Community health and social care

Performance 2025

ACCOUNTS COMMISSION

AUDITOR GENERAL

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Contents

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Key messages

1 Integration Authorities (IAs) and Health and Social Care Partnerships (HSCPs) need to ensure that they have good quality information to fully understand their performance, support effective decision-making, benchmark against others and provide transparent public performance reporting. However, there is a lack of comprehensive and consistent national performance information about community health and social care demand, workload, quality of care and outcomes.

2 The limitations of the performance information make it difficult to fully assess the performance and progress of IAs and HSCPs towards improving the quality of life for people using health and social care services. To support IAs and HSCPs to use the data and indirect measures that are currently available, we have developed an interactive data tool to allow comparisons to be made.

3 From this data, we have found a general long-term picture of declining performance and satisfaction:

- IAs and HSCPs are struggling to keep up with increasing demand across the health and social care system
- more progress is needed with shifting the balance of care to the community and to prevention
- the amount of choice and control service users feel they have remains variable
- there is a gap between the ambitions to address health inequalities and progress with improvement.

Recommendations

Integration Authorities (IAs) and Health and Social Care Partnership (HSCP) leaders need the support of councils, health boards, the Scottish Government and other partners to make more progress with integration, service redesign, and ensuring they have the information needed to plan and make effective decisions.

Public Health Scotland should:

- Over the next year, through consultation with IAs, HSCPs and other stakeholders, such as the Care Inspectorate, Health Improvement Scotland and the Improvement Service, agree and roll out a programme to:
  - assess the current measures for monitoring performance across community health and social care and agree a comprehensive suite of indicators that draws on and modifies existing measures as appropriate and addresses current gaps in information. The suite should support performance monitoring and decision-making at a national and local level
  - centrally manage the collection, cleansing and management of the data
  - organise the performance information into a publicly accessible dashboard that is maintained on an ongoing basis to support national or local evaluation of performance information.
- The suite of indicators should be annually reviewed to ensure the measures and the definitions of each remain relevant to supporting planning, monitoring and evaluation of delivery (paragraphs 12–17).

IAs and HSCPs should:

- Over the next six months, use the interactive data tool to compare performance with other areas to:
  - understand and explain in public reports their relative performance in terms of local context, priorities, policy and operational decisions
  - analyse performance alongside local data to support benchmarking, self-assessment and the development of improvement plans (paragraph 6).

Introduction

About health and social care integration

1. The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) requires councils and territorial NHS boards to work together in partnerships, known as Integration Authorities (IAs). As part of the Act, new bodies were created – Integration Joint Boards (IJBs). An IJB is a separate legal entity, responsible for the strategic planning and commissioning of a wide range of health and social care services across a partnership area.

2. Of the 31 IAs in Scotland, 30 are IJBs. Stirling and Clackmannanshire councils have formed a single partnership with NHS Forth Valley. Highland currently follows a lead agency model where a Joint Monitoring Committee takes a similar strategic oversight role of adult community health and social care. Each IA is supported by an operational delivery partnership – the Health and Social Care Partnership (HSCP) that manages the delivery of the services. The HSCP staff remain employees of the NHS or the council, depending on their role. More detail about integration can be found in our short guide – What is integration?

3. In December 2024, members of the Highland Council and NHS Highland Joint Monitoring Committee agreed to move from the lead agency model of integration to the IJB model. Both organisations agreed that moving away from the lead agency model would increase the pace of change towards an improved partnership culture and a more responsive system of care. The planning for transition is under way and a timeline for the full implementation is being developed.

4. The range of services each IA and HSCP are responsible for varies. In this briefing, for simplicity, we refer to 'community health and social care' to refer to the broad range of core services IAs and HSCPs cover, including primary care services and adult social care services, as well as unplanned health care, eg emergency admissions to hospitals.

What is integration?
A short guide to the integration of health and social care services in Scotland

April 2018

About the bulletin

The data tool

5. In March 2025, we published a data tool that sets out financial data in an interactive way so that members of the public and in particular IJB members and other stakeholders could view the data and compare financial performance across the 30 IJBs in one location. We have now added a range of publicly available national performance data, including the national core suite of integration indicators to this data tool. This allows users to also explore national and local performance, as well as compare the performance of individual IAs and HSCPs in an easily accessible way. The tool sets out national and local trends, charts that show performance by authority, and provides some contextual information.

Integration Joint Boards
Finance bulletin 2023/24

March

6. We expect IAs and HSCPs to use the tool to compare their performance with other areas and assure themselves that they understand and can explain their performance in terms of local context and priorities. We anticipate other stakeholders, such as the Care Inspectorate, Healthcare Improvement Scotland and third-sector organisations might also find this tool useful.

7. The range of publicly available national data is limited and does not provide a full picture of the performance of services or the outcomes for people. IAs and HSCPs should use the tool alongside other local data available to them, to support benchmarking, self-assessment, and the development of improvement plans.

8. Guidance on how to use the online tool is available on the Audit Scotland website. Within this briefing there are links to the relevant data in the tool, enabling access to a breakdown of the referenced indicator.

This briefing

9. This briefing accompanies our interactive online data tool. It summarises the main findings from our analysis set out in the tool, sets out how we expect the data tool to be used by IAs and HSCPs, as well as the limitations of the available data. It challenges members of IAs and the leadership of the HSCPs to consider how they can better use data to support planning, decision-making, improvement and public reporting of performance. It also prompts the wider sector, including the Scottish Government, COSLA and NHS boards and councils, to consider their key role in supporting progress with addressing the challenges in community health and social care, including the collation of national data through Public Health Scotland.

Community health and social care performance

IAs and HSCPs are struggling to keep up with increasing demand across the health and social care system. Long-term performance trends show an overall decline although there are some signs of improvement.

Community health and social care services continue to face significant challenges

10. The community health and social care sector plays a vital role in our health and wellbeing, keeping people at home and cared for out of hospital. Over the years we have highlighted in our national and local audit work the increasing pressures facing the sector including significant financial constraints, rising public and political expectations, workforce challenges including difficulties with recruitment and retention, widening health inequalities and the increasing demand of an ageing population.

Some of the many reports where we have set out the range of pressures and challenges for the health and social care sector include:

IJB Finance and performance 2024 and IJBs' Finance bulletin 2023/24

NHS in Scotland 2024 and NHS in Scotland 2025

Adult mental health, 2023

General practice: Progress since the 2018 General Medical Services contract, 2025

Improving care experience – Delivering The Promise, 2025

Delayed discharges, 2026

Demand pressures continue to rise

11. Unlike secondary care, where waiting lists and times are regularly monitored nationally, it is not easy to define or measure demand for community health and social care. However, there are **proxy measures** that clearly indicate that pressure on services has increased. These include an ageing population, growing numbers of people with one or more health conditions, an increased impact of long-term conditions on the population, and widening health inequalities (Exhibit 1, page 8).

A **proxy measure** is a strongly-related indicator used to help quantify a point that is otherwise difficult to measure directly or that there are no direct measures for.

Exhibit 1.

Indicators of increased pressure on community health and social care

Proxy measures clearly indicate that demand pressure on community health and social care has increased and may continue to increase.

Indicator of increased demand	
	**Growing population** 2014–24: Scottish population increased by 4 per cent.
	**Ageing population** 2014–24: Proportion of people in Scotland aged 65 and over increased from 18.2 per cent to 20.5 per cent.
	**More unpaid carers** 2011–22: Proportion of people that are unpaid carers increased from 9.4 per cent to 12 per cent in 2022. Of these, 59 per cent were female and 41 per cent were male.
	**More people with long-term health conditions and mental health issues** 2011–22: Proportion of people reporting a long-term illness, disease or condition increased from 18.7 per cent to 21.4 per cent. 2011–22: Proportion of people reporting a mental health condition increased from 4.4 per cent to 11.3 per cent.
	**Increased impact of disease on the population** Annual disease burden forecast to increase by 21 per cent by 2043.
	**Enduring and widening health inequalities** 2019–21: In the most deprived areas, people spend more than a third of their life in poor health compared to around 15 per cent in the least deprived areas.
	**Longer waiting times for secondary care** By the end of June 2025 there were 36,694 ongoing waits of more than a year for inpatient or day case treatment. Before Covid-19 (September 2019) there were around 1,640. This increases the demand for primary health and social care services.

Notes: Long-term illness, disease or condition includes a range of conditions such as arthritis, cancer, diabetes and epilepsy. The disease burden forecast calculates the impact of health loss across the population due to living with and dying from causes of injury or disease in terms of years of life lost – Scottish Burden of Disease study, Public Health Scotland, November 2022.

Source: Audit Scotland, National Records of Scotland, Public Health Scotland data (at 1 July 2025)

There remains a lack of comprehensive and consistent performance information to fully assess the performance of IAs and their service delivery partners

12. The lack of relevant data, or analysis of community health and social care data, has been a common theme across a range of our reports. Most recently, the Auditor General concluded in his report on general practice, that the data needed by the Scottish Government to make informed decisions on planning and investment across general practice is inadequate. There remains a lack of robust information about general practice demand, workload, workforce and quality of care.

13. In the Integration Joint Boards (IJBs): Finance and performance 2024 briefing, the Accounts Commission concluded that '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 of joint data sharing'. This continues to be the case and the following examples must be addressed:

- a consistent method for recording unmet need
- data about the impact and use of eligibility criteria for social care services across the country
- the impact of muti-disciplinary teams in primary care
- the quality of data on levels of self-directed support
- a coordinated approach to anticipating future demand for and costs of delivering services
- value for money assessments of local and national initiatives.

14. The lack of an individual social care record, in the same way that each member of society has an NHS record, puts limitations on the ease of gathering and processing information across all areas. Multiple IT systems across partner organisations and general practice, poor data quality, limited digital infrastructure to gather data from small independent and third-sector service providers and inconsistent recording, also remain barriers. This makes it difficult to gather the comprehensive and consistent information needed to fully assess performance across the country.

15. The Scottish Government, alongside COSLA, have committed to address this as part of a wider programme to improve health and social care data and to digitalise access to health and social care services. The Health and Social Care Service Renewal Framework launched in June 2025, states that 'We will build on the work already undertaken to identify gaps in our data landscape and make improvements'. It also states 'We will work with partners across Local Government and more widely to adopt the use of CHI [Community Health Index] in Local Government, ensuring that there is a common identifier for verification and data matching to support better information sharing across organisations'. This is a welcome development, however the timeline for full implementation is unclear and it is a long-term programme that will take many years to fully roll out across community health and social care services.

16. Good quality information to understand performance across health and social care is needed at a national level to support planning and evaluation of national health and social care initiatives and strategies. At a local level, IAs and HSCPs should ensure that they have good quality information to fully understand their performance, support effective decision-making, benchmark against others and provide transparent public performance reporting.

17. As a matter of urgency, PHS should lead the development and maintenance of a centralised suite of indicators, that draws on and modifies existing measures as appropriate and addresses current gaps in information. This should involve working collaboratively with IAs and HSCPs as well as other sector stakeholders including the Care Inspectorate, Health Improvement Scotland and the Improvement Service.

Local public performance reporting does not explain significant performance variation across Scotland

18. Our analysis of the data set out in our data tool, shows considerable variation in performance across IAs and HSCPs for many of the indicators. This significant variation cannot be fully explained by local contextual differences nor is it explored in local performance reports.

19. IAs and HSCPs should report publicly on their relative performance, including the impact of local priorities, policy, and operational decisions.

There is a long-term picture of generally declining performance and satisfaction

In this section we summarise the main observations from our analysis of data in the performance tool. Collectively, the data shows that in a challenging context, there is a long-term picture of declining performance and satisfaction, with a growing expectation gap, but there are some signs of improvement.

Theme 1: Prevention and early intervention and shifting the balance of care

20. Shifting investment from acute hospitals and reactive services to preventative and early intervention services, has been the sector's ambition for a number of years. The Public Bodies (Joint Working) (Scotland) Act, 2014 (the Act) was intended to ensure health and social care services were well integrated, so that people receive the care they need at the right time and in the right setting, with a focus on community-based care. The range of proxy indicators in the data tool suggest progress in shifting the balance of care to the community and to prevention is slow and more progress is needed (Exhibit 2, page 11).

Exhibit 2.

Prevention, early intervention and shifting the balance of care

More progress is needed with shifting the balance of care to the community and to prevention

Performance illustrated in the data tool	
	The rate of falls for individuals over 65 has remained generally consistent nationally since 2018/19 but the rate varies significantly across the country from 33.6 falls per 1,000 people over 65 years in Dundee compared to 14.8 in Highland.
	The number of individuals receiving community alarms and/or telecare is lower than the position prior to the pandemic. At the end of 2023/24 there were an estimated 131,560 people receiving community alarms and/or telecare, down from a high point of 136,900 in 2018/19.
	The rate of emergency admissions is slightly below pre-pandemic levels but there were recent increases across the majority of IA areas. There is notable variation across the country ranging from just under 15,000 emergency admissions per 100,000 adults in Falkirk to 8,300 in Edinburgh in 2023/24.
	The level of delayed discharges from hospital has remained challenging. Comparing the 2024/25 position to the 2018/19 pre-pandemic levels, there has been an overall 20.1 per cent increase in the number of days people aged 75+ spent in hospital when they are ready to be discharged (per 1,000 population).
	The data suggests that between April 2024 and the end of March 2025, the number of individuals waiting for a social care assessment and those waiting to receive a care at home package reduced. Alongside this progress, the estimated total number of hours of care at home yet to be provided for assessed individuals also improved.
	Progress to increase the percentage of adults with intensive care needs[1] receiving care at home is limited. Since 2018, the level has increased by only 2.5 percentage points to 64.7 per cent in 2024. There is significant variation across the country ranging from 77 per cent in North Ayrshire to 54.3 per cent in Eilean Siar.
	A significant proportion of the last six months of life is spent either at home or in a community setting. In 2023/24, an estimated 88.9 per cent of the last six months of peoples' lives were spent either at home or in a community setting. There has been a small (0.9 percentage point) increase since 2018/19.

Note 1. This is defined as the number of adults (18+) receiving personal care at home or direct payments for personal care, as a percentage of the total number of adults needing care.

Source: Audit Scotland, Public Health Scotland data (at 1 July 2025)

21. There is a clear focus on prevention and shifting the balance of care in the Scottish Government and COSLA's joint Population Health Framework (PHF) and Health and Social Care Service Renewal Framework (SRF). To progress these ambitions, IAs and HSCPs, responsible for so many of the services underpinning health and social care, need to be at the forefront of implementation planning to achieve the aims of the PHF and SRF.

More detail about delayed discharge performance across IAs and HSCPs is set out in our performance audit report Delayed discharges: A symptom of the challenges facing health and social care, January 2026.

Theme 2: Person centred and accessible care

22. Accessible care that is tailored to the needs and preferences of individuals and carers helps to promote independent living and better outcomes. The Social Care (Self-directed Support) (Scotland) Act 2013 set out how councils should offer people options for how their social care is managed. The latest data available[1] shows that the percentage of people who have a choice of how they receive social care services and support, through self-directed support options, is increasing – estimated at 88.5 per cent in 2021/22, up from 77.1 per cent in 2017/18 – but the levels are variable across the country. Public Health Scotland state on their website that the publication of the 2022/23 Self-directed support information is delayed while further investigations are undertaken regarding the quality of the data. Other national indicators also suggest the amount of choice and control service users feel they have remains variable (Exhibit 3, page 13).

More details about general practice performance are available in the Auditor General's General practice: Progress since the 2018 General Medical Services contract, March 2025.

[1] Public Health Scotland state on their website that the publication of the 2022/23 Self-directed support information is delayed while further investigations are undertaken regarding the quality of the data.

Exhibit 3.

Person centred and accessible care

The amount of choice and control service users feel they have remains variable

Performance illustrated in the data tool	
	In 2023/24, 60 per cent of adults supported at home agreed that they had a say in how their help, care or support was provided, leaving two in five adults feeling they had less influence. This varies across Scotland from 75 per cent in East Renfrewshire to 50.6 per cent in North Ayrshire.
	The proportion of respondents to the Health and Care Experience Survey indicating it is easy to contact their general practice has dropped from 87 per cent in 2017/18 to 76 per cent in 2023/24. This satisfaction measure varies across the country with for example, in 2023/24, 97 per cent of respondents in Orkney who found it easy to contact their GP practice compared to 57 per cent in North Lanarkshire.
	Satisfaction with the care that people receive from their general practices has decreased compared with 2017/18. In 2023/24, 69 per cent of survey respondents said the care was excellent or good, but this is 14 percentage points lower than in 2017/18.
	The proportion of people provided with advanced booking of a GP appointment (three or more working days in advance) has decreased by 18 percentage points compared to pre-pandemic levels. There are signs of improvement with an increase of two percentage points from 2021/22 to 2023/24. There is wide variation across the country from 82 per cent in the Orkney Islands to 30 per cent in North Ayrshire.
	The proportion of people that agreed they were given enough time at their GP practice has increased by two percentage points between 2021/22 to 2023/24 but remains below pre-pandemic levels.
	The majority of carers do not feel supported to continue in their caring role. The proportion that feel supported has increased very slightly between 2021/22 and 2023/24 (two percentage points) but overall has decreased by over five percentage points to 31.2 per cent of respondents in comparison to 36.6 per cent prior to the pandemic.

Source: Audit Scotland, Public Health Scotland data (at 1 July 2025)

Theme 3: Reducing inequalities

23. IAs and the HSCPs have a key role to play in helping address health inequalities. There is a gap between the national policy ambitions to address health inequalities and progress with improvement. Analysis using the data tool highlights some key findings (Exhibit 4).

Exhibit 4.

Reducing inequalities

There is a gap between the ambitions to address health inequalities and progress with improvement

	There is a significant health inequality gap in the total life expectancy between Scotland's most and least deprived areas. There is a strong statistical correlation between deprivation and the rate of premature mortality. The female life expectancy in the most deprived areas of Scotland was 10.5 years lower than in the least deprived areas in 2021-2023. There was a 13.2 year difference for males. More densely populated areas are also more likely to experience higher premature mortality.
	There is a clear relationship between the emergency bed day rate and deprivation. Using the Improvement Service's family groupings of IA areas shows that areas with higher levels of deprivation are more likely to have higher levels of emergency bed day rates than areas that are more affluent.
	More densely populated areas are more likely to have a higher premature mortality rate and they are more likely to have a higher rate of slips, trips and falls for those aged 65 and over.
	Areas that reported a higher percentage of the population that provide unpaid care were more likely to observe higher rates of emergency admissions and emergency bed days.

Source: Audit Scotland, Public Health Scotland data (at 1 July 2025), Scotland's Census 2022

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Performance 2025

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