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Agenda Item: 11

Integration Joint Board

Date of Meeting: 4 September 2024.

Subject: Accounts Commission– Integration Joint Boards – Finance and Performance 2024

1. Purpose

1.1. To advise the Integration Joint Board (IJB) on the key findings of the Accounts Commission's report (Appendix 1), prepared by Audit Scotland and published in July 2024, on finance and performance issues affecting IJBs in Scotland.

2. Recommendations

The Integration Joint Board is invited to note:

2.1. The findings of the Accounts Commission report and the implications for the Orkney IJB in the short to medium term.

It is recommended:

2.2. That the IJB agrees to dedicate a future development session to addressing the example questions suggested by the Accounts Commission in Supplement 2 of its report (Appendix 3 of this report).

3. Background

3.1. In 2022 and 2023 the Accounts Commission published bulletins setting out the financial position of the 31 Scottish Integration Authorities. This latest report expands on this and provides a high-level independent analysis of IJBs, commenting on:

- The financial performance of IJBs in 2022/23 and the financial outlook for IJBs in 2023/24 and beyond.
- Performance against national health and wellbeing outcomes and targets alongside other publicly available performance information.
- A 'spotlight' focus on commissioning and procurement of social care.

3.2. The report focuses solely on IJBs. While it comments on how the Boards interact and perform within the wider system, it does not comment on the work of councils, NHS Boards or the Scottish Government or make recommendations to these bodies. It is proposed that future reports will expand the scope to include these public bodies. This will allow consideration to be given to community health and social care as a whole system and look at how different parts work together when planning and delivering services.

3.3. The key findings contained within the report can be grouped under nine main areas and are detailed below.

3.4. **General**

- IJBs are facing significant financial sustainability challenges with cost pressures only increasing.
- The demand and need for services continue to increase and become more complex.
- The workforce is under immense pressure.
- The cost-of-living crisis is affecting the demand for services as well as the ability to provide them.
- Instability of leadership within IJBs continues to be a challenge with significant turnover of key leadership roles being seen across Scotland.
- Plans for a National Care Service have brought uncertainty for IJBs.

3.5. **Finance**

- The financial health of IJBs continues to weaken and there are indications of more challenging times ahead.
- IJB funding has decreased in real terms compared to 2021/22.
- Although savings plans were largely delivered by IJBs, over a third were only achieved on a one-off basis.
- Total reserves held by IJBs almost halved in 2022/23.
- The projected financial position is set to worsen.
- The increasing reliance on non-recurring sources of income is not sustainable.
- Financial sustainability risks have been identified by auditors in the vast majority of IJBs.
- Medium term financial plans need to be updated to reflect all costs pressures currently known.

3.6. **Data**

- Data quality is insufficient to fully assess the performance of IJBs and inform improvement of outcomes for service users with a lack of joined-up data across the system.
- Work to improve the data set is at an early stage but is progressing.
- Available national indicators show a general decline in performance and outcomes for people using social care and community health services.

3.7. **Prevention and Early Intervention**

- Collaborative, preventative and person-centred working is shrinking at a time when it is most needed. Instead of a focus on care at the right place at the right time, there is a shift to reactive services with little capacity to invest in early intervention and prevention.

3.8. **Shifting the Balance of Care**

- The percentage of expenditure on Adult Social Care services has largely remained static.
- There has been an increase in the number of individuals receiving care at home or in the community, but the increase is marginal when viewed over the time since the inception of health and social care integration in 2015.
- Lack of social care capacity remains an obstacle to improving patient flow and reducing the number of delayed discharges from hospital.

3.9. **Person-Centred Care**

- The amount of choice and control service users feel they have is variable across the country.

3.10. **Reducing Inequalities**

- The COVID-19 pandemic has exacerbated existing inequalities.
- The premature mortality rate is increasing with rates higher in more urban and more deprived areas.
- Emergency bed day rates are greater in areas with higher levels of deprivation.

3.11. **Unpaid Carers**

- The reliance on unpaid carers is increasing as the social care workforce is under added pressure.

3.12. **Commissioning and Procurement**

- Commissioning and procurement practices for social care services continues to be largely driven by budgets, competition and cost, rather than outcomes for people. Although improvements to commissioning and procurement arrangements are developing these have been slow to progress, with decision-making still driven by cost rather than outcomes.
- Current commissioning and procurement practices are a risk for the sustainability of service providers and workforce and are not always delivering improved outcomes for people.
- Although there is an increasing desire to move towards more ethical and collaborative commissioning models, these have not been universally adopted.
- National approaches to improve commissioning, although developing, have been slow to progress.

4. Performance Against the National Indicators

4.1. Alongside the publication of the Accounts Commission report, the updated performance data against the core suite of integration indicators was published as Supplement 1 (Appendix 2 of this report).

4.2. The data details the performance of all 31 Integration Authorities in easily readable table format. In addition to this, a further paper is attached (Appendix 5) that looks specifically at Orkney's performance against each of the indicators.

4.3. There are some key highlights worthy of mention. These are as follows:

- In Orkney, the percentage of people with a positive experience of care at their GP practice is 90.1%. This is higher than anywhere else in the country and significantly higher than the Scottish average of 68.5%.
- The percentage of adults in Orkney receiving any care or support who rate it as good or excellent is 82.5% which is the second highest in the country. The Scottish average is 70%.
- The percentage of adults in Orkney who are supported at home who agree that their services and support has had an impact on improving or maintaining their quality of life is 79.6%. This is the second highest in the country, with the Scottish average being 69.8%.
- The hospital emergency bed day rate in Orkney has reduced again and is currently the second best performing in Scotland.
- The rate of readmissions to hospital within 28 days of discharge has also fallen again and is joint second best in the country.
- Although the current Strategic Plan explicitly aims to improve support to unpaid carers, and although Orkney still sits higher than the Scottish average, the percentage of carers who feel supported to continue in their caring role has fallen to 34% from just over 40% two years ago.
- The number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population) increased in 2023/24 and is currently above the national average.
- Although the proportion of care services graded 'good' (4) or better in Care Inspectorate inspections has increased in 2023/24 to 70.7, this is below the Scottish average of 77 and equal third lowest in the country.

5. Report recommendations to IJBs

5.1. The Accounts Commission report sets out a number of recommendations for IJBs on the basis of the findings and the key themes emerging:

- Ensure that their Medium-Term Financial Plans are up to date and reflect all current known and foreseeable costs to reflect short and longer-term financial sustainability challenges.

- Ensure that the annual budgets and proposed savings are achievable and sustainable. The budget process should involve collaboration and clear conversations with IJB partners, workforce, people who use services and other stakeholders around the difficult choices required to achieve financial sustainability.
- Work collaboratively with other IJBs and partners to systematically share learning to identify and develop: – service redesign focused on early intervention and prevention – approaches focused on improving the recruitment and retention of the workforce.
- Work collaboratively with other IJBs and partners to understand what data is available and how it can be developed and used to fully understand and improve outcomes for those using IJB commissioned services. This should include a consideration of gaps in data. It should also include consideration of measures to understand the impact of preventative approaches.
- Evaluate whether the local commissioning of care and support services, and the contracting of these services, adheres to the ethical commissioning and procurement principles, improving outcomes for people.

5.2. Should the IJB accept the recommendation to devote a development session to the findings and questions arising through the Account Commission's report, it will be possible to review and assess progress in relation to these recommendations.

6. Contribution to quality

Please indicate which of the Orkney Community Plan 2023 to 2030 values are supported in this report adding Yes or No to the relevant area(s):

Resilience: To support and promote our strong communities.	No.
Enterprise: To tackle crosscutting issues such as digital connectivity, transport, housing and fuel poverty.	Yes.
Equality: To encourage services to provide equal opportunities for everyone.	Yes.
Fairness: To make sure socio-economic and social factors are balanced.	No.
Innovation: To overcome issues more effectively through partnership working.	Yes.
Leadership: To involve partners such as community councils, community groups, voluntary groups and individuals in the process.	No.
Sustainability: To make sure economic and environmental factors are balanced.	No.

7. Resource and financial implications

7.1. Although there are no immediate financial implications arising from this report, the detail provided via the Accounts Commission publication clearly highlights the extent of the financial challenges ahead.

8. Risk and equality implications

8.1. There are no direct risk and equality implications arising directly from this report.

9. Direction required

Please indicate if this report requires a direction to be passed to:

NHS Orkney.	No.
Orkney Islands Council.	No.

10. Escalation required

Please indicate if this report requires escalated to:

NHS Orkney.	No.
Orkney Islands Council.	No.

11. Author and contact information

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12. Supporting documents

12.1. Appendix 1: Integration Joint Boards Finance and Performance 2024 – Accounts Commission.

12.2. Appendix 2: Supplement 1 – Core Suite of Indicators.

12.3. Appendix 3: Supplement 2 – IJB Members Questions Supplement.

12.4. Appendix 4: Supplement 3 – Roundtable – Critical Issues in Social Care and Social Work.

12.5. Appendix 5: Orkney Integration Indicators – 2023/24.

Appendix 1

Integration Joint Boards

Finance and performance 2024

ACCOUNTS COMMISSION

Prepared by Audit Scotland
July 2024

Contents

Accessibility

You can find out more and read this report using assistive technology on our website www.audit.scot/accessibility.

Audit team

The core audit team consisted of: Kathrine Sibbald, Zoe McGuire, Chris Lewis, Chris Dorrian and Philip Keane, under the direction of Carol Calder.

Key messages

1. Integration Joint Boards (IJBs) face a complex landscape of unprecedented pressures, challenges and uncertainties. These are not easy to resolve and are worsening, despite a driven and committed workforce. The health inequality gap is widening, there is an increased demand for services and a growing level of unmet and more complex needs. There is also variability in how much choice and control people who use services feel they have, deepening challenges in sustaining the workforce, alongside increasing funding pressures.

2. We have not seen significant evidence of the shift in the balance of care from hospitals to the community intended by the creation of IJBs. They operate within complex governance systems that can make planning and decision making difficult. They cannot address the issues across the sector alone. Whole-system collaborative working is needed as part of a clear national strategy for health and social care that will promote improved outcomes across Scotland but reflects the need to respond to local priorities.

3. The workforce is under immense pressure reflecting the wider pressures in the health and social care system. Across the community health and social care sector there are difficulties in recruiting and retaining a skilled workforce. The Covid-19 pandemic, the cost-of-living crisis and the impact of the withdrawal from the European Union have deepened existing pressures. Unpaid carers are increasingly relied on as part of the system but are also disproportionately affected by the increased cost-of-living. Without significant changes in how services are

provided and organised, these issues will get worse as demand continues to increase and the workforce pool continues to contract.

4 Uncertainty around the direction of the plans for a National Care Service and continued instability of leadership in IJBs have also contributed to the difficult context for planning and delivering effective services. We are seeing examples of IJBs trying to work in new and different ways, but there is a lack of collaboration and systematic shared learning on improvement activities.

5 The financial outlook for IJBs continues to weaken with indications of more challenging times ahead.

- In common with other public sector bodies, financial pressures arising from rising inflation, pay uplifts and Covid-19 legacy costs are making it difficult to sustain services at their current level and, collaborative, preventative and person-centred working is shrinking at a time when it is most needed.
- The financial outlook makes it more important than ever that the budget process involves clear and open conversations with IJB partners, workforce, people who use services and other stakeholders around the difficult choices required to achieve financial sustainability.
- Overall funding to IJBs in 2022/23 decreased by nine per cent in real terms or by one per cent in real terms once Covid-19 funding is excluded. The total reserves held by IJBs almost halved in 2022/23, largely due to the use and return of Covid-related reserves. The majority of IJBs reported notable savings, but these were largely arising on a non-recurring basis from unfilled vacancies.

- IJBs have had to achieve savings as part of their partner funding allocations for several years. The projected funding gap for 2023/24 has almost tripled, in comparison to the previous year, with over a third anticipated to be bridged by non-recurring savings, with a quarter of the gap bridged using reserves. This is not a sustainable approach to balancing budgets.

6 Data quality and availability is insufficient to fully assess the performance of IJBs and inform how to improve outcomes for people who use services with a lack also of joined up data sharing. However, available national indicators show a general decline in performance and outcomes.

7 Current commissioning and procurement practices are driven largely by budgets, competition, and cost rather than outcomes for people. They are not always delivering improved outcomes and are a risk for the sustainability of services. Improvement to commissioning and procurement arrangements has been slow to progress but is developing. There are some positive examples of where more ethical and collaborative commissioning models are being adopted.

Recommendations

This report and the recommendations focus on IJBs, however to respond to the significant and complex challenges in primary and community health and social care all the bodies involved need to work collaboratively on addressing the issues – IJBs alone cannot address the crisis in the sector. The next iteration of this annual report will be produced jointly with the Auditor General for Scotland and will take a whole system approach and will make recommendations to the Scottish Government, councils, NHS boards as well as IJBs, as appropriate.

Integration Joint Boards should:

- ensure that their Medium-Term Financial Plans are up to date and reflect all current known and foreseeable costs to reflect short and longer-term financial sustainability challenges
- ensure that the annual budgets and proposed savings are achievable and sustainable. The budget process should involve collaboration and clear conversations with IJB partners, workforce, people who use services and other stakeholders around the difficult choices required to achieve financial sustainability
- work collaboratively with other IJBs and partners to systematically share learning to identify and develop:
  - service redesign focused on early intervention and prevention
  - approaches focused on improving the recruitment and retention of the workforce
- work collaboratively with other IJBs and partners to understand what data is available and how it can be developed and used to fully understand and improve outcomes for those using IJB commissioned services. This should include a consideration of gaps in data. It should also include consideration of measures to understand the impact of preventative approaches
- evaluate whether the local commissioning of care and support services, and the contracting of these services, adheres to the ethical commissioning and procurement principles, improving outcomes for people.

1. Introduction

About this report

1. In 2022 and 2023 the Accounts Commission published a bulletin setting out the financial position of the 30 Scottish IJBs. This year's report expands on this and provides a high-level independent analysis of IJBs, commenting on:

- the financial performance of IJBs in 2022/23 and the financial outlook for IJBs in 2023/24 and beyond
- performance against national health and wellbeing outcomes and targets alongside other publicly available performance information
- a 'spotlight' focus on commissioning and procurement of social care.

2. This report focuses solely on IJBs. While it comments on how they interact and perform within the wider system, the work does not comment on the work of councils, NHS boards or the Scottish Government or make recommendations to these bodies. In future reports we will expand the scope to include these public bodies. This will allow us to consider community health and social care as a whole system and look at how different parts work together when planning and delivering services.

3. Supporting this report we have also published:

- a supplement collating the performance information considered in the report
- a checklist of questions, based on the issues raised in this report, for IJB board members to consider
- a summary of the discussion at a stakeholders' roundtable session we hosted in February 2024 that has helped inform this report.

What is an IJB?

4. An IJB is responsible for the governance, planning and resourcing of social care, primary and community healthcare and unscheduled hospital care for adults in its area.

5. The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) requires the 32 Scottish councils and 14 territorial NHS boards to work together in partnerships to integrate how social care and community healthcare services are provided. IJBs were created as part of the Act as separate legal bodies. Exhibit 1 (page 9) sets out how these IJBs operate.

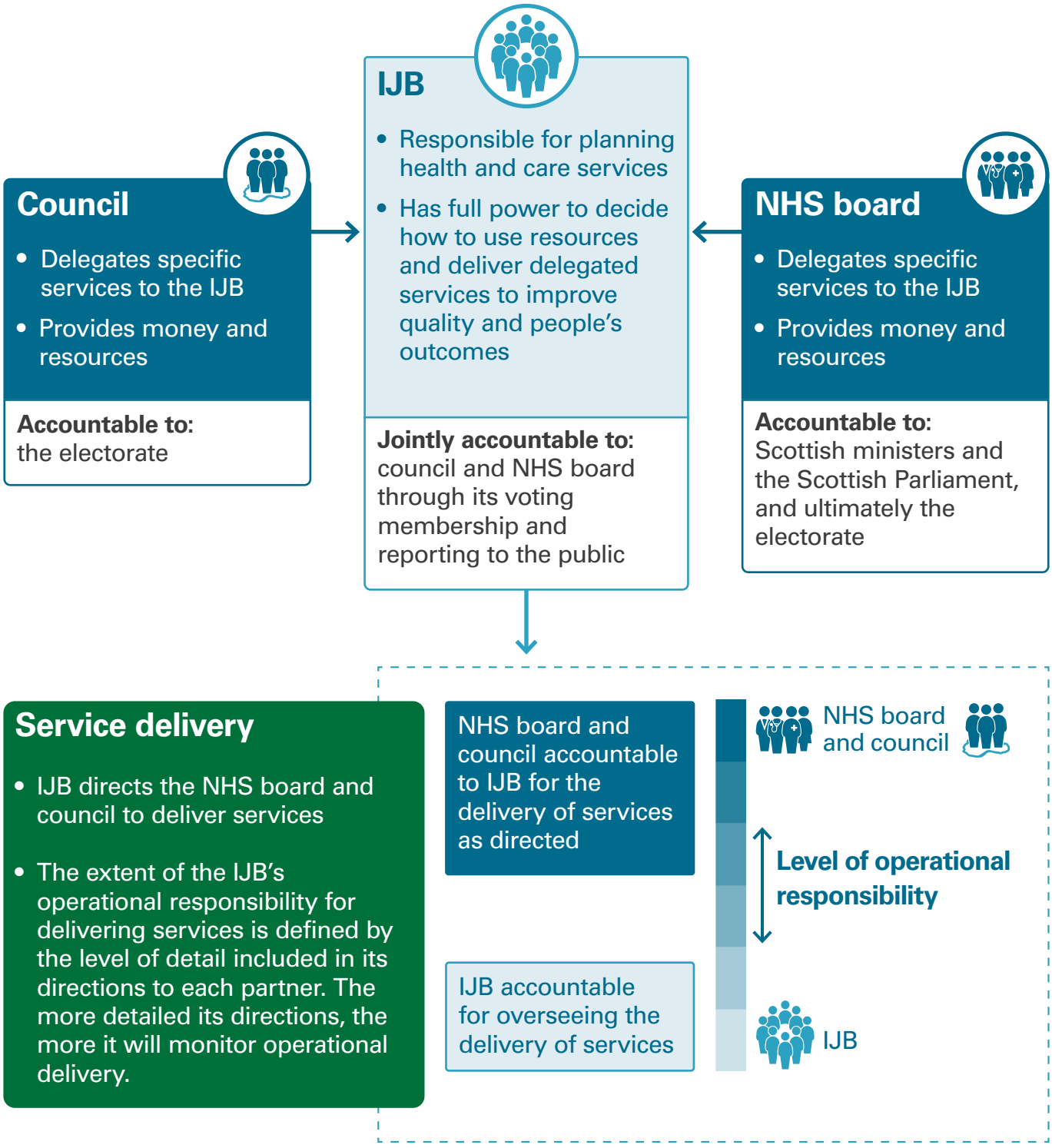
6. There are 31 partnerships across Scotland. Stirling and Clackmannanshire councils have formed a single partnership with NHS Forth Valley. The majority of NHS boards have a partnership with more than one IJB and five IJBs cover the same geographical area as their health boards.

7. Highland follows a different arrangement, a Lead Agency model.[1] This Accounts Commission report focuses on the work of the IJBs and does not comment on the performance of the Highland Health and Social Care Partnership as its scrutiny sits with the Auditor General for Scotland rather than the Accounts Commission.

8. The aim of integration is to ensure that people receive the care they need at the right time and in the right setting, with a focus on community-based, preventative care; improving the outcomes for patients, people who use services, carers and their families. The services are provided by a mixture of public, private and third sector providers dependent on who is most suitable to deliver those services.

9. The Act sets out which services are required to be delegated by councils and NHS boards to the IJBs as a minimum. This includes social care and primary and community healthcare. Services within this scope include for example, services for adults with physical disabilities, mental health services, drug and alcohol services and unscheduled health care. Some IJBs have also integrated other services. For example, 11 IJBs also have strategic responsibility for children's social care services and 16 IJBs have strategic responsibility for criminal justice social work.

Exhibit 1.
How IJBs work



Source: What is integration? A short guide to the integration of health and social care services in Scotland, April 2018, Audit Scotland

10. Audit Scotland has published reports and is currently undertaking work, on behalf of the Accounts Commission and the Auditor General for Scotland, on some of these service areas.

- Adult mental health Report published 13 September 2023.
- Children and young people who need additional support for learning Blog published 17 May 2022.
- Drug and alcohol services: An update Report published 8 March 2022 and Drug and alcohol services – audit scope Ongoing work to be published Autumn 2024.
- Social care briefing Report published 27 January 2022.
- General Medical Services contract progress Audit scope report to be published spring 2025.

2. The context

IJBs face a complex landscape of considerable challenges and uncertainties

11. Social care and primary and community healthcare services in Scotland currently face complex and unprecedented pressures and challenges. These challenges are not easily resolved and are worsening. There is an increased demand for services, deepening challenges in sustaining the workforce, alongside increasing financial pressures. These longstanding challenges have been exacerbated by the cost-of-living crisis, increasing cost of provision of services and a changing policy landscape. The Covid-19 pandemic has also had a lasting impact on this sector, given the impact on health and social care staff and the need to continue to protect vulnerable people.

12. The Independent Review of Adult Social Care[2] (Feeley Review) (published in February 2021), and the scrutiny of the National Care Service (Scotland) Bill has stimulated a lot of public debate and consideration of the need for change in the sector. But, to date there has been limited change for people experiencing or working in social care. It is important to emphasise that this is not a reflection on individuals working in the sector. Our experience, through this work, is that those involved, at all levels, are driven and passionate about improving the lives of people who need support.

13. IJBs cannot address the issues across the sector alone, whole-system collaborative working is needed as part of a clear national strategy. In the Auditor General for Scotland's NHS in Scotland 2023 report, he stated that 'there are a range of strategies, plans and policies in place for the future delivery of healthcare, but no overall vision. To shift from recovery to reform, the Scottish Government needs to lead on the development of a clear national strategy for health and social care. It should include investment in preventative measures and put patients at the centre of future services'.

IJBs are facing significant financial sustainability challenges and cost pressures are only increasing

14. In common with other public sector bodies, financial pressures arising from rising inflation, pay uplifts, the cost-of-living crisis and Covid-19 legacy costs are making it difficult to sustain services at their current level. IJBs are also experiencing an increase in prescribing costs. IJBs have had to achieve savings as part of their partner funding allocations for several years and achieving these savings, while maintaining service levels, has become increasingly difficult. IJBs are now having to consider more significant options as statutory duties have to be prioritised. This

includes ending funding for some care and support services, to ensure financial sustainability in the medium to long term.

The demand and need for services continue to increase and become more complex

15. Demographic changes and the increasing complexity of care needed are driving an increase in the demand for services. For example, an estimated one in 25 people of all ages in Scotland received social care support and services at some point during 2022/23. It is estimated that 76 per cent of these people are aged 65 and over, and 63 per cent are aged 75 and over.[3] An estimated 20 per cent of Scotland's population is aged over 65. In many rural and island areas this population group is even higher, for example 27 per cent of the population in Argyll and Bute and the Western Isles are over 65.[4]

16. The proportion of the population over the age of 65 is projected to grow by nearly a third by mid-2045. Since currently around three-quarters of people receiving social care support are aged 65 or over, this means that there will likely be a substantial rise in the number of people requiring social care support. It is likely this pattern reflects the challenges across most other services commissioned by IJBs. A recent study found that 93 per cent of people aged over 65 who received social care had two or more medical conditions simultaneously.[5] People over 75 are around twice as likely to require outpatient or inpatient care compared to those aged in their mid-20s.[6]

The workforce is under immense pressure

17. Across the primary and community health and social care sector there are difficulties in recruiting and retaining a skilled workforce. Without significant changes in how services are provided and organised, this issue will get worse as demand continues to increase and the workforce pool continues to contract. The number of people aged 25-44 is predicted to fall from 1.4 million to 1.3 million by 2045. Meanwhile the number of people aged over 75 will rise from 469,000 in 2021 to 774,000 in 2045.[7]

18. We have previously highlighted how the effects of the pandemic worsened existing pressures on the social care workforce causing experienced staff to leave their posts. Our ongoing monitoring and discussions with stakeholders show that these issues remain and the cost-of-living crisis and the ongoing impact of withdrawal from the European Union have added to the pressures.

19. The staff vacancy rates across social care and support services in Scotland is high. At 31 December 2022, 49 per cent of services reported vacancies; 63 per cent of these services with vacancies reported problems filling them. The percentage of care services reporting vacancies had been consistent over time up to and including 2020, before a large increase of 11 percentage points reported in 2021.[8]

20. Almost 90 per cent of social care providers stated recruitment and retention was problematic for them in a survey carried out by Scottish Care.[9] This survey also found that a quarter of staff leave an organisation within the first three months of joining. Providers find they are competing for staff:

- across other public, independent and third sector providers with differences in pay and terms and conditions
- with the hospitality and retail sectors, who pay more for less demanding roles
- with the health sector with an increasing disparity between health sector and social care sector wages – the current pay gap is 19 per cent between adult social care workers and NHS entry level pay.

The cost-of-living crisis is affecting the demand for services as well as the ability to provide them

21. The increased costs of living have exacerbated the workforce challenges as the low wages are making it a less favourable career choice. This is particularly an issue for those providing care at home services who are experiencing an increase in petrol costs and are not always reimbursed in a timely manner, or, in some cases, at all for all their journeys.

22. Unpaid carers are also disproportionately affected by the increased cost-of-living crisis. People in the most deprived areas are more likely to provide 50 or more hours of unpaid care a week compared to people living in the least deprived areas.[10]

23. The cost of provision of services has also increased. Homecare costs per hour have increased by 19 per cent between 2016/17 and 2022/23. Residential care costs per week (for those aged 65 and over) have increased by 23 per cent between 2016/17 and 2022/23. There are also significant cost differences between urban and rural areas.[11]

24. In particular, for smaller, independent and third sector service providers, increased costs are causing problems for the sustainability of services. For example, in residential care homes, an increase in fuel costs to heat and provide power for residents has made their financial viability increasingly challenging.

IJBs operate within complex governance systems that can make planning and decision making difficult

25. We previously reported in our Health and social care integration: update of progress report, that the current model of governance is complicated, with decisions made at IJB, council and health board level. We found that cultural differences between partner organisations are a barrier to achieving collaborative working and achieving key priorities. These challenges have not been resolved.

An unpaid carer is anyone who cares for someone who is ill, disabled, older, has mental health concerns or is experiencing addiction and is not paid by a company or council to do this. Primarily, this is a family member or friend.

Instability of leadership continues to be a challenge for IJBs

26. A notable turnover of senior leadership positions since the start of health and social care integration continues to be a concern. Half of all IJBs experienced turnover in either their chief officer and/or chief finance officer posts in the last two years. Across 2021/22 and 2022/23, seven Chief Officers, 11 Chief Financial Officers, one IJB chair and one chief social work officer changed. Instability in leadership teams has the potential to disrupt strategic planning at a time when difficult and significant decisions need to be made. It can affect the culture of an organisation at a time when the workforce is under pressure.

Plans for a National Care Service have brought uncertainty for IJBs

27. In June 2022, the Scottish Government introduced the National Care Service (Scotland) Bill to Scottish Parliament. The Bill was intended to ensure:

- consistent delivery of high-quality social care support to every single person who needs it across Scotland, including better support for unpaid carers
- that care workers are respected and valued.

28. The main elements of the Bill were the proposed creation of a National Care Service, including a national board, making Scottish Ministers accountable for social work and social care support. The original Bill also set out to transfer social care and social work council functions, staff and assets to Scottish Ministers or local care boards. This put in question the role and responsibility of IJBs and caused uncertainty for IJBs on the timescales for implementing the proposed National Care Service and what form it would likely take. This has complicated IJBs ability to undertake medium- and long-term financial planning.

29. After some delays, Stage 1 of the Bill was passed in March 2024. Amendments planned for the NCS Bill now mean IJBs will be reformed rather than replaced by 2029/30. IJBs should therefore ensure they have effective medium- and longer-term planning in place and continue to drive improvements in how they commission and deliver services.

3. Financial performance

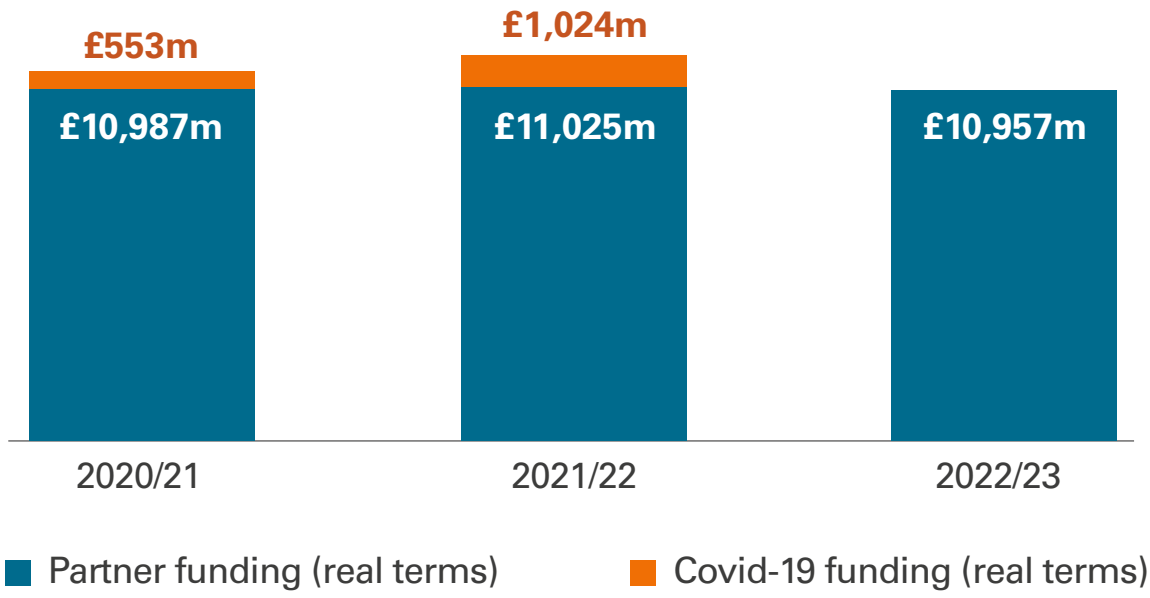
The financial health of IJBs continues to weaken and there are indications of more challenging times ahead

IJB funding has decreased in real terms compared to 2021/22

30. IJBs receive their funding as annually agreed contributions from their council and NHS board partners. Funding is largely received to cover in-year expenditure on providing services but can also be received for specific services and national initiatives to be funded in future years.

31. Funding to IJBs in 2022/23 decreased by £1.1 billion (nine per cent) in real terms to £11.0 billion; a £342 million decrease in cash terms Exhibit 2. IJBs received £1.0 billion of additional funding in 2021/22 to support their response to the Covid-19 pandemic. Excluding the 2021/22 Covid-19 related funding, this shows an underlying decrease of £68 million in real terms, representing a 1.0 per cent decrease.

Exhibit 2.
Real terms movement in IJB funding



Source: IJB audited annual accounts 2020/21, 2021/22 and 2022/23 and ONS deflators

Non-recurring savings, largely arising from unfilled vacancies, led to the majority of IJBs reporting a surplus on the cost of providing services

32. Nineteen IJBs reported a surplus on the cost of providing services, but these underspends were driven largely by vacancies and staff turnover (Exhibit 3, page 17). Three IJBs reported a break-even position and the remaining eight IJBs recorded an overspend of two per cent, or under, of their net cost of services. The three IJBs reporting a break-even position did so after receiving additional funding allocations from their partner bodies. The net underspend position on the costs of providing services across IJBs was £110 million.

33. The IJBs ability to meet the rising demand for their services and maintain service quality, is weakened by unfilled vacancies. The IJBs reporting a surplus would be unlikely to do so if the workforce was at full capacity.

The majority of the total planned savings were achieved, but over a third were achieved only on a one-off basis

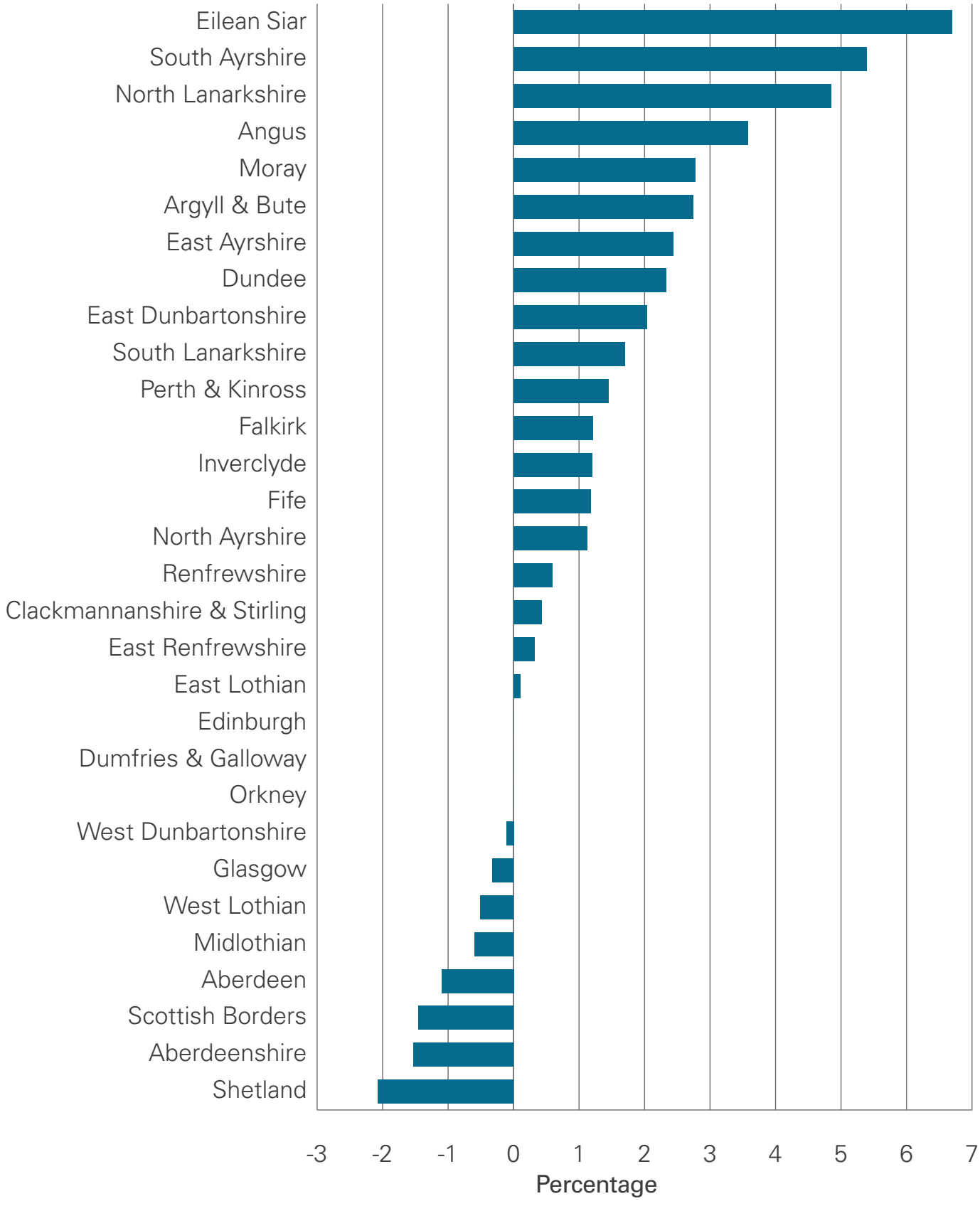
34. IJBs achieved 84 per cent of their £77 million planned savings target in 2022/23. Over a third of this was achieved on a non-recurring basis. This means that these savings will be carried forward to be found again in future years. Identifying and achieving savings every year on a recurring basis, and moving away from relying on one-off savings, is essential for IJBs to maintain financial sustainability.

Total reserves held by IJBs have almost halved in 2022/23 due largely to the use or return of Covid-19 related reserves

35. By the end of 2022/23, all IJBs reported a reduction in their total level of reserves, decreasing by £560 million to £702 million, a 44 per cent reduction.

36. The decrease in the overall reserves balance was largely the result of a reduction in the reserves of funding that the Scottish Government specifically provided for the response to the Covid-19 pandemic. The Covid-19 related reserves decreased by 97 per cent, from £502 million to £14 million. Auditors confirmed that over two-thirds (£333 million) of the Covid-19 reserve reduction was a result of unused balances being returned to the Scottish Government.

Exhibit 3.
Operational surplus as a proportion of net cost of service



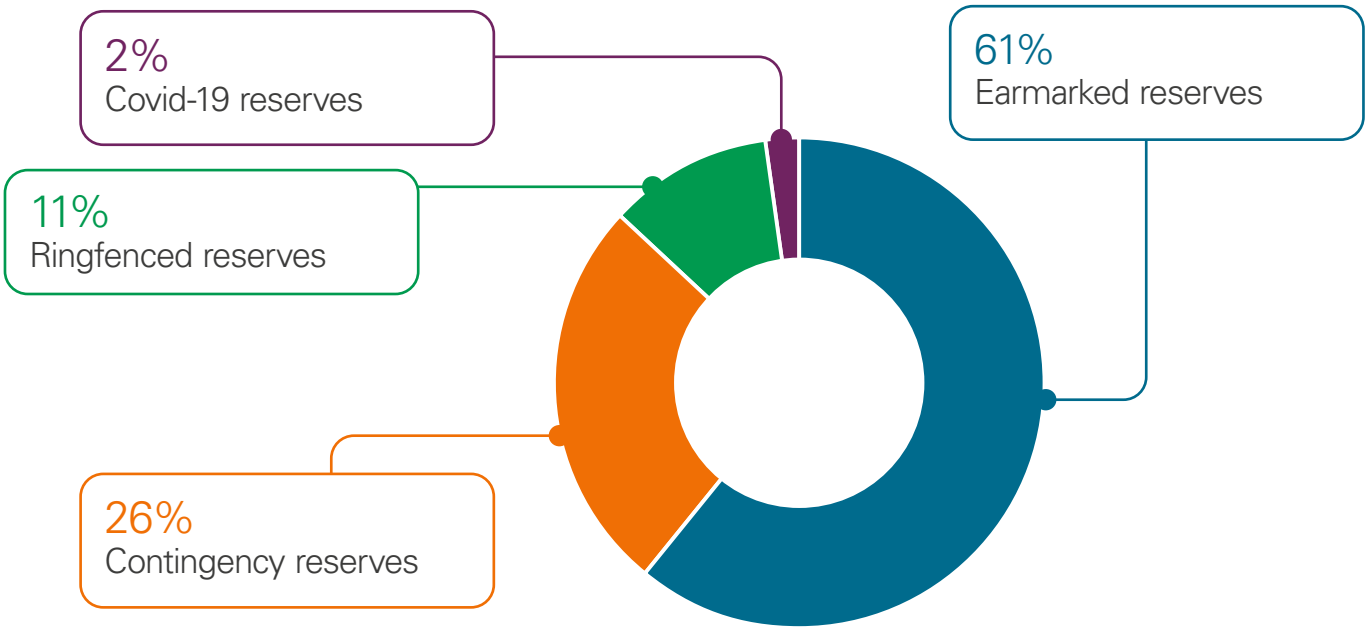
Source: IJB audited annual accounts 2022/23

37. The exceptional impact of Covid-19 reserve movements can obscure underlying reserve movements. When Covid-19 reserve movements are excluded, the total value of reserves was reduced by 10 per cent (£72 million) from £760 million to £687 million.

38. IJBs hold reserves for a variety of reasons, including reserves held to address specific local or national policy initiatives or to mitigate the financial impact of unforeseen circumstances. The reserves held by IJBs consisted largely of four main areas (Exhibit 4, page 19), as follows:

- Earmarked reserves of £426 million (£426 million in 2021/22) held by individual IJBs for a range of local planned purposes, such as reserves for multidisciplinary teams, interim care beds, as well as more generic reserves associated with winter planning and local reserves to support newer innovative practices that contribute towards strategic change.
- Ring-fenced reserves of £79 million (£185 million in 2021/22) provided to support Scottish Government national policy objectives. Examples include the Primary Care Improvement Fund, Mental Health Recovery and Renewal, Mental Health Action 15, Community Living Change Fund and Alcohol and Drug Partnership funding.
- Contingency reserves of £183 million (£148 million in 2021/22) that have not been earmarked for a specific purpose. IJBs have more flexibility on the use of this type of reserves which are often used to mitigate the financial impact of unforeseen circumstances.
- Covid-19 related reserves of £14 million (£502 million in 2021/22), representing all unspent funding received to support the impact of the pandemic on IJB services.

Exhibit 4.
2022/23 Reserves



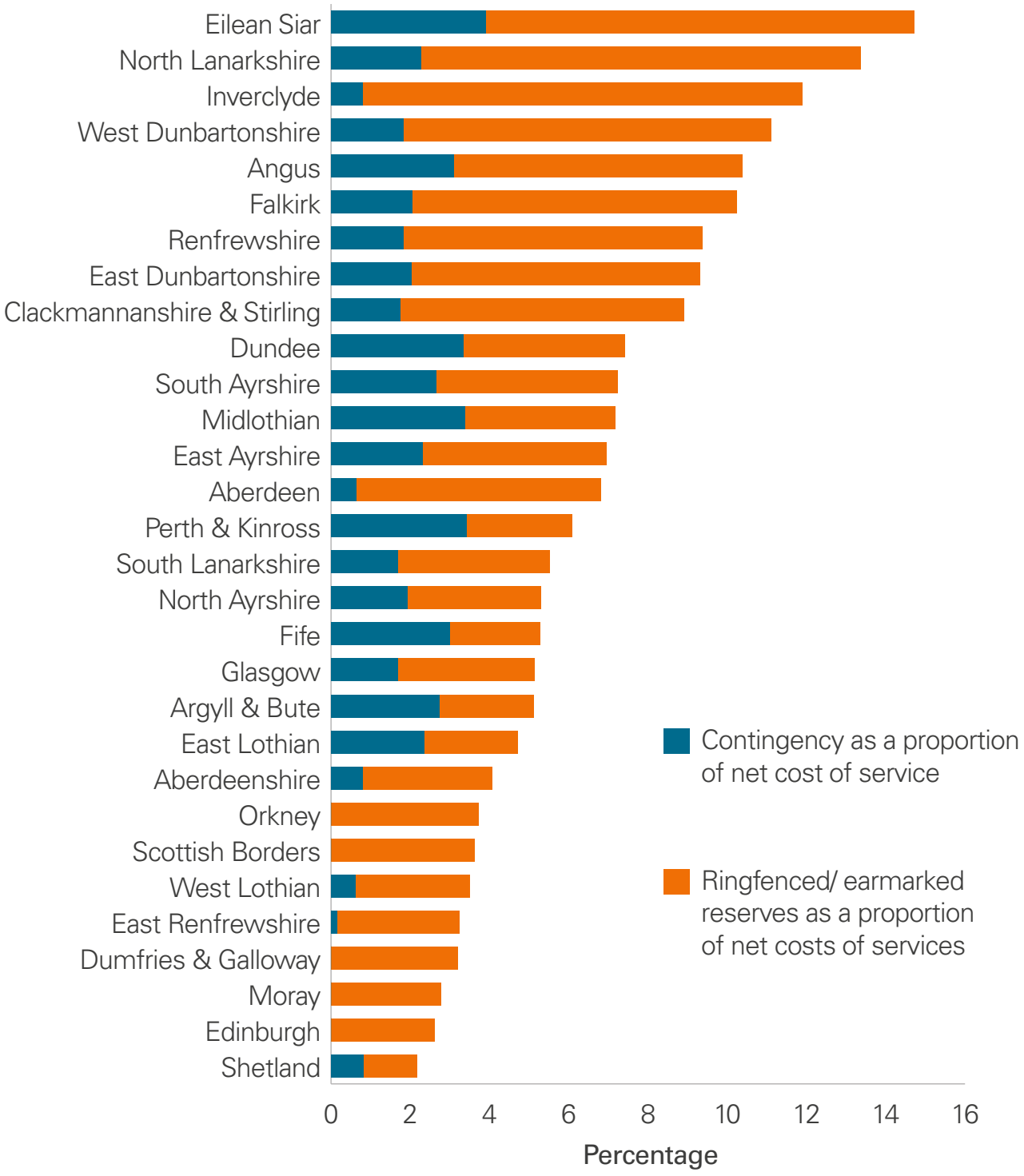
Source: IJB audited annual accounts 2022/23

39. Reserves ring-fenced to support Scottish Government national policy objectives saw a 57 per cent reduction of £106 million to £79 million. These national initiatives include programmes for primary care improvement and mental health programmes.

40. These reserve balances largely represent non-recurring amounts of money that can only be used for specific and defined national policy priorities. As these non-recurring reserves are utilised, funding will need to be identified to fund any continuing associated initiatives on a sustainable basis.

41. The reduction in reserves was slightly offset by increases in the contingency reserves and other locally earmarked reserves. Contingency reserves have continued to increase, largely as a result of unplanned vacancy savings, and now represent a quarter of the total year end reserves balance.

Exhibit 5.
Year end IJB reserves as a proportion of net cost of services



Source: IJB audited annual accounts 2022/23

42. Contingency reserves are uncommitted funds held by IJBs to mitigate the financial impact of unforeseen circumstances and the amount held will vary depending on individual IJB reserve policies. A review of a sample of ten IJB reserve policies showed that the majority (eight) had a contingency reserve target of two per cent of annually budgeted expenditure. There is no statutory maximum or minimum level of contingency reserves.

43. Seventeen IJBs reported an increase in their contingency reserves leading to a net increase of 24 per cent (£35 million) to £183 million between 2021/22 and 2022/23. Across the IJBs, contingency reserves, as a proportion of the net cost of services, ranged from zero per cent to four per cent (Exhibit 5, page 20). Two thirds of IJBs had contingency reserve levels of over two per cent of the net cost of services. Five IJBs had no contingency reserves.

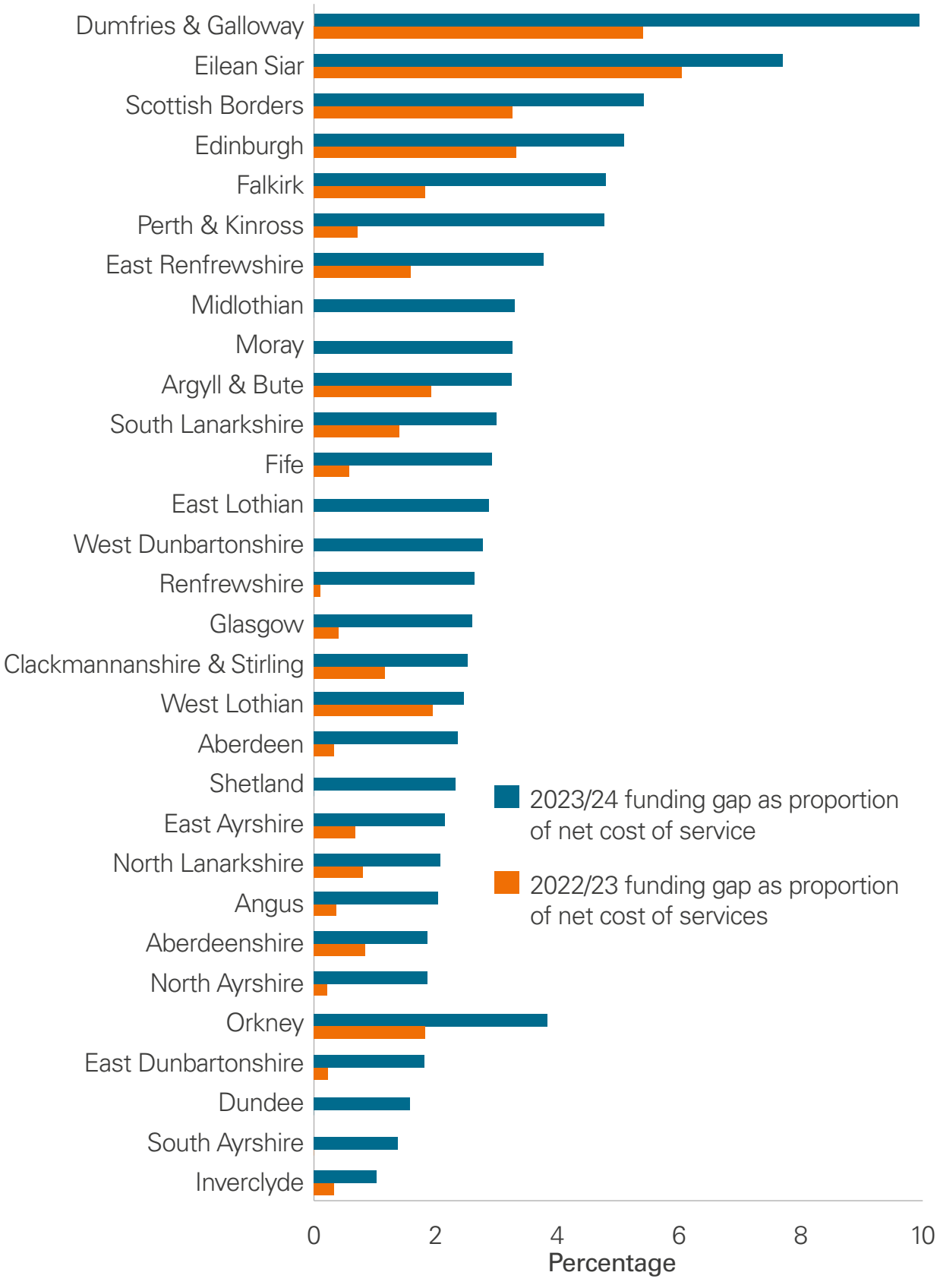
The projected financial position is set to worsen

44. Twenty five IJBs agreed their 2023/24 budget before the start of the financial year. Delays in the agreement of savings plans and uncertainty around NHS partner funding were the most common reasons for IJBs not agreeing a balanced budgets before the start of the financial year.

45. IJBs do not always receive notification of funding allocations from NHS boards before the start of the financial year. This adversely affects the IJBs' ability to plan expenditure, can cause delays to decision-making and lead to vacancies being held unfilled due to uncertainty over funding.

46. The projected funding gap for 2023/24 has almost tripled in comparison to the previous year. All IJBs reported an increase in their projected funding gap with the exception of Orkney IJB. The 2023/24 projected funding gap was £357 million representing a 187 per cent increase from the 2022/23 projected funding gap (£124 million). Funding gaps, as a proportion of the 2022/23 net cost of services, ranged from one to ten per cent (Exhibit 6, page 22).

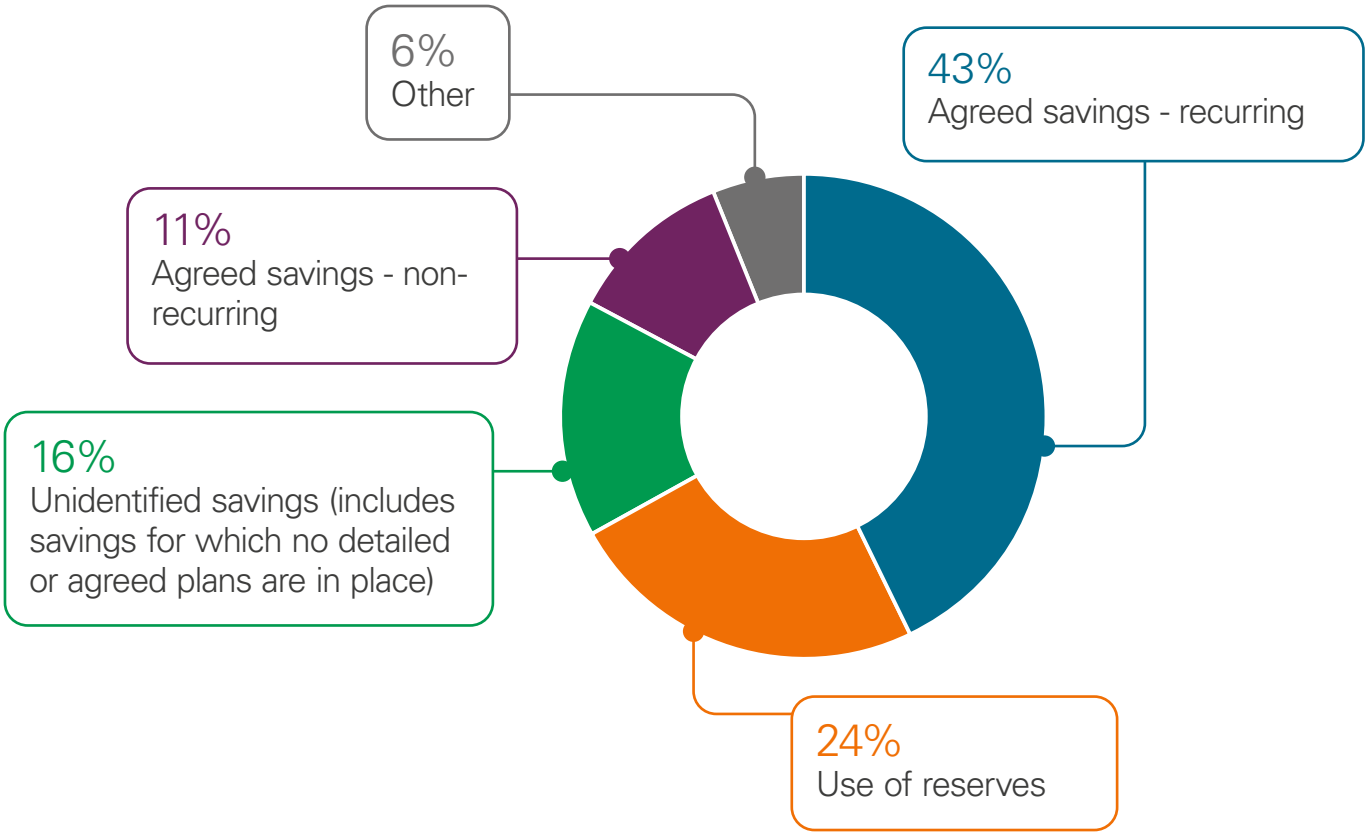
Exhibit 6.
Funding gap as a proportion of net cost of service



Source: Auditor data return

47. Of the total funding gap, 53 per cent (57 per cent in 2021/22) is anticipated to be met by identified savings, 24 per cent from the use of reserves, with actions yet to be identified to bridge the remaining gap Exhibit 7.

Exhibit 7.
2023/24 IJB funding gap planned action



Source: Auditor data return

The increasing reliance on non-recurring sources of income is not sustainable

48. At the time of the 2023/24 budget setting, over a third of the projected funding gap was anticipated to be bridged by one-off sources of funding, ie on a non-recurring basis. A quarter of the projected funding gap was planned to be bridged by the use of non-recurring reserves and a further fifth of the identified savings were anticipated to be non-recurring.

49. In addition, a significant proportion of the funding gap did not have planned savings action agreed against it at the time of budget setting. These unidentified savings made up 16 per cent of the total projected funding gap and were the result of eight IJBs not starting the 2023/24 financial year with a balanced budget.

50. The increased reliance on non-recurring sources of income to fund recurring budget pressures is unsustainable in the medium to long term. The identification and delivery of recurring savings and a reduced reliance on drawing from reserves to fund revenue expenditure will be key to ensuring long-term financial sustainability.

Financial sustainability risks have been identified by auditors in the vast majority of IJBs

51. Auditors identified financial sustainability risks for 80 per cent of IJBs as part of their 2022/23 audits. Findings suggested that there was a reliance on non-recurring savings and sources of income to achieve financial balance.

52. As recurring savings get more difficult to identify and achieve, the need for a more significant transformation of services, in order to achieve financial sustainability, becomes more important.

53. IJBs are currently facing a range of significant and growing challenges and uncertainties impacting financial sustainability and service provision, including:

- uncertainty around the level and terms of future funding settlements and funding allocations for specific initiatives
- significant recruitment and retention challenges, both with the IJB and partner bodies and with external providers in the sector
- rising demand and increasing complexity of care arising from the demographic challenges of an ageing population
- cost-of-living crisis and inflationary cost pressures, including prescribing costs, making it more expensive to maintain the same level of services

- ongoing legacy cost impacts of Covid-19, including vaccination programmes, testing and Personal Protective Equipment costs.

54. An initial analysis of 2024/25 budget setting reveals that the projected funding gap for IJBs has increased again to £456 million. This increase underlines the importance of IJB board members having clear and frank conversations not only at the board level, but with partners, providers and the wider public, about the decisions that will be required to achieve future savings and the likely implication these decisions will have on the services individuals currently receive.

Medium-Term Financial Plans need to be updated to reflect all cost pressures currently known

55. The majority of IJBs have an up to date Medium-Term Financial Plan in place, but auditors found a third needed to update their plan. It is essential that IJBs ensure Medium-Term Financial Plans are updated, reflecting all known and foreseeable costs, to allow informed decision-making on the delivery of sustainable service provision and reform in the future.

4. Performance

Data quality and availability is insufficient to fully assess the performance of IJBs, but national indicators show a general decline in performance and outcomes

Data quality and availability is insufficient to fully assess the performance of IJBs and inform actions to improve outcomes for service users with a lack of joint data across the system

56. The Public Bodies (Joint Working) (Scotland) Act 2014 sets out nine National Health and Wellbeing Outcomes. These seek to measure the impact that integration is having on people's lives. These national outcomes are underpinned by 23 associated national indicators, although four indicators have not been finalised for reporting. These national indicators have been developed from national data sources to provide consistency in measurement. IJBs are also encouraged to devise their own performance indicators for their area. Each IJB produces an annual performance report which sets out publicly its performance against key performance indicators.

57. Our review of IJB annual performance reports for 2022/23 shows the majority report against the key national performance indicators. All set out performance against their own identified strategic priorities. Some IJBs have developed their own indicators, as suggested in the Act, to help demonstrate how they are working towards their strategic outcomes. This allows for flexibility in reporting on local performance but means that describing a comprehensive national picture of performance is not possible.

58. Published performance information is not always clearly linked to the National Health and Wellbeing Outcomes with some gaps in the completeness of national performance information. Nine of the national integration performance indicators are based on the biennial Health and Care Experience Survey (HACE). Response rates for the HACE are generally quite low, with more deprived areas experiencing the lowest response rates. This increases the risk that there may be underrepresentation of the experience of certain groups of people and areas.

The IJB Performance Supplement to this report sets out the performance of each IJB against the 19 national indicators available under the National Health and Wellbeing Outcomes.

59. In our engagement with stakeholders, we heard a consistent message that data is key to a whole system approach and performance management needs to be redefined to reflect this. They indicated a range of challenges around data that is currently collected:

- The current data does not provide good evidence on how the performance of one part of the system impacts on either other parts of the social care system or the system as a whole. This means the current performance data is of limited use in helping to inform system changes which might improve performance and deliver better long-term outcomes.
- There is too much emphasis on data that is used by individual organisations for their governance and operational purposes rather than the collective partnership focus on its priorities. Current arrangements do not reflect a 'whole-systems' approach to performance management and reporting.
- A lack of good data on primary care as it is voluntary for GP's to report.
- Data is more routinely collected and published on health services than social care services.

Work to improve the data sets is at an early stage but is progressing

60. Work is being carried out by the Scottish Government and Public Health Scotland to improve data and allow the comparison of performance including the development of the Care & Wellbeing dashboard. This was launched in November 2023 and is populated with management information and updated on a weekly basis. IJB chairs and chief officers have access to the system to monitor significant shifts in performance and anomalies in the data. The system is still in its early stages of development and use.

61. There are other resources that can be utilised to assist in the analysis of data. In our Health and social care integration: update of progress 2018 report we set out the existence of Local Intelligence Support Team (LIST) analysts. Using a LIST analyst to tailor and interpret local data helps IJBs to better understand local need and demand and to plan and target services.

62. There are also examples of individual IJBs starting to manage their data in more innovative ways, for example at Midlothian IJB.
(Case study 1, page 28)

Case study 1.
Midlothian IJB outcome mapping

Midlothian IJB coordinates health and social care support to nearly 97,000 people. To better understand how the IJB contributes to personal outcomes for people, it asked all Midlothian HSCP services to track their contribution to improving outcomes using an outcome mapping approach by January 2024.

Outcome mapping is a way to understand how services contribute to people achieving the outcomes that matter to them and can help services make more targeted, locally informed decisions about how to design, deliver or commission services. This approach allows them to describe what they do, who with, what people learn and gain as a result, how this makes them feel and the difference this makes in their lives. The outcome mapping approach was developed by 'a Scottish software and consultancy company in partnership with the Midlothian HSCP Planning and Performance team.

Each 'stepping-stone' of the outcome map framework includes a set of success criteria aligned to the Care Inspectorate joint inspection framework. The outcome map is colour-coded to show an evaluation of the extent to which the service is making progress towards personal outcomes and confidence in how strong the evidence is to support that progress rating. This results in a two-factor rating system for each 'stepping-stone' in the outcome map.

The IJB also uses outcome mapping and has developed a Strategic Commissioning Map that provides a real-time picture of the whole system progress towards their strategic aims and the nine National Health and Wellbeing Outcomes by linking to service outcome maps.

Outcome mapping is now central to performance measurement in the planning and performance teams. It is part of the triangulation of three types of data: service activity, population experience, and personal outcomes. The information collected from each of these three areas together provides objective, whole system evidence that supports services to develop meaningful action plans for change.

Currently 60 per cent of service areas are using the framework. Some services are using this system to articulate, record, examine, and evaluate service provision and actively using this tool to support service redesign. Resourcing pressures continue to present challenges for some areas to find the time and space to complete a first map and a programme of targeted support is in place to help those areas with the most significant delivery pressures.

The partnership has shared this work with Healthcare Improvement Scotland (HIS), the Scottish Government team developing the National Improvement Framework for Adult Social Care and Community Health and most recently the team developing a new improvement framework for health that will support person centred care.

Source: Midlothian HSCP

Available national indicators show a general decline in performance and outcomes for people using social care and primary and community healthcare services

63. As set out in the thematic sections below (and in the performance information supplement) there is a general decline in performance against the national indicators.

64. The following sections draw out performance findings against key themes set out in the bullet points below. Alongside nationally available data, for each theme we also describe the context and challenges. Some case studies of examples are also set out in Appendix 1 (page 50). These illustrate examples of where IJBs are using or developing different working practice to improve performance and outcomes.

- Theme 1 – Prevention and early intervention
- Theme 2 – Shifting the balance of care
- Theme 3 – Person-centred care/choice and control
- Theme 4 – Reducing inequalities
- Theme 5 – Unpaid carers/community resilience.

Theme 1 Indicators – Prevention and early intervention

Collaborative, preventative and person-centred working is shrinking at a time when it is most needed. Instead of a focus on care at the right place at the right time, there is a shift to reactive services with little capacity to invest in early intervention and prevention.

65. Addressing individuals' health and social care needs at an earlier stage through prevention and early intervention promotes better outcomes for individuals, improving their quality of life and independence, and reduces the need for costly support and care later on. The 2021 Independent Review of Adult Social Care in Scotland (Feeley Review) set out the need for an increased focus on preventative, early intervention and anticipatory forms of support and a shift away from a crisis intervention. However, this is difficult to progress when the pressures on services are so acute.

66. As financial pressures have increased, eligibility criteria for individuals accessing social care services have tightened. With this, opportunities to undertake prevention and early intervention focused services have decreased. IJBs and their partner bodies have instead signposted less formalised support in the community, often provided by third and voluntary sector organisations. However, we have found that the financial challenges are leading IJBs and other funding bodies such as NHS boards and councils to reduce grant funding to these service providers reducing the capacity to meet and address these lower level, often more preventative focused needs.

67. Leaving lower-level health and social care needs unaddressed until they become more significant tends to lead to increased complexity of need, the requirement for a more resource intensive intervention and less positive outcomes for individuals in the longer term. It is essential that IJBs and their partner bodies find ways to protect and increase the health and social care interventions at an earlier stage. This will be key to addressing future demand pressures arising from demographic shifts to an older population in a more financially sustainable manner.

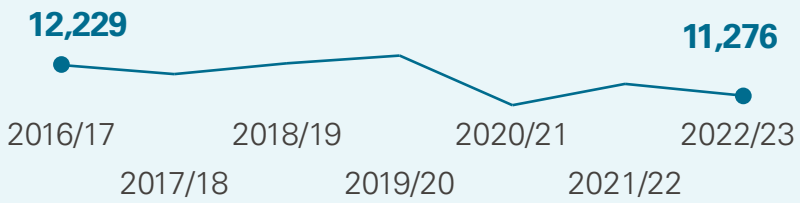
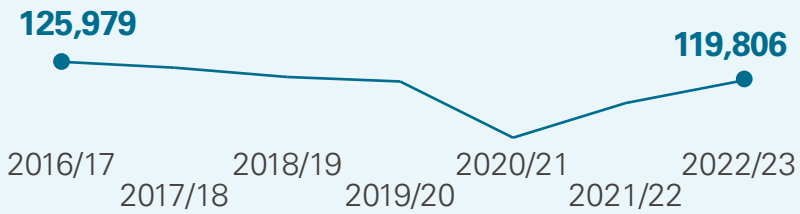
68. How well individuals consider themselves able to look after their health is indicative of the IJBs' and partner bodies' effectiveness in addressing and supporting individual needs to sustain healthy lives in the community. Since 2013/14, there has been a deterioration by four percentage points of adults who are able to look after their health either 'very well' or 'quite well' Exhibit 8. All the IJBs recorded a reduction in this measure over the period 2013/14 to 2022/23. Fourteen IJBs saw a reduction greater than average over this period, with three IJBs recording a reduction greater than five percentage points.

Exhibit 8.
Theme 1 indicators

Percentage of adults able to look after their health very well or quite well

Source: Core Suite of Integration Indicators, Public Health Scotland

Exhibit 9.
Theme 1 indicators

Emergency admission rate (per 100,000 population)		-8%
Emergency bed day rate (per 100,000 population)		-5%

Source: Core Suite of Integration Indicators, Public Health Scotland

69. Emergency admissions rate and the emergency bed day rate are often used as indicators of how well IJBs are reducing unnecessary hospital stays and situations where individuals remain in hospital while they are deemed to be fit enough to return to a more community-based setting.

70. Positively, there has been an eight per cent reduction in the emergency admissions rate as well as a five per cent reduction in the emergency bed day rate since 2016/17. Compared to 2020/21 there is an 16 per cent increase in the emergency bed day rate, however this reflects the impact of the Covid-19 pandemic Exhibit 9.

71. Eighteen IJBs recorded a reduction in emergency bed day rate over the period 2016/17 to 2022/23 Exhibit 9. Of the twelve that recorded an increase, two IJBs record an increase of over 10 per cent.

72. Some IJBs have put in place schemes and plans and maintain early intervention and prevention services. For example, Aberdeen City have set up a listening service to offer first-level support for people with low-level mental health challenges, addressing issues such as bereavement, redundancy, and life changes that can impact overall wellbeing. In Fife, a text chat service was launched in November 2022 enabling young people aged 12 to 19 to have direct, confidential access to the school nursing service. Further examples are set out in Appendix 1 (page 50).

Theme 2 Indicators – Shifting the balance of care

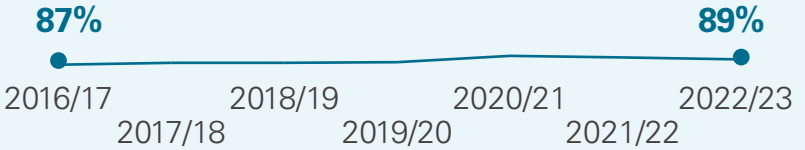
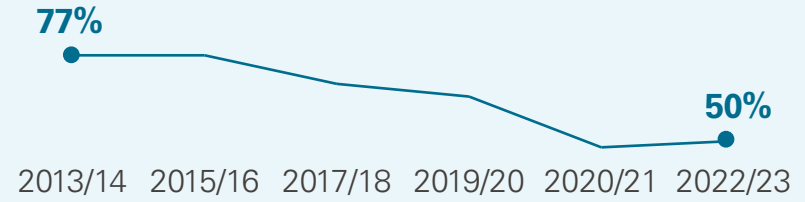
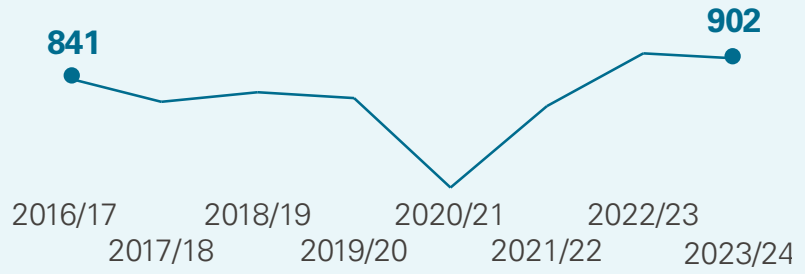
There is a recognition by the Scottish Government, councils and NHS boards that the balance of care needs to shift out of hospital to the community. Although this was the intention of the creation of IJBs, we have not seen significant evidence of this happening.

73. Part of the aims of the integration of health and social care was to help shift resources away from the institutional settings, such as hospitals and residential care institutions, and into more community-based services. The rationale for this is that, alongside it often being a more cost-effective way of providing services, it also helps promote greater independence and improved outcomes for the individual.

74. There has been an increase in the provision of services in the community, with an increase in the percentage of adults with intensive care needs receiving care at home and in the proportion of end-of-life care provided at home or in a community setting. At the same time, the percentage of expenditure on institutional and community-based Adult Social Care services has largely remained static with a small increase in the proportion spent on accommodation-based services.

75. Indicators tracking the balance of care and provision of services in the community have largely shown an increase in the number of individuals receiving care at home or in the community. However, these changes are marginal when viewed over the period since the inception of health and social care integration in 2015. There are also indications of pressures impacting the access to community-based services and the capacity of community services (Exhibit 10, page 33).

Exhibit 10.
Theme 2 indicators

Percentage of adults with intensive care needs receiving care at home		+3%
Proportion of last 6 months of life spent at home or in a community setting		+2%
Percentage of patients provided with advanced booking to GP practice (3 or more working days in advance)		-27%
Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)		+7%

Source: Core Suite of Integration Indicators, Public Health Scotland

76. At the same time there has been a deterioration in the experience of those receiving those services in the community nationally Exhibit 11.

Exhibit 11.
Theme 2 indicators

Percentage of adults supported at home who agree that they are supported to live as independently as possible	81% (2019/20) → 79% (2021/22)	-2%
Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	80% (2019/20) → 78% (2021/22)	-2%

Source: Core Suite of Integration Indicators, Public Health Scotland

77. The Auditor General for Scotland NHS in Scotland 2023 report states that 'lack of social care capacity remains an obstacle to improving patient flow and reducing the number of delayed discharges from hospital. This is supported by data showing that many patients whose discharge is delayed are awaiting the completion of care arrangements to allow them to live in their own home (awaiting social care support), waiting for a place in a nursing home, or awaiting the completion of a post-hospital social care assessment'.

78. Examples of approaches to shift the balance of care from the hospital to community settings are set out in Appendix 1 (page 50).

Theme 3 Indicators – Person-centred care: choice and control

The amount of choice and control service users feel they have is variable across the country

79. In 2010, the Scottish Government and COSLA set out a ten-year self-directed support (SDS) strategy with the aim of supporting people's right to direct their own social care support. The Social Care (Self-directed Support) (Scotland) Act 2013 was part of the SDS strategy and set out how councils should offer people options for how their social care is managed.[12]

80. The Scottish Government, IJBs, councils, providers and service users and their carers recognise the gap between what the SDS legislation is designed to do and what is happening for people trying to access services in parts of Scotland. While there are examples of people being supported in effective ways through SDS, not everyone is getting the choice and control envisaged through the strategy. Some people who use services feel they have a lack of choice and need to accept what is offered with the type of care they receive being driven by the service provider. This is most recently evidenced in the Scottish Parliament's Health, Social Care and Sport Committee post-legislative scrutiny of the Self-directed Support (Scotland) Act 2013 phase 1 report.[13] Examples of increased flexibility, choice and control were given for both individuals and unpaid carers but the Committee also reflected that many areas of improvement are required. For example, a need to improve the consistency of implementation between councils and improve clarity and knowledge around SDS by providing more support and guidance to navigate the process.

81. People who use services and their carers highlight issues accessing services. Either the times at which services are available is unsuitable or the process required to access them is overly complicated. Service users also highlighted a lack of coordination and communication between services, often having to repeat their symptoms or issues multiple times as they move from service to service. Poor data sharing was highlighted as a contributing factor.

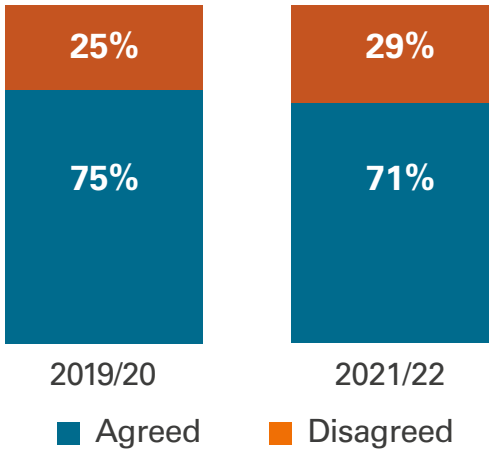
82. People who use services described being put to bed at 2pm or left in bed for hours at a time during the day. This was largely attributed to care services being under-resourced and care workers having to schedule their day to fit in additional people.

83. Research[14] has found that while those who received SDS generally had positive experiences and found it beneficial, more than one-quarter of people who use SDS had their option chosen by someone else.

84. The percentage of people who are receiving social care support through SDS is increasing, estimated at 88.5 per cent in 2021/22, up from 77.1 per cent in 2017/18.

Exhibit 12.

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



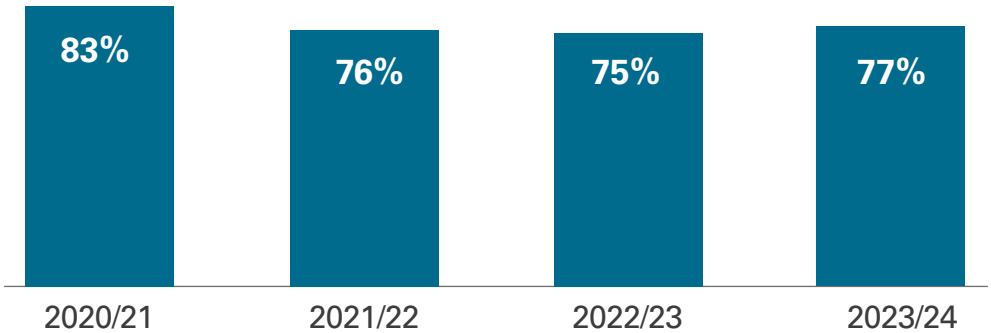
Source: Core Suite of Integration Indicators, Public Health Scotland

85. In general, there has been a deterioration in the proportion of adults who felt that they had a say in how their care is provided Exhibit 12. The latest year of data (for 2023/24) shows that 60 per cent of adults supported at home who disagreed that they had a say in how their help, care or support was provided. Due to how the data is collected this data is not comparable to previous years.

86. The Care Inspectorate amended their approach to inspections of care services in response to the Covid-19 pandemic. Inspection activity was shifted to focus on services where there were concerns or intelligence suggesting that they are a higher risk. The overall trend since 2020/21 has seen a reduction in the number of care services graded as either 'good' or better Exhibit 13.

Exhibit 13.

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

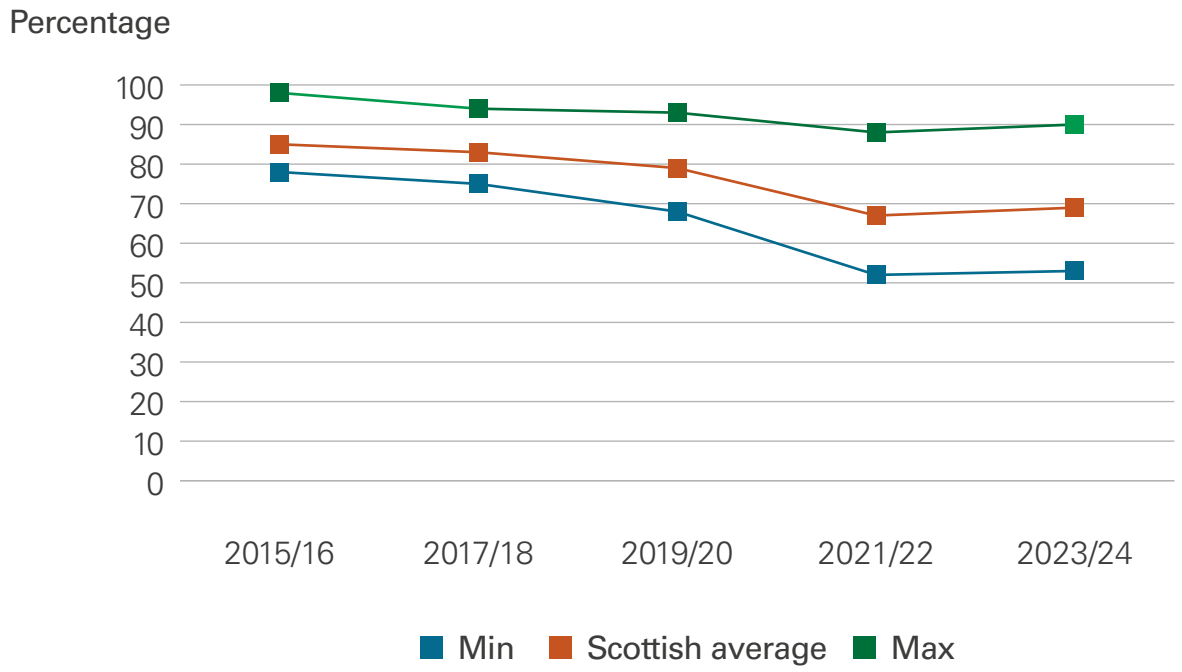


Source: Core Suite of Integration Indicators, Public Health Scotland

87. There is limited national data on access to GPs. (The Auditor General for Scotland's upcoming report on the General Medical Services contract will look further at the availability and quality of data.) However, the percentage of people reporting a positive experience of care at their GP practice between 2015/16 and 2023/24 has declined by 17 points Exhibit 14. There has been a decline across all IJBs and the gap between the best and worst performing areas has widened.

88. Some examples of IJBs working with partners to intervene to give people more choice and control and feedback on the services they receive are set out in Appendix 1 (page 50).

Exhibit 14.
Percentage of people with positive experience of care at their GP practice



Source: Core Suite of Integration Indicators, Public Health Scotland

Theme 4 Indicators – Reducing inequalities

The Covid-19 pandemic has exacerbated existing inequalities

89. A recent review[15] of health inequalities found that the health of people living in Scotland's most deprived areas is not keeping up with the rest of society. The health inequality gap is widening, evident through increased drug deaths, infant mortality and a fall in life expectancy in more deprived areas. People living in deprived areas have a significantly lower healthy life expectancy, 26 years less for males and 25 for females in the most deprived decile compared to the least deprived decile. This gap has been widening over the past decade.[16]

90. Research has found people who access social care, unpaid carers and those who work in the social care sector have been disproportionately impacted (both directly and indirectly) by the Covid-19 pandemic and mitigation measures.[17] The review also highlights that some groups could experience multiple and compounding inequalities. There is a risk that equality groups and people most at risk of having their human rights breached are set back by changes to and reductions in service provision, particularly as finances become tighter.

91. Respondents to a survey about their experiences of social care[18] who did not receive support but felt they needed it, were proportionally more likely to be non-white, disabled, living in deprived areas, LGBO (lesbian, gay, bisexual, other) and unpaid carers.

The premature mortality rate is increasing with rates higher in more urban and more deprived areas

92. The premature mortality rate is increasing across Scotland Exhibit 15 with a one per cent increase between 2016 and 2022.

Exhibit 15.
Theme 4 indicator

Source: Core Suite of Integration Indicators, Public Health Scotland

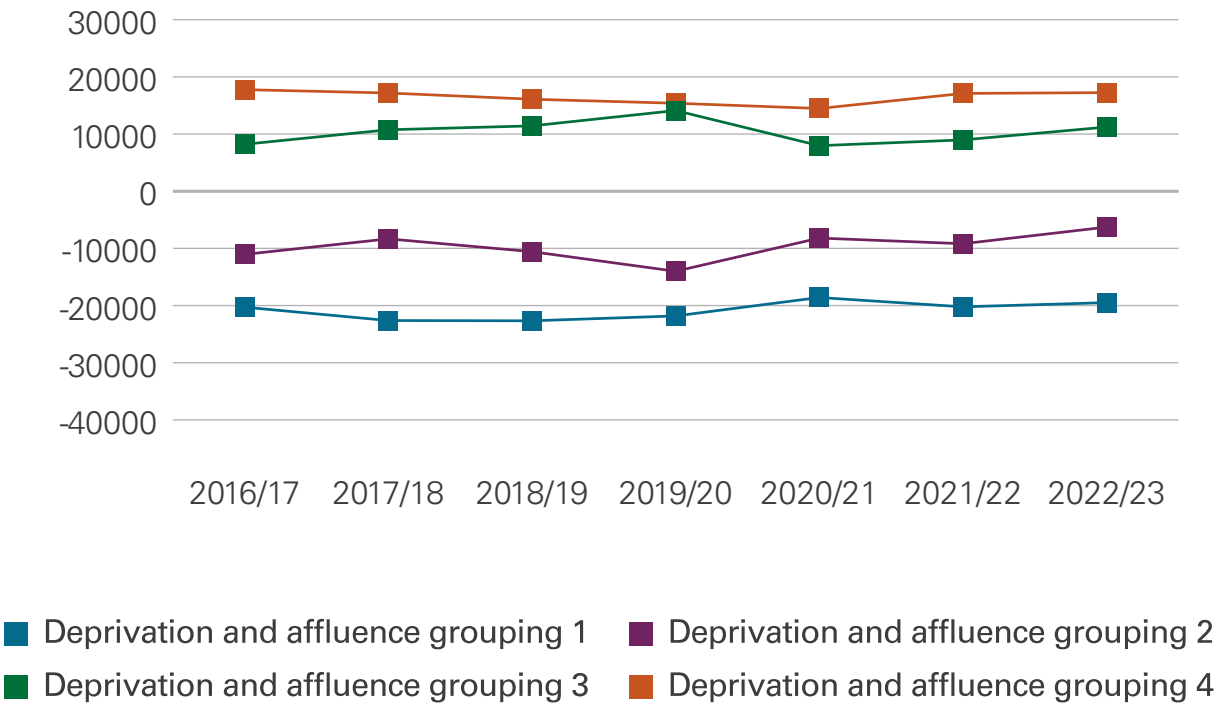
93. IJBs were found to have consistently lower rates of premature mortality in areas that were more rural and/or relatively more affluent. Five IJBs, all from more urban and less affluent areas (Dundee, Glasgow City, Inverclyde, North Lanarkshire, West Dunbartonshire), have consistently had relatively high premature mortality rates.

Emergency bed day rates are greater in areas with higher levels of deprivation

94. There is a clear relationship between the emergency bed day rate and the deprivation and affluence of an area. Using the Improvement Service's **family groupings of IJB** areas, shows that areas with higher levels of deprivation have higher levels of emergency day bed rates than areas that are more affluent Exhibit 16.

Family groups are groupings of IJBs that are similar in the type of population they serve (deprivation and affluence levels) as well as the type of area they serve (rural, semi-rural and urban).

Exhibit 16.
Emergency bed day rate (per 100,000 population): Difference to Scottish rate



Note: Grouping 1 represents the least deprived/affluent IJB areas and grouping 4 represents the most deprived/affluent

Source: Core Suite of Integration Indicators, Public Health Scotland, Improvement Service (deprivation and affluence grouping)

95. Example case studies in Appendix 1 (page 50) set out some programmes IJBs have in place to tackle inequalities in their communities and improve outcomes for all.

Theme 5 Indicators – Unpaid carers

The reliance on unpaid carers is increasing as the social care workforce is under added pressure

96. There is an enormous reliance on unpaid carers to support the social care system. These carers provide support to friends or family who need it. Carers can claim an allowance of £81.90 a week if they care for someone at least 35 hours a week. An additional carer support payment of £288.60 twice a year is also available to some carers. Although the exact number of unpaid carers is not known, as many carers don't identify themselves as such, there are an estimated 800,000 unpaid carers in Scotland; this includes 30,000 young carers under the age of 18.[19] The social care system relies on the contribution of the community and unpaid carers with the value of unpaid care estimated at £36 billion a year in Scotland.[20] The Feeley Review stated that 'The role communities play in supporting adults to remain active in their community simply cannot be overstated.'[21]

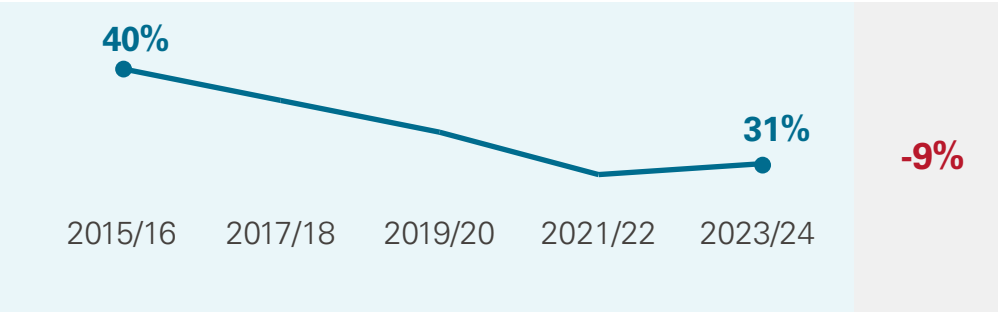
97. This reliance on unpaid carers is increasing as the social care paid workforce is under increased pressure. This is unsustainable.

98. Carers are feeling the mental, physical and financial pressure of a system under strain. Carers Scotland's latest State of Caring survey[22] found that over half (54 per cent) of carers said that their physical health had suffered because of their caring role, with one in five (20 per cent) suffering a physical injury from caring. Forty-four per cent of those on Carers Allowance are cutting back on food and heating. Research[23] carried out by the Carers Trust on the experience of older carers found:

- 80 per cent said their physical health had been affected by their caring role
- 87 per cent said their mental health and wellbeing had been affected by their caring role
- 82 per cent felt as though their caring role has financially affected them; 37 per cent have used less gas and electricity in their homes as a way to save money, and 19 per cent have skipped meals in the past 12 months
- 46 per cent of carers had missed some form of health appointment due to their caring role. This will have knock effects for the efficiency of the health service.

Exhibit 17.
Theme 5 indicator

Percentage of carers who feel supported to continue in their caring role



Source: Core Suite of Integration Indicators, Public Health Scotland

99. Caring responsibilities fall disproportionately on women, people living in rural areas and people living in deprived areas. National indicators also illustrate the declining sense of wellbeing for unpaid carers and those needing care Exhibit 17. There are provisions in the NCS Bill to improve support to unpaid carers but this has been subject to ongoing delays.

100. Some IJBs have set up interventions to support unpaid carers such as Falkirk and Clackmannanshire Carers Centre who provide information and signposting to those who are assessed as low or moderate on the unpaid carers eligibility for support.

5. Commissioning and procurement

Commissioning and procurement practices for social care services continue to be largely driven by budgets, competition, and cost rather than outcomes for people. Improvements to commissioning and procurement arrangements have been slow to progress but are developing

101. Our 2022 Social Care briefing highlighted commissioning arrangements as a key issue stating: 'Commissioning tends to focus on cost rather than quality or outcomes. Current commissioning and procurement procedures have led to competition at the expense of collaboration and quality.' In this section of this report, we focus on this issue and consider what progress is being made.

What are commissioning and procurement?

102. Commissioning identifies what is to be provided. It is the process each IJB uses to set out to its partner councils and NHS boards, what it requires them to provide to meet its strategic plan for social care and primary and community health services, based on population needs and available budgets. Procurement establishes how and who will provide the services. It is the process of contracting or purchasing specific services to meet those requirements. The IJBs do not procure the services. This is done by the relevant councils or the NHS and can be from the public, private and third sector. Scotland Excel assists some councils in procuring services and has developed national adult social care frameworks. Currently, the private sector provide 54 per cent of social care services, 24 per cent by councils, 21 per cent by the third sector and the remaining element (one per cent) by health boards.[24]

103. All IJBs have integration strategic commissioning plans. The 2014 Act sets out requirements for the plans that are also supported by Scottish Government guidance issued in 2015.[25] The plans are required to:

- be reviewed at least every three years
- set out what the arrangements are to carry out the tasks of the IJB over the three years

- divide the area geographically into at least two localities for setting out these arrangements with each locality done separately
- include how the arrangements are intended to contribute to achieving the national health and wellbeing outcomes.

104. The commissioning of social care and primary and community health services is a cyclical process carried out by a Strategic Planning Group for each IJB. This group must consider the outcomes for people and how the needs and availability of services change. Healthcare Improvement Scotland and the Care Inspectorate have produced a quality framework[26] to evaluate the effectiveness of strategic planning.

105. The Independent Review of Adult Social Care in Scotland, considered in detail the arrangements for commissioning and procuring social care services in Scotland. The review identified ten changes needed in commissioning and procurement practices.

Improvements to commissioning and procurement arrangements have been slow, with cost rather than outcomes driving decision-making

106. Commissioning and procurement decisions are currently driven largely by achieving the range and volume of services required at the lowest cost. This is understandable given the financial pressures and increased demand faced by IJBs, but the pressure on the service providers to remain competitive can reinforce a focus on driving down prices. This can be at the cost of promoting service quality, equality, innovation and collaboration with others, to improve people's outcomes.

107. Tenders for support packages for people are often constructed around time and task of the service, rather than the outcomes. This lack of flexibility in the system means that NHS and council resources can get tied up in providing services that aren't effective in improving outcomes. More flexibility is needed across the system.

108. The cyclical nature of the commissioning and procurement, mean that time and resource are focused on contracts renewal processes instead of a more strategic long-term approach.

109. As set out at paragraph 25, the current model of governance is complicated. This can cause difficulties when trying to commission services in a collaborative way. All stakeholders, including providers and users need to be part the strategic commissioning process in order to reflect what people need and want. This current approach also does not fully allow for innovation of the sector in finding solutions.

110. The current commissioning and procurement system lacks a process of accountability when people do not receive the services they need. People have described the process of accessing social care as

'notoriously difficult' and 'over-complicated' and needing to 'fight for' and 'justify' their support where they had a negative experience.[27]

Current commissioning and procurement practices are a risk for the sustainability of service providers and the workforce

111. Current arrangements are heavily reliant on a stable provider market and workforce but there are exacerbating financial and workforce issues facing providers, risking the viability of some.

112. A consequence of the current cyclical commissioning and procurement arrangements is that many risks around the effective delivery of service are largely put onto the providers. For example, where the cost of energy makes a service more expensive to deliver than the contract provides for, the provider is still required to provide the service, bearing the loss.

113. There is uncertainty for all providers, particularly in the third sector around future funding and their role in service provision. Providers are also experiencing challenges with providing services and fulfilling contracts largely due to difficulties with workforce recruitment and retention:

- Private and third sector providers find that council commissioning rates are not enough to deliver social care and support and residential, personal and nursing care, and pay expenses such as staff, training and overheads. These providers say they cannot compete with councils where pay and terms and conditions are better than they can provide due to the flat cash settlement local government receives from the Scottish Government.
- Non-committal framework agreements leading to zero hours or short hour contracts for staff.
- Contracts that do not cover travel costs, especially challenging in rural Scotland which were particularly badly affected by fuel price rises.
- Growth in split shifts and reduction in paid sleepovers for staff.
- Although there has been an uplift in adult social care workers' wages, this has not been universally applied for all social care workers as some roles have been out of scope for the intended policy outcome. This has focused on uprating pay for those on the lowest incomes. There is no equivalent uplift for those with supervisor or manager roles making these positions less desirable.
- High levels of overtime and agency costs.
- High and ongoing recruitment costs, particularly in more rural areas.

114. Local government have been calling for multi-year funding settlements from the Scottish Government to support providers with medium- to long-term planning. This is currently being discussed through the Verity House Agreement and the fiscal framework discussions.

115. As set out in the context section, the workforce feel undervalued in the system and there are unprecedented numbers of vacancies (paragraph 19). The **Fair Work** Convention Report[28] set out that 'Despite some good practice and efforts by individual employers, the wider funding and commissioning system makes it almost impossible for providers to offer fair work.' Without urgent progress on the fair working agenda nationally it is likely that the risks to the sustainability of the sector will deepen.

Fair work is work that offers all individuals an effective voice, opportunity, security, fulfilment and respect. It balances the rights and responsibilities of employers and workers.

Current commissioning and procurement practices are not always delivering improved outcomes for people

116. People who use services are often not involved in commissioning and procurement processes and therefore services are not necessarily reflective of what people need and want. The Independent Review of Adult Social Care in Scotland[29] reported that commissioning using generic frameworks based on an hourly rate does not work well for people who have fluctuating needs for support, particularly support for mental health.

117. The Self-directed Support (Scotland) Act 2013 was designed to ensure people had choice and control in how their social care support is provided. As highlighted at paragraph 80, there is a recognised implementation gap in this policy. The Scottish Parliament's Health, Social Care and Sport Committee post-legislative scrutiny of the Act has highlighted concerns around commissioning in relation to SDS including:

- the importance of facilitating collaborative commissioning conversations
- a need to develop a marketplace of providers
- a need to end competitive tendering and restrictive procurement processes
- the disparity in the relative available funding under different SDS options.

There is an increasing desire to move towards more ethical and collaborative commissioning models but it has not yet been universally adopted

118. There are examples of IJBs attempting to adopt collaborative and **ethical commissioning** processes in their strategies but these appear to be at an early stage. Almost a third of IJBs have adopted the Unison Ethical Charter for Social Care Commissioning[30] which is based on ethical commissioning principles.

Ethical commissioning aims to embed ethical standards into the commissioning and procurement process to ensure the process is around equity and quality for people, not just around efficiency and cost.

119. IJBs are reaching out for support from IRISS (Institute for Research and Innovation in Social Services) in collaborative commissioning, for example work to improve outcomes-based commissioning with East Dunbartonshire, East Ayrshire and Orkney IJBs with Healthcare Improvement Scotland. IRISS has also been supporting West Dunbartonshire and North Ayrshire IJBs to change commissioning to a more collaborative approach. Both projects are at an early stage but they have highlighted that the relationship between stakeholders are a key aspect of addressing commissioning arrangements. Significant time and resource capacity is needed to work out these relationship issues.

120. There are some strong examples of how IJBs are working to commission in a more collaborative and flexible way including Aberdeen IJB and Fife IJB. Two examples are set out in Appendix 1 (page 50).

National approaches to improve commissioning have been slow to progress but are developing

121. Across stakeholders we have engaged with, there is a recognition that commissioning needs to improve. The Feeley Report recommended that the Scottish Government and COSLA develop and agree ethical commissioning principles and core requirements. This is happening through the development of the NCS Bill, an Adult Social Care Ethical Commissioning Working Group was set up (also including the Institute for Research and Innovation in Social Services (IRISS), Social Work Scotland (SWS) and the Coalition of Care and Support Providers in Scotland (CCPS)). This group is developing a framework for ethical commissioning and has identified nine ethical commissioning principles:

- Person-led care and support
- Outcomes-focused practices
- Human rights approach
- Full involvement of people with lived experience
- Fair working practices
- High-quality care and support
- Climate and circular economy

- Financial transparency, sustainable pricing and commercial viability
- Shared accountability.

122. Current Scottish Government plans are that the NCS Bill will include a clear and comprehensive definition of ethical commissioning, with a National Care Service Board[31] providing national oversight, guidance and practical support.[32]

Endnotes

1 Lead Agency model - In Highland the NHS Board and council have adopted a different model for integration, a lead agency model. NHS Highland leads on adult services and Highland Council leads on children's services. Therefore, there is no Integrated Joint Board but an Integration Joint Monitoring Committee to monitor the planning and delivery of services. Revisions to the National Care Service Bill currently being developed, propose that Highland adopt a reformed IJB model as these are implemented.

2 Independent Review of Adult Social Care in Scotland, Derek Feeley, February 2021

3 People supported through Social Care Services: Support provided or funded by health and social care partnerships in Scotland 2022/23, Public Health Scotland, March 2024.

4 Mid-2022 Population Estimates, Scotland, National Records of Scotland, March 2024.

5 Scotland's Health and Demographic profile, Social Research, Scottish Government, June 2022.

6 Scotland's Unsustainable Health Service Modelling NHS demand to 2040, Our Scottish Future Health Commission, December 2023.

7 Population projections of Scotland - National Records of Scotland January 2023.

8 Staff vacancies in care services 2022, Care Inspectorate and Scottish Social Services Council, September 2023.

9 Workforce Recruitment and Retention Survey Findings, Scottish Care, September 2021

10 People who access social care and unpaid carers in Scotland, Scottish Government, June 2022

11 Local Government Benchmarking Framework, Improvement Service, February 2024

12 Self-directed support (SDS) aims to improve the lives of people with social care needs by empowering them to be equal partners in decisions about their care and support. Four fundamental principles of SDS are built into legislation – participation and dignity, involvement, informed choice and collaboration. The Social Care (Self-directed Support) (Scotland) Act 2013 gave councils responsibility, from April 2014 onwards, for offering people four options for how their social care is managed:

- Option 1: The individual or carer chooses and arranges the support and manages the budget as a direct payment.
- Option 2: The individual chooses the support and the authority or other organisation arranges the chosen support and manages the budget.
- Option 3: The authority chooses and arranges the support.
- Option 4: A mixture of options 1, 2 and 3.

13 Post-legislative scrutiny of the Social Care (Self-directed Support) (Scotland) Act 2013: Phase 1: SP Paper 577, Health, Social Care and Sport Committee, May 2024.

14 My Support My Choice: People's Experiences of Self-directed Support and Social Care in Scotland National Report, ALLIANCE and Self Directed Support Scotland, October 2020.
15 Leave No-one Behind The state of health and health inequalities in Scotland, The Health Foundation, An Independent Review, David Finch, Heather Wilson, Jo Bibby, January 2023.
16 Health Life Expectancy in Scotland 2019-2021, National Records of Scotland, December 2022.
17 Adult Social Care in Scotland – Equality Evidence Review, Scottish Government, June 2022.
18 Health and Care Experience Survey, Scottish Government, May 2022.
19 Scotland's Carers Update Release, Scottish Government, December 2022.
20 Independent Review of Adult Social Care in Scotland, Derek Feeley, February 2021.
21 Independent Review of Adult Social Care in Scotland, Derek Feeley, February 2021.
22 State of Caring Survey 2023, Carers Scotland, November 2023.
23 Experiences of Older Adult Unpaid Carers in Scotland, Carers Trust Scotland, March 2023.
24 Summary of No. of registered care services at 31 March 2024, Care Inspectorate.
25 Strategic commissioning plans: guidance, Scottish Government, December 2015.
26 Evaluating the Effectiveness of Strategic Planning: Quality Framework, Care Inspectorate and Healthcare Improvement Scotland.
27 Independent Review of Adult Social Care in Scotland, Derek Feeley, February 2021.
28 Fair Work in Scotland's Social Care Sector 2019, Fair Work Convention, February 2021.
29 Independent Review of Adult Social Care in Scotland, Derek Feeley, February 2021.
30 UNISON's ethical care charter, UNISON.
31 The remit and membership of a National Care Service Board will be determined by at Stage 2 of the National Care Service Bill. The overarching purpose of the Board 'will be to ensure consistent, fair, human rights-based social care support and community health services, underpinned by effective complaints mechanisms and enhanced advocacy services'.
32 National Care Service (NCS) (Scotland) Bill: Scottish Government Response to Stage 1 report, Letter from Minister for Social Care, Mental Wellbeing and Sport to Health, Social Care and Sport Committee, March 2024.

Appendix 1

Case studies

These case studies set out some examples of where integrated joint boards are using or developing different working practice to improve performance and outcomes.

Case study 2.
Early intervention and prevention services

Preventing Frailty by Improving Nutrition (Shetland)

People providing care and support have an important role in recognising risk and preventing malnutrition. A project in the summer of 2022 led by the dietetics department in collaboration with Shetland residential teams including social care workers, seniors, care home cooks and care at home staff in the community. The project included reviewing dietetic patients care, menu and mealtime observations and advice, training needs analysis and delivery of MUST (Malnutrition Universal Screening Tool) training.

The IJB reported that confidence in ability to screen for malnutrition, provide nutrition advice and care, and actioning nutritional care plans was considerably increased following training, which was provided to more than 100 staff across Shetland.

Whole Family Wellbeing Funding programme (national scheme)

The Whole Family Wellbeing Funding (WFWF) is a £500 million Scottish Government investment in preventative whole family support measures. The aims of the fund are to support the change that is necessary for reducing the need for crisis interventions in families, and to move investment towards early intervention and prevention. The scheme is funded nationally from 2022 to 2026 with any new systems or services funded locally after that period.

The programme is split into three parts:

- to provide direct support to Children's Services Planning Partnerships (CSPPs) to help expand and deliver whole family support services as well as support transformational change
- to support local transformation through National Support for Local Delivery
- support projects that take a cross Scottish Government approach to system change which progress the aims of WFWF.

An evaluation report of year one funding of the first two parts reports that substantial progress has been made so far across most CSPPs. However, they have found it difficult to achieve the pace of progress envisaged by the Scottish Government in year one of the funding.

In South Lanarkshire, the funding has enabled the recruitment of peer support workers with lived experience who are able to reduce the stigma of needing support. The funding also enabled the creation of a team of early years staff, based in NHS Lanarkshire, that will give support to families that have children under the age of five. In addition, the funding enabled the expansion of Pathfinders, a school-based family project that aims to reduce the need for later intervention.

The funding has supported North Ayrshire to add two further locations to their Family Centred Wellbeing Service. The fund has also seen the expansion of North Ayrshire's Health Visiting Team, which aims to support early intervention and prevention for children by working with the whole family.

Source: Scottish Government and Shetland Health and Social Care Partnership

Case study 3.
IJBs shifting the balance of care

Home First Response Service (Glasgow)

Glasgow's Home First Response Service has the aim of ensuring frail people spend less time in hospital. The service is community led and made of multi-disciplinary frailty teams. Each team is led by advanced frailty practitioners based in hospitals with 26 now in post following a successful pilot of the service.

One in three people identified during the pilot were discharged the same day with a care plan having been put in place.

To enable fast access to the community services needed to move frail people out of hospitals and back home, the service uses a hub and spoke service model with each of the six Health Partnerships in Glasgow having their own frailty teams.

The teams liaise with other healthcare colleagues in the community including advanced nurse practitioners, pharmacists and allied health practitioners. This ensures that people receive the same level of care that they would in a hospital setting.

The Home First Response Service has been achieving, on average, a 50 per cent early turnaround rate per month.

Integrated Discharge Hub (West Lothian)

The West Lothian Integrated Discharge Hub (IDH) was set up in 2018 at St John's Hospital to improve delayed discharges and reduce the time it was taking make arrangements for people requiring care and support in the community following discharge from hospital.

To plan the safe and timely discharge of patients, an inter-agency team consisting of discharge coordinators, hospital social workers, Carers of West Lothian as well as inhouse care team staff work with patients and their families to plan their discharge and how their ongoing requirements will be met in the community.

Since the implementation of the discharge hub the IJB reports that improvements have been seen, with reduced lengths of stay, reduced occupied acute bed days, improved performance for days lost to delays in discharge and improved processes for interim placements when a patient is waiting for care home placement.

Between December 2022 and April 2023, the average number of days between a person being admitted to St John's Hospital and being identified as needing the support of the discharge hub has been reduced by 52 per cent. The length of stay for patients getting help from the discharge hub has also been reduced by 28 per cent during the same period.

The success of the discharge hub has drawn interest from other IJBs across Scotland.

The Joint Dementia Initiative (Falkirk)

The Joint Dementia Initiative (JDI) is a registered service in the Falkirk Health and Social Care Partnership. It has two main services: a one-to-one support service, which provides care and support at the user's own home, and a Home from Home service, which provides support to users in a group setting.

The JDI service aims to help people with dementia to continue to live the life they want to live by continuing to live at home in their own communities for as long as possible. This is delivered through meaningful engagement with service users, families, and key stakeholders from across Falkirk HSCP following a person-centred approach to the care provided.

A review of the JDI was carried out in April 2021 that included arranging engagement events with service users, their families, carers, staff, and stakeholders. The aim was to improve outcomes for families and carers and identify specific areas of concern and gaps in service delivery.

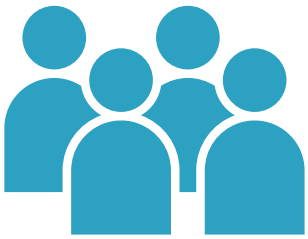
Identified as an important issue at the engagement events, the partnership looked at the flexibility of the service and dementia being a 24/7 illness. The partnership is working to provide evening and weekend support for families and carers, due to start in August 2024. These improvements would allow the partnership to achieve outcomes from their strategic plan.

A current project is being carried out to change Adult Placement Carers in the Home from Home service from self-employed to employees of the partnership. This change aims to improve recruitment and retention rates for the service.

The JDI has been successful in achieving funding from multiple funds including the Dementia Innovation Fund and the Carers Challenge Fund. This has allowed the Initiative to renovate their community space as well as create two part time support worker posts to help provide evening and weekend support to service users

Source: NHS Greater Glasgow and Clyde, West Lothian Health and Social Care Partnership, and Falkirk Health and Social Care Partnership

Case study 4.
Choice and control



Community Brokerage Network (North and South Ayrshire)

The Community Brokerage Network is well established in the Ayrshires and provide brokers, who offer free independent information about self-directed support to people and their carers at any stage in their social care journey, whether they are entitled to a formal social care assessment or not. They have successfully connected people with services that have helped them achieve their personal outcomes in a way that works for them. A Brokerage Framework for Scotland has recently been produced by Self-directed Support Scotland and its partners to help encourage the use of this model further across Scotland.

Care Opinion (Falkirk)

Care Opinion is an online integrated platform where people can safely share their experience of any health service or Care Inspectorate-registered providers of adult social care services. Care Opinion has national scale and visibility and has worked with all Scottish health boards as well as ten HSCPs. Over 29,000 stories have been shared about health and social care services in Scotland on the Care Opinion platform.

Care Opinion enables Falkirk HSCP and the commissioned providers to use online feedback as one method of learning from lived experience. The aim is to drive forward quality service improvements, build a reputation for openness, to potentially avoid formal complaints, and develop a culture of transparency across the Partnership.

Source: Self Directed Support Scotland, Falkirk Health and Social Care Partnership

Case study 5.
Work to reduce inequalities

Welfare Advice & Health Partnerships (WAHPs) programme (Glasgow)

Scottish Government funding is enabling 84 GP Practices across the most deprived parts of Glasgow to host a dedicated welfare and health adviser one day per week. According to the Partnership this has had a positive impact on patient health, poverty and health inequalities, while also freeing up staff time for clinical care. In the last year, there have been 3,997 referrals made by WAHP practice staff across Glasgow, achieving a reported £3.3 million in financial gains and £1.1 million in debt managed for people.

eFRAILTY Power BI dashboard (West Lothian)

The eFRAILTY Power BI Dashboard was created with the aim to provide a snapshot of the make-up of frailty within the West Lothian population with the goal of identifying people who could benefit from help, improving the health inequality gap. The dashboard also has the aim of mapping frailty data by GP postcode to enable the targeting of resources.

The data in the dashboard uses the Rockwood clinical frailty score from patient and carer self-assessment forms. These forms are collected at vaccination centres each year during the patient's annual flu jab. The frailty data is collected by the vaccination nurses and then entered into GP systems before being extracted and used to populate the eFRAILTY dashboard.

The dashboard is still in the scoping and data-gathering phase, however the Partnership is looking at options for how to put the data to use. An example given by the Partnership for the use of the data was to refer patients graded as having mild frailty to their Xcite Exercise referral scheme.

Source: Glasgow City Health and Social Care Partnership, Scottish Government, and West Lothian Health and Social Care Partnership

Case study 6.
Granite Care Consortium

Established in October 2020, Granite Care Consortium (GCC) is composed of a mix of ten independent and third sector care providers delivering over 12,000 hours of care a week to more than 1,200 people.

GCC was set up with the aim of creating market stability, improving outcomes for service users and building a consistent trained and skilled workforce. Competitive methods of commissioning and procurement were identified as presenting a risk of providers reducing their services or exiting the market completely. Providers also often work in silos with little input or communication from other services.

Aberdeen City Health and Social Care Partnership (ACHSCP), commissioned GCC to take a collaborative approach, with a focus on the outcomes for the individual. This saw GCC move away from a 'time and task' model towards one built around the service user. The collaboration between providers allows different types of support to be added to a care plan without the need for time consuming reassessments.

For example, someone receiving mental health support who then required personal care could have this added to their care plan in a matter of hours.

Collaboration has also enabled greater data sharing and visibility. GCC use data at a local level as well as city wide to inform decision-making. A recent test of change has seen the introducing of hotspots allowing GCC to focus on where demand for care is greatest.

Funding is provided in monthly blocks by ACHSCP which allows GCC to flex individual care and support packages without the need for social worker authorisation. This speeds up the process, improving outcomes for individuals. The number of days those aged 75+ in Aberdeen City are waiting to be discharged from hospital (per 1,000 population) stands at 112 as of November 2023. This is down from 579 in 2019/20.

GCC faces the same workforce challenges as the wider sector but is using its outcomes focussed model as a positive tool to aid recruitment and retention. Learning and development is also a large part of the workforce strategy with GCC working in partnership with Robert Gordon University to develop new ways of delivering training.

I have felt partnership working between ACHSCP and GCC has been stronger than my previous experience before GCC – Social Worker

Building trust, both from ACHSCP and the ten partnering service providers, was crucial in delivering this model. Challenging traditional ways of working and thinking was acknowledged by GCC as difficult but it reports that there is now genuine trust between all parties and the culture of collaboration is now embedded within the consortium.

The Scottish Parliament Health, Social Care and Sport Committee have identified this work as a good model to provide the basis to develop best practice in ethical commissioning.

Source: LGBF Indicators, GCC Annual Report 2020-21

Case study 7.
Fife Care Collaborative

Established in 2021 the Care at Home Collaborative was a Collaborative of 16 Independent Care at Home Providers who delivered over 90 per cent of externally commissioned care at home services in the Fife IJB area. The Collaborative in June 2024 are now made up of 41 care at home Providers including Fife Council. The split between service delivery is approximately 30 per cent Council and 70 per cent Collaborative.

The aim of the collaborative is to involve all member organisations in active engagement and participation as well as to share best practice and lessons learned. The collaborative also aims to benefit from the economy of scale of working together, for example securing funding to maintain a higher weekend pay rate has helped the retention of staff.

One of the members of the collaborative, Cera Care, commented:

'Since joining the Collaborative we have seen a dramatic improvement in the services we deliver as a whole in Fife. It has given us the opportunity to communicate with Scottish Care, Fife Council and External Providers together to input ideas and suggestions across to help each other and the people we care for.'

The collaborative makes use of a GPS tool called 'Pin-Point' which is a live dashboard of services used to manage commissioning. The IJB is able to manage capacity across the whole system by using monitoring and escalation systems that are connected to the collaborative.

A recent self-evaluation saw that previous recruitment and retention issues encountered by providers have been continuously improving and attributable to the success of the Collaborative.

Source: Fife Health and Social Care Partnership

Appendix 2

Methodology

Previous work

In 2022 and in 2023, the Accounts Commission published bulletins setting out the financial performance of IJBs. Together with the Auditor General for Scotland and Audit Scotland, we have reported more widely on the progress of health and social care integration and social care in Scotland. This includes reports in 2015 and 2018 setting out improvements needed by integration authorities. Our work in 2014 and 2017 set out the progress of the self-directed support legislation implementation and found while implementation was happening successfully in some areas, not everyone was getting the choice and control in their social care support envisaged in the legislation. In January 2022, a joint Social Care briefing set out the significant ongoing challenges impacting the delivery of social care services.

We aim to answer the following audit questions in this report:

- How well are IJBs responding to contextual challenges and improving their performance and the outcomes for people?
- How financially sustainable are IJBs and how are they responding to the financial challenges they face?
- How are IJBs using commissioning and procurement to improve performance and deliver improved outcomes in the lives of people who use social care services?

Our findings are based upon:

- the 2022/23 audited accounts and annual audit reports of IJBs and supplementary returns provided by appointed auditors
- the 2022/23 annual performance reports and Chief Social Work Officer reports of IJBs
- national data sets including core integration indicators and the Local Government Benchmarking Framework (LGBF)
- a review national reports and guidance
- a review of relevant published research
- interviews with key stakeholders including IJB chief officers and chief finance officers.

In February 2024, we hosted a roundtable discussion bringing together key stakeholders to consider the critical issues for IJBs and in particular

the provision of social care. The discussion covered immediate challenges as upcoming issues in the medium and long term. The discussion helped to inform this report and also identify future work for the Accounts Commission. The additional output sets out a summary of discussion.

Advisory Group

To support our work, an Advisory Panel was established to provide challenge and insight at key stages of the audit process. Members sat in an advisory capacity only and the content and conclusions of this report are the sole responsibility of Audit Scotland.

Members of the group included representatives from Health and Social Care Scotland, COSLA, Care Inspectorate, The ALLIANCE, Coalition of Care and Support Providers Scotland, Scottish Care and SPICe. We would like to thank them for their support.

Integration Joint Boards

Finance and performance 2024

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Core suite of integration indicators

IJB Finance and performance 2024

ACCOUNTS COMMISSION

1. The Public Bodies (Joint Working) (Scotland) Act 2014 created a legislative requirement for IJBs to report on their performance against a suite of care integration indicators.

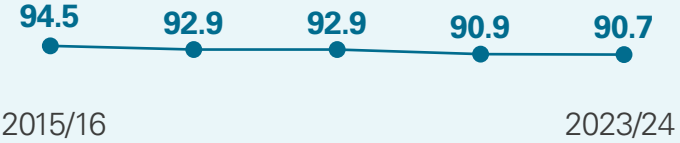
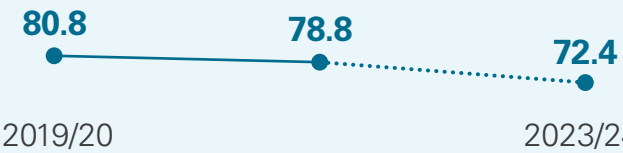
2. Around half of the indicators are based on information coming out of the biennial Health and Care Experience Survey and the remaining indicators are largely based on health, community and death information and are available on an annual basis.

3. Public Health Scotland collect and report on this information annually. Background Information on the core integration indicators, including caveats and detailed source information, can be found here.

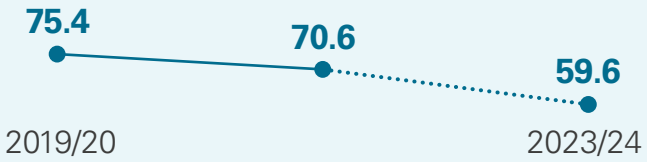
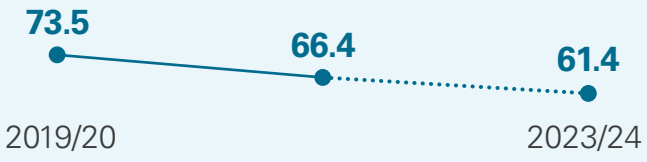
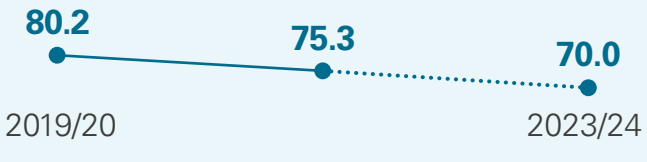
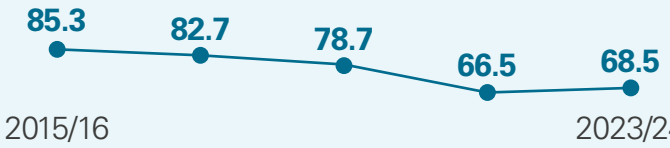
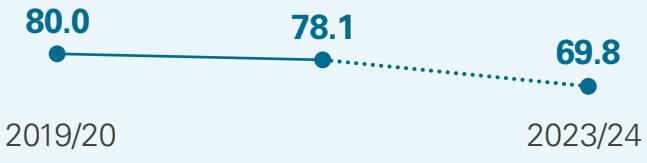
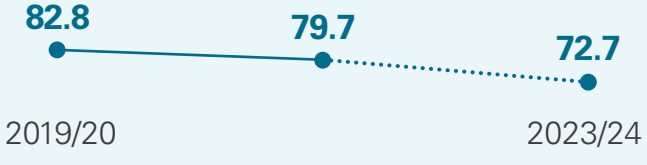
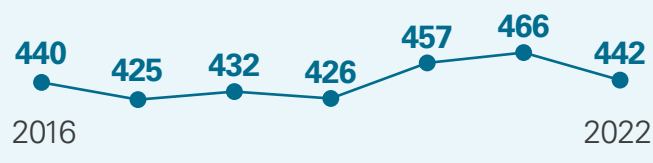
4. Below, we set out the trend in the available data and an indication of the movement since the indicator was last reported on.

National trend information

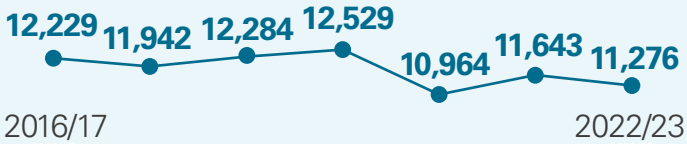
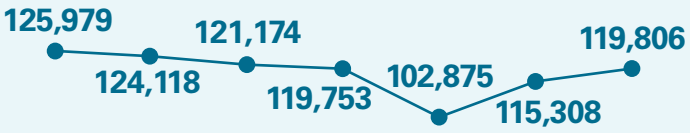
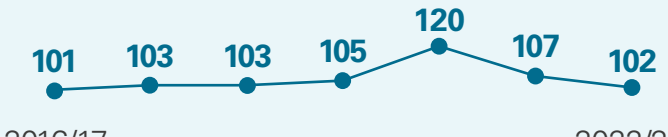
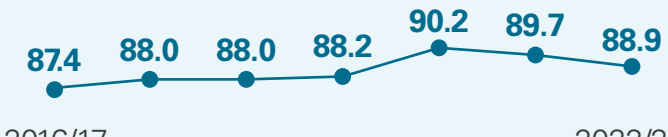
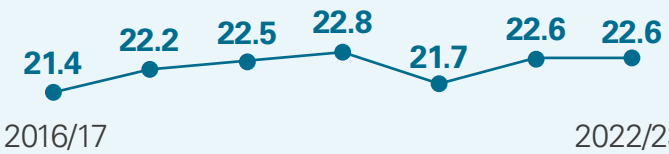
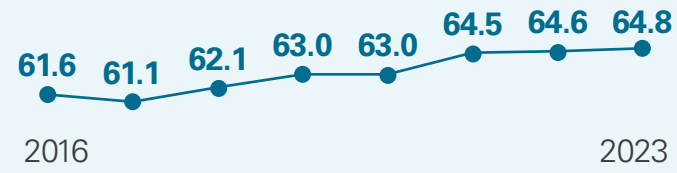
Note: Where there is an asterix * the data for 2023/24 is not comparable to previous years due to changes in survey question wording. Where the data is not directly comparable in the trend data a dotted line depicts the change.

National Indicator	Yearly trend data for all IJBs across Scotland	Latest year change (percentage points)
1. Percentage of adults able to look after their health very well or quite well		-0.2 ↓
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible		*Data not comparable

Cont.

National Indicator	Yearly trend data for all IJBs across Scotland	Latest year change (percentage points)
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided		*Data not comparable
4. Percentage of adults supported at home who agree that their health and social care services seemed to be well coordinated		*Data not comparable
5. Percentage of adults receiving any care or support who rate it as excellent or good		*Data not comparable
6. Percentage of people with positive experience of care at their GP practice		2.0 ↑
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life		*Data not comparable
8. Percentage of carers who feel supported to continue in their caring role		1.5 ↑
9. Percentage of adults supported at home who agree they felt safe		*Data not comparable
11. Premature mortality rate per 100,000 persons		-5.1 ↓

Cont.

National Indicator	Yearly trend data for all IJBs across Scotland	Latest year change (percentage points)
12. Emergency admission rate (per 100,000 population)		-3.2 ↓
13. Emergency bed day rate (per 100,000 population)		3.9 ↑
14. Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)		-4.3 ↓
15. Proportion of last 6 months of life spent at home or in a community setting		-0.8 ↓
16. Falls rate per 1,000 population aged 65+		0 ↔
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections		1.8 ↑
18. Percentage of adults with intensive care needs receiving care at home		0.2 ↑
19. Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)		-1.9 ↓

Individual current IJB performance, change since previous year reported and comparison to Scottish average in current year

1. Percentage of adults able to look after their health very well or quite well

IJB	2023/24	Trend from previous year	Compared to Scottish average
Scotland average	**90.7**		
Aberdeen City	90.4	Down	Below
Aberdeenshire	93.4	Down	Above
Angus	91.1	Down	Above
Argyll and Bute	92.4	Up	Above
Clackmannanshire and Stirling	90.8	Down	Above
Dumfries and Galloway	91.2	Down	Above
Dundee City	88.3	Down	Below
East Ayrshire	89.1	Down	Below
East Dunbartonshire	93.8	Up	Above
East Lothian	92.0	Down	Above
East Renfrewshire	92.7	Up	Above
Edinburgh	91.9	Up	Above
Falkirk	91.0	Up	Above
Fife	91.4	Up	Above
Glasgow City	87.6	Down	Below
Inverclyde	88.9	Down	Below
Midlothian	92.5	Up	Above
Moray	92.2	Down	Above
North Ayrshire	89.1	Up	Below
North Lanarkshire	87.4	Down	Below
Orkney Islands	93.7	Up	Above
Perth and Kinross	93.9	Up	Above
Renfrewshire	88.7	Down	Below
Scottish Borders	93.5	Up	Above
Shetland Islands	94.6	Up	Above
South Ayrshire	91.9	Up	Above
South Lanarkshire	89.4	Down	Below
West Dunbartonshire	88.4	Down	Below
West Lothian	89.5	Down	Below
Western Isles	91.7	Down	Above

2. Percentage of adults supported at home who agree that they are supported to live as independently as possible		
IJB	**2023/24**	**Compared to Scottish average**
Scotland average	**72.4**	
Aberdeen City	76.8	Above
Aberdeenshire	78.4	Above
Angus	74.1	Above
Argyll and Bute	79.4	Above
Clackmannanshire and Stirling	67.2	Below
Dumfries and Galloway	73.0	Above
Dundee City	77.1	Above
East Ayrshire	81.2	Above
East Dunbartonshire	79.8	Above
East Lothian	74.7	Above
East Renfrewshire	80.4	Above
Edinburgh	75.2	Above
Falkirk	67.6	Below
Fife	70.0	Below
Glasgow City	72.3	Below
Inverclyde	75.9	Above
Midlothian	76.5	Above
Moray	71.9	Below
North Ayrshire	67.5	Below
North Lanarkshire	67.7	Below
Orkney Islands	77.7	Above
Perth and Kinross	73.9	Above
Renfrewshire	65.5	Below
Scottish Borders	77.4	Above
Shetland Islands	95.4	Above
South Ayrshire	70.5	Below
South Lanarkshire	67.2	Below
West Dunbartonshire	62.7	Below
West Lothian	69.7	Below
Western Isles	78.9	Above

Note: results for indicators 2, 3, 4, 5, 7 and 9 for 2023/24 are not comparable to previous years due to changes in survey wording.

3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided		
IJB	**2023/24**	**Compared to Scottish average**
Scotland average	**59.6**	
Aberdeen City	56.5	Below
Aberdeenshire	66.2	Above
Angus	62.4	Above
Argyll and Bute	56.9	Below
Clackmannanshire and Stirling	57.9	Below
Dumfries and Galloway	60.3	Above
Dundee City	65.1	Above
East Ayrshire	69.5	Above
East Dunbartonshire	67.7	Above
East Lothian	63.9	Above
East Renfrewshire	75.0	Above
Edinburgh	57.2	Below
Falkirk	59.7	Above
Fife	51.0	Below
Glasgow City	61.5	Above
Inverclyde	67.8	Above
Midlothian	61.9	Above
Moray	59.5	Below
North Ayrshire	50.6	Below
North Lanarkshire	57.1	Below
Orkney Islands	68.1	Above
Perth and Kinross	67.9	Above
Renfrewshire	54.3	Below
Scottish Borders	63.4	Above
Shetland Islands	66.5	Above
South Ayrshire	59.5	Below
South Lanarkshire	55.4	Below
West Dunbartonshire	59.1	Below
West Lothian	53.5	Below
Western Isles	69.0	Above

Note: results for indicators 2, 3, 4, 5, 7 and 9 for 2023/24 are not comparable to previous years due to changes in survey wording.

4. Percentage of adults supported at home who agree that their health and social care services seemed to be well coordinated		
IJB	**2023/24**	**Compared to Scottish average**
Scotland average	**61.4**	
Aberdeen City	63.1	Above
Aberdeenshire	69.8	Above
Angus	55.6	Below
Argyll and Bute	66.2	Above
Clackmannanshire and Stirling	56.0	Below
Dumfries and Galloway	61.3	Below
Dundee City	63.9	Above
East Ayrshire	70.4	Above
East Dunbartonshire	66.4	Above
East Lothian	67.1	Above
East Renfrewshire	63.6	Above
Edinburgh	63.1	Above
Falkirk	53.9	Below
Fife	53.0	Below
Glasgow City	65.2	Above
Inverclyde	68.7	Above
Midlothian	74.4	Above
Moray	65.7	Above
North Ayrshire	55.5	Below
North Lanarkshire	56.0	Below
Orkney Islands	68.2	Above
Perth and Kinross	57.3	Below
Renfrewshire	55.3	Below
Scottish Borders	62.1	Above
Shetland Islands	72.8	Above
South Ayrshire	62.8	Above
South Lanarkshire	58.2	Below
West Dunbartonshire	54.3	Below
West Lothian	58.2	Below
Western Isles	63.2	Above

Note: results for indicators 2, 3, 4, 5, 7 and 9 for 2023/24 are not comparable to previous years due to changes in survey wording.

5. Percentage of adults receiving any care or support who rate it as excellent or good		
IJB	**2023/24**	**Compared to Scottish average**
Scotland average	**70.0**	
Aberdeen City	74.9	Above
Aberdeenshire	70.0	Equal
Angus	65.2	Below
Argyll and Bute	76.8	Above
Clackmannanshire and Stirling	64.8	Below
Dumfries and Galloway	68.8	Below
Dundee City	68.0	Below
East Ayrshire	78.6	Above
East Dunbartonshire	77.7	Above
East Lothian	76.3	Above
East Renfrewshire	74.0	Above
Edinburgh	74.1	Above
Falkirk	73.1	Above
Fife	63.0	Below
Glasgow City	71.2	Above
Inverclyde	70.7	Above
Midlothian	65.6	Below
Moray	68.7	Below
North Ayrshire	68.4	Below
North Lanarkshire	65.8	Below
Orkney Islands	82.5	Above
Perth and Kinross	70.1	Above
Renfrewshire	66.1	Below
Scottish Borders	72.6	Above
Shetland Islands	88.2	Above
South Ayrshire	75.4	Above
South Lanarkshire	66.7	Below
West Dunbartonshire	66.9	Below
West Lothian	62.1	Below
Western Isles	76.1	Above

Note: results for indicators 2, 3, 4, 5, 7 and 9 for 2023/24 are not comparable to previous years due to changes in survey wording.

6. Percentage of people with positive experience of care at their GP practice

IJB	2023/24	Trend from previous year	Compared to Scottish average
Scotland average	**68.5**		
Aberdeen City	60.2	Down	Below
Aberdeenshire	62.3	Up	Below
Angus	62.1	Down	Below
Argyll and Bute	83.9	Up	Above
Clackmannanshire and Stirling	72.3	Up	Above
Dumfries and Galloway	77.0	Up	Above
Dundee City	71.2	Up	Above
East Ayrshire	55.7	Down	Below
East Dunbartonshire	69.4	Up	Above
East Lothian	71.1	Up	Above
East Renfrewshire	74.9	Up	Above
Edinburgh	75.1	Up	Above
Falkirk	69.4	Up	Above
Fife	65.1	Up	Below
Glasgow City	73.7	Up	Above
Inverclyde	65.0	Up	Below
Midlothian	67.9	Up	Below
Moray	68.6	Up	Above
North Ayrshire	60.0	Down	Below
North Lanarkshire	52.8	Up	Below
Orkney Islands	90.1	Up	Above
Perth and Kinross	75.7	Up	Above
Renfrewshire	63.3	Down	Below
Scottish Borders	73.7	Up	Above
Shetland Islands	87.4	Up	Above
South Ayrshire	78.0	Up	Above
South Lanarkshire	56.5	Up	Below
West Dunbartonshire	63.8	Down	Below
West Lothian	65.7	Up	Below
Western Isles	85.5	Up	Above

7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life		
IJB	**2023/24**	**Compared to Scottish average**
Scotland average	**69.8**	
Aberdeen City	74.4	Above
Aberdeenshire	73.6	Above
Angus	70.1	Above
Argyll and Bute	75.0	Above
Clackmannanshire and Stirling	66.1	Below
Dumfries and Galloway	69.1	Below
Dundee City	71.3	Above
East Ayrshire	74.0	Above
East Dunbartonshire	69.8	Equal
East Lothian	76.1	Above
East Renfrewshire	89.6	Above
Edinburgh	72.0	Above
Falkirk	61.4	Below
Fife	67.0	Below
Glasgow City	69.7	Below
Inverclyde	73.6	Above
Midlothian	76.0	Above
Moray	69.3	Below
North Ayrshire	67.6	Below
North Lanarkshire	67.7	Below
Orkney Islands	79.6	Above
Perth and Kinross	75.8	Above
Renfrewshire	64.2	Below
Scottish Borders	76.2	Above
Shetland Islands	70.7	Above
South Ayrshire	67.4	Below
South Lanarkshire	63.3	Below
West Dunbartonshire	64.0	Below
West Lothian	64.9	Below
Western Isles	67.0	Below

Note: results for indicators 2, 3, 4, 5, 7 and 9 for 2023/24 are not comparable to previous years due to changes in survey wording.

8. Percentage of carers who feel supported to continue in their caring role

IJB	2023/24	Trend from previous year	Compared to Scottish average
Scotland average	**31.2**		
Aberdeen City	37.1	Up	Above
Aberdeenshire	29.7	Down	Below
Angus	33.7	Up	Above
Argyll and Bute	37.6	Down	Above
Clackmannanshire and Stirling	32.8	Up	Above
Dumfries and Galloway	28.8	Down	Below
Dundee City	34.3	Up	Above
East Ayrshire	36.0	Up	Above
East Dunbartonshire	25.8	Down	Below
East Lothian	35.8	Up	Above
East Renfrewshire	28.4	Up	Below
Edinburgh	31.3	Up	Above
Falkirk	30.7	Up	Below
Fife	30.3	Up	Below
Glasgow City	34.5	Up	Above
Inverclyde	31.9	Up	Above
Midlothian	34.6	Up	Above
Moray	28.2	Down	Below
North Ayrshire	31.6	Up	Above
North Lanarkshire	28.5	Up	Below
Orkney Islands	34.0	Down	Above
Perth and Kinross	31.9	Down	Above
Renfrewshire	28.5	Up	Below
Scottish Borders	28.0	Down	Below
Shetland Islands	46.3	Up	Above
South Ayrshire	30.0	Down	Below
South Lanarkshire	28.1	Down	Below
West Dunbartonshire	26.7	Down	Below
West Lothian	25.8	Up	Below
Western Isles	32.6	Down	Above

9. Percentage of adults supported at home who agree they felt safe		
IJB	**2023/24**	**Compared to Scottish average**
Scotland average	**72.7**	
Aberdeen City	72.4	Below
Aberdeenshire	79.3	Above
Angus	63.7	Below
Argyll and Bute	72.6	Below
Clackmannanshire and Stirling	66.8	Below
Dumfries and Galloway	76.3	Above
Dundee City	76.5	Above
East Ayrshire	75.8	Above
East Dunbartonshire	84.6	Above
East Lothian	79.6	Above
East Renfrewshire	79.5	Above
Edinburgh	78.6	Above
Falkirk	69.5	Below
Fife	69.1	Below
Glasgow City	72.6	Below
Inverclyde	72.7	Equal
Midlothian	79.9	Above
Moray	70.0	Below
North Ayrshire	67.5	Below
North Lanarkshire	68.4	Below
Orkney Islands	84.1	Above
Perth and Kinross	76.8	Above
Renfrewshire	66.9	Below
Scottish Borders	71.9	Below
Shetland Islands	87.5	Above
South Ayrshire	73.6	Above
South Lanarkshire	66.2	Below
West Dunbartonshire	66.7	Below
West Lothian	67.6	Below
Western Isles	75.8	Above

Note: results for indicators 2, 3, 4, 5, 7 and 9 for 2023/24 are not comparable to previous years due to changes in survey wording.

11. Premature mortality rate per 100,000 persons, by calendar year

IJB	2022	Trend from previous year	Compared to Scottish average
Scotland average	**442**		
Aberdeen City	441	Down	Below
Aberdeenshire	338	Down	Below
Angus	390	Down	Below
Argyll and Bute	398	Up	Below
Clackmannanshire and Stirling	407	Down	Below
Dumfries and Galloway	428	Down	Below
Dundee City	546	Down	Above
East Ayrshire	515	Down	Above
East Dunbartonshire	302	Up	Below
East Lothian	357	Down	Below
East Renfrewshire	264	Down	Below
Edinburgh	411	Up	Below
Falkirk	473	Down	Above
Fife	431	Down	Below
Glasgow City	615	Down	Above
Inverclyde	542	Up	Above
Midlothian	428	Up	Below
Moray	330	Down	Below
North Ayrshire	527	Down	Above
North Lanarkshire	510	Down	Above
Orkney Islands	393	Up	Below
Perth and Kinross	380	Up	Below
Renfrewshire	463	Down	Above
Scottish Borders	358	Up	Below
Shetland Islands	282	Down	Below
South Ayrshire	422	Down	Below
South Lanarkshire	459	Down	Above
West Dunbartonshire	551	Down	Above
West Lothian	439	Down	Below
Western Isles	473	Up	Above

12. Emergency admission rate (per 100,000 population)

IJB	2022/23	Trend from previous year	Compared to Scottish average
Scotland average	**11,276**		
Aberdeen City	9,360	Down	Below
Aberdeenshire	8,572	Up	Below
Angus	11,525	Up	Above
Argyll and Bute	11,968	Down	Above
Clackmannanshire and Stirling	13,037	Up	Above
Dumfries and Galloway	12,102	Down	Above
Dundee City	13,097	Up	Above
East Ayrshire	13,582	Down	Above
East Dunbartonshire	11,098	Up	Below
East Lothian	9,173	Down	Below
East Renfrewshire	9,216	Down	Below
Edinburgh	7,340	Down	Below
Falkirk	14,679	Up	Above
Fife	12,872	Up	Above
Glasgow City	11,163	Down	Below
Inverclyde	12,444	Down	Above
Midlothian	9,517	Down	Below
Moray	8,273	Down	Below
North Ayrshire	13,449	Down	Above
North Lanarkshire	15,111	Down	Above
Orkney Islands	9,538	Down	Below
Perth and Kinross	12,526	Up	Above
Renfrewshire	10,778	Down	Below
Scottish Borders	9,840	Down	Below
Shetland Islands	9,746	Up	Below
South Ayrshire	14,303	Down	Above
South Lanarkshire	12,530	Down	Above
West Dunbartonshire	13,015	Down	Above
West Lothian	11,153	Down	Below
Western Isles	14,277	Up	Above

13. Emergency bed day rate (per 100,000 population)			
IJB	**2022/23**	**Trend from previous year**	**Compared to Scottish average**
Scotland average	**119,806**		
Aberdeen City	99,923	↑ Up	⊖ Below
Aberdeenshire	87,853	↑ Up	⊖ Below
Angus	96,778	↑ Up	⊖ Below
Argyll and Bute	118,552	↑ Up	⊖ Below
Clackmannanshire and Stirling	115,181	↑ Up	⊖ Below
Dumfries and Galloway	142,256	↑ Up	⊕ Above
Dundee City	114,287	↑ Up	⊖ Below
East Ayrshire	130,667	↑ Up	⊕ Above
East Dunbartonshire	126,381	↑ Up	⊕ Above
East Lothian	115,986	↓ Down	⊖ Below
East Renfrewshire	108,721	↑ Up	⊖ Below
Edinburgh	98,783	↓ Down	⊖ Below
Falkirk	135,305	↑ Up	⊕ Above
Fife	118,148	↑ Up	⊖ Below
Glasgow City	133,843	↑ Up	⊕ Above
Inverclyde	154,188	↑ Up	⊕ Above
Midlothian	118,079	↑ Up	⊖ Below
Moray	98,741	↑ Up	⊖ Below
North Ayrshire	151,553	↓ Down	⊕ Above
North Lanarkshire	126,261	↑ Up	⊕ Above
Orkney Islands	86,572	↓ Down	⊖ Below
Perth and Kinross	121,394	↑ Up	⊕ Above
Renfrewshire	130,472	↓ Down	⊕ Above
Scottish Borders	131,395	↑ Up	⊕ Above
Shetland Islands	72,909	↑ Up	⊖ Below
South Ayrshire	172,992	↑ Up	⊕ Above
South Lanarkshire	122,237	↑ Up	⊕ Above
West Dunbartonshire	152,062	↑ Up	⊕ Above
West Lothian	95,797	↑ Up	⊖ Below
Western Isles	133,554	↑ Up	⊕ Above

14. Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)			
IJB	**2022/23**	**Trend from previous year**	**Compared to Scottish average**
Scotland average	**102**		
Aberdeen City	119	Down	Above
Aberdeenshire	92	Down	Below
Angus	115	Up	Above
Argyll and Bute	84	Down	Below
Clackmannanshire and Stirling	126	Down	Above
Dumfries and Galloway	95	Up	Below
Dundee City	139	Down	Above
East Ayrshire	104	Down	Above
East Dunbartonshire	79	Down	Below
East Lothian	88	Down	Below
East Renfrewshire	69	Down	Below
Edinburgh	92	Down	Below
Falkirk	141	Down	Above
Fife	117	Up	Above
Glasgow City	96	Down	Below
Inverclyde	76	Down	Below
Midlothian	96	Down	Below
Moray	80	Down	Below
North Ayrshire	100	Down	Below
North Lanarkshire	117	Up	Above
Orkney Islands	69	Down	Below
Perth and Kinross	137	Up	Above
Renfrewshire	80	Down	Below
Scottish Borders	121	Up	Above
Shetland Islands	68	Down	Below
South Ayrshire	100	Down	Below
South Lanarkshire	100	Down	Below
West Dunbartonshire	82	Down	Below
West Lothian	95	Down	Below
Western Isles	108	Down	Above

15. Proportion of last 6 months of life spent at home or in a community setting			
IJB	**2022/23**	**Trend from previous year**	**Compared to Scottish average**
Scotland average	**88.9**		
Aberdeen City	90.3	Down	Above
Aberdeenshire	90.7	Down	Above
Angus	92.2	Down	Above
Argyll and Bute	89.6	Down	Above
Clackmannanshire and Stirling	89.3	Down	Above
Dumfries and Galloway	88.5	Down	Below
Dundee City	90.0	Down	Above
East Ayrshire	88.9	Down	Equal
East Dunbartonshire	88.1	Down	Below
East Lothian	88.0	Up	Below
East Renfrewshire	87.7	Down	Below
Edinburgh	88.0	Down	Below
Falkirk	88.1	Down	Below
Fife	89.8	Down	Above
Glasgow City	88.0	Down	Below
Inverclyde	87.8	Down	Below
Midlothian	87.1	Down	Below
Moray	90.5	Down	Above
North Ayrshire	87.9	Down	Below
North Lanarkshire	89.0	Down	Above
Orkney Islands	90.9	Down	Above
Perth and Kinross	88.7	Down	Below
Renfrewshire	88.8	Up	Below
Scottish Borders	87.7	Down	Below
Shetland Islands	93.4	Down	Above
South Ayrshire	87.6	Down	Below
South Lanarkshire	88.8	Down	Below
West Dunbartonshire	87.7	Down	Below
West Lothian	89.8	Down	Above
Western Isles	90.1	Down	Above

16. Falls rate per 1,000 population aged 65+

IJB	2022/23	Trend from previous year	Compared to Scottish average
Scotland average	**22.6**		
Aberdeen City	20.8	Down	Below
Aberdeenshire	17.2	Down	Below
Angus	26.5	Up	Above
Argyll and Bute	27.6	Down	Above
Clackmannanshire and Stirling	23.8	Up	Above
Dumfries and Galloway	20.2	Up	Below
Dundee City	33.5	Up	Above
East Ayrshire	18.4	Down	Below
East Dunbartonshire	22.6	Up	Equal
East Lothian	21.3	Down	Below
East Renfrewshire	23.7	Down	Above
Edinburgh	23.1	Down	Above
Falkirk	25.3	Up	Above
Fife	26.8	Down	Above
Glasgow City	27.3	Down	Above
Inverclyde	23.7	Up	Above
Midlothian	20.0	Down	Below
Moray	17.7	Down	Below
North Ayrshire	20.4	Up	Below
North Lanarkshire	20.0	Down	Below
Orkney Islands	19.9	Up	Below
Perth and Kinross	27.8	Up	Above
Renfrewshire	25.1	Up	Above
Scottish Borders	15.8	Down	Below
Shetland Islands	24.4	Up	Above
South Ayrshire	19.4	Down	Below
South Lanarkshire	22.7	Up	Above
West Dunbartonshire	23.7	Up	Above
West Lothian	19.8	Down	Below
Western Isles	22.8	Down	Above

17. Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections

IJB	2023/24	Trend from previous year	Compared to Scottish average
Scotland average	**77.0**		
Aberdeen City	70.7	Up	Below
Aberdeenshire	78.5	Up	Above
Angus	71.3	Up	Below
Argyll and Bute	77.3	Down	Above
Clackmannanshire and Stirling	84.6	Up	Above
Dumfries and Galloway	74.2	Down	Below
Dundee City	77.5	Up	Above
East Ayrshire	78.0	Up	Above
East Dunbartonshire	85.6	Down	Above
East Lothian	82.5	Up	Above
East Renfrewshire	89.3	Up	Above
Edinburgh	83.5	Up	Above
Falkirk	86.9	Up	Above
Fife	68.7	Up	Below
Glasgow City	82.7	Up	Above
Inverclyde	80.6	Up	Above
Midlothian	76.4	Up	Below
Moray	81.1	Up	Above
North Ayrshire	82.9	Up	Above
North Lanarkshire	75.8	Down	Below
Orkney Islands	70.7	Up	Below
Perth and Kinross	70.8	Down	Below
Renfrewshire	75.4	Down	Below
Scottish Borders	70.6	Down	Below
Shetland Islands	88.9	Up	Above
South Ayrshire	73.4	Up	Below
South Lanarkshire	79.9	Up	Above
West Dunbartonshire	81.4	Down	Above
West Lothian	85.1	Up	Above
Western Isles	89.8	Up	Above

18. Percentage of adults with intensive care needs receiving care at home

IJB	2023	Trend from previous year	Compared to Scottish average
Scotland average	**64.8**		
Aberdeen City	54.6	Equal	Below
Aberdeenshire	62.9	Down	Below
Angus	63.1	Up	Below
Argyll and Bute	68.3	Down	Above
Clackmannanshire and Stirling	70.4	Up	Above
Dumfries and Galloway	77.8	Up	Above
Dundee City	61.8	Up	Below
East Ayrshire	71.6	Up	Above
East Dunbartonshire	65.1	Down	Above
East Lothian	62.0	Up	Below
East Renfrewshire	64.4	Down	Below
Edinburgh	68.8	Up	Above
Falkirk	67.8	Up	Above
Fife	59.2	Down	Below
Glasgow City	59.3	Up	Below
Inverclyde	67.4	Down	Above
Midlothian	70.3	Up	Above
Moray	60.6	Down	Below
North Ayrshire	77.7	Up	Above
North Lanarkshire	69.9	Down	Above
Orkney Islands	69.5	Down	Above
Perth and Kinross	63.8	Down	Below
Renfrewshire	63.8	Up	Below
Scottish Borders	59.5	Down	Below
Shetland Islands	77.7	Down	Above
South Ayrshire	63.6	Down	Below
South Lanarkshire	62.9	Down	Below
West Dunbartonshire	70.2	Down	Above
West Lothian	63.7	Up	Below
Western Isles	60.2	Equal	Below

19. Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)			
IJB	**2023/24**	**Trend from previous year**	**Compared to Scottish average**
Scotland average	**902**		
Aberdeen City	220	Down	Below
Aberdeenshire	667	Up	Below
Angus	166	Down	Below
Argyll and Bute	912	Up	Above
Clackmannanshire and Stirling	814	Up	Below
Dumfries and Galloway	1,304	Down	Above
Dundee City	428	Down	Below
East Ayrshire	700	Up	Below
East Dunbartonshire	444	Down	Below
East Lothian	238	Up	Below
East Renfrewshire	391	Down	Below
Edinburgh	1,087	Down	Above
Falkirk	1,283	Down	Above
Fife	681	Down	Below
Glasgow City	962	Down	Above
Inverclyde	554	Up	Below
Midlothian	639	Down	Below
Moray	980	Down	Above
North Ayrshire	1,087	Up	Above
North Lanarkshire	973	Up	Above
Orkney Islands	1,002	Up	Above
Perth and Kinross	664	Down	Below
Renfrewshire	150	Down	Below
Scottish Borders	1,605	Up	Above
Shetland Islands	452	Down	Below
South Ayrshire	1,943	Down	Above
South Lanarkshire	1,008	Down	Above
West Dunbartonshire	1,327	Down	Above
West Lothian	871	Up	Below
Western Isles	1,478	Up	Above

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Integration Joint Boards Finance and performance 2024

IJB members questions supplement

ACCOUNTS COMMISSION

IJB members questions

This tool is designed to provide IJB members with examples of questions they may wish to use to consider the IJB's financial and performance position. The questions relate to points raised in our report Integration Joint Boards: Finance and performance 2024.

Please note, this is not an exhaustive list of questions and considerations should be made of your individual IJB's particular circumstances and level of applicability in relation to the findings.

Findings	Questions	Notes
General		
• IJBs face a complex landscape of considerable challenges and uncertainties. • IJBs are facing significant financial sustainability challenges and cost pressures are only increasing. • The demand and need for services continue to increase and become more complex. • The workforce is under immense pressure. • The cost-of-living crisis is affecting the demand for services as well as the ability to provide them. • Instability of leadership continues to be a challenge for IJBs. • Plans for a National Care Service have brought uncertainty for IJBs.	• Do we, the IJB, have a comprehensive understanding of the present and longer-term needs of the population we serve? • Do we have a clear plan on how to address the significant challenges facing community health and social care? • How are we seeking to address recruitment and retention challenges? • Is there sufficient leadership capacity within the IJB to effectively plan service provision and transformation? • Are you clear about what your roles and responsibilities are as an IJB Board member?	

Cont.

Findings	Questions	Notes
Finance		
• The financial health of IJBs continues to weaken and there are indications of more challenging times ahead. • IJB funding has decreased in real terms compared to 2021/22. • Non-recurring savings, arising from unfilled vacancies, led to the majority of IJBs reporting a surplus on the cost of providing services. • The majority of the total planned savings were achieved, but over a third were only achieved on a one-off basis. • Total reserves held by IJBs have almost halved in 2022/23 largely due to the use or return of Covid-19 related reserves. • The projected financial position is set to worsen. • The increasing reliance on non-recurring sources of income is not sustainable. • Financial sustainability risks have been identified by auditors in the vast majority of IJBs. • Medium-term financial plans need to be updated to reflect all costs pressures currently known.	• Has the Medium-term financial plan been updated to reflect all costs pressures currently known? • What proportion of the IJB budget is proposed to be funded from non-recurring sources of income? • Are reserve levels in line with the IJBs reserve policy? How long can current levels of use be maintained? • Are the savings targets achievable on a recurring basis?	

Cont.

Findings	Questions	Notes
Data		
• Data quality is insufficient to fully assess the performance of IJBs but national indicators show a general decline in performance and outcomes. • Data quality is insufficient to fully assess the performance of IJBs and inform improvement of outcomes for service users with a lack of joined-up data across the system. • Work to improve the data sets is at an early stage but is progressing. • Available national indicators show a general decline in performance and outcomes for people using social care and community health services.	• Is the current available data sufficient to assess how well the IJB is performing? • How well does performance data support decision making? • What actions are the IJB undertaking to improve data collection, quality and sharing?	
Prevention and early intervention		
• Collaborative, preventative and person-centred working is shrinking at a time when it is most needed. Instead of a focus on care at the right place at the right time, there is a shift to reactive services with little capacity to invest in early intervention and prevention.	• How are the IJB prioritising and targeting resources on prevention and early intervention? • How are the IJB working with partner bodies to promote and signpost to preventative services?	

Cont.

Findings	Questions	Notes
Shifting the balance of care		
• The percentage of expenditure on institutional and community-based Adult Social Care services has largely remained static with a small increase in the proportion spent on accommodation-based services. • Increase in the number of individuals receiving care at home or in the community. However, these changes are marginal when viewed over the time since the inception of health and social care integration in 2015. • Lack of social care capacity remains an obstacle to improving patient flow and reducing the number of delayed discharges from hospital.	• Are the IJB successfully shifting service provision from an institutional setting to a community setting? • How are the IJB increasing the capacity of services provided in the community?	
Person centred care – choice and control		
• The amount of choice and control service users feel they have is variable across the country.	• How are the IJB ensuring that the views of service users are considered as part of decision-making? How clearly can you see the impact of this? • What actions are the IJB undertaking to increase the choice and control for service users over their support and care?	

Cont.

Findings	Questions	Notes
Reducing inequalities		
• The Covid-19 pandemic has exacerbated existing inequalities. • The premature mortality rate is increasing with rates higher in more urban and more deprived areas. • Emergency bed day rates are greater in areas with higher levels of deprivation.	• What steps are the IJB taking to identify and address inequality? • Is consideration of inequalities embedded in IJB decision-making?	
Unpaid carers		
• The reliance on unpaid carers is increasing as the social care workforce is under added pressure.	• Does the IJB know the number of unpaid carers in their area? • What proportion of these unpaid carers have carer support plans in place? • How is the IJB improving support for unpaid carers?	

Cont.

Findings	Questions	Notes
Commissioning and procurement		
• Commissioning and procurement practices for social care services continues to be largely driven by budgets, competition, and cost rather than outcomes for people. Improvements to commissioning and procurement arrangements have been slow to progress but are developing. • Improvements to commissioning and procurement arrangements have been slow, with cost rather than outcomes driving decision-making. • Current commissioning and procurement practices are a risk for the sustainability of service providers and the workforce. • Current commissioning and procurement practices are not always delivering improved outcomes for people. • There is an increasing desire to move towards more ethical and collaborative commissioning models but it has not yet been universally adopted. • National approaches to improve commissioning have been slow to progress but are developing.	• What steps have the IJB made to move towards commissioning in a more collaborative way? • What steps have the IJB taken to move the focus of commissioning to a basis of quality or outcomes rather than on cost?	

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Roundtable

The critical issues in social care and social work

Introduction

This note is a supplement to the IJB finance and performance report, published in June 2024. It is a summary of issues and messages captured from a roundtable discussion held 15 February 2024, hosted by the Accounts Commission sponsors and the Audit Scotland team leading on the work.

The aim of the roundtable was to hear from a range of people, in strategic roles, from across the sector about the issues currently affecting social services in Scotland. The purpose was to help inform the work for the report and to contribute to deliberations about the potential scope and focus of future pieces of work.

We would like to thank the participants for their time and the valuable contributions made to the very full and informative discussion.

Overarching messages from the discussion

Collaborative thinking is shrinking at a time when it is most needed

- We know what better/good looks like, but it is difficult to take the actions to fix it. More radical change is needed.
- Instead of collaborative thinking, we are seeing more protectionism and a silo-based culture. Funding pressures and accountability processes are intensifying this. This is happening at a time when organisations need to work collaboratively to alleviate pressures in the system.
- We recognise that we need more holistic services based around the needs of users with a focus on prevention and early intervention. While this would reduce dependency on expensive, acute care these kinds of services are most at risk of being cut as public bodies try and balance their budgets. It is difficult to work in a way that is consistent with a whole systems approach when resources are so tight.

We need to demonstrate the value of investing in social care across the whole system

- The case for investment in social care needs to be clearly set out demonstrating how the money spent on social care will achieve better outcomes for people across Scotland and save money spent on more expensive, acute care. Many people in the health sector recognise that they would spend less money and achieve better value for the taxpayer if there was more investment in social care.
- The case for investment should be supported by an evidence-base. Data across the whole system is key to a whole system approach.

We need an honest debate in public and with the public about the challenges and solutions

- We need 'permission' to have an open and honest dialogue in public and with the public about the difficult challenges across the whole system and potential solutions. Need to get all partners 'around the table' and have a national conversation.
- It is difficult to have these conversations as the media frame what they see as things the public will tolerate and politicians can apply pressure if something is seen as unpalatable.

We need a better forum for and culture around sharing and learning from good practice

- Important to bring hope during extremely challenging times and supporting improvement and innovation.
- There are opportunities to draw out good practice and share it.

Themes from the discussions

People	
Public bodies need to better understand demand for services and how this is changing across Scotland.	• Demand is changing and varies across different parts of Scotland. • Scotland has an increasingly older population, and this is leading to an increased demand for services. Needs are also becoming more complex as people often live with co-morbidities. Demographic changes also include young people leaving rural areas and moving to urban areas for work, while older people may move to rural areas to retire. • Overall, there is a growing level of unmet need.
Instead of care in the right place at the right time we are seeing a shift towards a crisis response.	• Everyone is entitled to support that protects their human rights and is offered in a destigmatised way. • Services should be seamless around the needs of people. Instead, people often find that they get batted between different professionals in health, social work and social care. • People often don't get the care they need at the right time in the right place – this can lead to poorer outcomes for people as well as being costly for example: – Unable to leave hospital due to a lack of access to appropriate social care packages. – Presenting at A&E or primary care with challenges rooted in more social issues for example housing. – Escalating mental health issues that involve the police. • Joined up, early intervention/preventative approaches within community settings can help alleviate pressures on acute care by stopping things reaching crisis point. These approaches are best when we go to the places where people are in the community. However, services aimed at prevention /early intervention are most at risk of being cut. We are seeing this with cuts to community link worker funding; a tightening of health and social care eligibility criteria; and increasingly risk-averse approaches in social work where the risk is removed rather than good support provided. • Services vary across the country. While this may seem unacceptable, it can also reflect local need. • While there are pockets of good practice across the country, these are not widely shared or understood.
An open and honest dialogue needs to take place with the public on the future of health and social care.	• We need to create a space for a public discussion on the future of health and social care and sell the importance of good social care so that it becomes a higher priority for the public. Otherwise, people will always be reliant on high-cost treatments in acute settings. This includes conversations on the type of care people want in the future for example, should care be focused on preserving life or improving quality of life? • Public bodies need to engage with people honestly on how services can be changed to support this.

Workforce	
Long-standing issues with pay and job dissatisfaction continue to affect recruitment and retention in social care and social work.	• Issues in social care and social work include: – Lack of parity of esteem. NHS pays more than social care for same job level. NHS and social care pay deals are negotiated separately and differently. It is difficult for IJBs to challenge SG on these decisions. Social care workers lack a strong national voice advocating pay as they are not unionised in the same way as health. – Poor and uncompetitive pay for social care workers. Across social care, pay is often lower in the third and independent sector than the council. In general, the pay doesn't compete with other jobs in less demanding roles such as hospitality and retail. Paying the living wage isn't enough. It is a skilled job and SG needs to significantly invest in social care workers pay after years of underfunding. – Low retention rates. Average time working in social care at home is 24 months. – Needs to be a better understanding of the complex/professional role of social workers. – Poor public image of the roles, unattractive to join or stay in the roles. – Workers are doing the best they possibly can and often doing very well, despite systemic problems. – Many staff leave because they can't do the job they set out to do (referred to as moral injury). – Workers aren't sufficiently empowered to make the changes they know need to be made. – Experience low morale, feelings of frustration and anger.
We don't have a workforce fit for the future.	• The overall size of the workforce is shrinking especially relative to the scale of demand. • The current workforce is ageing, it is unstable with a high turnover and rural areas can't recruit enough staff. • We need to plan for a workforce for the future but instead roles are being reconfigured in crisis response for example: – 80 per cent of drug and alcohol people are doing community link work because there isn't the funding of link roles. – Children's social workers are being moved to adult services in a 'crisis approach'. • We need to reconfigure the workforce in a long-term, planned way that will improve outcomes for people for example: – More nurses in care homes instead of hospitals. – Roll out developments in technology. At present, leaders lack the bravery/resource to implement some of the good work on roles in social care such as care technologists. – Decide, with the public, if the focus is on preserving life or quality of life.

Shared leadership	
The relationship between health and social care needs redefined.	• The debate about social care 'versus' health is contrary to the intention and ethos of the legislation that underpins health and social care integration, which was about collaboration with a focus on the needs of service users. The relationship needs to be rebalanced with health and social care treated as equals. • The message about what IJBs were set up to do and deliver has not been clear enough. Scotland still has two systems of health and social care defined by historical legacies, gender imbalance, lack of parity of esteem. It was hoped IJBs could bridge this. But there is an inability to give up power and control and trust others. • The IJB model isn't fixing the fragmented system and maybe it needs to be a different model. The impact of delegating children's services is unclear and there are variations in the interpretation of duty of services. • Lots of barriers to shifting the balance of care – governance structures, regulatory, union, political, organisational barriers. • Drivers in the current system contribute to a continued focus on acute services: – Politicians intervening in ways that aren't consistent with strategic plans. – Downgraded Chief Social Work Officer role – more operational than strategic role. – Mental health is not prioritised to the same degree as physical health. – Strategic decisions can be driven by clinicians rather than by equity/ most vulnerable. – Constant focus on delayed discharges. – Key performance measures that are collected and reported on are health driven.
Leaders need to agree a long-term plan that supports a whole system view.	• We all share the same overall vision of wellbeing and good outcomes but need a shared understanding on what the problem is, and a shared plan on how to get there. We need to look at the whole system, not go back into silos. There are challenges in all parts of the system. We need to reach a shared view on transformation for an area and understand early intervention. • Planning needs to be longer term and strategic with incentives and rewards for partnership working. People with direct operational experience need to be involved in shaping the new system. • There hasn't been a strategic approach across the whole system since the ministerial group that recommended IJBs. There is no senior, open mechanism where health and social care comes together – bits and pieces happen behind closed doors.

Cont.

Shared leadership	
Financial pressures are leading to more focus on protectionism rather than a whole system view.	• Financial pressures lead to: – Organisations looking inward rather than shared priorities and resources. – Firefighting and pulling back from longer-term strategic thinking. – Protectionism gets worse with less resources but it's more important than ever to take a whole system view. • The health sector can see that it would spend less money and achieve better value for the taxpayer if there was more investment in social care, but it would be a courageous leader to say this money is better spent elsewhere. • Every part of the system is under pressure. People are pulling back from things they would have done but this has implications for the rest of the system. When people have issues accessing services, it drives demand into acute care.
The debate on the NCS is losing focus on improving outcomes.	• NCS is moving further away from Feeley recommendations. Concern is it won't deliver Christie ambitions. • We're dealing with the legacies of how organisations were set up and evolved and now bolting things on to this. • Frustrations about the time, energy and cost being taken up by planning and engagement around the NCS, about the way reform seems to be focused on who has power and control rather than on improving services and outcomes. Focusing on structures instead of tackling need and it has become a proxy battle for accountability and organisational and structural priorities/interests/incentives. • Perceived lack/loss of trust between government and others. • Planning inertia created by uncertainty has implications for organisations plans to invest and reshape services. • Need to consider accountability and assessment of performance in NCS if/as it evolves.

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Shared leadership

Shared accountability requires good performance data across the whole system.

- Shared accountability is important but isn't happening.
  - Accountability is upwards in an organisation rather than to partners, the communities they are serving and users.
  - There's too much emphasis on data from an organisational viewpoint. This feeds into protectionism.
  - Data is key to a whole system approach – we need to redefine performance management to reflect this.
- We don't have good data across the whole system and this impacts on decisions and priorities.
  - Lack good measures on shared outcomes that reflect the whole system.
  - Need more focus on citizen data and wider population health.
  - Lack good data on population shifts.
  - Lack good data on primary care.
  - We haven't managed to define best outcomes in social care which leads to a lack of transparency on social care performance.
  - Best data is on acute care. But the focus here is on inputs, waiting times, financial returns.
  - Lack the data which shows the issues across the system, for example, people have access issues and aren't seen in the right place.
- We need to get better at sharing data.
  - Sharing data is critical in responding to significant events with people.
  - Who does the data belong to? Should it be the citizens?
  - Public perception that all health data is shared across all of health system.
  - Primary care data sharing is voluntary but it's mandatory elsewhere in the UK.
  - Data duplication issues.
  - Consider sensitivities around personal data.
  - Dashboard now being used across IJBs that shows some early progress, allows some national/regional comparisons.
- Organisations aren't held to account on learning.
  - This links to the lack of a good improvement culture.

Money	
Financial pressures mean that critical need is prioritised at the expense of prevention yet the impact of this is not being fully assessed.	• IJBs are struggling to balance their budgets. – Inflationary pressures. – Vacancies are saving IJBs financially. – Reliance on reserves/non-recurring sources of finance. – Councils' and NHS boards' financial situations are very visible; IJBs' finances are much less visible. • IJBs are concentrating on critical need but the impact of this is not being clearly assessed and risks placing more demand on the acute system. – Concentrating on critical need only to balance the budget. This comes at the expense of prevention and early intervention. – Easier to necessitate the case for retaining money and services in acute services as they have more data. Lack of data makes it harder for some services to argue for additional investment. – Decisions to cut services are not always based on equality impact assessments and an understanding of impact on demand on other parts of the system. Community link workers is an example here. – The right care isn't happening in the right place. It is expensive treating people in the wrong place for example inappropriate admissions to A&E, delayed discharges, presenting to GP with social issues. Current system creates more demand. – Money spent on prevention/early intervention is less expensive than costly, acute care later on.

Cont.

Money

- Funding streams make it harder to do things differently.
  - No budget for transformation.
  - IJB reserves allowed transformation and testing new ways of working. Much more challenging to do that now with current financial pressures.
  - Trying to do everything we used to do pre pandemic with less resource.
  - Political/public pressure not to close hospitals/care homes etc.
- Protected spend, fragmented funding streams.
  - Extra money from SG is earmarked and not available for flexible, innovative spending.
  - Some ringfenced budgets can be too prescriptive.
  - Fragment funding for example small pockets allocated to specific areas such as drugs and alcohol.
  - Risk to sustainability of unprotected services. Can't protect prevention spend but prevention is more important than ever.
  - Those working within services have a better understanding of costs and how to get value for money.
- Lack long-term funding.
  - One-year funding. Having to make decisions in the short term without understanding what's going to happen longer term. Things are only going to get harder.
  - Insecurity over future spending.

Commissioning and procurement	
Current commissioning and procurement processes do not promote collaborative, outcome focused care.	• The priority should be delivering the best outcome for supported people, but this part of the conversation is often missing in current processes which are not centred around individual choice and control. • We need to think more holistically about supporting a person's complex needs and outcomes and social care as part of this. • Procurement processes tend to be transactional processes and reflect inputs of social care rather than the outcomes they want to achieve. • The frequency of procurement processes/tendering impacts on the scope to take a longer term, strategic approach. • In some remote/rural areas, there is no real market for social care as there are so few suppliers. • The procurement processes don't give enough weight to a professional assessment of eligibility and need but rather reflect a tightening of eligibility criteria. • Can be a race to the bottom, going for the cheapest provider given pressure on commissioners to make savings. • Internal audit can focus on controlling the risks associated with self-directed funds, but this can be too punitive and miss the wider picture.
We need better relationships with external providers.	• Third/independent sector need a seat at the table. • There can be a reluctance to engage and collaborate with the private sector. Despite high usage of external providers there can be a lack of trust with more scrutiny of the private sector. This may be linked to local media scrutiny and coverage of issues. • Current attitudes and behaviour within care are damaging and have deteriorated in the face of pressures in the sector.
Concerns about progress towards ethical commissioning.	• It's important that developing ethical commissioning arrangements themselves embody ethical commissioning principles in the programme of work. • There is variation in approaches across the country. • Some authorities are doing some good work with commissioning approaches for example Fife and Aberdeen City • In general, we still a long way to go to put ethical commissioning into practice – lots of different components to it.

Improvement culture	
We don't have the right culture or processes in place to encourage and nurture innovation. Some innovative practices and approaches are being carried out, but this is in 'despite of' rather than by design and is not always shared.	• We don't have a good culture around innovation and good practice. – A focus on criticising IJBs comes at the expense of overlooking the good work happening. – There is a reluctance to share and to seek out and learn from good practice elsewhere – inwards focus, arrogance or fear of implying to colleagues and elected members that things are done better elsewhere. – Leaders lack the bravery/resource to implement some of the good work on roles in social care for example, care technologists. – We need to understand and address what's stopping the spread of good practice and improvement.
We lack the capacity and funding needed for innovation	• It's difficult to have the space to think about transformation when you're firefighting – can't do everything. • We keep adding more to the existing system and never take things away. • Lack opportunities to invest and do tests of change for example we've lost investment funds for transformation, and it can be difficult to get funding needed to get ideas off the ground – this may rely on match funding from academic institutions. • Rolling out successful pilots involves deciding on what to de-fund. Not enough money to do everything. • Staff aren't sufficiently empowered to make changes. • Improvement needs to be owned by people who need to make the change. • There isn't funding available for flexible, innovative spending. • Ring-fenced money can stifle innovation. • Too much focus on delayed discharges all the time at expense of other things. Can only do interesting initiatives if delayed discharges are under control.
Lack national strategic drive and oversight of improvement.	• Need to be bolder that things need to change rather than just improve. • Some good practice at operational level but not at a strategic level. • Lack an evidence-based understanding of initiatives and what works. • Improvement work is not being driven by improvement agencies. • Don't want more frameworks and standards – too cluttered as it is. • There is an appetite to change, but this can only be done with wider shifts in the system, including leadership, accountability, etc. that need a radical rethink.

Cont.

Improvement culture	
Examples of good practice mentioned.	• Improvements in care at home with district nurse/GP input. These approaches prevent readmissions. • Community care homes decrease hospital admissions. • Some good work on roles for example care technologists but not implemented. • Fife and Aberdeen City doing good collaborative work with independent sector around commissioning and procurement. • Glasgow City Council – has been good work on mental health and commissioning done jointly with services and communities. • Link worker programme – showed impact. • Canada reduced commissioning and procurement process from six months to six weeks.

Attendees

Angela Leitch	Accounts Commission
Malcolm Bell	Accounts Commission
Joe Chapman	Policy Manager, Accounts Commission
Iona Colvin	Chief Social Work Advisor, Scottish Government
Angie Wood	Co-Director for Social Care & National Care Service Development Directorate, Scottish Government
Jackie Irvine	Chief Executive, Care Inspectorate
Ralph Roberts	Chief Executive, NHS Borders
Alison White	Chief Officer, West Lothian IJB
Dave Berry	Chief Finance Officer, Dundee IJB
David Robertson	Chief Executive, Scottish Borders Council
Robert Emmot	Director of Finance, Dundee City Council
Ben Farrugia	Director, Social Work Scotland
Maree Alison	Director of Regulation, Scottish Social Services Council
Dee Fraser	Chief Executive, Institute for research and innovation in social services
Karen Hedge	Deputy CEO, Scottish Care
Diana Hekerem	Associate Director of Transformational Redesign, Healthcare Improvement Scotland
Justine Duncan	Director of Communications and Engagement, The Alliance
Dorry McLaughlin	Chief Executive, Scottish Autism
Jill Laspa	Policy Manager, COSLA
Antony Clark	Executive Director PABV, Audit Scotland
Kathrine Sibbald	Senior Manager Social care portfolio, Audit Scotland
Leigh Johnston	Senior Manager Health portfolio, Audit Scotland
Tricia Meldrum	Senior Manager Education and children's services portfolio, Audit Scotland
Jillian Matthew	Senior Manager Equalities and human rights portfolio, Audit Scotland
IJB finance and performance report audit team members	

AUDIT SCOTLAND

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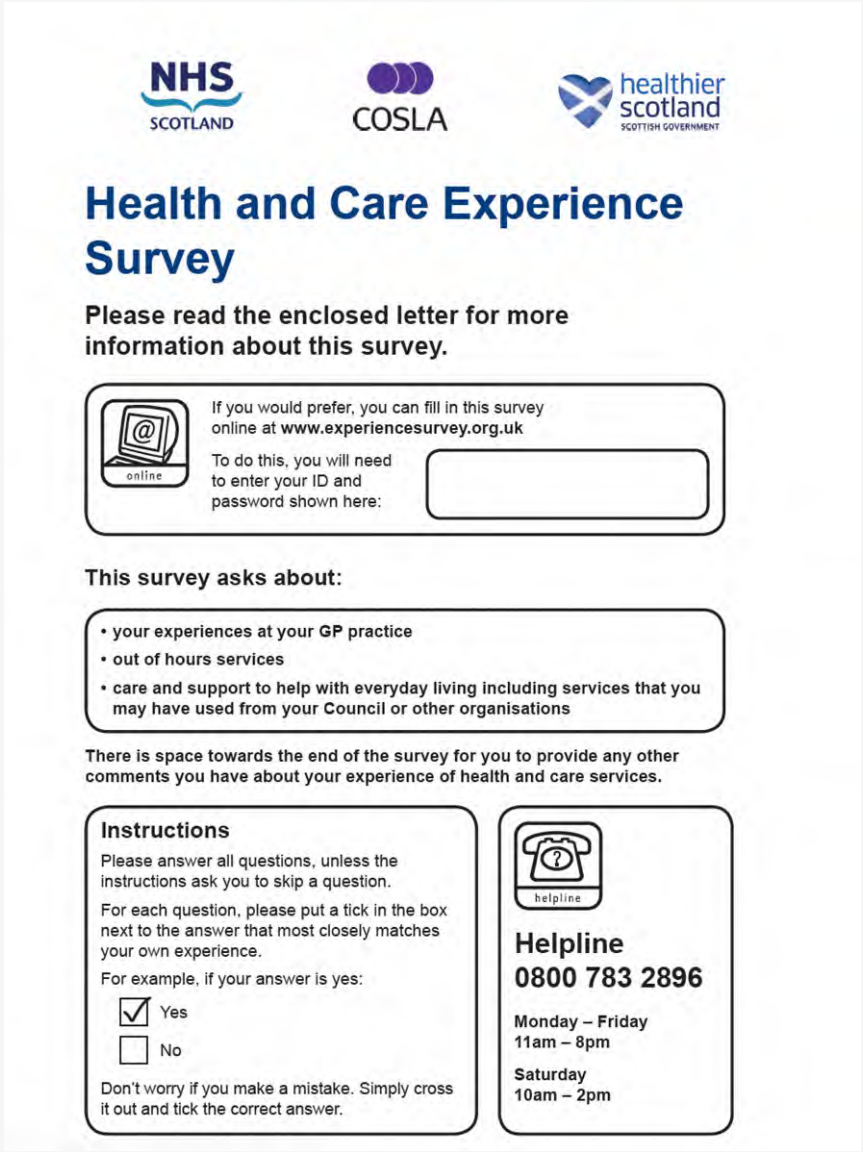
Core Suite of Integration Indicators

Orkney Performance 2023/24

OHAC orkney health and care



NHS SCOTLAND

COSLA

healthier scotland
SCOTTISH GOVERNMENT

Health and Care Experience Survey

Please read the enclosed letter for more information about this survey.

online

If you would prefer, you can fill in this survey online at **www.experiencesurvey.org.uk**

To do this, you will need to enter your ID and password shown here:

This survey asks about:

- your experiences at your GP practice
- out of hours services
- care and support to help with everyday living including services that you may have used from your Council or other organisations

There is space towards the end of the survey for you to provide any other comments you have about your experience of health and care services.

Instructions

Please answer all questions, unless the instructions ask you to skip a question.

For each question, please put a tick in the box next to the answer that most closely matches your own experience.

For example, if your answer is yes:

☑ Yes

☐ No

Don't worry if you make a mistake. Simply cross it out and tick the correct answer.

helpline

Helpline
0800 783 2896

Monday – Friday
11am – 8pm

Saturday
10am – 2pm

Indicators 1-9

The Health and Care Experience (HACE) survey asks about people's experiences of:

- **accessing and using their general practice and out of hours services**
- **aspects of care and support provided by local authorities and other organisations**
- **caring responsibilities and related support.**

It is an online and postal survey sent to a random sample of people registered with a general practice in Scotland. The survey, successor to the GP and Local NHS Services Patient Experience Survey, has been run every two years since 2009.

Public Health Scotland

health and social care

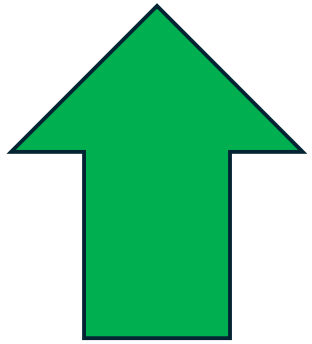
Indicators 11-19

Public Health Scotland (PHS) presents annual rates for the Core Suite of Integration Indicators for each Integration Authority area and Scotland.

These indicators were developed to help Integration Authorities to review progress towards achieving each of the National Health and Wellbeing Outcomes which focus on improving how services are provided and the difference that integrated health and social care services should make for people.

These indicators are derived from data routinely collected for other purposes, such as hospital activity data and National Records of Scotland death records.

1. Percentage of adults able to look after their health very well or quite well

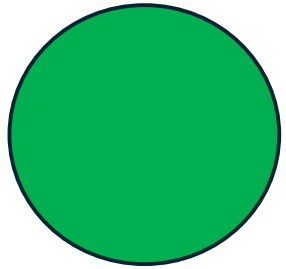


Orkney 93.7%

Scottish Average 90.7%

4th best in the country

2. Percentage of adults supported at home who agree that they are supported to live as independently as possible



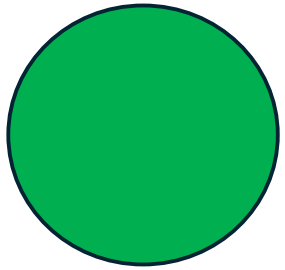
Orkney 77.7%

Scottish Average 72.4%

8th best in the country

* Results for indicator 2 for 2023/24 are not comparable to previous years due to changes in survey wording

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



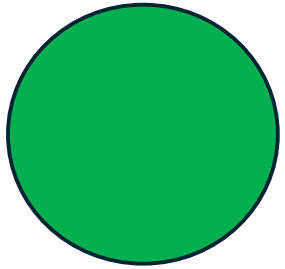
Orkney 68.1%

Scottish Average 59.6%

4th best in the country

* Results for indicator 3 for 2023/24 are not comparable to previous years due to changes in survey wording

4. Percentage of adults supported at home who agree that their health and social care services seemed to be well coordinated



Orkney 68.2%

Scottish Average 61.4%

6th best in the country

* Results for indicator 4 for 2023/24 are not comparable to previous years due to changes in survey wording

5. Percentage of adults receiving any care or support who rate it as excellent or good

Orkney 82.5%

Scottish Average 70.0%

2nd best in the country

* Results for indicator 5 for 2023/24 are not comparable to previous years due to changes in survey wording

6. Percentage of people with positive experience of care at their GP practice

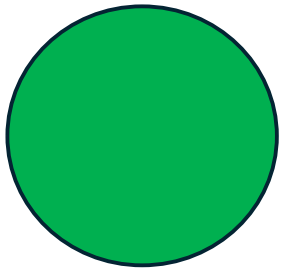
Orkney 90.1%

Scottish Average 68.5%

Best in the country

* Results for indicator 6 for 2023/24 are not comparable to previous years due to changes in survey wording

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



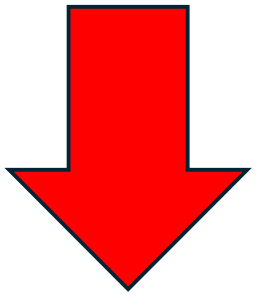
Orkney 79.6%

Scottish Average 69.8%

2nd best in the country

* Results for indicator 7 for 2023/24 are not comparable to previous years due to changes in survey wording

8. Percentage of carers who feel supported to continue in their caring role

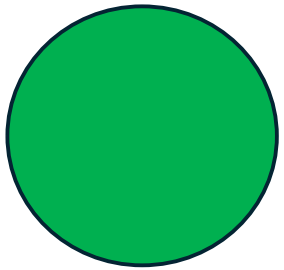


Orkney 34.0%

Scottish Average 31.2%

9th best in the country

9. Percentage of adults supported at home who agree they felt safe



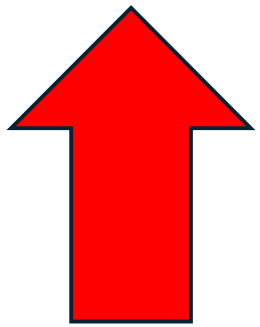
Orkney 84.1%

Scottish Average 72.7%

3rd best in the country

* Results for indicator 7 for 2023/24 are not comparable to previous years due to changes in survey wording

11. Premature mortality rate per 100,000 persons, by calendar year



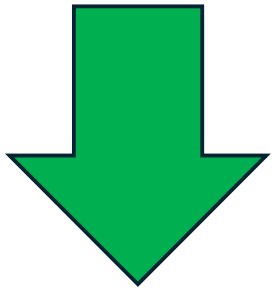
Orkney 393

Scottish Average 442

10th best in the country

* Note that these figures relate to calendar year 2022, the most recent data available

12. Emergency admission rate (per 100,000 population)



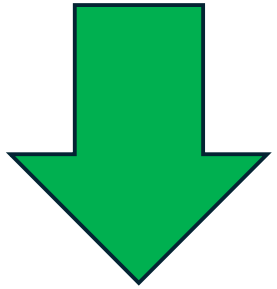
Orkney 9538

Scottish Average 11,276

6th best in the country

* Note that these figures relate to 2022/23, the most recent data available

13. Emergency bed day rate (per 100,000 population)



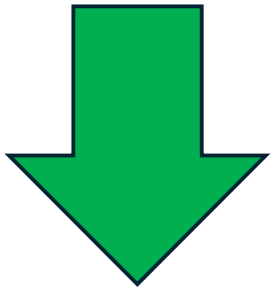
Orkney 86,572

Scottish Average 119,806

2nd best in the country

* Note that these figures relate to 2022/23, the most recent data available

14. Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)



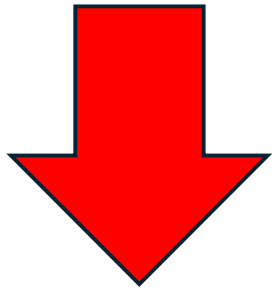
Orkney 69

Scottish Average 102

Joint 2nd best in the country

* Note that these figures relate to 2022/23, the most recent data available

15. Proportion of last 6 months of life spent at home or in a community setting



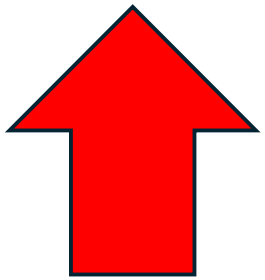
Orkney 90.9

Scottish Average 88.9

2nd best in the country

* Note that these figures relate to 2022/23, the most recent data available

16. Falls rate per 1,000 population aged 65+



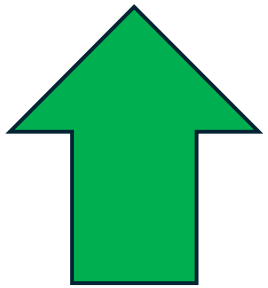
Orkney 19.9

Scottish Average 22.6

6th best in the country

* Note that these figures relate to 2022/23, the most recent data available

17. Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections



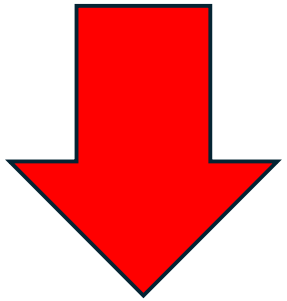
Orkney 70.7

Scottish Average 77.0

Equal 3rd worst in the country

* Note that these figures relate to 2023/24

18. Percentage of adults with intensive care needs receiving care at home



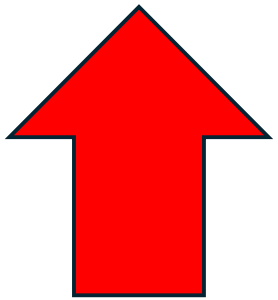
Orkney 69.5

Scottish Average 64.8

9th best in the country

* Note that these figures relate to calendar year 2023

19. Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)



Orkney 1002

Scottish Average 902

10th worst in the country

* Note that these figures relate to 2023/24