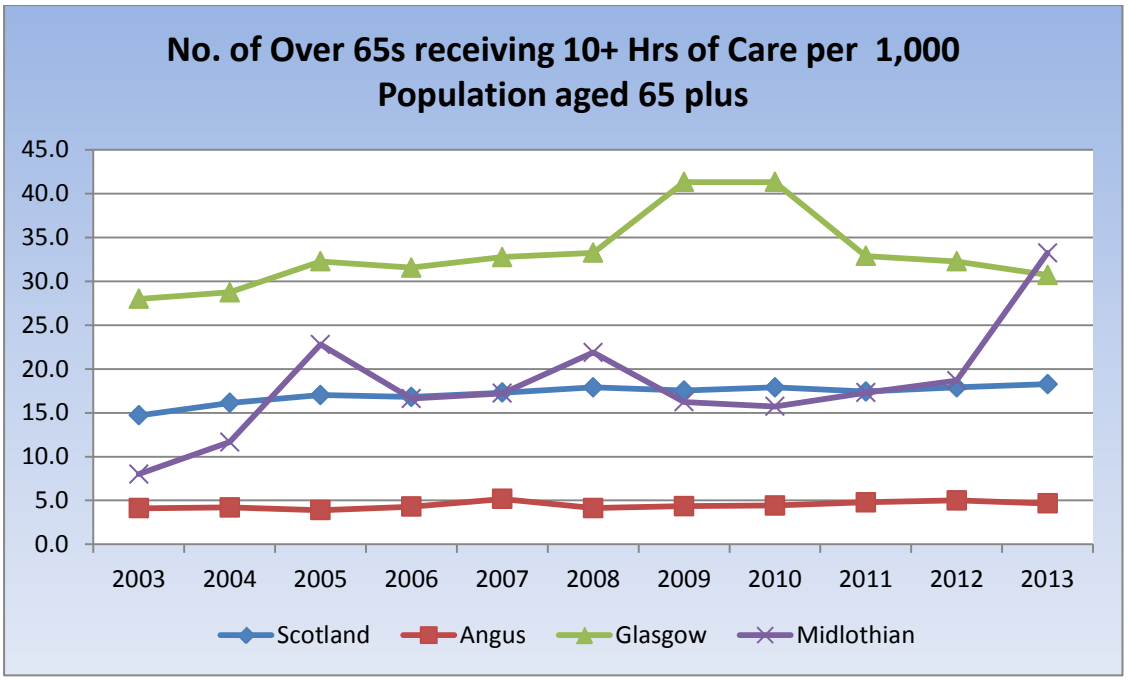


Fig 8.

2.2.16 As noted, nationally there appears to have been a shift in the balance of care towards the provision of more intensive care provision in the community.

Figure 9 below provides further evidence of this national shift, with the number of long stay residents in care homes reducing over the last decade by some 5.4%. In real terms this is a greater reduction over the decade, given that the growth in the population over 65 grew by 15.6% over this period.

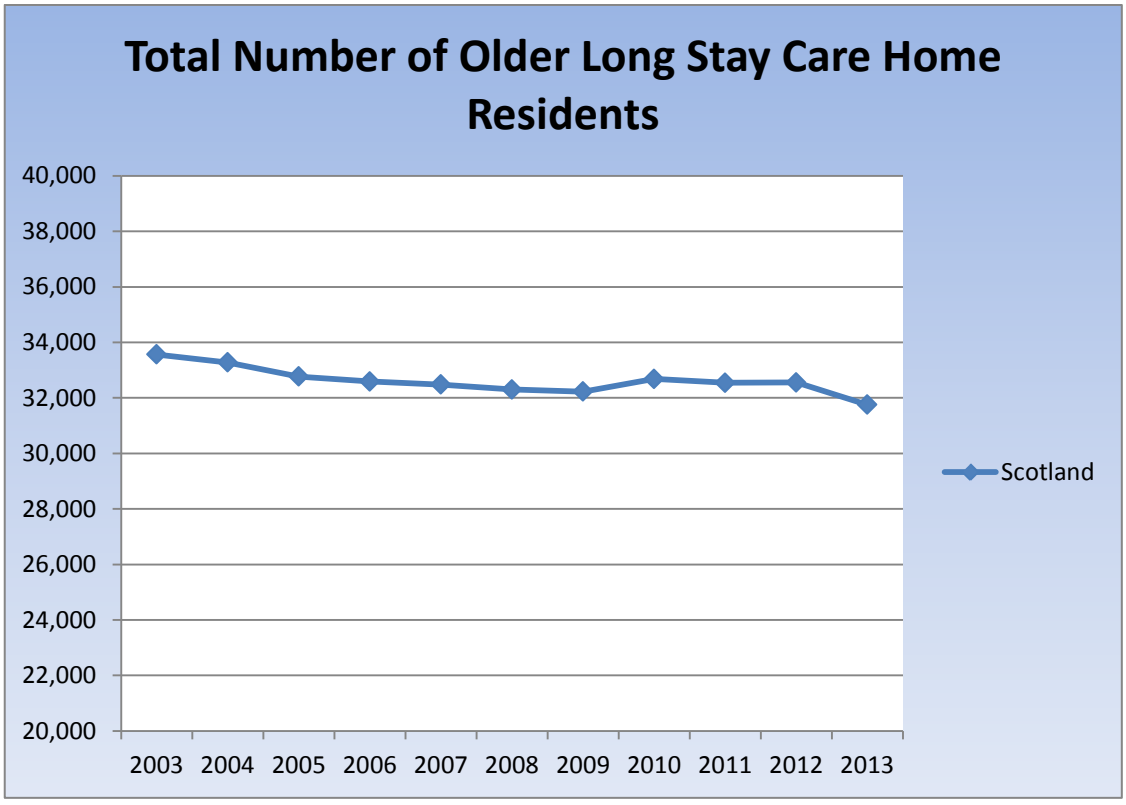


Fig 9.

2.2.17 However, once more this national trend masks some variation across local authorities. Perhaps surprisingly, one local authority's provision of both community and residential care appears to be at odds with the national commitment to shift the balance of care into the community, with the growth of long stay residents in care homes over the period outstripping population growth for this age group. At the same time numbers of care at home clients, as well as hours provided to these clients, have both reduced considerably.

2.2.18 The Scottish Government has introduced recent legislation to increase the control and choice which clients of care at home services have over the care that they receive. This was introduced in the form of Self Directed Support *(SDS)*. Receiving direct payments to direct their care and support is one option available to older people within SDS. However, it should be noted that the option of direct payments has been available for some time prior to the introduction of the SDS legislation. Over the decade, more and more clients have received direct payments to purchase their own care as shown in Figure 11 below.

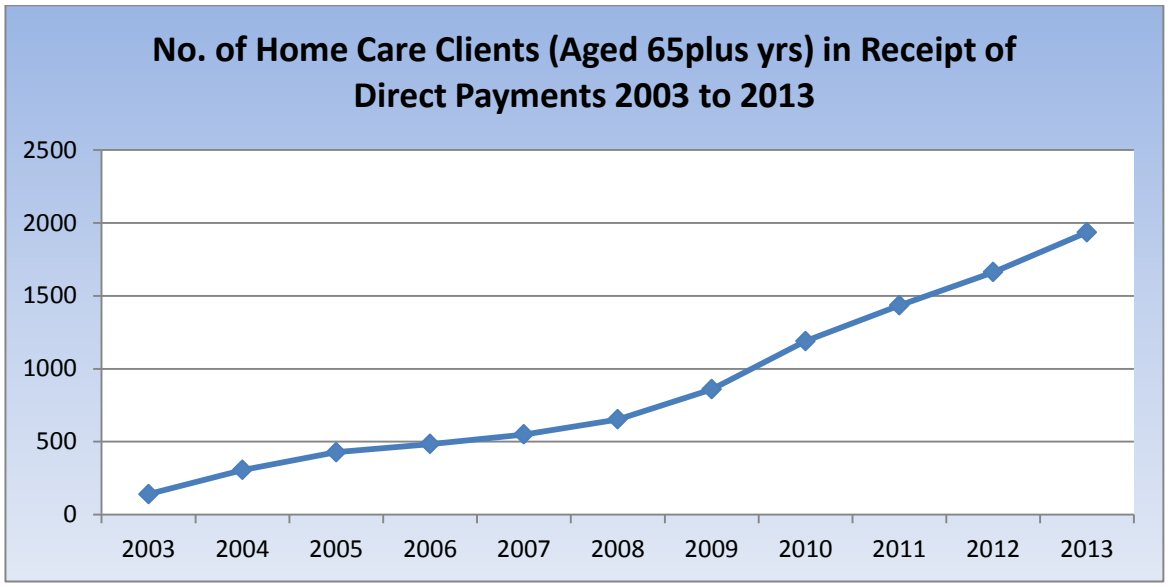


Fig 11.

2.2.19 In 2013, the 1,936 older persons who received a direct payment represented 35.8%of all clients receiving a direct payment. Therefore, despite the fact that more care at home clients are over 65, those in receipt of direct payments are still in the minority across Scotland as a whole.

2.2.20 There are five local authorities where older people make up more than 50% of all those clients in receipt of a direct payment. These are Moray, East Dunbartonshire, Perth and Kinross, Argyll and Bute and East Lothian. There are also three local authorities where older persons in receipt of direct payments as a proportion of all clients receiving direct payments is less than 10%. These are West Dunbartonshire, where older persons make up 7.8% of clients in receipt of direct payments, North Lanarkshire where the figure is 5.9% and Eilean Siar where no elderly care at home clients in the council area are in receipt of a direct payment to purchase their own care. Evidently, there is considerable local variation in the uptake of direct payments amongst older people. A possible explanation for this local variation may be due to how older people are made aware by Social Work staff of the pros and cons of direct payments.

2.2.21 Recent Self Directed Support legislation was designed to ensure that all clients are given the option of a direct payment along with three other options *(see para. 1.1.5)*. Whilst this is still in its early stages of implementation, it is crucial that local authorities promote all four options to clients equally.

2.2.22 In 2012/13, the value of direct payments to older people receiving care at home was £17.09m. This accounted for just over a quarter of expenditure on direct payments to all care at home clients. Despite the fact that more than half of clients in receipt of a direct payment in both Argyll and Bute and East Lothian were older persons, the value of the direct payments allocated to these clients did not amount to more than 50% of the value of direct payments in these areas. Rather, the value of direct payments for older people in theseareas was 36.7% and 34.6% respectively.

2.3 Summary of Care at Home Provision over the Past Decade

2.3.1 **To summarise care at home provision, the data has shown that:**

- The number of clients receiving care at home has fallen across Scotland over the last decade;
- The number of clients with non-personal support needs who have these met through Free Personal Care has dramatically reduced over the decade
- The number of hours of care at home provided in Scotland has increased and
- The number of clients receiving 10 plus hours of care at home has increased

2.3.2 This profile would appear to be consistent with national policy, that is, to shift the balance of care from residential settings to the community. As noted above, almost all authorities are reducing the number of long stay residents in care homes across Scotland.

2.3.3 While almost all local authorities are reducing in real terms the number of long stay residents in care homes, there is much more variation in terms of the provision of care at home. While the overall number of care at home hours are increasing in line with national policy, there are ten councils who have reduced their overall care at home hours, in some cases by over 40%, and some six councils who have reduced their 10+ hours provision, in one case by 28.4%.

2.3.4 For these councils, a mix of their own local priorities and budgetary pressures may explain why these reductions are at odds with the national policy agenda. However, the issue for older people within these particular councils is that this may mean they will receive a reduced care at home service or even no service. Even in other councils where overall hours have gone up, in particular for those receiving 10+ hours, the total number of clients has reduced. Therefore clients who used to receive small packages of care at home services, may no longer be receiving the same level or any service at all.

2.3.5 As such, it appears that the policy ambition of increasing the number of older people who require intensive support in the community has been met at the expense of those older people requiring less support in their own homes. While this provides an obvious benefit to those with intensive care needs, the longer term impact for those no longer in receipt of care at home may be felt in the future in a number of ways. For example, older persons no longer in receipt of any service are denied the benefits of support that would allow them to live independently for as long as possible in their own home. This lack of support may lead some older people to move to a residential setting earlier than would otherwise have been the case if they had received adequate care at home support or even, in some cases, to a hospital admission that may have been preventable with the appropriate support at home.

2.3.6 These concerns were highlighted in the Audit Scotland report on Social Care Commissioning in 2012, which concluded that: **"This suggests that people who need less intensive support are not being offered some services that might help delay or avoid their needing more intensive services."** *(p.22)*

2.3.7 It may be, of course, that some older persons have the option to purchase this care privately or rely on family members to support them. However, many older people will not have these options available to them. Further work would have to be undertaken in order to establish what the impacts are on those no longer receiving any care at home service.

2.3.8 A challenge for the sector, therefore, is to ensure more older persons with intensive care needs are cared for in the community without compromising the care of older persons who require lower levels of support, as this may have adverse consequences in the long term.

2.4 Care at Home Organisations and Workforce

2.4.1 In 2013, there were 814 services registered to provide care at home services in Scotland[2]. Of these, 72% were registered to provide care at home combined with housing support services, and only 28% provided solely care at home support.

2.4.2 The three sectors providing care at home are local authority, private and voluntary. Whilst the voluntary sector make up slightly more than half *(51%)* of organisations in the sector, they actually provide a service for only 6.0% of home care clients[3]. The reason for this is the majority of voluntary care at home providers are very small scale. Almost a third employ less than ten staff and a further 51.7% employ between ten and fifty staff.[4]

2.4.3 Thus the majority of care at home services in Scotland are provided almost evenly between local authorities and private companies. Between the two they provide 78% of all hours of care at home in Scotland and provide a service for 93.6% of all clients. **"Local authorities only"** provide 40% of all hours of care at home and **"private companies only"** provide 38% of all hours[5]. This pattern of provision has changed markedly over the last decade. In 2003, for example, almost 70% of all hours were provided by local authorities andonly 15% of hours were provided by the private sector. Figure 12 below shows how the pattern of provision has changed over the last decade.

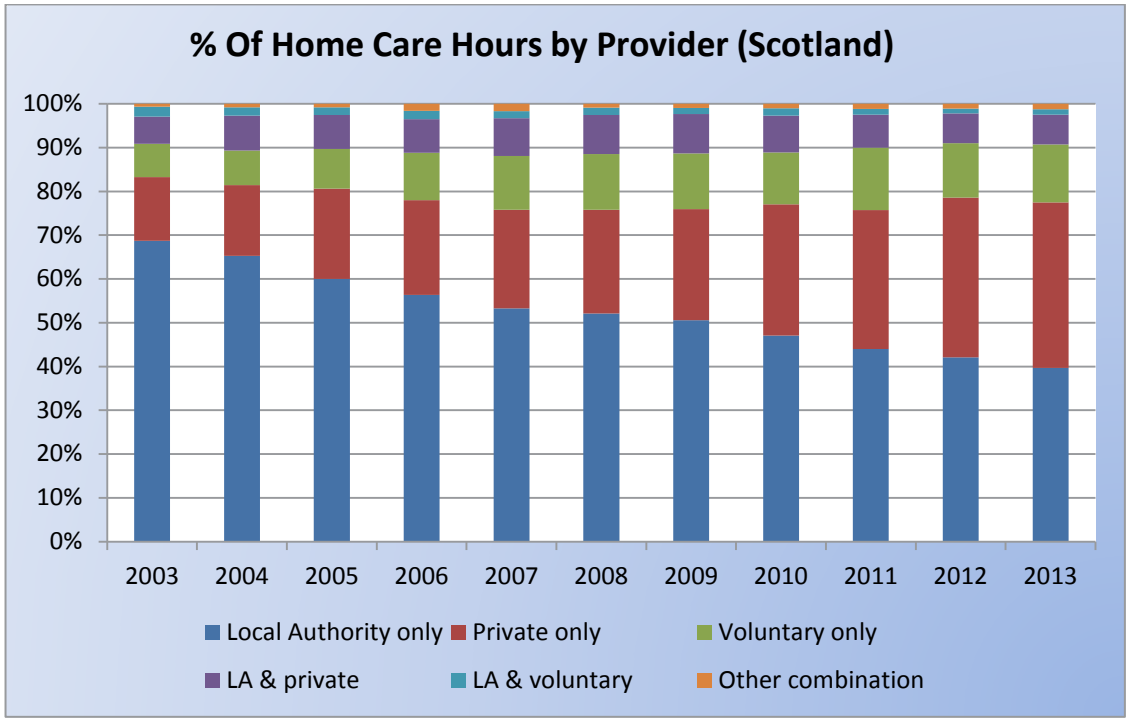


Fig.12

2 Caring for people at home: How care at home services operate in Scotland and how well they performed between 2010 and 2013, Care Inspectorate. p.7

3 ISD Number of Home Care Clients by sector of provider, 1998-latest

4 Caring for people at home: How care at home services operate in Scotland and how well they performed between 2010 and 2013, Care Inspectorate. P.16

5 See 3. above

2.4.4 The trend across Scotland has been of declining local authority provision and increasing private provision, with four local authorities in Scotland having reduced their local authority provision by more than 50%. These councils include East Dunbartonshire, East Lothian and Perth and Kinross. Argyll and Bute saw the biggest reduction in local authority provision across the period. In 2003, 92% of care at home hours were provided by the local authority but by 2013, this figure had reduced to 19%.

2.4.5 This trend has not been uniform across Scotland, however, and in some councils, the level of local authority provision has remained consistently high across the decade. For example, in the Orkney Islands, local authority provision has increased from 88% in 2003 to 100% in 2013. The pattern of provision in two other local authorities also goes against the national trend. For example, Glasgow City Council now provides 98% of care at home hours internally, up from 75% and West Dunbartonshire has increased its in-house provision of care at home from 80% to 86%.

2.5 Care Inspectorate Care at Home Quality Grades for Scotland

2.5.1 The majority of all providers of care at home services (across the local authority private and voluntary sectors) in Scotland have been graded either 'excellent' or 'very good' by the Care Inspectorate[6] for; 'care and support', 'staffing' and almost half of all providers have been awarded these two grades for 'management and leadership'. More organisations received an 'excellent' grade for their 'care and support' than for the other two categories. As Figure 13 below shows, only a small number of care at home services have been deemed to be either weak or unsatisfactory by the Care Inspectorate. 19 providers were awarded these grades for 'staffing', and 25 services for both the 'quality of care and support' and 'management and leadership'.[7]

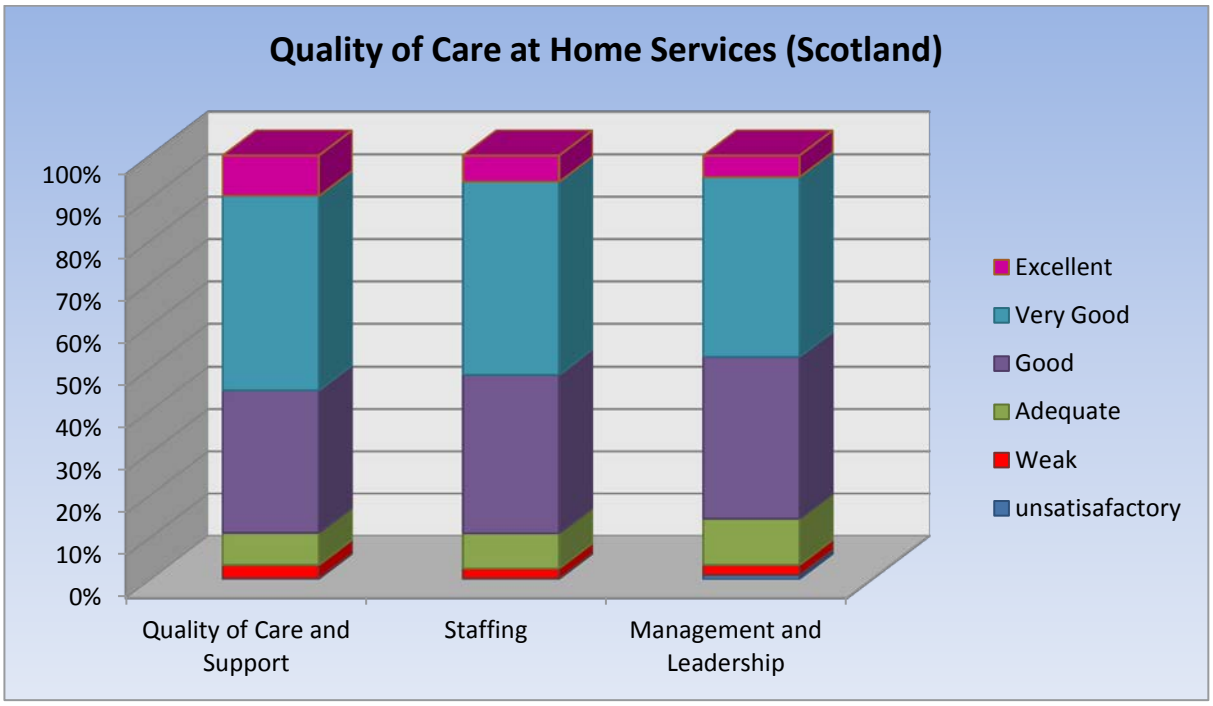


Fig. 13

6 In 2013, the Care Inspectorate moved from a 5 point Likert scale to a 6 point scale to grade services. It is therefore not possible to compare this data to previous years.

7 Caring for people at home: How care at home services operate in Scotland and how well they performed between 2010 and 2013, Care Inspectorate. p.21

2.5.2 When this data is examined geographically, in three council areas over 70% of all care at home services *(local authority, private and voluntary)* achieved either a very good or excellent grade across each of the three quality categories; these are Renfrewshire, South Ayrshire and Eilean Siar. North Lanarkshire is the only area across Scotland to have any service graded as unsatisfactory across all three quality categories.

2.5.3 It is possible to examine how providers from the three sectors were rated for each of the three quality criterion. The following chart shows the assessments of 'quality of care and support' delivered by different types of providers across the whole of Scotland. The vast majority of these organisations have received a rating of 'good' or above.

2.5.4 Some 13.7% of voluntary or not for profit organisations received an 'excellent' grade. While many private organisations received a very good or excellent grade, a small proportion 6.3% of private organisations received a 'weak' or 'unsatisfactory' grading- higher than the other two providers.

2.5.5 The grades for service providers followed the same pattern for the other two quality criterion, i.e. 'quality of staffing' and 'management and leadership'. In other words, a greater proportion of voluntary sector providers were graded as excellent compared to providers from the other two sectors and as before, a greater proportion of providers from the private sector were graded as weak or unsatisfactory.

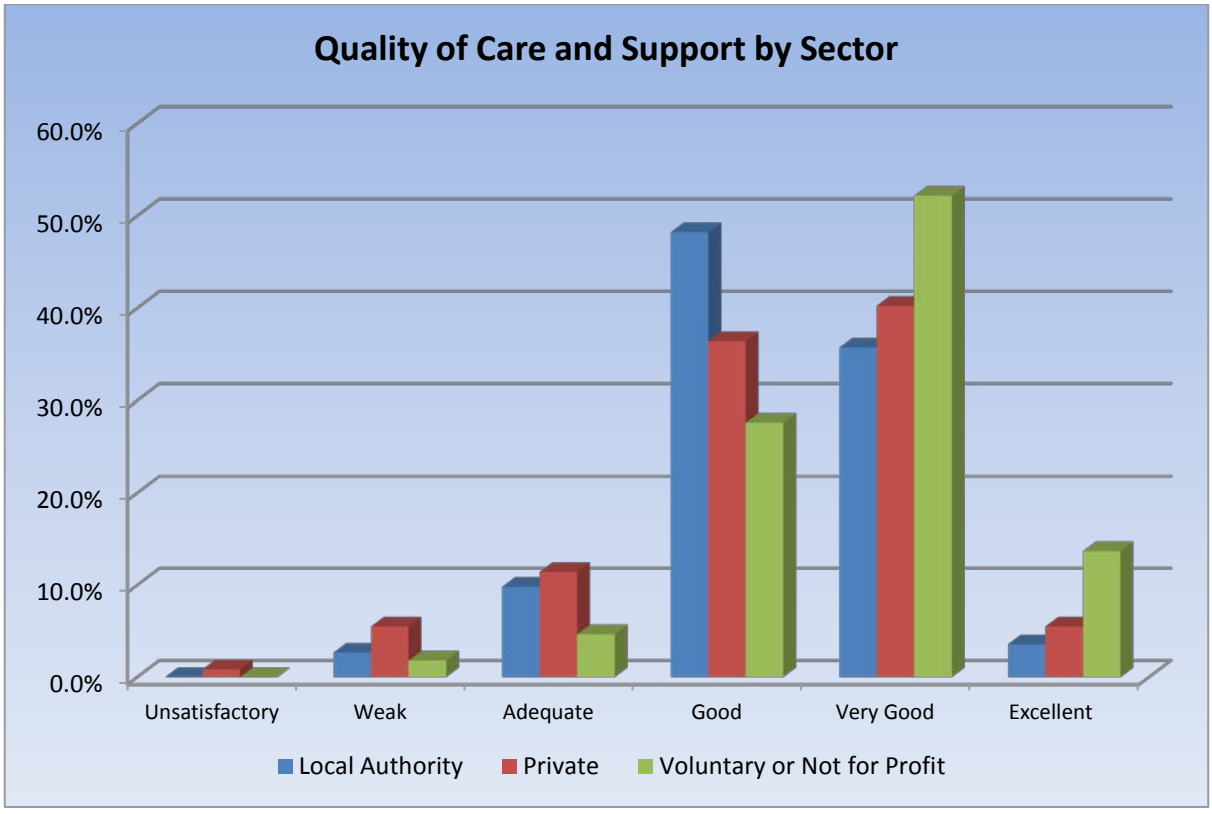


Fig.13

2.6 Care at Home Commissioning

2.6.1 In 2012, Audit Scotland produced a report titled Commissioning Social Care that looked at how councils and the NHS worked together to plan and commission services to provide social care and reduce expenditure on unnecessary hospital and residential care. Even at this time, it was found that only eleven of the thirty-two council areas had commissioning strategies covering all social care services. Eight of these were analysed by Audit Scotland in more detail and it was found that none of these contained a full analysis of current service provision for each of the care groups. Audit Scotland was critical of this and suggested that any strategy should include, as a minimum, elements such as quality, cost, capacity and accessibility of all services in the area. While councils felt that they had good relationships with providers and involved them in this strategic process, providers stated that they were often not involved in this process and if they were, they were not listened to.

2.6.2 More specifically, providers expressed concerns with councils about the perceived protection of in-house services while freezing or reducing funding to the independent and voluntary sectors.

2.6.3 Providers described the nature of the relationship between themselves and councils as one in which it is difficult to challenge councils around commissioning issues. However, providers understood that the current climate in which commissioning is carried out by councils is greatly affected by budget constraints. Audit Scotland noted that as well as these budget constraints, the commissioning process has become more complex due to increasing demand, population change and moves towards more personalised care. However, the report notes that providers have found the current care at home market to be very challenging, with provider organisations having to implement pay freezes, reduce staff numbers and change the terms and conditions of their staff's contracts.

2.6.4 The Scottish Government issued guidelines about commissioning following South Lanarkshire's utilisation of an E-auction process to purchase care services. This was deemed inappropriate for commissioning care at home services by the Scottish Government, citing that a focus solely upon costs with no or little consideration of quality or outcomes for older people was not a practise to be encouraged.

2.6.5 The United Kingdom Home Care Association *(UKHCA)* have produced a report[8] which focuses on the monetary aspect of the commissioning process. The aim of the report was to provide an answer to the question 'What is the minimum price for an hour of home care?' A model was constructed to arrive at a robust minimum price based on the Minimum Wage, the Living Wage and Living Wage in London. The prices were £15.74, £18.59 and £21.33 respectively. One criticism of the model was that it did not take enough account of local conditions. The president of the Association of Directors of Adult Social Services *(ADASS)*, Sandie Keene has said that:

> **"We're strongly recommending that people use the UKHCA model to work through with providers alongside looking at all local conditions that would then determine what is a reasonable price for care... but there isn't a set amount for the price of home care because of course it costs very different amounts of money depending on where people are in the country, whether it's a rural area or a city and urban area."**

2.6.6 Such a model would be useful as part of supporting the commissioning process in Scotland. However, some recognition of the extreme rurality facing some providers combined with issues of quality and outcomes for older people would have to be included. Current prices being paid to providers of care at home in Scotland, which amount to an average price of £13.68, are lower than those suggested in the model according to UKCHA[9]. Within this average there is evidence of higher prices in rural areas, with the average price in Western Isles Council being £15.70[10]. The only area in Scotland where the average price paid for an hour of care at home services was greater than that suggested by UKHCA's minimum wage model is Highland Council, where the average price paid was £15.97.

8 UKHCA Briefing A Minimum Price for Homecare Version 2.1, November 2014

9 UUKHCA Summary An Overview of the Domiciliary Care Market March 2015

10 UKHCA The Home Care Deficit A report on the funding of older people's homecare across the United Kingdom Version 1 | March 2015

2.6.7 Another issue raised by providers in relation to their commissioning frameworks was the different commissioning criteria providers had to comply with in order to bid for contracts. In research commissioned by Scottish Care in 2013, this point was noted, with one provider stating,

> **"We are on the framework for one Council and exceed their quality standards- but did not qualify with the same business and quality model for the adjoining Council."**

2.6.8 The concerns noted above by providers in terms of contractual and funding arrangements are even more acute for the large number of very small organisations, particularly the large number of small voluntary organisations, which exist in this sector. Research undertaken by the authors on behalf of CCPS in 2003 shows that similar issues around the commissioning of social care were also prevalent over a decade ago.

2.7 Care at Home Workforce

2.7.1 SSSC advised that it is not possible to provide the data solely for care at home staff. Instead, data is collected for both care at home and the housing support sector combined. In 2013, there were 62,170 workers employed in the care at home/housing support sector across 1,875 separate companies[11]. Staff within the care at home/housing support sector comprise 2.4%[12] of the entire Scottish workforce. Both the number of companies employing care at home/housing support staff and the number of workers employed has reduced since 2011. The number of registered services has reduced by 0.3% and the workforce has reduced by 3.3% over this time. The median staffing complement in each of the three sectors is 21 employees in voluntary sector organisations, 25 employees in public sector organisations and 26 in private organisations[13].

2.8 Characteristics of Workforce

2.8.1 The care at home/ housing support sector is predominately female – with 81% female and 19% male.[14] The median age of the entire care at home/ housing support workforce is 46. There is little difference in the median age of those working in the private sector and voluntary sector- 43 and 44 years respectively. Those employed in the public sector are slightly older – with the median age being 49 years old[15].

2.8.2 Three quarters of the workforce are employed with a permanent contract. However, over 15% are either employed on an agency, bank, sessional or casual contract *(the remainder of staff are employed on a permanent contract but with no guaranteed hours or fixed term)*.

Geographical Variations in Workforce Profile

2.8.3 Figure 14 below shows the geographical variation across Scottish local authority areas in terms of the gender of the entire care at home workforce *(across local authority, private and voluntary sectors)*. This ranges from 70.1% of the workforce being female in South Lanarkshire to 90.8% in Highland[16]. It is interesting to note that most of the local authority areas classified as Large Urban or Other Urban in Scotland using the Scottish Government's Urban Rural Classification[17] have below average proportions of females in their workforce. For instance, Glasgow City Council, West Dunbartonshire, North Lanarkshire, City of Edinburgh Council, Renfrewshire, Inverclyde, East Renfrewshire and Dundee City have a higher than average proportion of males in their care at home workforce.

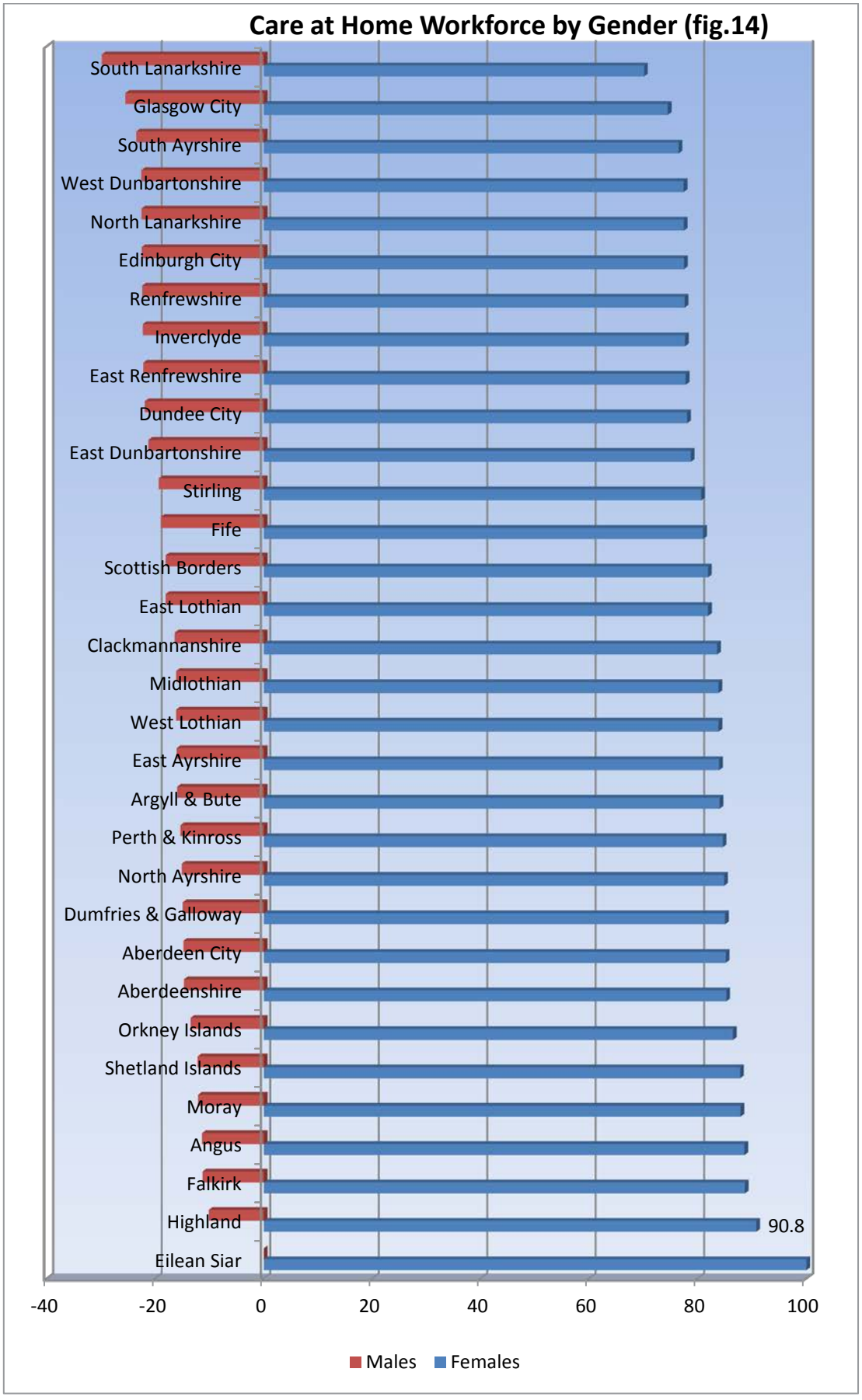
2.8.4 Conversely, many of those local authority areas defined as Remote Rural, such as Eilean Siar, Highland, Orkney, Shetland and those described as Accessible Rural, such as Moray, Aberdeenshire and Angus have an above average female proportion of the workforce in the care at home/ housing support sector.

2.8.5 This data was tested statistically to determine the strength of correlation between the percentage of females in the care at home/ housing support workforce and rurality in Scotland[18].The test showed that the more rural an area, the more likely it is to have a greater proportion of females employed in the care at home workforce.

11 Scottish Social Services Council: Report on 2013 Workforce Data p.7, p.9

12 Ibid p.7 13 Ibid p.21 14 Ibid p.26 15 Ibid p.22

16 It should be noted that figures on gender from Eilean Siar (100% female) do not include those from the local authority as insufficient individual records were available, only private and voluntary organisations i.e. the figures are based on 60 out of a total 420 workers. We have therefore excluded them.



17. Data for rurality was extracted from the 6 fold classification in the Urban Rural Classification Population Tables (2012) from the Scottish Government.

18 The test applied was the Pearson's Product Moment Correlation Coefficient. The correlation was r=0.66 showing a strong positive correlation between these two variables.

2.8.6 A similar pattern emerges when we examine the geographical spread of the care at home/ housing support workforce by age. As with gender, this data is for the entire care at home/ housing support workforce from local authority, private and voluntary providers. This data is presented in the following figure and shows the proportion of this workforce aged under 45 years old and those aged 45 and over.

2.8.7 Of the five local authority areas with the highest proportion of their care at home staff aged 45 and over, four are defined as Remote Rural and one as Accessible Rural *(Eilean Siar,Shetland, Highland, Orkney and Moray)*. Eilean Siar has 71.4% of its workforce aged 45 and over while Shetland has 61%. In terms of workforce planning in the coming years this will be a pressing issue for Eilean Siar, where currently over a quarter of the care at home workforce are aged 65 and over. This ageing workforce is exceptional in Scotland, even amongst the other four councils who have a similar age profile in their general population,with just under a quarter of the total population aged 65 and over[19].

2.8.8 As with gender, there appears to be a significant link[20] between an older workforce and rurality. The five local authority areas with higher proportions of this workforce under 45 are defined as Large Urban or Other Urban, with one mixed. These are Falkirk, East Lothian, City of Edinburgh, Clackmannanshire and East Renfrewshire. Falkirk has only 34% of this workforce aged 45 and over with East Lothian having 39.3%.

19 http://www.gro-scotland.gov.uk/statistics/theme/population/estimates/mid-year/mid-2013/list-of-tables.html Table 3

20 r=0

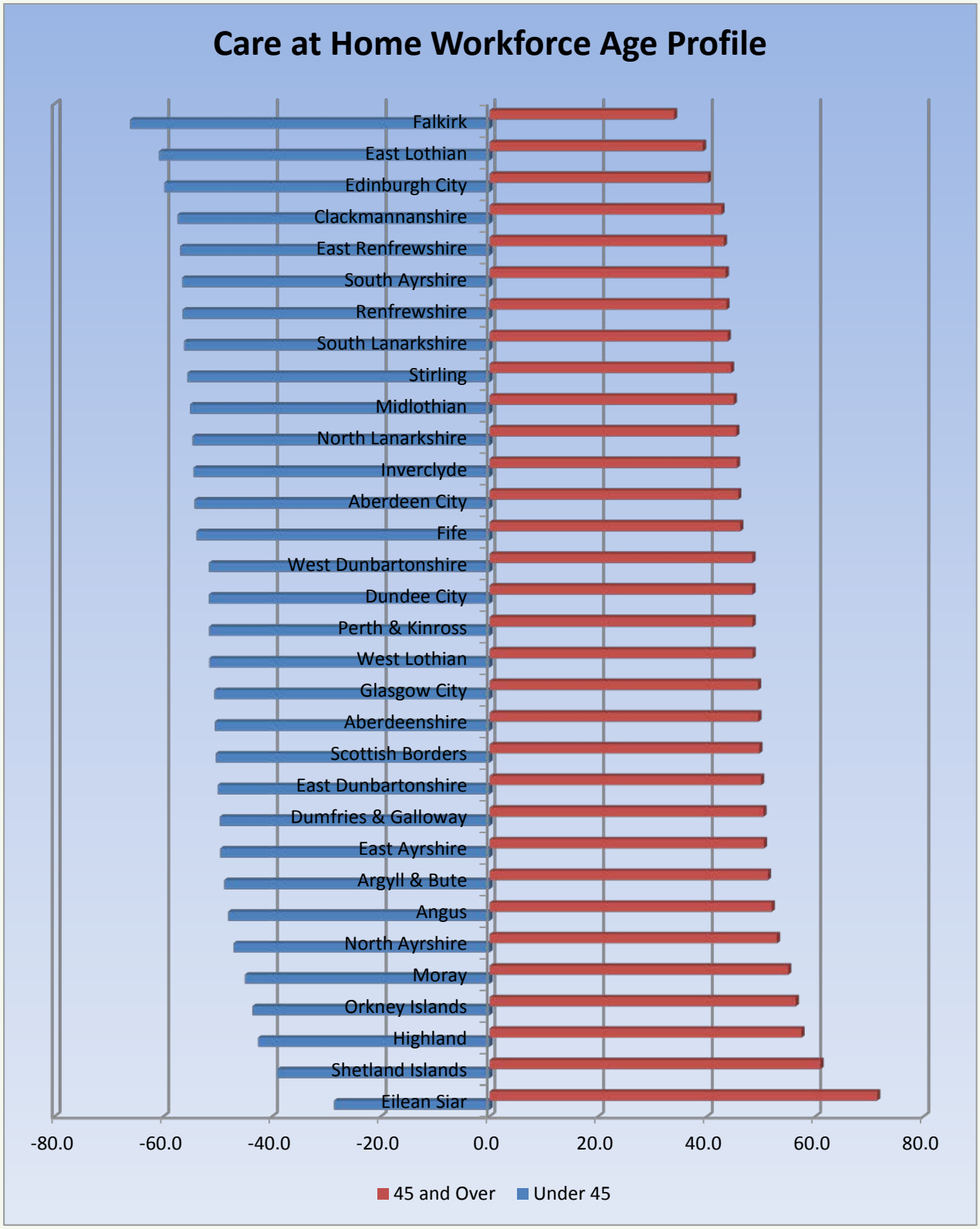

Care at Home Workforce Age Profile
Falkirk
East Lothian
Edinburgh City
Clackmannanshire
East Renfrewshire
South Ayrshire
Renfrewshire
South Lanarkshire
Stirling
Midlothian
North Lanarkshire
Inverclyde
Aberdeen City
Fife
West Dunbartonshire
Dundee City
Perth & Kinross
West Lothian
Glasgow City
Aberdeenshire
Scottish Borders
East Dunbartonshire
Dumfries & Galloway
East Ayrshire
Argyll & Bute
Angus
North Ayrshire
Moray
Orkney Islands
Highland
Shetland Islands
Eilean Siar
-80.0
-60.0
-40.0
-20.0
0.0
20.0
40.0
60.0
80.0
45 and Over
Under 45

Fig.15

2.8.9 As with gender and age, occupational status also appears to be greatly affected by rurality. Once more, this data is for the entire care at home/ housing support workforce from local authority, private and voluntary providers. The figure below shows that the local authority areas with the highest proportions of the workforce in part time contracts are from Remote Rural areas. Some 86.1% of the care at home workforce in Orkney are employed on part time contracts alongside 85.7% in Eilean Siar and 80.5% in Shetland. This contrasts sharply with the proportion of staff in full time contracts from more urban and mixed areas. Clackmannanshire has 39.1% of this workforce on part time contracts while West Lothian has 40.8%. For the largest cities, Glasgow City Council has some 54% on part time contracts and Edinburgh City Council has 55.2%. These are slightly lower than the median figure of 57.9% of the workforce on part time contracts across Scottish councils.

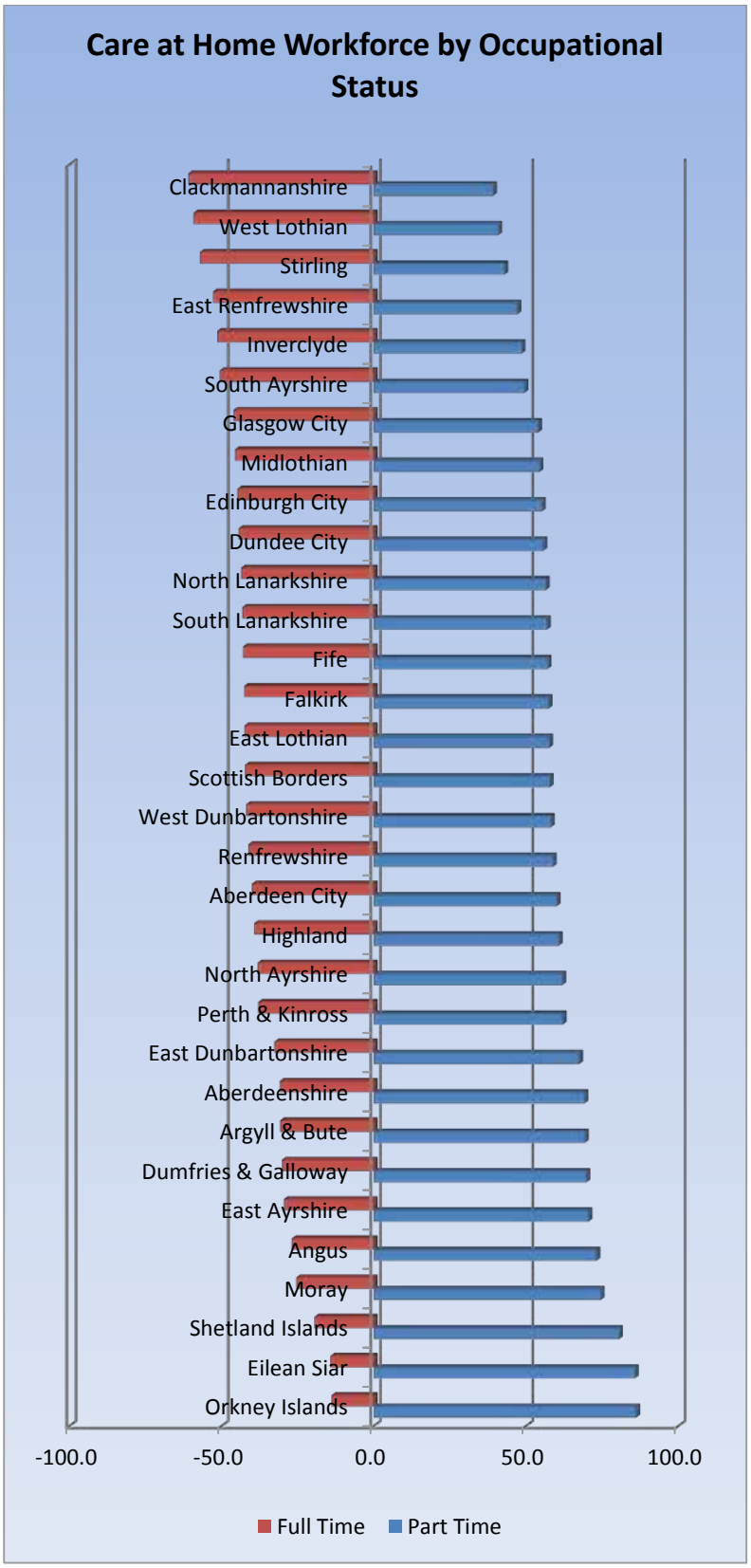


Fig.16

2.8.10 It is clear that for many rural councils, the care at home/ housing support workforce tends to have a higher proportion of women, a higher proportion of older workers and are much more likely to have full time contracts compared to their colleagues in more urban councils. It may be that the difficulty to attract and retain staff in very rural areas necessitates the offer of more full time contracts than in more urban areas.

2.9 Pay Rates of Workforce

2.9.1 There is currently no national or UK data about the pay of care workers. This data used to be collected as part of the core minimum dataset by SSSC, however, due to poor quality of data returned, it no longer forms part of this dataset. In order to provide some data on pay rates amongst care staff, a separate exercise was carried out by Scottish Care as part of this report. The exercise sought to ask members of Scottish Care to provide pay rate data for both qualified and non-qualified care staff through a survey exercise. 46 companies responded to the survey, with 27 companies returning data specifically on pay rates. Companies operating across the whole of Scotland have been excluded from the figures below.

2.9.2 Figures 17 and 18 below show the rates of pay for qualified *(SVQ2 or above)* and non-qualified care staff. Both figures show pay rates for each of the companies, including the local authority in which each company is based. Not all geographical areas in Scotland are represented in the returns.

2.9.3 Pay rates for non-qualified staff range from the National Minimum Wage of £6.50 in companies operating in Glasgow City Council and Aberdeenshire to £8.10 in Aberdeen City. Even within a particular local authority area there can be considerable variation in pay rates. For example, in Aberdeenshire, pay rates vary from £6.50 to £8.00.

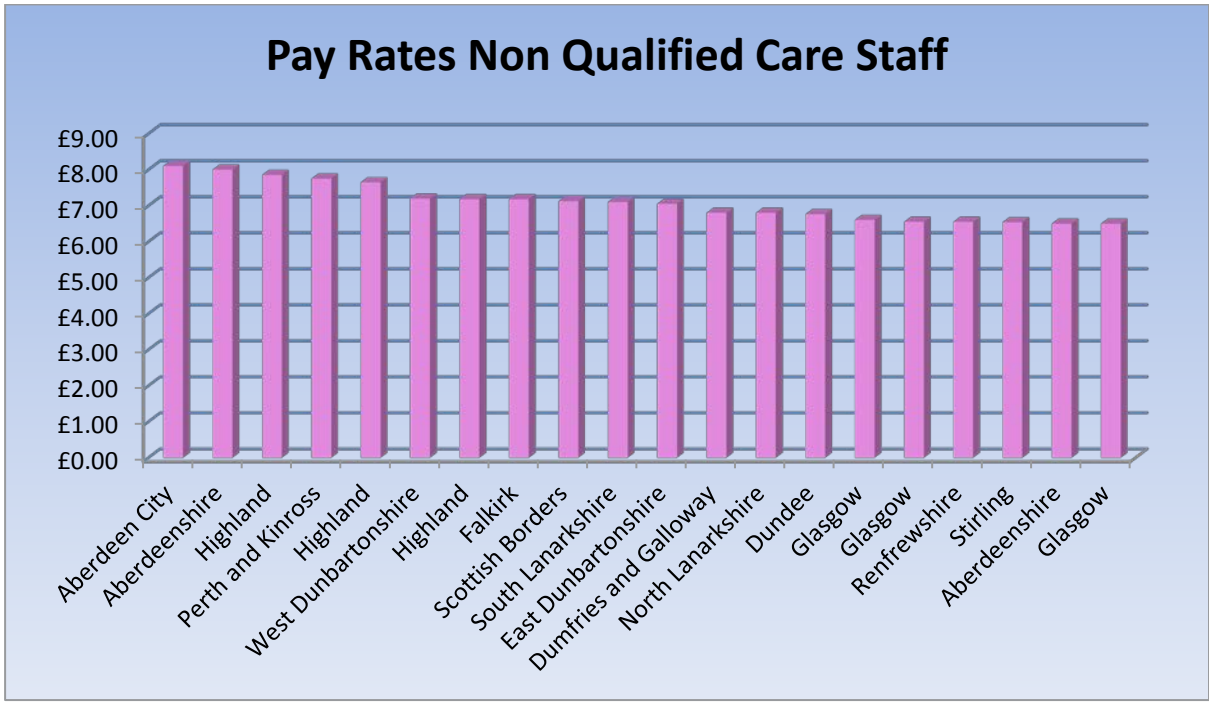


Fig.17

17. Data for rurality was extracted from the 6 fold classification in the Urban Rural Classification Population Tables (2012) from the Scottish Government.

18 The test applied was the Pearson's Product Moment Correlation Coefficient. The correlation was r=0.66 showing a strong positive correlation between these two variables.

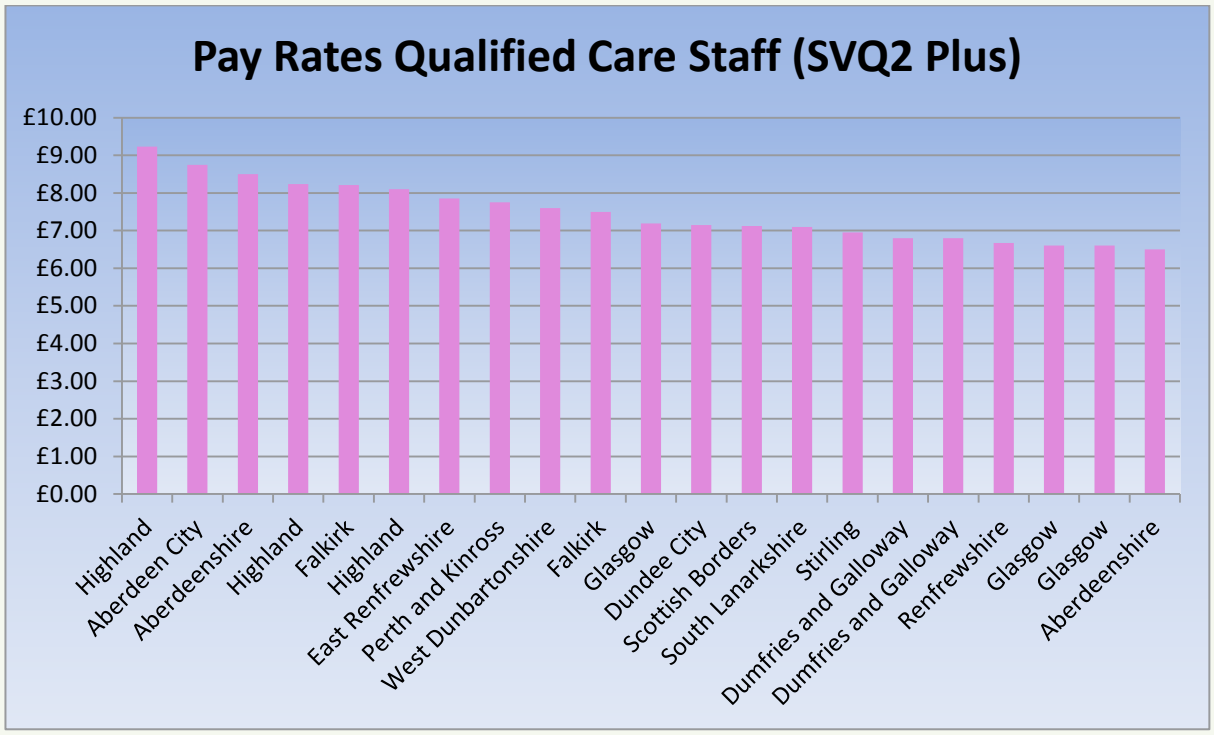


Fig.18

2.9.4 Figure 18 shows the pay rates for qualified staff across Scotland and these range from £6.50 for a company based in Aberdeenshire to £9.23 for one based in Highland Council. While the rates of pay are generally higher for qualified and non-qualified staff in the north of Scotland, it should be noted that this is not always the case, with one company in Aberdeenshire paying both qualified and non-qualified staff the Minimum Wage. The survey does not provide information on the reason for differential rates of pay across Scotland, but it is most likely due to supply and demand issues in the workforce in terms of employment opportunities across Scotland.

2.9.5 While it is clear that there are variations in the rates of pay for care workers across Scotland, it is also important to compare these rates of pay in the care at home sector to national average rates of pay. Such a comparison will allow some assessment of how this workforce and by extension the care profession generally is valued in terms of pay compared to others across Scotland. Comparison data has been extracted from the NOMIS dataset which conducts an annual survey of hours and pay rates by a range of criteria across the UK. In terms of this exercise, data has been extracted to provide the average hourly pay for a female full time worker in Scotland, which is £14.28 per hour or £10.91 for a part-time female worker. Both full time and part time national rates are considerably more than the average for qualified staff *(£7.67)* and for unqualified staff *(£7.16)* based upon the 27 companies in the care at home sector.

2.10 Summary of Workforce and Organisational Issues

2.10.1 Over the decade the care at home market has changed substantially. Local authorities now contract out more than half *(60%)* of all care at home hours, having previously provided almost 70% of care at home hours in-house in 2003. Local authorities are therefore more reliant on the independent (private and voluntary) sector and the commissioning of services is more important than ever. Despite this, there is recent evidence to suggest that the commissioning process remains problematic. More broadly, some of the concerns raised by Audit Scotland include the lack of strategic commissioning by local authorities and health boards in Scotland, with issues such as quality, cost and capacity often lacking in the joint strategies.

2.10.2 More specifically, however, independent sector providers interviewed by Audit Scotland felt that they were not involved enough or at all in the commissioning process. It is difficult to see how a detailed and developed outcomes-based approach can be achieved without the full participation of those commissioned to provide care at home services.

2.10.3 As well as commissioning issues, the challenge that has faced the sector over the past decade has been to provide more hours of care with fewer staff. What's more, the care itself has shifted towards older persons with more intensive care needs.

2.10.4 The data above has shown that there are a number of workforce related issues for the sector. While there is local variation in terms of the composition of the care at home workforce, as a whole it remains predominately female, and employs a workforce that is older than would be expected given the age profile of Scotland's working age population. In terms of workforce planning, these factors taken together pose considerable challenges in terms of recruitment and retention in the sector. With such low pay rates combined with the challenging work environment that employees face, the sector will find it increasingly difficult to attract quality staff. As one voluntary sector focus group participant noted:

> **"Why would people put up with increasingly challenging and dangerous behaviours from clients, reduced wages, and lack of understanding from commissioners, when they could earn as much sitting on a till [21]."**

2.10.5 As well as these workforce issues, the care at home sector also faces possible demand challenges as a result of the Reshaping Care agenda. For example, if the Reshaping Care agenda is successful in 2014-15 then there will be a greater demand for care at home hours and residential places to support step up/step down provision, as well as implications for other health and social care professionals who support intermediate care.

2.10.6 It is important that work is undertaken to ascertain the potential capacity for independent providers of care at home and care homes to be able to progress the Reshaping Care agenda by meeting the increased demands placed upon them. It will be important that a strategic review is undertaken to assess the potential to increase the provision in the sector. As the profile shows in this report, over 15% are employed on zero-hours or temporary contracts. It may be that from within this pool of workers, a significant number of additional hours could be provided. However, it may equally be the case that this pool may be unable to meet the additional capacity required and that further recruitment into the sector will have to consider the pay and conditions for new workers to meet this demand.

21 Audit Scotland Commissioning of Social Care 2012

Section Three

scottishcare

The voice of the independent care sector in Scotland

The Care Pound

3.1 Introduction

3.1.1 The previous section profiled the care at home sector by examining data across a number of criteria including the number of older persons in receipt of care, the intensity of care and the number of people employed to provide the care services. This section, however, will focus upon the cost of providing care at home to the over 65s. More broadly it will consider how the 'Care Pound' in Scotland is spent. That is, the section will examine the level of expenditure that is currently spent on different types of social and health care and what care could be provided if the care pound was used for alternative care pathways.

3.1.2 Expenditure on care at home will be examined alongside expenditure on residential care. As well as this, NHS spending on emergency admissions and expenditure on delayed discharge for the over 65s will also be considered. To assist understanding of Care Pound expenditure, a modelling approach will be adopted in order to demonstrate what anticipatory and preventative services could be provided as an alternative to inappropriate emergency hospital admissions and delayed discharge. This will involve illustrating the number of older persons that could receive care at home packages or residential care if the money used for inappropriate emergency admissions and delayed discharges could be used for these purposes.

3.1.3 The approach does not assume that monies associated with savings due to reductions in emergency admissions and delayed discharges, set within Scottish Government Health targets *(HEAT)* targets, could wholly or even easily be released and utilised to provide more care at home provision. Instead, the model simply provides a clear demonstration of the levels of alternative care that could be provided for the same levels of expenditure that are currently utilised on emergency admissions and delayed discharges..

3.2 Levels of Care Expenditure in Scotland

3.2.1 In Scotland in 2012-13, £458.027 million[22] of public expenditure was spent on care at home for the over 65s, providing a service for 50,354 people. This expenditure has increased over the last three years by 5.3%, largely as a result of more hours of care at home being provided in Scotland.

3.2.2 At the same time, expenditure on residential care over the same period has reduced by 7.2% to £581.694 million *(See Appendix 3, which also provides council level expenditure)*. While overall expenditure on residential care remains higher than that for care at home, as Figure 19 below shows, the gap between the two is clearly narrowing. This is in line with the policy drive to shift the balance of care towards providing more care in the community. If the pattern of the last three years persists, it is likely that by the end of the decade expenditure on care at home will outstrip that of residential care, thus showing the growing importance of the care at home sector.

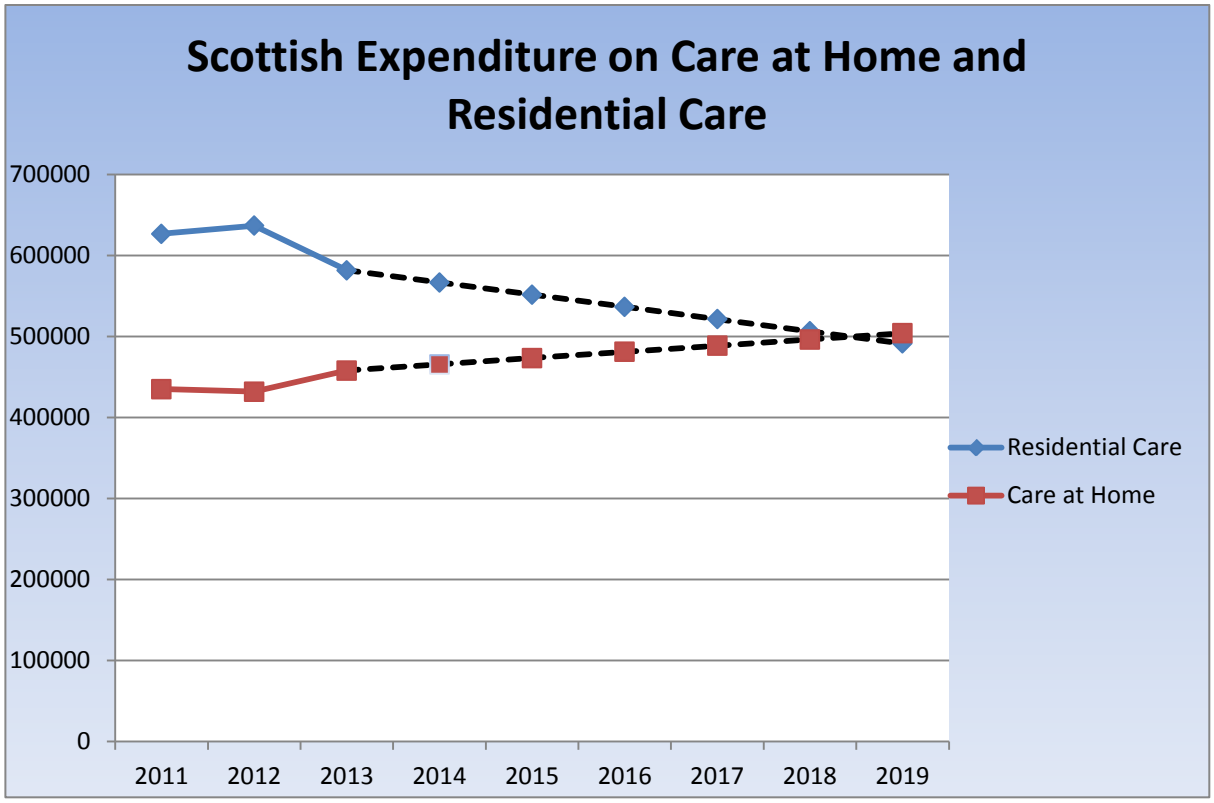


Fig 19.

22 Data from Improvement Service Benchmarking Framework see Appendix 2 (which also provides Council level Expenditure)

3.2.3 While these figures reflect a shifting balance of care at a national level, not all councils have followed this pattern of reduced expenditure on residential care at the same time as increased expenditure on care at home. For example, twelve councils in Scotland actually reduced their expenditure on care at home over the period. However, it should be noted that a reduction in care at home expenditure as is the case in East Lothian Council *(see Appendix 2)* does not necessarily mean that the council is not making inroads into shifting the balance of care. In East Lothian, despite the fact that expenditure in care at home has reduced, across the same period they have actually increased the numbers of care at home hours provided. One explanation for this may be that savings in East Lothian's budget have been achieved by increasing efficiencies.

3.2.4 It should be noted that the combined expenditure for care at home and residential care is less than that for emergency admissions into hospital for the over 65s, which in 2012-13 was £1.39 billion (See figure 20 below).

3.2.5 In fact, the costs of emergency admissions for over 65s account for a third of the total costs of providing health and social care for older people in Scotland, which was estimated at £4.5 billion in 2007-08[23]. Other areas of expenditure that make up this total include prescribing, community care, other hospital care, other social work and Family Health Service *(FHS)*.

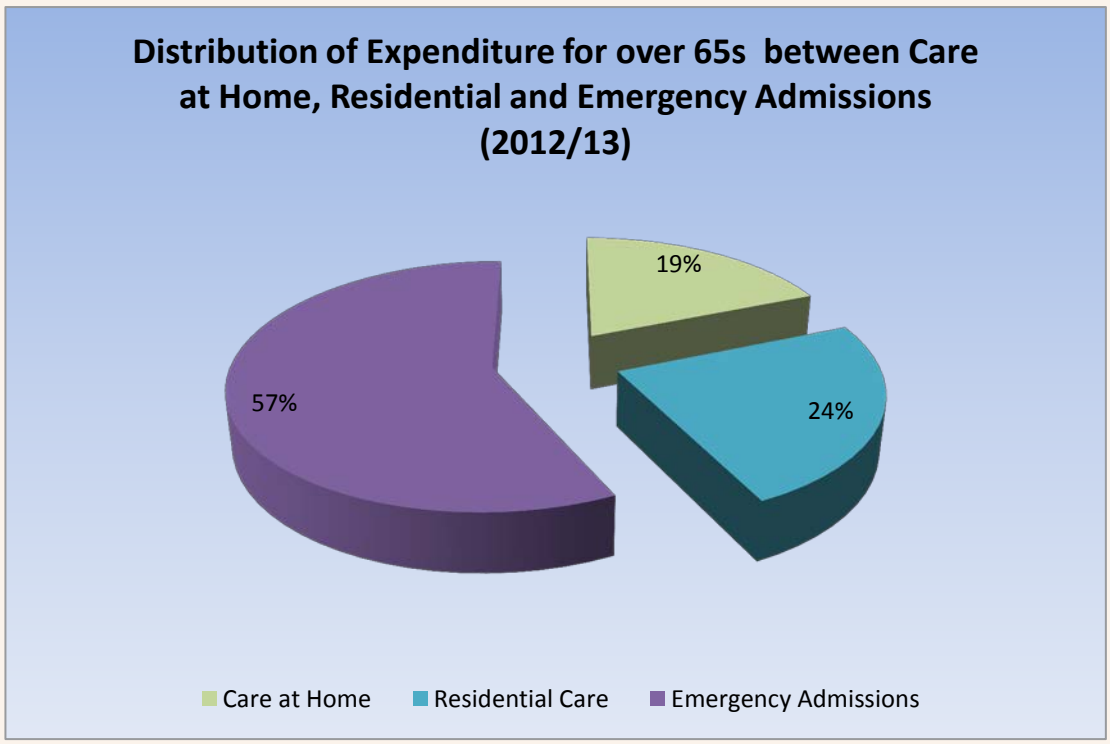


Fig 20.

23 Reshaping Care for Older People: A Programme for Change 2011-2021. Scottish Government, COSLA and NHS Scotland

3.3 Modelling the Care Pound

3.3.1 The recent Reshaping Care for Older People report, as noted in the introduction, has highlighted the issue of shifting the balance of care. The report focuses specifically on hospital care and the need to reduce inappropriate emergency admissions as well as the length of stay following admission.

> **"Many admissions are absolutely necessary and cannot be avoided. Some however can be avoided - if we take the right preventative action and if we ensure that good effective alternatives are available in the community."**
>
> **Reshaping Care for Older People: A Programme for Change 2011-2021. Scottish Government, COSLA and NHS Scotland**

3.3.2 One health board, NHS Glasgow, undertook their own audit of emergency admissions and concluded that 20% of these admissions could have been avoided.

3.3.3 The report concludes that 'resource release' is possible from emergency admissions. However, the report does note the difficulties, both practical and political, of achieving resource release from hospitals. It is nevertheless valid to consider alternative means of utilising resources that are currently being consumed by higher than desired levels of emergency admissions and delayed discharges from hospitals, given the political drive to reshape care as well as the national HEAT targets in these areas.

Emergency Admissions

3.3.4 The following section provides a model that gauges the level of expenditure consumed by emergency admissions and considers alternative forms of care that could be purchased with the same expenditure.

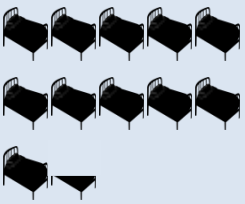
Emergency Admission		1 average admission
Care at Home		27.7 care at home clients for one week
Residential Care		9.28 weeks of residential care

Fig 21.

24 Average hours per week is the product of total number of hours of Care at Home for Scotland for over 65s 430,071 (IS Benchmarking data, Appendix 6) divided by the total number of older clients 50,354 (see fig. 1). Average hourly cost of home care (£20.48) was taken from IS Benchmarking data.

25 £522 is the average of 'without nursing care' and 'with nursing care 'costs for publically funded residents. From: Care Home Census 2013, ISD Scotland

3.3.5 In 2012-13, some 232,269 over 65s were admitted as emergency admissions to hospitals across Scotland. In total, these admissions accounted for 2,744,740 bed days which means that the average emergency admission lasted for 11.8 days per person *(see Appendix 4)*. An important part of the modelling required the development of an average cost per emergency admission. This was calculated utilising ISD Cost Reports as well as NHS length of stay data following an emergency admission. From this, the cost per average emergency admission was calculated at £4,846.62 *(see Technical note for full methodology and Appendix 5 for relevant costs)*. The model allows comparison between the average cost of an emergency admission with alternative forms of care.

3.3.6 The model compares the cost per average emergency admission to both average care at home costs and residential care costs. As Figure 21 below shows, the cost of one average emergency admission could alternatively be used to purchase an average week of care at home provision for 27.7 older persons *(based on the average of 8.5 hours of care at home per older person costing £20.48 per hour)*.[24] The £20.48 is calculated by dividing the total local government expenditure on care at home by the total number of hours purchased or provided in-house. Likewise, for the same level of expenditure, it would be possible to purchase 9.28 weeks in a residential care home *(based on the average cost of a residential care placement of £522 per week[25])*.

3.3.7 It is clear from the figure above that there is great potential in terms of care that could be provided if expenditure related to inappropriate admissions to hospital of the over 65s could be utilised in a community setting. As part of the Scottish Government's response to inappropriate admissions, a HEAT target has been developed which aims to reduce the rate of emergency bed days for over 75s. Specifically the target was to reduce this rate by 12% between 2009/10 and 2014/15. The good news is that this target has been surpassed and in 2013/14 the reduction in bed days per 1,000 of the population aged over 75 was in fact 13.7% as shown in Figure 22 below.

3.3.8 Across the period of the target, this equates to a reduction of 146,407 bed days. The cost of these bed days amounts to £58,733,650.[26]

3.3.9 The figure below shows what alternative forms of care could be purchased for the same spend. For the same level of expenditure, an additional 7,282 older clients could receive care at home for a year *(based on an average package of 8.5 hours per week and cost of £20.48 per hour)*. Similarly, 2,440 older persons could receive care for a year in a residential care home *(assuming an average weekly cost of £522)*.

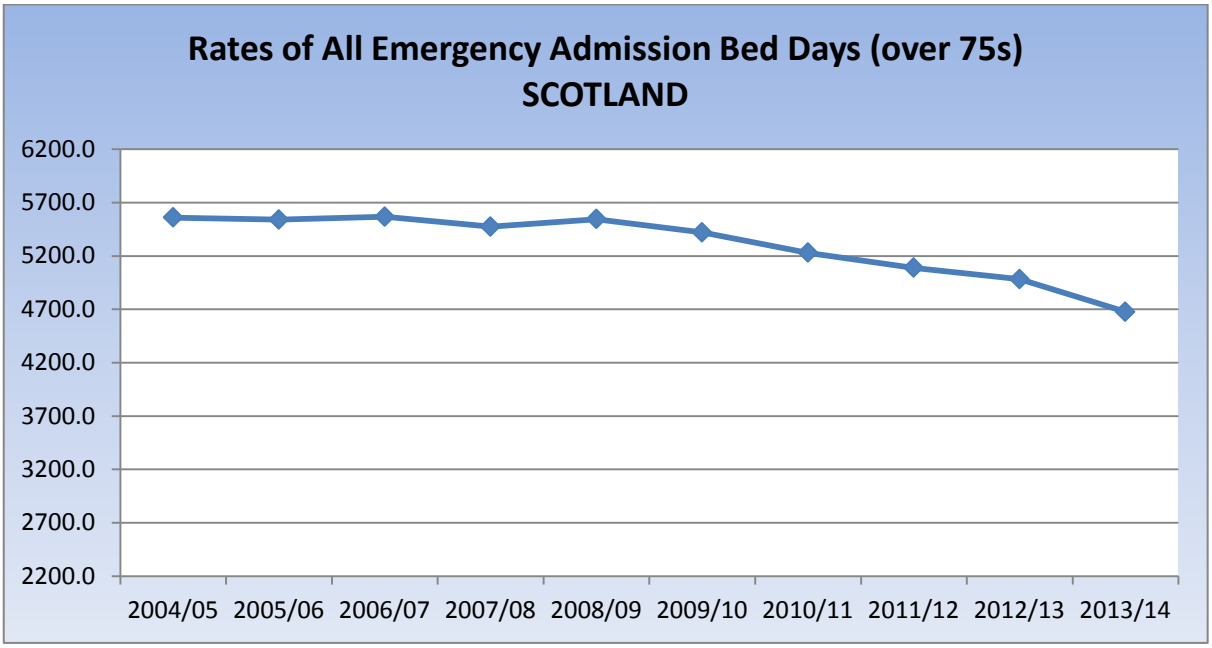


Fig 22.

26 £58,733.650 is a product of the number of bed days saved over 4 years (146,407) multiplied by cost per day in general hospital (£401.17 See Appendix 5)

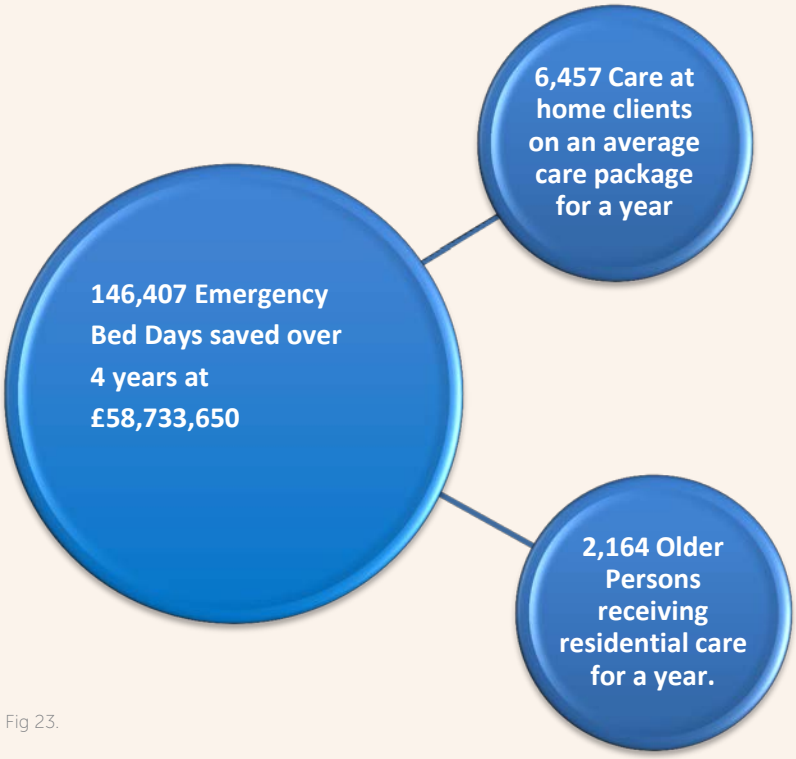


Fig 23.

Delayed Discharge

3.3.10 Another important area in the debate about Reshaping Care is delayed discharge from hospital. NHS Scotland define a delayed discharge as:

> **"a hospital inpatient who has been judged clinically ready for discharge by the responsible clinician in consultation with all agencies involved in planning the patient's discharge and who continues to occupy a bed beyond the ready for discharge date.[27]"**

3.3.11 There are a number of primary reasons as to why an individual can experience a delay in being discharged from hospital. These include; community care assessment has either not happened or has not been completed; awaiting either funding for or availability of a care home place; waiting to go home either due to funding or awaiting social care arrangements; awaiting health care arrangements, and some 'other' reasons. In the period April to June 2014, 9 out of 1028 people who experienced a delayed discharge were delayed due to social care issues such as awaiting an assessment, a care home place or a care at home package. Around 40% are awaiting a community care assessment to be carried out or completed and nearly a fifth are waiting to go home pending social care arrangements being made.

27 Delayed Discharges in NHS Scotland Figures from July 2014 Census Publication date – 26 August 2014, ISD Scotland

28 Quarterly Delayed Discharge Figures Standard Delays (Tab 3)

3.3.12 Like emergency admissions, delayed discharge has been incorporated into the HEAT targets and NHS Boards are given two targets to reach. Firstly by April 2013, the target was to have no patients experiencing delays of over four weeks. By April 2015, this target is to have no patients experiencing delays of more than two weeks. Unfortunately the first of these targets was not met by 2013 and a considerable number of bed days are still being occupied by those whose discharge has been delayed.

3.3.13 As Figure 24 below shows[29], the number of bed days occupied by both the over 75s and all ages has increased over the last two years. The figure also usefully demonstrates that the majority of delayed discharge bed days are occupied by the over 75s. In 2014, the proportion of delayed discharge days occupied by the over 75s was 77.2%.

3.3.14 Once more, if we analyse the expenditure associated with delayed discharge bed days in terms of the Care Pound, Figure 25 below shows the levels of care that could be purchased as an alternative to what is currently spent on delayed discharge bed days for the over 75s[30]. In the quarter April to June 2014, delayed discharges accounted for 91,644 bed days.[31] The figure below shows what alternative care could have been provided[32].

3.3.15 Again, significant levels of residential and community care for the elderly could be provided for the same level of expenditure that is spent on delayed discharges. Over 1,300 older persons could receive residential care for a year, or 4,042 care at home clients could receive an average care package for a year.

3.4 Summary of Care Pound

3.4.1 This section has shown the national growth in care at home expenditure, while spend on residential care over the same period has been decreasing. This growth is due to an increased number of hours of home care being provided across Scotland, particularly due to an increase in packages of 10 plus hours. This is in line with the national policy drive to reshape and rebalance care provision to ensure that older people are able to remain at home within their communities for as long as possible. Despite the growth in expenditure on care at home this expenditure, taken alongside expenditure on residential care, is still less than what is spent nationally on emergency admissions into hospitals.

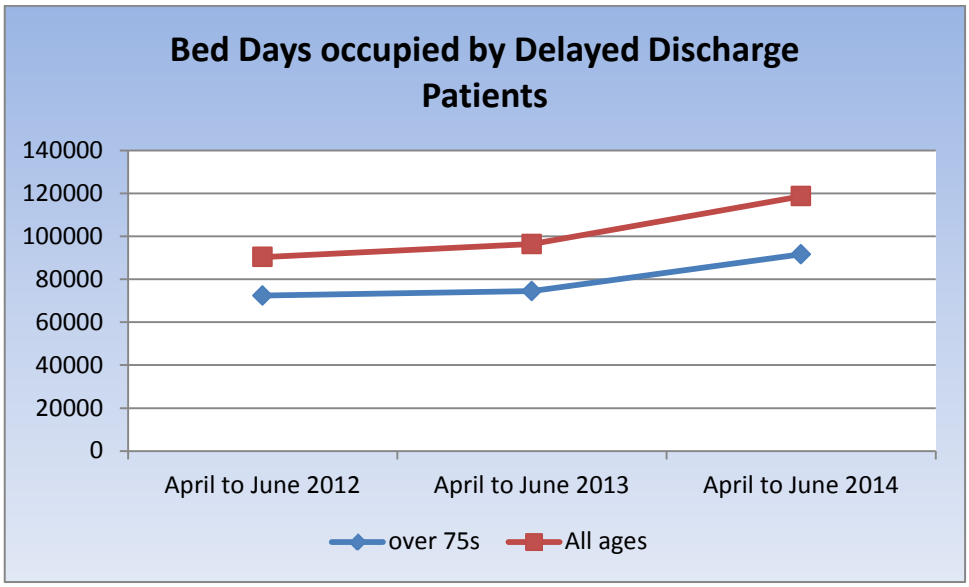


Fig 24.

29 From ISD Bed Days Occupied by Delayed Discharge (April to June 2014, Table 2). These are standard delays which exclude 'Code 9' i.e. patients delayed due to awaiting place availability in a high level needs specialist facility and where an interim option is not appropriate, patients for whom an interim move is deemed unreasonable or where an adult may lack capacity under adults with incapacity legislation.

30 Over 75s are the subject of the national HEAT target.

31 From ISD Bed Days Occupied by Delayed Discharge (April to June 2014, Table 2).

32 £36,764,548.00 is a product of the number of days due to standard delayed discharge (91,644 days for over 75s) multiplied by £401.67 (cost per day in General hospital see Technical note)

3.4.2 This section developed a modelling approach to consider how expenditure is distributed in the health and care sector and to specifically consider what the Care Pound buys. It has shown how many people can be supported at home or in a residential care setting for each emergency admission to hospital. As well as this, it has shown what can be provided if a similar level of expenditure associated with the bed days saved through the emergency admission HEAT targets could be used to provide care at home or residential care. Finally, a similar approach was used in terms of expenditure associated with delayed discharges.

3.4.3 Our analysis in this section is based on average costs in 2012-13. It may be that the Change Fund and the innovative practice that it has facilitated will lead to an increase in the cost of both care at home and residential care as more intermediate care is provided. By definition, intermediate care suggests a lower level of intensive support than is required in a hospital setting, but a higher level of care than is required by the average care at home client. It is hoped that at the end of the Change Fund programme, cost information will be available for these types of service. It is probable that this would have a knock-on effect on the average cost to be used in any future analysis of the Care Pound.

3.4.4 The Reshaping Care Agenda and in particular the HEAT targets to reduce inappropriate hospital admissions and delayed discharges is inextricably linked with social care provision in the community. To reach these targets, sufficient levels of homecare packages, residential care placements, intermediate support, etc, are required. This is an opportunity for the care at home sector to expand. However, as noted above in Section 2, the sector faces real challenges in terms of the workforce issues already highlighted.

3.4.5 More broadly, the real challenge facing the sector is having sufficient resources to facilitate the expansion of social care in the community. The Change Fund was introduced to assist in the development of social care services to facilitate this shift in the balance of care and more specifically, to reduce levels of inappropriate hospital admissions and delayed discharge by developing intermediate and preventative services to allow this. However, the critical question to address is how these social care services are to be funded in the long term.

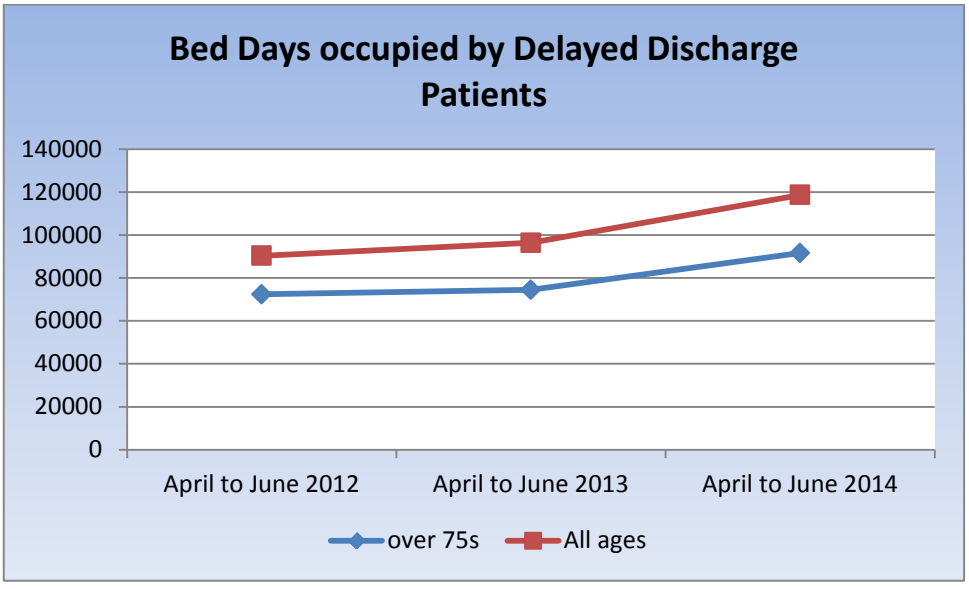


Fig 24.

Section Four

scottishcare

The voice of the independent care sector in Scotland

The Human Narrative

4.1 Introduction

4.1.1 This section provides an overview of research which has considered care at home from the clients' perspective. This is an important element in terms of completing the profile of care at home within Scotland. Only primary research from the UK has been included i.e. research based on surveys, focus groups or interviews with clients to ensure that the main focus is on a human narrative from older people using this service. Within the UK, most of the primary research has been undertaken in England. However, Scottish research in this area has been drawn upon wherever possible. The narratives have been organised around the following themes;

- The importance of the care at home service and the benefits to clients;
- Views on the quality and the quantity of service being received;
- Views on care workers and organisations providing a care package;
- Suggested areas for improvement.

4.2 The Importance of the Care at Home Service and the Benefits to Clients

4.2.1 Overwhelmingly, older people who took part in the various research studies were very positive about the role that care at home plays in allowing them to remain living in their own home in their own community. In a survey undertaken of people who access health and social care services on Westside of the Isle of Lewis *(2004)*, the vast majority of older people wanted to live in their own home for as long as possible.[33] Some 95.8% believed their own home to be the best care setting for them. Similarly, when all clients of care at home services in Perth and Kinross were asked, 93.3% believed that services should be provided in their own home.[34] Even if high quality alternative living environments were on offer in sheltered housing or residential homes, over three quarters of care at home clients still chose their own home as their preferred living environment.

4.2.2 Recent research into older people's experiences of care at home in England found similar results and, for the majority of respondents, care at home represents a lifeline that allows them to continue to live in their own home[35]. While it was suggested that older people did not necessarily welcome the fact that they now had to rely upon such services because it meant they were not managing for themselves any more, people saw it in practical terms as a good thing. It was pointed out that many people had been living at the same address for many years, and were attached to their familiar surroundings and local networks. Above all, people wanted to preserve their independence and to avoid residential care:

> **"I know that I am being looked after..., and the family are pleased because they know that without that care I would have to go into a care home. (Woman, 83, lives alone, local authority funded)"**

33 Report On The Survey Of Health & Social Care Services For Older People In Ness, Mcleod, B and Wright, M University of Strathclyde (2004).

34 Survey Responses: Perth & Kinross Joint Strategy for Older People McLeod, B. and Bennett, M. University of Strathclyde (1997).

35 Older People's Experiences of Home Care in England Sykes, W and Groom, C. Independent Social Research (2011) Equality and Human Rights Commission Research Report 79

4.2.3 In a recent study by Cordia[36] of care at home clients in Glasgow, 84.7% said that "the contact I have with home carers has improved my quality of life". Similarly, the Patient and Client Council found that over three quarters of respondents said that the home care they received improved their quality of life 'a lot.'

> **"If I didn't have the care workers I couldn't have managed on my own. Most important things for me are getting up in the morning and being put into bed."**

> **"This service is crucial and invaluable to us. Without it, my wife would be in a nursing home.** Respondents from Reading Borough Council Home Care Users Research Project April 2013"

> **"It means I can live as normal a life as possible in my own home."**

4.2.4 It is clear from the research that many older people value the care at home services they receive and in particular value the ability to remain in their own home within their own community.

4.2.5 Another benefit of the care at home service for older people found in one study was that care at home staff are an important source of information about other social and health care services which are available for older people. When clients in Perth and Kinross were asked "Who do you rely upon for information about social and health care services?", the most popular responses were as follows:

- Care at Home Staff *(47.9%)*
- Friend or Relative *(42%)*
- G.P *(41.1%)*
- Social Work Department *(30.9%)*

4.3 Views of Clients on Quality and Quantity of Care Provided

4.3.1 A number of research studies have sought older persons' views on both the qualityand quantity of care received.

4.3.2 In Aberdeenshire, seventy five percent of respondents said that the service they receive from their carer is good all of the time, with a further 22% stating they receive a good service most of the time[37]. This is similar to findings in Reading Council *(2013)* and in North Lanarkshire Council *(2009)* where the majority of people interviewed *(72%)* in the former described their experiences of home care overall as being positive, and in the latter, 76% of clients were satisfied or very satisfied with their experience of home care. In other studies across the UK satisfaction levels were not quite as high, for example in a survey across the whole of England, 58% said they were either extremely or very satisfied with the service they received.[38] This was similar to another more recent survey of more than 20,000 clients in England[39] which found that 60% of those asked were either extremely or very satisfied with the care at home services they received. Therefore, even in the large scale studies that have been undertaken, a clear majority of clients have said that they were either extremely or very satisfied with the care at home services they were receiving.

4.3.3 One research project noted that clients wanted to see jobs well done and to a high standard, and they often praised the skill and professionalism of their care workers. This was of particular importance to respondents whose safety was dependent on their care worker; for example, if they were being helped with taking medication or had a lot of complex careneeds.[40]

36 Cordia (Services) LLP Home Care Services Consultation Report 2012-2013

37 Aberdeenshire Council Service User Consultation Home Care Service 2009

38 Personal Social Services Home Care Users in England aged 65 and over, 2008-09 Survey

4.3.4 People who accessed care at home services from the Perth and Kinross research *(1997)* also had high satisfaction ratings with regard to the quality of service that care at home staff provided. Nevertheless, nearly a third of respondents said that they did not get as much home help as they would like. Interestingly, when the data is examined in relation to the state of health of the older person, more of those in poor health *(37.8%)* felt that they did not receive enough care at home in comparison those in better health *(17.4%)*.

4.3.5 In many of the research studies of care at home users that have been undertaken, this is a common theme which emerges. That is, the desire amongst users to receive more care at home services than they are currently receiving. Indeed, in one study[41], when asked to select the top three factors most important in offering good homecare, the number one factor to emerge was "sufficient time for care". Respondents in this study thought that one of the key challenges facing care workers who currently provide care at home was time limitations. This view seems to be prevalent amongst care at home clients as well as care at home workers. For example, in Reading *(2013)*, some people felt it was a struggle for their care workers to get through everything they needed to in the time given. The study found that despite this, "when care workers and service users were used to one another, users were more likely to feel their support could be delivered effectively in a shorter space of time." Some respondents in Aberdeenshire *(2009)*[42] felt that care at home staff should have more time in each client's house as they were a bit rushed.

4.3.6 More than half *(55.6%)* of the care workers who took part in the best value review of home care services in North Lanarkshire felt that the time they had with clients was "too little".[43] In Northern Ireland, most respondents in the study of older people's experience of domiciliary care *(88%)* felt that their views were taken into consideration when the socialworker came to talk to them about what help they might need. However, 16% of people felt the help offered would not meet their needs specifically because not enough time was allocated to care workers in order to effectively attend to the older person receiving care.

4.3.7 These views, particularly in the more recent studies in Scotland, might seem surprising given that on average, clients are now receiving more hours of care at home per week than they once were. It appears though, that despite the average client receiving more hours of home care per week, many clients are of the opinion that they still are not receiving as much care at home as they think they need.

One respondent who was in residential care from the Perth and Kinross research commented:

> **"I had a conflict with the Home Help Organiser. I was living alone, aged 93, and I had been unwell. I knew I could not get by without added timefrom the Home Help Organiser. He said I could not have more help - He did not have enough resources at his disposal."**

39 Performance And Quality: User Experiences Of Home Care Services PSSRU Discussion Paper 2014/3

40 Older People's Experiences of Home Care in England Sykes, W and Groom, C. Independent Social Research (2011) Equality and Human Rights Commission Research Report 79

41 Department of Health and Guardian Social Care Network: Attitudes to Homecare in England Oct. 2013

42 Aberdeenshire Council Service User Consultation Home Care Service 2009

43 Best Value Review of Home Care, Housing and Social Work Services, (2009), North Lanarkshire Counc

4.3.8 Some of the users interviewed in the Equality and Human Rights Commission Research commented that care workers rushed through their work, 'getting it done as quickly as possible'.

> **"They'll come in, do what they've got to do and then off to the next client.I mean I don't mind, but it's as though they want to get all their clients finished..."** (Woman, 74, lives alone, local authority funded)

4.3.9 Clients complained that tight schedules from the provider agencies that were imposed on the care at home staff meant that care workers, who were often praised by clients for their personal touches in delivering support, were too busy or in too much of a rush to spend time talking to clients.

> **"They are so inundated these care workers, whether they work for an agency or the council. They are all the time having to look at their watch,got someone else they have to fly to."** (Woman, 76, lives with partner, direct payments from ILF

4.3.10 These views of clients - that care at home workers do not have enough time to complete tasks - are widely reflected in recent policy reviews in the UK. In particular, the move to 15 minute care slots has come under the spotlight. According to the Adult Care Blog of Community Care, such slots have "lead to the some of the worst care practices" often described as call cramming. The significant increase in the commissioning of 15 minute slots is at odds with the Department of Health who have said that these "very short home care visits are not normally appropriate".[44]

4.3.11 The recent Burstow Commission and Kingsmill review have agreed with this view and described 15 minutes slots as "contributing to the worst practices in home care"[45]. They have urged the Care Quality Commission in England to put "an end to 15 minute slots"[46], which are associated with pay rates below the Minimum Wage and poor quality of care.

44 "15-minute care visits: an indignity that should be banned or a 'fully justified' commissioning practice?" by Mithran Samuel on 7 October , 2013 in Community Care Adult Care Blog

45 Key to Care: Report of the Burstow Commission on the future of the home care workforce, (Dec. 2nd 2014 LGIU)

46 The Kingsmill Review: Taking Care An independent report into working conditions in the Care Sector (2014)

4.3.12 A recent survey by the United Kingdom Home Care Association *(UKHCA)* found that they were 'alarmed' by the commissioning of such short care at home visits and pointed out that some 73%[47] of care at home visits in England seem to be 30 minutes or shorter, with a lower rate of 42% in Scotland. As in the above studies, UKHCA feel that such short visits account for reports of care at home services 'appearing to be rushed, or lacking sufficient dignity.' The report goes so far as to say that such 'inappropriate commissioning' by councils may amount to 'institutional abuse.'

4.3.13 It is noted that the reason for the lower rates of shorter visits in Scotland, compared to England and Northern Ireland, may be a result of 'the impact of public spending constraints being felt at different speeds across the UK.' It is feared that similar high rates may be down the line for Scotland and Wales if, as appears likely, further spending cuts in council expenditure are made.

4.3.14 Overall, it is clear that satisfaction levels with care at home services are high amongst clients. Nevertheless, a constant theme in many of these studies is the desire amongst clients to receive more care at home services than they have currently been allocated. The increasing use of short visits is also becoming a serious issue for many who feel that these slots do not leave staff enough time to do their job well and leave little or no space for personal interaction.

4.4 Views on Care Workers and Organisations Providing a Care Package

4.4.1 As well as seeking views on their overall satisfaction with care at home provision, many of the studies conducted have also sought clients' views of care workers and the organisations that arrange and manage their care. The research shows that older persons' views towards their individual care workers are inclined to be very positive. Across the studies though, there tends to be lower levels of satisfaction with respect to the organisations that arrange and provide care.

4.4.2 In England, there is a statutory duty to have nationally comparable satisfaction surveys across care services. This was first announced in the White Paper, Modernising Social Services, published in 1998. In the latest national publication[48] which covers 65,900 clients, almost two thirds *(63.6%)* reported that they were either extremely or very satisfied with the care and support services they received. Earlier versions of the survey asked respondents specifically about their care worker. For example, in 2008-09[49], 95% of respondents said that they were either always or usually happy with their care worker. Similarly high levels of satisfaction can be found in smaller surveys of care at home users. For example, in a study of care at home users on the Westside of the Isle of Lewis *(2004)* 95.8% were either very satisfied or satisfied with their home carer.

4.4.3 In most of these studies, clients tend to be much more positive about their care worker than they are about the organisation providing their care. For example, a survey carried out by the Department of Health and Guardian Social Care network across England[50] found that whilst 46% rated individual care workers as excellent or very good, only 17% of respondents rated councils who assessed care needs and arranged care as excellent or very good. This survey asked respondents: based on your experience in the last two years, how easy do you think it is to choose how home care services are delivered (e.g. time of visits, who visits, what care workers do). 66% of respondents said this was very difficult or quite difficult to do.

47 Care is not a commodity: UKHCA Commissioning Survey (2012).

48 Personal Social Services Adult Social Care Survey, England (2012-13), Final Release

49 Personal Social Services Home Care Users in England aged 65 and over, (2008-09) Survey

50 Department of Health and Guardian social Care Network Attitudes to Homecare in England (October 2013)

4.4.4 Similarly, a survey undertaken by Aberdeenshire Council found extremely positive responses towards care workers themselves. For example, "respondents indicated that staff are always trustworthy *(95%)*, friendly *(93%)* and caring *(90%)*. The only issue to score less than 80% was punctuality"[51] However, the same survey found that respondents were less positive about home care services. Of particular note was communication and information from the home care service. Most people said that there had been some initial information provided at the commencement of the service but little ongoing information. Poor communication was also found in the study by Reading Council *(2013)*, "where most spoke negatively or were disappointed by the lack of communication about late calls. For some people, the most significant consequence was the anxiety they felt waiting for the care worker to arrive, and sometimes wondering if the care worker would arrive at all."

4.4.5 A similar pattern emerged in the Cordia study of care at home clients in Glasgow, where the majority of satisfaction indices relating to care workers were over 90% satisfied or very satisfied. Satisfaction levels pertaining to the administration and management of the care were lower, although still positive. For example, 71.5% of respondents agreed or strongly agreed that I have no problems with speaking to office staff on the phone and 62.8% agreed or strongly agreed the home care manager acts on complaints and comments.[52]

4.4.6 Finally, similar findings were discovered in the Patient and Client Council survey of home care clients in Northern Ireland. Whilst 87% of respondents rated the quality of their care as 'very good' or 'good', more than half of the carers interviewed identified problems with their relative's care provider at an organisational level.53 One particular aspect of organisational communication that clients commented upon in the research was the lack of review from the organisation arranging care. For example, the PSSRU[54] found that just over half *(51%)* of care at home clients indicated that someone from social services had been in contact to check that they were satisfied with the home care they received, with 49% of respondents having no such contact.

4.4.7 Research from the Human Rights Commission noted that for many older people receiving care at home services, care workers were among the few people they saw regularly. For those older people who lived alone, care at home staff offered a much valued chance for social interaction. It is difficult to overstate, the researchers noted, the high value that many respondents placed on the conversation, 'the laughs' and even the friendship that could develop with care workers.

> **"(They) mean everything... (They) are a godsend."**
> (Woman, 79, lives with partner, local authority funded)

> **"I'd love you to meet her; she is a beautiful girl... She is the sort of woman you can really cotton on to."**
> (Man, 76, lives alone, self funded)

> **"We have a good laugh which I need, they do the job, but we joke and laugh at the same time. (It is important) because when you are like us, you don't go out, you don't... see anybody. They are friends."**
> (Woman, 70, lives with partner, self funded)[55]

51 Aberdeenshire Council Service User Consultation Home Care Service 2009

52 Cordia (Services) LLP Home Care Services Consultation Report 2012-2013

53 Patient and Client Council Care at Home Older people's Experiences Of Domiciliary Care (2012)

54 Performance And Quality: User Experiences Of Home Care Services PSSRU Discussion Paper 2014/3

55 Older People's Experiences of Home Care in England by Wendy Sykes and Carola Groom. Independent Social Research (2011) Equality and Human Rights Commission Research Report 79.

4.4.8 One older person felt that getting too friendly with clients was probably discouraged,but was very glad that her current care at home workers were approachable.

> **"They're not supposed to get close to us... (but) how can you care for a person (if you are not friends). It's not something the policy wants them to be... I had one (care worker)... that you were just a number... I mean she is good in her own way, but there is that distance... But these other two... they don't keep away from you. They make you feel as if they enjoy coming to see you and that's important to me."**
> (Woman, 83, lives alone, local authority funded)

4.4.9 Older people in this research did note that care packages could be 'overly prescriptive' with 'little flexibility' for care workers to help out clients if things are not written into their care plan. Other areas were raised by clients that they would like help with – such as nail-cutting – that were not available.

4.4.10 A similar issue raised by clients in a best value review of home care services in North Lanarkshire[56] was the lack of control over when care staff provide services

> **"There is a lack of flexibility about the service, you must take the hours given to you"**

4.4.11 Focus group meetings from the Perth and Kinross research revealed that the most vulnerable older people were very unsure about how to access more health and social care services if they required them. One older person in a focus group was a wheelchair-user, and could not go to the toilet on her own. Her care package consisted of one hour of care at home provision per day, which was split into two periods of morning and early evening. Without the help and support provided by her daughter, she would have been alone and unable to go to the toilet for up to 23 hours. The client stated that she had no idea who to contact to secure additional support. It was felt by some that information about their care package was not provided at the time or in a format that they could fully understand. This problem was exacerbated by the fact that for many care at home clients, their social isolation meant that they were 'cut off' from other sources of information.

4.4.12 It is clear from the research that the views of those accessing care at home services are very positive about care at home staff with whom they interact. However, across a number of studies there are many instances where older people were unhappy about poor communication with those who organise their care package and a lack of flexibility, and were unclear how they might go about making changes to such care packages.

4.5 Suggested Areas for Improvement

4.5.1 Many of the research projects asked older people receiving care at home services about improvements that could be made. One improvement mentioned in a number of studies was to extend the types of services currently available through care at home provision.

55 Older People's Experiences of Home Care in England by Wendy Sykes and Carola Groom. Independent Social Research (2011) Equality and Human Rights Commission Research Report 79.

56 Best Value Review of Home Care, Housing and Social Work Services, 2009

4.5.2 Several of the research studies which have sought the views of care at home clients asked them what services they would like support with, but which are not currently provided by their care at home service. In most studies, the services that users mentioned are essentially 'mopping and shopping' tasks. For example, clients in Aberdeenshire were asked to state what tasks they think their home carers could do that they are not doing at present. The following are a list of the main tasks stated by clients:

- Light cooking
- Housework
- Laundry
- Ironing
- Shopping
- Make the bed

In a Joseph Rowntree Foundation study[57] one participant told researchers:

> **"A little help with housework, hoovering especially would help**
>
> **If you haven't got a family, who is going to do the windows, the surfaces dusting and polishing if you can't?"**

4.5.3 The Patient and Client Council in Northern Ireland, in their focus groups with clients,discussed the decrease in less personal tasks such as cleaning, laundry and shopping, which has occurred over the years. Many people in the focus groups felt that help with these activities were just as essential in enabling older people to remain at home as personal care. In the survey undertaken by the Council, almost a third of clients said there were activities they would like their care worker to help them with that they did not receive assistance with at the time of the survey.

4.5.4 In an earlier survey by the Department of Health, Social Services and Public Safety[58] a lack of correlation was found between the activities most clients identified as those they were "not able" to perform, such as shopping and housework, and the activities most clients indicated they receive help with, including getting dressed/undressed and washing. That is, many of the tasks which people felt were needed were not actually being provided.

4.5.5 This raised a broader point; that many care at home users find it difficult to take part in normal everyday activities such as going to the shops, gardening or going to the park. When the researchers in the Perth and Kinross research asked questions about this subject it was clear that people were 'unhappy' and 'frustrated' about having such severe limitations on their lives, but had accepted that this was an area that care workers failed to offer help with and that such support was just not available. One suggestion was that care at home staff could augment their roles by adopting befriending services, accompanying older people and enabling them to take part in some of these tasks. The introduction of Self Directed Support now provides older people with some opportunity to purchase more flexible and personalised services that should enable them to engage in such activities.

4.5.6 As well as increasing the range of activities that are encompassed within care at home services, another area of improvement suggested by some care at home clients has already been mentioned above in relation to the agencies who manage and provide care packages, namely flexibility, particularly in relation to the timing of visits. The Equality and Human Rights Commission research noted that timing of care worker visits was an issue raised by almost every client. Clients wanted visits to be timed to suit their own routines, rather than their day been dictated by the exigencies of the service. People wanted to be able to count on care workers arriving when expected so as not to disrupt their plans, limit their opportunities to go out if they were able, or delay medication and trips to the toilet. Clients also raised the importance of receiving their full allocation of care.

57 Getting older people's views on quality home care services, Joseph Rowntree Foundation 2001

58 DHSSPS (2009), Survey of Home Care Service Users Northern Ireland, Belfast: DHSSPS.

59 Reading Borough Council Home Care Users Research Project (April 2013)

4.5.7 Where visits sometimes did not take place at all, or care workers arrived late, this caused a great deal of anxiety, particularly where people needed help to take medication, go to the toilet or eat. Not being told about delays also added considerably to the clients' anxiety.

4.5.8 Another issue raised by a number of surveys was the importance of continuity of care. "Some users also found seeing strange care workers made them quite anxious."[59] A common complaint was that clients were rarely informed if an existing care worker was leaving and someone new was starting, so they had no idea who was coming into their home. [60]

4.6 Recent Service Developments and Legislative Changes

4.6.1 In recent years across Scotland, the majority of councils have looked to develop the provision of care at home services by introducing a more intensive form of care at home service, such as reablement, as part of their wider care at home provision. This new reablement service benefits clients by working with them to set goals that clearly contribute towards increasing active participation and becoming as independent as possible. In an evaluation of reablement in Edinburgh City Council[61], the majority of the clients interviewed had been discharged from hospital and said they simply would not have been able to cope in the first few weeks after being discharged without the support that they had received. As one client pointed out:

> **"The social care worker encouraged me to do for myself, watched to see how I managed, let me do what I could and help with the things I couldn't."**

4.6.2 A more recent study of the benefits of reablement was undertaken in Glasgow's North East Reablement pilot in 2013.[62] The aim of the qualitative research was to carry out a longitudinal study to examine the impact of reablement, taking account of client and stakeholders' views in terms of satisfaction levels and reablement processes. The following comments are an example of the positive views put forward about this form of intensive care at home:

> **"Fantastic"**
>
> **"Better because it makes you do for yourself."**
>
> **"Great for self encouragement and stops deterioration."**
>
> **"I was terribly bad at first but things have started to come together again."**

60 Patient and Client Council Care at home Older people's Experiences Of Domiciliary Care (2012)

61 Evaluation of City of Edinburgh Council Home Care Re-ablement Service by Barry McLeod and Mari Mair, Scottish Government Social Research 2009.

62 Reablement in Glasgow: Quantitative and Qualitative Research (2013) by Harminder Ghatorae, Glasgow City Council, Cordia and NHS Greater Glasgow and Clyde.

4.6.3 This research found that by the end of reablement process, clients were able to:

- 'resume their usual activities' *(82%)* and
- 'do more things for themselves' *(74%)*.

Satisfaction of this service was rated as high.

4.6.4 There have been a number of legislative changes in recent years which have led to the development of what has come to be known as the 'personalisation agenda' across the UK. In broad terms this has meant that people are encouraged to be actively involved in selecting the services that are most appropriate for them as individuals.

4.6.5 In Scotland, this agenda has followed a path that began with older people becoming more involved in shaping their social and health care through the mechanism of direct payments *(DP)*. This is where cash payments are made for health and social care services to support an older person in their own home. As noted in Figure 8, the number of older people using DPs has increased sharply from 141 in 2003 to 1,936 in 2013. DPs are now seen as one mechanism to fund older people looking to personalise their care package alongside several other mechanisms within the umbrella of Self Directed Support *(SDS)*.

4.6.6 SDS seeks to involve clients, including care at home clients, more by involving them in the early stages of organising the type of support they would wish. For instance, SDS involves the older person more fully by letting them know the budget that is available to select and shape the types of services they want. In addition, there is now a focus on the outcomes that are hoped to be achieved by such support. Also, a wider range of services are available, such as befriending and social activities.

4.6.7 In a recent evaluation of SDS[63] test sites in Scotland, while there were some issues about the information provided and the assessment process, "the majority of people reported a change in their relative support for the better. This was usually because of the increased flexibility and choice that SDS enabled..." The researchers found that "SDS has expanded choice and control for the vast majority we interviewed." Unfortunately, only one of the 30 people interviewed was over 65. The experience of personalisation in England from the Equality and Human Rights Commission research showed that some of older persons interviewed were reluctant to change the way in which their care at home service was provided, because that might involve additional administrative burdens for them.

4.7 Summary

4.7.1 The research studies are very clear about the positive role that care at home services play in supporting older persons to live independently in their own home. Overall, satisfaction levels with care at home services are high. Nevertheless, many of the studies demonstrate that many clients would like to receive more care at home services than they have currently been allocated. The issue of short visits by care at home staff has recently come under close scrutiny, with many arguing that these slots do not leave staff enough time to do their job well and leave little or no space for personal interaction.

4.7.2 It is evident from the research that while the views of those using care at home services are very positive about care at home workers, there are many instances where older people were unhappy about poor communication with those who organise their care package. In relation to the care package itself, there is some criticism over the lack of flexibility offered and some older people were unclear about how they might go about making changes to their care packages.

4.7.3 Many of the studies noted that their care packages were lacking in an adequate provision of what was termed 'mopping and shopping' services as well as befriending services that would allow older people to take part in a wider range of activities. The shift towards the personalisation agenda, in the shape of SDS in Scotland, should allow older people the freedom to choose a package that may include some of these services if they so wish.

63 Evaluation of SDS Test Sites in Scotland J.Ridley et al (2011), Scottish Government.

Section Five

scottishcare

The voice of the independent care sector in Scotland

Issues and Challenges

5.1 Introduction

5.1.1 In many ways, the policy agenda for health and social care in Scotland is good news for the care at home sector. That is, a combination of the following factors means that expansion in the care at home sector is highly likely.

- the desire to shift the balance of care away from residential settings to community
- targets to reduce delayed discharge and inappropriate hospital admissions for older people and
- general agreement from all stakeholders that, as far as possible, older people should be supported to live independently in their own homes.

The only factor acting against these drivers is the very tight constraint on public finance, and the corresponding drive to restrict eligibility and squeeze funding.

5.1.2 This demand for care at home services will be exacerbated by the demographics in Scotland with more old and very old persons projected across the next few decades.

This report has sought to profile this sector within this policy context and has raised a number of issues and challenges for the care at home sector.

5.2 Challenges for Consideration

- The review has shown that older persons in receipt of care at home consider the service to be invaluable. Despite this, there are some key issues that are raised time and time again such as quantity of service received and the lack of flexibility in the provision of the service. **Given the financial constraints facing the public sector as well as the increasing demands on the service, the challenge is how providers and commissioners address the issues being raised by clients.**
- The report shows that, across Scotland, care at home hours, particularly those receiving 10+ hours of care, are increasing in line with national policy. However, the data also shows that the number of clients receiving 10 plus hours of care has actually reduced in some council areas. **The challenge is how to ensure that all older people with intensive care and support needs, irrespective of where they live, have these needs met in the community.**
- The number of older people in receipt of 10+ hours of care at home is increasing across Scotland. However, the data shows that this appears to have been at the cost of reducing provision of care at home hours for those older people with lower levels of need. A concern is that without such support at home, this may lead to earlier admittance to residential or hospital care than would otherwise be the case if adequate care at home provision was in place. **The challenge is to have adequate resource and flexibility of service provision, to meet the needs of those with intensive care and support needs, and those with lower level needs, simultaneously.**
- The data shows that the uptake of direct payments by older people varies greatly across Scotland. Direct payments and Option 2 *(para. 1.1.5)* are key area in facilitating the personalisation agenda for older persons. **The challenge is to ensure all local authorities are providing quality information about SDS, and the necessary support, to maximise uptake.**

- The Reshaping Care agenda to reduce inappropriate hospital admissions and delayed discharges for older people, combined with increasing numbers of older people due to demographic changes will inevitably increase demand for social care services in the community. **The challenge is to develop capacity among care at home providers and their workforce to cope with the increasing numbers of older people, with increasingly complex needs, who will require care and support services in their own homes.**

- Meeting the additional care at home demand that results from Reshaping Care and population increases will require to be funded. Whether this can be met by resource transfer from the NHS as a result of freeing up beds, given the HEAT targets around inappropriate hospital admissions and delayed discharges for older people, remains to be seen. **The challenge is to ensure services are funded in the future on a stable and secure footing, beyond mechanisms such as the Change Fund and Integrated Care Fund that have been established to deal with these issues on a short-term basis.**

- Over the last decade, there has been a shift in the provision of care at home services, with over half now being provided by the third and independent sectors. However, the report shows that there is evidence that the commissioning of services by local authorities remains problematic. **The challenge is to improve the commissioning relationship between providers and local authorities on a partnership basis, in line with Audit Scotland and Scottish Government recommendations.** Representative bodies such as Scottish Care may be able to assist this process by offering a programme of support to both commissioners and providers.

- The report has highlighted the range of workforce planning issues which the sector faces. For instance, the reliance on zero-hours contracts and agency staff combined with lower than average pay rates. **The challenge is how the care at home sector manages to expand in response to growing demand, and succeeds in recruiting and retaining new staff, given current terms and conditions and pay rates, coupled with the increasingly complex workload that workers face.**

Based upon the analysis of the care at home sector, the distribution of the Care Pound and the views of older people, the above summary of issues is aimed at stimulating debate about whether this key sector is able to support the wider policy agenda and the needs of the growing older population in Scotland. The challenges are not simple. However, to achieve the desired outcomes, the ability of the care at home sector - commissioners, providers, sector representatives and clients - to shape the current policy and strategic agendas nationally and locally, and to find solutions to the challenges, is clearly going to be crucial.

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No. of Hours of Care at home Provided 2003-2013 (All clients)											
	2003	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
Aberdeen City	12,426	17,090	20,002	20,253	22,831	17,414	15,176	15,598	16,230	16,499	15,130
Aberdeenshire	19444	20193	22162.2	20887.8	22619.0	22331.1	21452.3	19530.4	14759.1	15340.4	17161.2
Angus	5855	6329	6014.0	6635.0	7288.0	6264.0	6462.0	6556.0	6294.5	6597.0	6176.2
Argyll & Bute	7814	8527	7958.5	7220.8	8216.0	8577.1	7842.9	8224.1	8623.6	9673.7	10419.5
Clackmannanshire	6169	6467	8272.3	7505.0	8196.0	8040.0	6876.5	6693.9	6498.2	6667.9	7539.5
Dumfries & Galloway	21443	27753	28104.8	28453.3	26237.4	21166.6	20673.8	34998.2	31189.1	43781.2	29752.3
Dundee City	8610	9047	11690.7	12447.2	13037.2	14026.4	15306.3	15233.5	14976.4	14885.4	14672.3
East Ayrshire	11790	17021	19044.0	22593.0	25245.8	26381.2	26241.5	24513.9	18897.7	26672.7	18559.7
East Dunbartonshire	5499	6185	5806.5	6360.5	13590.2	13271.5	16375.6	16566.2	16919.2	16730.7	17559.5
East Lothian	7506	10904	15561.0	15992.0	17657.6	18945.0	16607.0	19450.8	19847.0	22165.7	22200.8
East Renfrewshire	6000	6951	7420.0	7695.9	6357.3	6340.8	6865.5	8076.5	8347.5	8627.0	13106.6
Edinburgh, City of	36086.99	39011	39571.5	39419.2	41440.0	41307.0	38512.2	44066.6	44730.8	44235.5	51418.5
Eilean Siar	5864	5864	6267.6	5682.7	5460.1	5134.2	5261.8	5794.3	5120.0	5121.7	5060.3
Falkirk	13633	14247	14438.0	19364.0	22037.0	22287.0	23311.0	24293.5	23398.6	22504.6	22589.6
Fife	26962	34258	49075.0	53989.5	68913.2	76024.9	72858.6	64938.6	93609.5	89067.5	51718.9
Glasgow City	96206	84011	84611.1	82824.1	83724.1	81971.1	80049.6	77804.5	71170.3	70656.4	62505.5
Highland	14750	15275	16113.4	15874.9	15134.0	12426.3	12182.2	12872.1	14902.2	14869.0	13658.4
Inverclyde	7012	15265	15097.0	16024.0	14253.0	14865.0	14860.0	14913.2	11464.7	11163.0	13590.8
Midlothian	7095	7289	9599.0	10915.0	11031.0	12829.0	12302.0	10718.7	10981.4	10681.7	11340.0
Moray	8016	9261	10572.3	8396.0	8671.0	8377.5	12456.0	10558.2	10339.3	10522.4	10501.7
North Ayrshire	12810.97	13106	11676.0	9984.0	10327.0	12319.6	12991.0	11025.4	11251.0	25545.6	26654.7
North Lanarkshire	47678	39573	39825.5	33907.0	35053.3	33812.6	34833.0	34911.3	29973.8	27409.3	27392.3
Orkney Islands	2645	2811	3095.3	2751.5	2247.8	2193.5	1886.1	1819.0	1581.6	1536.3	1481.9
Perth & Kinross	9039	10211	6932.0	8560.0	8593.0	8903.0	9015.0	11606.7	11907.1	10716.9	9364.7
Renfrewshire	17376	15609	16849.0	16063.9	16917.7	14653.8	14275.6	12673.4	27770.1	28451.8	12738.8
Scottish Borders	10985	11432	10754.5	10220.8	9325.8	9141.3	10172.0	10876.5	9899.9	10710.0	9933.1
Shetland Islands	2793	2995	3116.6	2990.5	2854.3	2870.3	3075.0	3274.5	3770.8	3089.3	2682.5
South Ayrshire	17611	23494	25518.5	30501.0	32753.2	35859.1	36791.3	37166.6	39957.4	37688.8	38205.0
South Lanarkshire	22166	26461	34318.1	46169.2	51367.8	54176.5	52088.2	57553.0	55902.9	54398.9	47156.2
Stirling	7413	11990	11617.6	11926.6	10875.0	14562.4	13878.2	16680.7	17099.2	18547.4	19184.3
West Dunbartonshire	13534	15941	14668.3	13911.0	13574.7	13561.7	12915.0	12800.2	12143.1	12774.4	11510.2
West Lothian	8798	8812	8407.2	8562.7	9213.7	10980.0	12134.0	14645.6	14305.9	15562.9	16821.3
Scotland	**501029.96**	**543383**	**584160**	**604081**	**645041**	**651014**	**645727**	**666434**	**683862**	**712894**	**637786**

Appendix 1: ISD

Appendix 2: **Improvement Service Benchmarking Framework**

Total Care at home (Over 65s) Expenditure 2010-11 to 2012-13			
£'000	**Total Care at home Expenditure 2010-11**	**Total Care at home Expenditure 2011-12**	**Total Care at home Expenditure 2012-13**
Aberdeen City	13516	13902	16345
Aberdeenshire	15125	17071	13968
Angus	6439	7413	7616
Argyll & Bute	12096	12064	12435
Clackmannanshire	2765	2149	4004
Dumfries & Galloway	16573	17427	17426
Dundee City	15540	15854	16206
East Ayrshire	11193	10215	11228
East Dunbartonshire	9334	9829	10038
East Lothian	7647	8244	5431
East Renfrewshire	3320	4557	6065
Edinburgh, City of	28970	31779	40234
Eilean Siar	5369	1907	4986
Falkirk	15101	15257	14838
Fife	24254	27223	29808
Glasgow City	67845	62384	63798
Highland	16862	17250	15593
Inverclyde	9596	7781	8089
Midlothian	5651	5941	6334
Moray	7671	8322	10245
North Ayrshire	12589	13321	14405
North Lanarkshire	23853	22791	24531
Orkney Islands	1949	1909	2213
Perth & Kinross	11474	11149	11198
Renfrewshire	11578	10512	10959
Scottish Borders	8978	7889	7725
Shetland Islands	3992	3648	5454
South Ayrshire	14273	13212	14527
South Lanarkshire	24669	25343	25704
Stirling	6355	5982	5671
West Dunbartonshire	8507	8599	9038
West Lothian	11957	10864	11915
Scotland	**435041**	**431788**	**458027**

Appendix 3: **Improvement Service Benchmarking Framework**

Total Residential care (Over 65s) Expenditure 2010-11 to 2012-13			
£'000	**Total Residential care Expenditure 2010-11**	**Total Residential care Expenditure 2011-12**	**Total Residential care Expenditure 2012-13**
Aberdeenshire	27022	30945	26692
Angus	16093	16762	14523
Argyll & Bute	13922	12920	11821
Clackmannanshire	5077	4215	4128
Dumfries & Galloway	9300	8250	9726
Dundee City	19001	18575	19775
East Ayrshire	16331	14365	13951
East Dunbartonshire	6414	5643	5786
East Lothian	12543	12997	16482
East Renfrewshire	9350	10280	10973
Edinburgh, City of	54344	51394	43832
Eilean Siar	5968	6574	6145
Falkirk	13075	14599	13799
Fife	41174	41430	41102
Glasgow City	80543	83387	76120
Highland	29971	30986	27029
Inverclyde	11131	11265	10542
Midlothian	7307	7751	7723
Moray	7525	7338	7987
North Ayrshire	17670	16365	16635
North Lanarkshire	41202	36022	27894
Orkney Islands	4727	4433	4933
Perth & Kinross	17834	29133	14927
Renfrewshire	18533	18592	18117
Scottish Borders	11649	11170	11710
Shetland Islands	9106	7917	6947
South Ayrshire	16049	15947	16591
South Lanarkshire	34892	37245	35430
Stirling	10884	9602	9176
West Dunbartonshire	14974	14697	11862
West Lothian	14646	13833	12447
Scotland	**626834**	**636893**	**581694**

Scotland	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13[p]
No. Of Emergency Admissions (65yrs+)	189931	191,883	193,565	203,470	209,236	216,530	213,381	218,947	227,493	232,269
No. Of Emergency Admission Bed Days (65yrs+)	2,806,074	2,811,095	2,830,528	2,887,550	2,860,536	2,924,118	2,875,815	2,825,641	2,787,236	2,744,740
No. Of Bed days per Admission	14.8	14.7	14.6	14.2	13.7	13.5	13.5	12.9	12.3	11.8

Appendix 5

General Medicine Costs per Day														
	Average Length of Stay	**Direct Cost per Case**							Total Allocated Cost per Case	**Total Costs per Case**				
		Medical & Dental	Nursing	Pharmacy	AHP	Other Direct Care	Theatre	Laboratory		Gross	Income ACT	Income Other	Net	Cost per Day
All Hospitals (General medicine)		£	£	£	£	£	£	£	£	£	£	£	£	£
2010-11	**4.0**	221.37	558.24	194.77	75.53	21.81	1.26	119.57	538.06	1730.60	-31.47	-106.24	**1592.89**	**396.59**
2011-12	**3.7**	220.69	537.95	156.91	66.78	19.42	9.44	115.34	504.99	1631.52	-30.89	-102.20	**1498.43**	**404.69**
2012-13	**3.7**	223.96	521.90	150.21	61.62	19.00	10.11	112.95	496.28	1596.03	-22.68	-105.08	**1468.27**	**401.17**

Accident and Emergency Attendance Costs						
	Inpatients			Outpatients		
	Net Expenditure	Discharges	Cost per Case	Net Expenditure	Total Attendances	Cost per Attendance
	£000s		£	£000s		£
2010-11	12230.96	15507	788.74	170878.90	1700178	**101**
2011-12	13142.75	15938	824.62	175143.95	1680388	**104**
2012-13	14113.80	15303	922	174,272	1,641,402	**106**

Appendix 6

No. Of Care at home Hrs provided per Week (Over 65s)			
	2010-11	2011-12	2012-13
Aberdeen City	672104	702936	617993
Aberdeenshire	534261	579436	694946
Angus	281883	261820	245085
Argyll & Bute	395157	451724	498654
Clackmannanshire	201193	217776	251776
Dumfries & Galloway	1056037	1392040	977461
Dundee City	660030	625248	634741
East Ayrshire	530681	636012	596867
East Dunbartonshire	392724	409708	475298
East Lothian	478686	552396	560010
East Renfrewshire	389480	404040	620870
Edinburgh, City of	1633275	1615536	1818951
Eilean Siar	214854	217776	214304
Falkirk	711080	651560	648740
Fife	1120652	1107340	1138991
Glasgow City	3173222	3146156	2982369
Highland	576705	575380	564056
Inverclyde	495357	475904	519432
Midlothian	348288	349752	508300
Moray	416562	436540	434564
North Ayrshire	534321	699764	732850
North Lanarkshire	1500200	1405144	1239407
Orkney Islands	71924	67028	69725
Perth & Kinross	527898	479492	424406
Renfrewshire	536159	537628	516314
Scottish Borders	453293	483808	454743
Shetland Islands	184158	146016	126503
South Ayrshire	939351	793052	856152
South Lanarkshire	1583976	1557972	1437659
Stirling	360910	398944	426263
West Dunbartonshire	503232	548808	512430
West Lothian	503644	533052	563833
Scotland	422717	431919	430071

ii Technical Note Emergency Admission Costs

This Technical Note explains the methodology used to arrive at the costs for Emergency Admissions for Scotland *(over 65s)*. The data was sources from Information Services Division *(ISD)* from the Costs Report (2011-13).

The data was extracted from specialty summary - all specialties *(exc. long stay)*, by patient type, by board *(R04X)* for each of the 3 years. This provided data on per attendance costs for Accident and Emergency units across Scotland. These costs were added to further costs derived from R040: Speciality group costs - inpatients in all specialties *(exc long stay)*. This Costs Report provides information on Total Net Cost per case *(General Medicine)* and Average Length of Stay per case. These were used to calculate a Net cost per day in General hospitals *(see Appendix 5)*. The latter was then combined with data from ISD Publication Analysis of Patients Aged 65+ on Emergency Admissions *(Numbers, Bed Days & Rates)* and Multiple Emergency Admissions *(Patients, Bed Days & Rates)*. This provides information on the number of bed days resulting from emergency admissions by the over 65s in Scotland and also the number of admissions. Therefore it was possible to calculate the average number of bed days per admission for the over 65s. The average length of stay in hospital following an emergency admission by an over 65 in Scotland in 2013 was 11.8 days. This was multiplied by a daily cost per day in a General Hospital as well as including a cost of an attendance at A&E to get the average total cost of an emergency admission for over 65 *(£4846.62)*.

This allowed a total figure for all over 65 emergency admissions in Scotland which in 2013 was £1.13 Billion;

Reader Notes

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