ARGYLL AND BUTE COUNCIL	COMMUNITY SERVICES COMMITTEE
COMMUNITY SERVICES	8 MAY 2014

JOINT PERFORMANCE REPORT

1. SUMMARY

1.1 The Community Services Committee is asked to note that a monthly Joint Performance Report captures a selection of data in respect of adult care across the partnership.

1.2 Children and Families information is reported separately at the Community Services Directorate meeting.

1.3 A copy of the report for February 2014 is appended.

2. RECOMMENDATIONS

2.1 The Community Services Committee is asked to note the content of the report.

3. DETAIL

3.1 The Joint Performance Report has evolved over the last 5 years. It provides information from both health and social care and is used across the partnership for strategic and operational management purposes.

3.2 The report is produced monthly, approved by both partners and circulated to a range of health and social care managers. It is also reviewed at the Health & Care Strategic Partnership.

3.3 Much of the information in the report is available on Pyramid but a number of managers expressed a preference for continuing to have a written report with narrative as well as data.

3.4 From April 1st 2014 the Service Development Team assumed responsibility for oversight of Delayed Discharge information, Pyramid data in respect of the Balance of Care and production of the Joint Performance Report. There will be some changes to incorporate information from Reshaping Care for Older People (RCOP).

3.5 Unplanned hospital admissions: during 2013/14 there was a local target to reduce unplanned admissions to Argyll & Bute hospitals by 10%, with an aspiration to reduce admissions to the Glasgow hospitals. The target has not been met; unplanned admissions have risen, as compared to 2012/13.
File audit revealed that there are issues with coding, whereby people transferred back from Glasgow hospitals and those regularly admitted for interim care are sometimes wrongly coded. This is being addressed.

The CHP Lead Nurse has set up scrutiny Groups in each locality to closely examine unplanned admissions. Work is on-going to develop a data collection tool that will help identify avoidable unplanned admissions and re-admissions, so that preventative services can be directed toward those people.

The national HEAT Target for 2014/15 seeks a 12% reduction in unplanned admissions. This does not apply to community hospitals, so in Argyll & Bute the target will only apply to Lorn and The Isles Hospital.

3.6 Balance of Care: The local target is for 80% of people receiving care services from the partnership to be cared for at home. This is a challenging target that is difficult to achieve for a number of reasons – the geography of Argyll & Bute means that we do not have equity of services across the area, because of variations in population density. In more remote areas we do not have the benefit of overnight care teams, have difficulties recruiting to home care posts (whether provided by the Council or contracted) and people have less access to other supports such as daycare and Meals on Wheels. A combination of these factors can lead to a care home admission at an earlier stage than might be the case if the person lived in a more urban area.

3.7 Care Home Vacancies: In total we have relatively high numbers of care home vacancies, with the majority of provision in Cowal. Forward planning needs to highlight future requirements for care home provision, so that we have the right numbers and types of provision in each area. For example, our ability to provide specialist dementia care is currently limited to Cowal and Campbeltown, whilst there is demand for this specialism in all areas.

3.8 Delayed Discharge: The target for Delayed Discharge decreased to zero delays at 2 weeks on 1st April 2014. We have a good record of achieving the previous target (zero delays at 4 weeks) but the 2 week target will challenge our practice and provision.

We need to develop a greater sense of collective urgency in getting people discharged when they are medically fit. Earlier referrals and better allocation of cases is needed to support a more rapid assessment output.

There are difficulties in commencing homecare packages in some areas because of the low response to recruitment of staff. We need to find a solution to this problem.

Care homes frequently only have one manager with the responsibility for assessing and accepting new residents and there are delays if the decision-maker is unavailable. We need to address this with the care homes.

Housing in Argyll & Bute can be unsuitable for the person to return home. We need to ensure that our stock of Sheltered and Extra Care Housing is allocated effectively, so that people who need a dwelling more appropriate to increasing needs can access one in a timely manner.

4. CONCLUSION

4.1 The Joint Performance Report is widely used across the partnership. It is a living document and should continue to change over time to reflect the changes in the way we work with people, for example through RCOP and in accord with the integration of Health and Social care, going forward.

The joint managers are well placed to influence the updating of the report at an operational level, whilst the Health and Care Strategic Partnership and the Community Services Committee can provide a strategic overview of future requirements.

5. IMPLICATIONS

Policy None

Financial: None

Legal; None

Personnel: None

Equal Opportunities: None

Risk: None

Customer Service: None

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