Sharing Intelligence for Health & Care Group

Annual report for 2018–2019

Published August 2019

A report produced jointly by: Audit Scotland, Care Inspectorate, Healthcare Improvement Scotland, Mental Welfare Commission for Scotland, NHS Education for Scotland, NHS National Services Scotland and Scottish Public Services Ombudsman.

Contents

This is the fourth annual report from the Sharing Intelligence for Health & Care Group. It summarises key messages about our work during 2018–2019.

The report describes why we were set up, how we work, and what we did during 2018–2019. It also provides our observations on important issues that are relevant to the quality of care delivered for the people of Scotland. This report is written with a broad audience in mind, including the public and healthcare professionals, and with the aim of stimulating constructive discussion and further action.

Please contact **hcis.sihcg@nhs.net** if you have any queries about this report or the Sharing Intelligence for Health & Care Group.

Professor Stewart Irvine
Co Chair of the Sharing Intelligence for Health & Care Group

Director of Medicine and Deputy Chief Executive, NHS Education for Scotland

Ann Gow
Co Chair of the Sharing Intelligence for Health & Care Group

Director of Nursing, Midwifery and Allied Health Professionals and Deputy Chief Executive, Healthcare Improvement Scotland

What is the Sharing Intelligence for Health & Care Group?

The Sharing Intelligence for Health & Care Group (referred to as 'the Group') is a mechanism that enables seven national organisations to share, consider, and respond to intelligence about care systems across Scotland (in particular NHS boards[1]). The organisations, each of which has a Scotland-wide remit related to the improvement and/or scrutiny of health and care services, are:

- Audit Scotland
- Care Inspectorate
- Healthcare Improvement Scotland
- Mental Welfare Commission for Scotland
- NHS Education for Scotland
- Public Health and Intelligence, part of NHS National Services Scotland
- Scottish Public Services Ombudsman

The Group was set up in 2014, and our overall aim is to support improvement in the quality of care provided for the people of Scotland by making good use of existing data and intelligence.

1 The Group focuses predominantly on healthcare, and we also consider some integrated health and social care services delivered by Integration Authorities. The term 'health and care' is used throughout this report to describe the services covered by the Group's remit.

Our main objective is to ensure that any potentially serious concerns about the quality of care identified by member organisations are shared and acted upon appropriately. Sharing concerns at the right time can help identify emerging problems so these can be addressed. The organisations also inform each other about aspects of health and care systems that are working well. Sharing information helps the different organisations on the Group carry out their work in an informed way.

Establishing the Group was an important part of Scotland's response to a public inquiry about a serious failure of a healthcare system in England[2]. One of the recommendations from this inquiry, published in 2013, was that intelligence sharing within and among national organisations should be improved. The member organisations of the Group report there is now much better sharing and consideration of key intelligence, and they are now better prepared to take additional action when required.

Members of the public should be confident that, through the Group, national organisations in Scotland are sharing and responding to important information about the quality of care. In parallel with this, the individual organisations continue to respond to concerns as they arise, in line with their own remits[3].

We seek to use available data and information wisely and collaboratively for the purpose of maximising improvements in the quality of care. We are also open and honest about how we share and use data and information. This includes involving service provider organisations in our approach, and increasingly putting information about our work into the public domain.

2 Available from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf

3 The Group does not consider the practice of individual care professionals, but other agencies do. We will continue to explore our relationships with the regulators of individual care professionals, which include the General Medical Council (doctors), the Nursing & Midwifery Council (nurses and midwives), the General Dental Council (dentists), and the General Pharmaceutical Council (pharmacists).

What did we do in 2018–2019?

The Group met six times between April 2018 and February 2019 to share and consider key pieces of data and information that we hold about the following 18 NHS boards:

- NHS Ayrshire & Arran
- NHS Borders
- NHS Dumfries & Galloway
- NHS Fife
- NHS Forth Valley
- NHS Grampian
- NHS Greater Glasgow and Clyde
- NHS Highland
- NHS Lanarkshire
- NHS Lothian
- NHS Orkney
- NHS Shetland
- NHS Tayside
- NHS Western Isles
- Scottish Ambulance Service
- State Hospitals Board for Scotland
- Golden Jubilee Foundation
- NHS 24

Examples of the intelligence we shared before each of our meetings, and then discussed at the meetings of our Group, include:

- findings from inspections and other reviews of care provider organisations
- quantitative analyses from Scotland-wide care datasets, including about service delivery, complaints and workforce
- survey results of doctors in training
- information about financial and resource management.

We provided feedback to each of the 18 NHS boards we considered, including meeting with the NHS board to discuss key issues.

During 2018–2019, none of our member organisations were required to initiate additional work in response to intelligence shared at the Group. As highlighted in our annual report for 2017–2018, there have previously been some occasions when this has happened, and there are instances where the partner organisations continue to work together to support front line care systems to improve. More broadly, the organisations on the Group continue to run significant programmes of scrutiny and improvement work in line with their own remits.

We continue to find it helpful to learn from each other about various aspects of local care systems. We will continue to share intelligence, in order to inform the work we carry out as seven national organisations.

During 2017-2018 we commissioned an independent evaluation of our work[4], and as a result we have also made some improvements during 2018–2019 to how we work as a Group. For example, we now structure our discussions on the basis of themes identified by various public inquiries and reviews (such as leadership, culture, governance, financial performance, workforce, clinical and care performance and outcomes).

4 www.healthcareimprovementscotland.org/our_work/governance_and_assurance/sharing_intelligence/sharing_intelligence_2017-2018.aspx

What did we observe about the quality of care across Scotland?

The Sharing Intelligence for Health & Care Group is in a position where we can observe and learn about many important things happening in the health and care system across Scotland. These include the high standard of care experienced by many people, but also a number of challenges being faced by care systems and the staff working in them.

The member organisations have a responsibility to be aware of, and responsive to, the challenges facing the health and care system across Scotland. Further development of strong partnership working amongst national organisations, including members of the Group and other agencies, is essential in order to support front line services to address the main challenges facing our care systems.

The seven national organisations who are members of the Group have prepared the commentary below about the important issues we've observed that are relevant to the quality of care delivered for the people of Scotland. Many of these points have been described previously, often in reports published by some of our individual organisations. Nonetheless, we highlight them together in this report, given their significance to the health and care system as seen through our collective perspective.

The Group's core business is to share and consider intelligence about individual NHS boards. On the basis of this, we have also observed some key themes that are relevant across Scotland. This report draws together these themes, and it is not intended to be a comprehensive assessment of the state of the health and care system across Scotland.

Scale of change needed

The people of Scotland continue to benefit enormously from health and care services that can be accessed freely at the point of delivery. Since the NHS was created in 1948, the range of services offered has changed dramatically. So has the demand for these services, and also public and political expectations.

In its report on the NHS in Scotland in 2018[5], Audit Scotland reported that the demands of a growing and ageing population, coupled with significant financial and workforce pressures, means the current healthcare delivery model is no longer sustainable. This is despite a committed workforce in Scotland that has continued to deliver high-quality care.

On the basis of our work as seven national organisations, we believe that a greater scale and pace of change is required to ensure that people's health and care needs are met in future. There needs to be open and honest debate, locally and nationally, about the changes that are needed to sustainably deliver health and care services in Scotland that are of high quality and value, and also to more fully integrate health and social care services.

5 www.audit-scotland.gov.uk/report/nhs-in-scotland-2018

Leadership and culture

Leadership and culture are critically important factors when considering the quality of care in the wider sense. Everyone working in the health and care system in Scotland has an important role to play, and having effective leaders in place is vital. As a Group, we are aware that the leaders of today's care systems are working within an environment of extreme pressure and great complexity. Leaders are working to meet increasing public expectations and demand for services while also maintaining or improving performance. At the same time, the care systems they are leading are facing significant financial and workforce challenges (see below). There is added complexity as health and social care systems become more integrated.

The King's Fund recently highlighted a problem of 'churn' within senior leadership roles in English NHS trusts[6], such as high vacancy rates and short tenures. A culture of blaming individuals for failure was identified as making leadership roles less attractive. As a Group, we have observed 'churn' within senior leadership roles across Scotland. For example, during 2018–2019, there was a change in Chief Executive for six of the 18 NHS boards we considered. There has also been significant turnover in other key leadership positions in NHS boards and in Integration Authorities (such as Chief Officers).

Audit Scotland's progress report[7] on health and social care integration highlighted the importance of collaborative leadership across the different components of local health and social care systems. As a Group we agree that building collaborative leadership and strategic capacity, while minimising the 'churn' in leadership teams across the health and care system, are key factors for making good progress with integrating health and social care services.

6 www.kingsfund.org.uk/publications/leadership-todays-nhs
7 www.audit-scotland.gov.uk/report/health-and-social-care-integration-update-on-progress

As a Group, we endorse the view expressed by the King's Fund that national organisations have a key role to play in modelling the behaviours they expect of local leaders, and to treat the leaders of local care systems with dignity and respect. It is important that the member organisations of the Group demonstrate this in our day-to-day interactions with local health and care systems.

We also continued to acknowledge many examples of effective leadership across the care system in Scotland. This includes constructive responses to the findings from external reviews, even when these sometimes drew attention to challenging issues. For example, Healthcare Improvement Scotland and the Care Inspectorate reported that positive and constructive engagement with their inspection teams is helping with the improvement of services locally. The Mental Welfare Commission for Scotland reported that managers generally respond well to the recommendations from its programme of visits.

A recently published report from an independent review[8] in one NHS board drew attention to the importance of cultural issues in the NHS in Scotland. To learn more about culture and the experience of staff, this year our Group has started to consider the results from the NHSScotland iMatter staff survey. This is a survey based approach that is designed to help learn about the experience of staff across Scotland, and to take action based on this. iMatter results[9] for 2018 show that, overall, respondents felt they were treated with dignity and respect at work. Areas for improvement included staff being given time and resources to support their learning growth. We noted that the response rate to the iMatter survey varied markedly between NHS boards, and only half of the 18 NHS boards we considered achieved the response rate of 60% or over required to receive a more detailed iMatter report.

8 www.gov.scot/publications/report-cultural-issues-related-allegations-bullying-harassment-nhs-highland/
9 www.gov.scot/publications/health-social-care-staff-experience-report/pages/1/

Culture can vary within organisations, from one department/team to the next. There is a need to learn from those areas that are doing well in relation to inspiring vision and values, collaborative leadership, innovation and learning, and support and compassion. We have also observed that different cultures and priorities can sometimes exist across different local authority areas within a wider NHS board region. This can impact on the collaborative approach and the delivery of integrated services within NHS board areas.

Governance and finances

In October 2018, Audit Scotland published its report on the NHS in Scotland[10]. The total Scottish Government annual health budget for core services was £13.1 billion. Health remains the single largest area of Scottish Government spending, accounting for 42 percent of the total budget. The majority of health funding was provided to territorial NHS boards to deliver services. NHS boards delegated almost half of their budget to Integration Authorities to fund services, including primary and community care.

The NHS met its overall financial targets but NHS boards are struggling to break even, which they have been required by the Scottish Government to do at the end of each financial year. The majority of NHS boards have relied on short-term measures to balance their books, eg reallocating capital to revenue, and postponing investments. A few NHS boards required a loan from the Scottish Government to break even, and the amount provided by the Scottish Government for this purpose has increased. In October 2018, the Cabinet Secretary for Health & Sport announced that all territorial NHS boards' outstanding loans would be written-off at the end of the 2018–2019 financial year.

10 www.audit-scotland.gov.uk/report/nhs-in-scotland-2018. This report is for 2017-2018, and the key messages from the report highlighted here are still relevant given the intelligence that the appointed auditors have shared with the Group during 2018–2019.

While the level of savings achieved by NHS boards is unprecedented, and has involved hard work and innovation, there has also been a heavy reliance on one-off savings. This reliance on such 'non-recurring' savings is unsustainable, because they are becoming increasingly difficult to identify. They also reflect a focus on short-term actions rather than transformational change and long-term financial planning. The financial pressures facing the NHS continue to intensify. Pressures such as drug costs, a backlog of maintenance, and the use of temporary staff are predicted to continue in future years.

In October 2018, the Scottish Government published its Medium Term Health & Social Care Financial Framework[11]. This is an important step in enabling an open debate about the scale of the financial challenges ahead and the potential options for dealing with the impact this will have on delivering services. In addition, territorial NHS boards will now be allowed to break even over a three year period, rather than at the end of each financial year. This should provide NHS boards and Integration Authorities with greater flexibility in planning and investing over the medium to longer term, for example to achieve the aim of delivering more community-based care. It also makes it even more important that NHS boards plan their finances over a medium to longer-term period.

Each NHS board is responsible for ensuring that health services are delivered safely, efficiently and effectively, and to give the public confidence in the NHS. There has been a lot of attention on NHS governance over the past year. Audit Scotland's report on the NHS in Scotland highlighted that there is evidence that not all NHS boards are operating effectively. The Scottish Government is leading work with the aim of strengthening governance arrangements in NHS boards. This includes piloting a standardised review of corporate governance, NHS Scotland Blueprint for Good Governance.[12]

11 www.gov.scot/publications/scottish-government-medium-term-health-social-care-financial-framework/
12 www.sehd.scot.nhs.uk/dl/DL(2019)02.pdf

The financial constraints in which Integration Authorities are operating are impacting on strategic planning and commissioning, and on the development and delivery of services. There is more to be done in terms of Integration Authorities using their finances to develop and deliver new and innovative ways of working across health and social care. Lines of accountability for health and social care integration are still not universally clear. Auditors have highlighted that in some regions there is a need for greater clarity to: avoid duplicating governance arrangements; manage overspends in Integration Authorities, and: have ownership of performance management. Nonetheless there is evidence, from joint inspections of integrated services for adults, of increasingly integrated governance of health and social care services.

Workforce

Despite the challenges outlined above, there is a committed workforce in Scotland that has continued to deliver high-quality care. Care systems across the country are, however, experiencing some significant workforce challenges. Again, Scotland is not alone in this regard. In May this year, the Nuffield Trust reported an estimated vacancy level of 8% (around 1 in 12 posts) in hospital and community services south of the border[13]. These shortages are distributed unevenly across England.

The significant workforce issues facing the NHS in Scotland include difficulties with recruiting and retaining doctors. The rate of vacant consultant posts is about 8%. Consultant vacancies are highest for clinical radiology (a vacancy rate consistently in excess of 10% since 2016), and there is growing pressure on psychiatry with posts in old age psychiatry in particular proving difficult to fill. The Mental Welfare Commission for Scotland reported that the increasing number of vacancies for consultant psychiatrists across Scotland has resulted in a high use and reliance on locum consultant psychiatrists. This can lead to fragmentation of care and frustration for patients.

13 www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers#2-what-is-the-overall-shortfall-in-staff-in-the-nhs

There are also challenges with recruiting and retaining nursing staff. The vacancy rate for nurses and midwives has increased to about 5%. Vacancy rates for nurses working in mental health and learning disability are also increasing.

Different NHS boards have different workforce challenges. For example there are particular challenges associated with recruiting to medical posts in the more remote and rural parts of Scotland.

When considering workforce-related issues more broadly, an important source of intelligence that the Group considers is feedback from trainee doctors. The General Medical Council, which is the professional regulator responsible for oversight of medical education and training, conducts an annual National Training Survey[14]. The results of this show that quality of training in Scotland remains high, in the face of significant workforce challenges and workload pressures[15] and, generally, compares favourably with the position elsewhere in the UK. For example, there is positive feedback overall about the experience in training posts, and almost 9 in 10 doctors training in Scotland rate the quality of clinical supervision as 'very good' or 'good'. However, the results also highlight challenges about workload, and about 1 in 5 doctors training in Scotland report feeling burnout because of their work to a 'very high degree' or to a 'high degree'.

14 www.gmc-uk.org/education/how-we-quality-assure/national-training-surveys
15 www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk

NHS Education for Scotland shares intelligence about the enhanced monitoring process that it runs with the General Medical Council. Enhanced monitoring[16] is a valued quality management tool that can be initiated when there are concerns about the local environment for medical education and training. The process is designed to support improvement in the quality of training environments. Cases vary in their size and complexity, ranging from a single issue in a single department to multiple issues among a grouping of multiple specialties/departments. At the beginning of 2018–2019, there were nine cases in Scotland on enhanced monitoring. Three of these had been on enhanced monitoring for more than three years, and this reflects in part some of the very challenging issues that NHS boards are trying to address. Two cases were de-escalated from enhanced monitoring following the demonstration of sustained improvements. The Group was pleased to note that no new enhanced monitoring cases were initiated during 2018–2019, and this reflects the positive training environments for doctors that exist across the country.

Significant staff recruitment and retention challenges are impacting on the wider care system across Scotland, and not only the NHS. In some regions there are key professional roles and management positions that are challenging to fill, and this is impacting on planning and delivery of health and care services. This has resulted in a loss of organisational knowledge and expertise in the partnership areas affected. In many regions, there are also ongoing workforce challenges that are impacting on the care home sector and also the delivery of care at home.

EU withdrawal has the potential to significantly affect the health and care system across Scotland. It has been difficult to assess the scale of the risk, particularly in terms of workforce as data on the nationality of employees is not routinely collected, and there is still significant uncertainty about what form EU withdrawal will take.

16 www.gmc-uk.org/education/how-we-quality-assure/postgraduate-bodies/enhanced-monitoring

Clinical and care performance and outcomes

As might be expected, we see a mixed picture when we consider data/intelligence about the quality and outcomes of care across Scotland. There are many very positive messages about aspects of care that are good and/or improving. There are, however, also signs of a health and care system that is highly pressured[17].

In May this year, Public Health and Intelligence reported that the Hospital Standardised Mortality Ratio for Scotland had decreased by 14% between 2014 and 2018, exceeding the Scottish Patient Safety Programme aim of reducing mortality by 10%. There are a number of possible contributing factors, including improvements to patient safety made by teams delivering care across the country. The Scottish Patient Safety Programme has reported that improvements in patient safety include a reduction of 28% in the rate of cardiac arrest, and a reduction of 16% in the rate of falls with harm[18]. Over the past decade, there has also been a significant reduction in the rate of infant deaths (deaths within the first year of life). Some of the main messages from Healthcare Improvement Scotland's hospital inspections include the many instances where NHS staff are showing care and compassion to patients. Common areas for improvement include patients being assessed within required timeframes when they are admitted to hospital, and documented care planning that describes how patients' identified needs will be met.

17 www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk
18 These data are for hospitals that have reported data consistently, and are not for Scotland as a whole.

Healthcare Improvement Scotland also shared with the Group numerous examples of where front line teams have engaged well with nationally-led quality improvement work, including some of the main successes in terms of improvements made. A key challenge observed across the country is ensuring that there are the skills and capacity in quality improvement methodology that are required for leading and delivering the scale of improvements that need to be made.

The pressure on the NHS is increasing, and performance against some national performance targets continues to decline. For example, when considering access to services, recent years have seen a striking reduction in the percentage of people waiting 12 weeks or less for inpatient or day case treatment. As of March 2019, almost 1 in 3 patients waited longer than 12 weeks for treatment. There is a similar pattern observed for new outpatient appointments, with 1 in 4 patients waiting longer than 12 weeks. There has also been a significant reduction in the percentage of people urgently referred with a suspicion of cancer who began treatment within 62 days of referral – this is at 81%.

Over recent years, there has been an encouraging reduction across Scotland in the rate of prescribing antibiotics in community settings. Making a contribution to this is the work of the Scottish Antimicrobial Prescribing Group, which works with NHS boards across different health and care settings to improve antibiotic use and patient outcomes, while minimising the harm to individuals and to the population more widely from antibiotic use.

The Mental Welfare Commission for Scotland reported that the quality of care, and the care environment, for mental health services varies across the country. There are challenges with the availability of beds in admission wards, and the provision of adequate intensive community support to prevent admissions. This means that service users are sometimes admitted to non-admission wards or even to services in another NHS board area.

Audit Scotland published a report[19] which highlighted that mental health services for children and young people are under significant pressure. The number of referrals to specialist services has increased, and children and young people are waiting longer for treatment with access to services varying markedly across Scotland. This makes it difficult for children, young people, and their families and carers to get the support they need. A step change in the way that the public sector in Scotland responds to the mental health needs of children and young people is required.

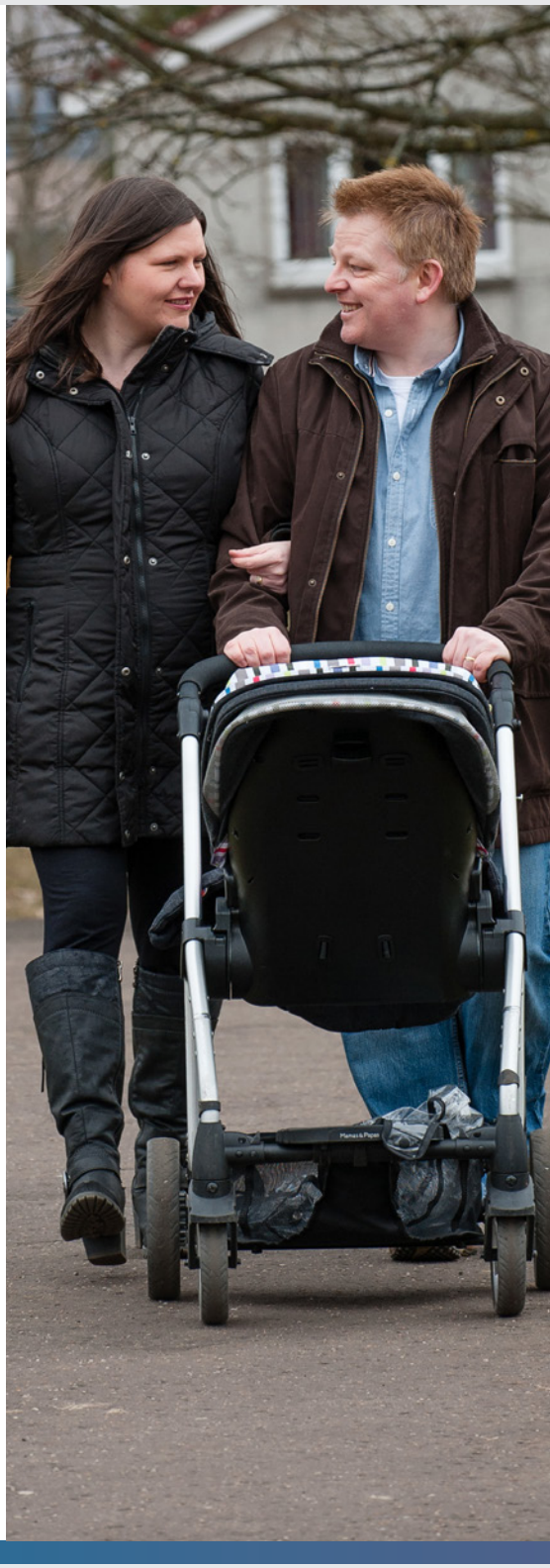
Every year the Mental Welfare Commission for Scotland produces an independent overview of the operation of either the Mental Health (Care & Treatment) (Scotland) Act 2003 or the Adults with Incapacity (Scotland) Act 2000. The use of both Acts continues to rise, although there is often wide variation across the country in how these Acts are used.[20] The Mental Welfare Commission is looking into the reasons for this.

In terms of the experience of people using services, a key source of information is complaints. The Scottish Public Services Ombudsman confirmed that all NHS boards have adopted the NHS Model Complaints Handling Procedure. This brings the NHS into line with other Scottish public service sectors in having standardised complaints handling processes. Integral to this is the requirement to learn from complaints to drive improvements in the experiences of people using NHS services. The NHS Model Complaints Handling Procedure is an important building block in enabling good complaints handling practice across the NHS in Scotland. The next challenge for the Ombudsman is to monitor practice to ensure it is applied consistently.

19 www.audit-scotland.gov.uk/report/children-and-young-peoples-mental-health
20 www.mwcscot.org.uk/publications/statistical-monitoring-reports

During 2018–2019, around a quarter of all health related complaints considered by the Ombudsman identified some issues in the way complaints were handled locally. This included, for example, complaints not being accurately identified or responded to, poor communication with the complainant and others, and complaints not responded to in good time.

The Ombudsman made 840 recommendations on health cases in 2018–2019[21], all of which were accepted by NHS boards and are being implemented. This is illustrative overall of a system that is open to feedback, learning and improvement.



21 www.spso.org.uk/our-findings

Analytical support required

The overall aim of the Group is to support improvement in the quality of care provided for the people of Scotland – by making good use of existing data and intelligence. Analytical support has a critical role in supporting change and improvement in health and care services. There are numerous purposes for which data/intelligence have a key role, including designing and evaluating new models of care, and helping members of the public made decisions about their own care and treatment.

A recent report from The Health Foundation about analytical capability in the NHS in England[22] mirrors what we observe, as a Group, in Scotland. In particular, while it sometimes feels like we are awash with data about our health and care systems, we are not always making the best use of these data. At the same time there are aspects of our care systems that are relative 'blind spots' when it comes to nationally available data, in particular the quality of healthcare delivered in community settings. If the balance of front line services is to successfully shift toward community settings, then we need to get a much better understanding of activity and performance of community based services. This will involve developing new Scotland-wide datasets.

We also need to further develop the analytical support that is available within our care systems in Scotland. We need to ensure that the analytical workforce is focusing on work that is going to add the greatest value for patients and the public. The organisations on the Group have an important role in making these changes. This includes leadership from Public Health and Intelligence, the lead agency for health analytics in Scotland, and also how we use data/information collectively as a Group. Public Health and Intelligence is due to become part of a newly formed Public Health Scotland in April 2020. It is anticipated that this development will lead to some enhanced intelligence/insight being input to the Group, building upon the data that are already provided.

22 www.health.org.uk/publications/reports/untapped-potential-investing-in-health-and-care-data-analytics

What are our commitments for 2019-2020?

Transparency and the voice of the public

'Transparency should be complete, timely and unequivocal. All data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public'

(recommendation 7, A Promise to Learn – A Commitment to Act, 2013[23]).

The Group fully supports this statement on information about the quality of care being freely available in an accessible format. Transparency is also a characteristic of good governance. This is why, from 2019-2020, we are placing more information about our work into the public domain. In particular, from September 2019 the Group will proactively publish the feedback letter that we send to each NHS board identifying the key points about that local care system. We also publish our schedule of when we consider specific NHS boards, together with a description of the range of data/intelligence we consider[24].

The Group has already committed to ensuring that the voice of the public features more prominently in our work. This is to build upon the input that the Scottish Health Council (part of Healthcare Improvement Scotland) already provides by sharing information on its activities with NHS boards. As stated in our published response to an independent evaluation of the Group, we invited a colleague with expertise in public involvement to observe how the Group works. This led to us hosting a focus group with some public representatives, who recommended to us that we raise public awareness of our work and ensure that the information we put into the public domain is written in language that is easy to understand. We accept these recommendations.

23 www.gov.uk/government/publications/berwick-review-into-patient-safety
24 www.healthcareimprovementscotland.org/our_work/governance_and_assurance/sharing_intelligence.aspx

Sharing intelligence about Integration Authorities

We have started to consider how our work can best take account of the changing landscape of increasingly integrated health and social care services in Scotland. Our early work on this during 2018–2019 highlighted the complexity of the issues involved. For example it's vital that when national agencies share intelligence, then this is done in a way that helps the front line organisations that the information relates to. We will do more work on this during 2019-2020, and are seeking to work with at least one Integration Authority to explore the issues and options.

Making the best use of data, including about care provided in community settings

During 2018–2019, we have continued to explore which of the many metrics from Scotland-wide datasets might be of greatest use to help learn about the quality of care. In 2019-2020, we will refine the set of indicators that we consider. We will also ensure we are routinely identifying key patterns of variation in the data for each of these indicators, including variation over time and in comparison with the Scottish average.

There has traditionally been a relative lack of data from national datasets about the quality of care provided in community settings. Public Health and Intelligence is, however, leading developments that will help ensure there is better data in the future about care delivered in the community. For example, there are increasingly better data becoming available about general practice/primary care, community-based mental health services, and district nursing.

In addition, there has also recently been the initial publication of a report which provides a digest of information and analyses on social care, covering self-directed support, home care service provision, care homes, and community alarms/telecare[25]. In a development that will mature over time, these data are now also being linked with other datasets to gain better insights into the wider health and social care system and to develop a number of outcome measures.

Between April 2019 and March 2020 we will:

- consider our collective intelligence about eighteen NHS boards
- publish our feedback to each of these NHS boards
- raise public awareness of our work and ensure that the information we put into the public domain is written in language that is easy to understand
- prepare proposals for if/how we involve Integration Authorities in our work
- identify patterns of variation on a refreshed set of indicators, and use additional pieces of data about the quality of care in the community

25 www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/2019-06-11/2019-06-11-Social-Care-Report.pdf

Published August 2019

You can read and download this document from our website.
We are happy to consider requests for other languages or formats. Please contact our Equality and Diversity Advisor on
0141 225 6999 or email **contactpublicinvolvement.his@nhs.net**