Joint Performance Report: February 2014.

Executive Summary.

- The overall balance of care describes people aged 65+ who receive funded care provision from the Partnership. In February 2014 77% were cared for in the community and 23% in an institutional setting. The overall Balance of Care target increased in April 2013 to 80%/20%
- The in-year Balance of Care shows 81% of people being cared for in the community as at February 2014. The target is 80%.
- At the February census date there were a total of 11 delayed discharges. We achieved the national target of zero delays at 4 weeks.
- We had a total of 80 permanent and 5 respite care home vacancies across the area at the end of February 2014.
- The Overnight Care teams work in 8 main towns and as far as possible the areas outlying their base, details of this work are given within the report. We need to review provision and reporting on this service.
- The Balance of Care for Learning Disability (LD) service users is 91% cared for in the community.
- The Balance of Care for Mental Health (MH) Service users is 99% cared for in the community as opposed to residential care. Data for Mental Health unplanned admissions in shown in this report.
- Data for Children & Families services are to be included in the report at a future date, to be agreed by the Head of Service and Area Manager, Service Development.
- Key points for discussion by Joint Managers are highlighted within the report.
- Data capture of Enhanced Community Care Team (ECCT) work began in January; this work is being taken forward by the CHP Lead Nurse. At present the entire number of reported referrals has been fitted into the Integrated Care Team's (ICT) sections of Pyramid, to maintain continuity of the way the ICT work was reported, until the end of this financial year. From April 1st 2014 Pyramid will be amended to show only ECCT service users who have no other input in Balance of Care, thus avoiding double counting. The rest of the ECCT work will be shown in Pyramid in the Social Care Report section, in order that we can capture the full range of work carried out by the teams. In February no ECCT data were received from Bute or Tiree and Coll, but all other areas provided data as requested.

- Joint Performance reporting will transfer to the Service Development Team on April 1st 2014. The team will be consulting on the content and presentation of the report and ultimately will provide an updated format, in accord with contributors and users of the report.

Joint Performance Action Plan:

	Action	Responsible person	Timescale	Status
1	Re-design Alcohol and Drug Partnership Pyramid scorecard using data from national database and change data interval to monthly.	Area Manager, Service Development/ADP Co-ordinator & Information Officer	To be agreed	Amber
2	Achieve a 10% reduction in unplanned hospital admissions during the financial year 2013/14 (will be monitored monthly on Pyramid for reduction on the 2012/13 data)	CHP Director of Operations and Lead Nurse	31st March 2014.	Red
3	Children and Families dataset to be included in this report	Head of Service Children and Families, Area Manager Service Development.	August 2014	Amber
4	A range of measures (as described on page 10) will be implemented to investigate emergency hospital admissions and seek to reduce them	CHP Lead Nurse	February 2014	Green
5	Develop an action plan for 2014 to identify key priorities for managing and reducing the number of delayed discharges in order to meet the zero-at-2-weeks target from April 2014 (Links to Business Process Re-engineering programme)	Service Manager Operations/CHP Lead Nurse	August 2014	Amber
6	Review Carr Gomm overnight Teams and reporting mechanism for this.	Service Manager Resources	May 2014	Amber
7	Manage the transfer of Delayed Discharges, Balance of Care and Joint Performance Reporting to Service Development Team	Area Manager Service Development/ Project Officer Integration	April 2014	Green

Adult Care

1. Joint Performance and Balance of Care, Older People.

Table 1.1 *Emergency hospital admissions to local and Glasgow hospitals – February 2014*

Area	Emergency admissions to local hospitals	Emergency admissions to Glasgow hospitals	Totals
Bute	21	26	**47**
Cowal	31	68	**99**
Helensburgh	35	54	**89**
Mid Argyll	14	14	**28**
Kintyre	30	6	**36**
Islay	8	2	**10**
Oban	68	12	**80**
Mull	3	0	**3**
Totals	**210**	**182**	**392**

Table 1.1a *Emergency Hospital Admissions and Re-admissions to local hospitals February 2014*

Area	Total emergency admissions	Number of these with 2 or more emergency admissions in 12 months	Re-admissions as a % of the total	Age 65+	Age 75+	Cumulative Variance YTD *(compared to 2012/13)*	Target and RAG status
Lorn	68	30	44%	23	45	+91	-61
Mull & Iona	3	1	33%	0	3	+21	0
Tiree & Coll							0
Cowal	31	12	39%	11	20	+81	-35
Bute	21	4	19%	8	13	+19	-16
Mid Argyll	14	5	36%	6	8	-19	-23
Kintyre	30	6	57%	10	20	-6	-30
Islay & Jura	8	6	75%	5	3	-4	-10
Helensburgh (Vale of Leven)	35			12	23	+28	-34
Totals	**210**	**64**	**37%**	**75**	**135**	**+211**	**-209**

A 10% reduction target for unplanned admissions continues to be applied to Argyll & Bute hospitals and Vale of Leven. There is an aspiration to reduce unplanned admissions to the Glasgow hospitals, but no target is applied at this stage, therefore these admissions are show separately in Table 1.1a

High levels of unplanned admissions incur high cost hospital care, which reduces the capacity for investment in community based services. Lengthy or repeated hospital stays can reduce confidence and self-management capacity for the person and increase the likelihood of the person being admitted to residential or nursing care.

None of the reduction targets have been achieved and all areas except MAKI have increased numbers of unplanned admissions compared to 2012/13.

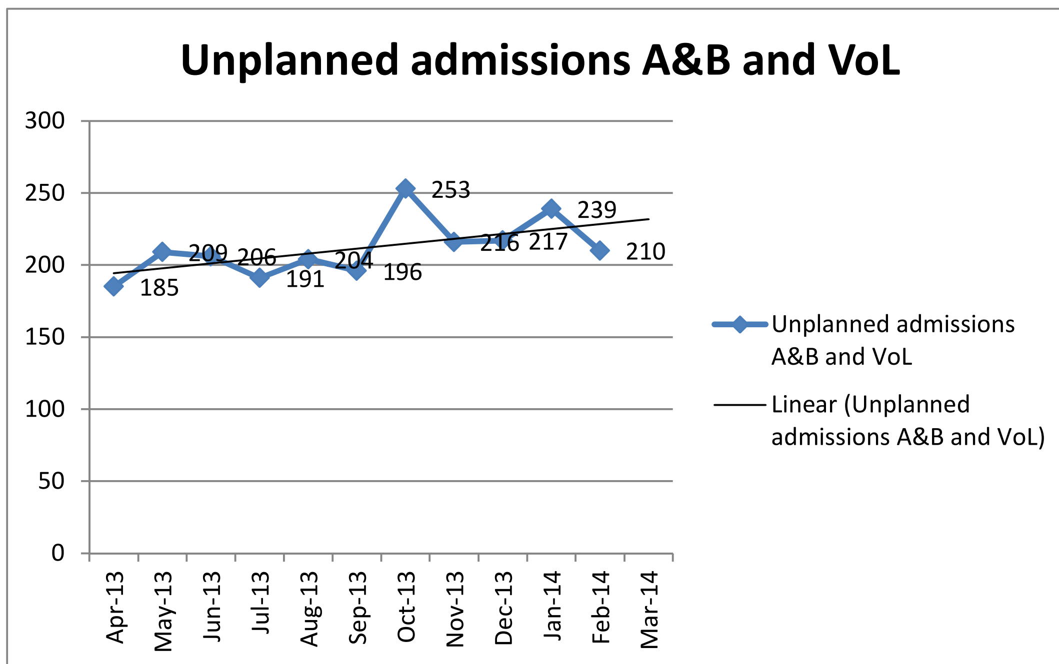
Scrutiny groups are already in place in all localities and analysis of unplanned admissions, using a variety of criteria is regularly being carried out. Work is underway in each locality to ensure that the correct codes are applied to each emergency admission as there have been some issues related to coding accuracy – for example planned admissions for intermediate care and hospital transfers have been coded as emergency admissions in some cases.

Increased focus on anticipatory care planning, intensive case management for those at greatest risk in the community, extended working hours of community teams will be

included within ongoing plans to ensure that avoidable admissions are supported in the community.

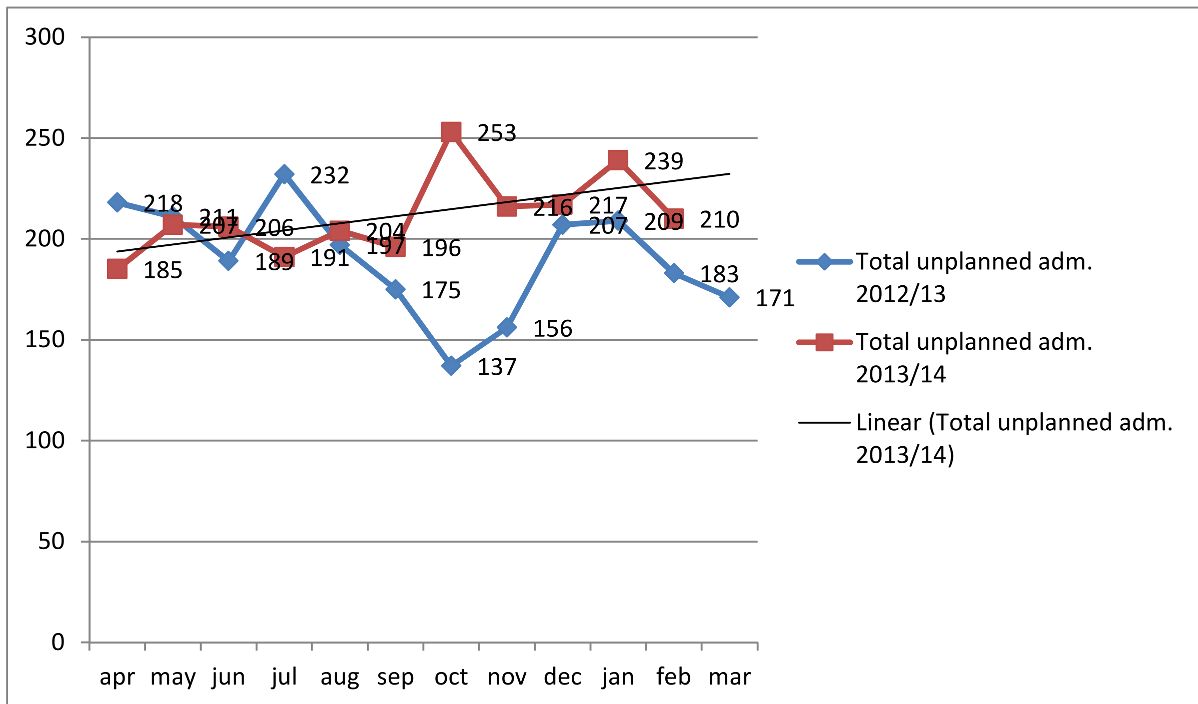
Emergency admissions by month/financial year 2013/14

Table 1.2 *Total unplanned admissions 65+ – Argyll & Bute and Vale of Leven, 2013/14 showing linear trend.*



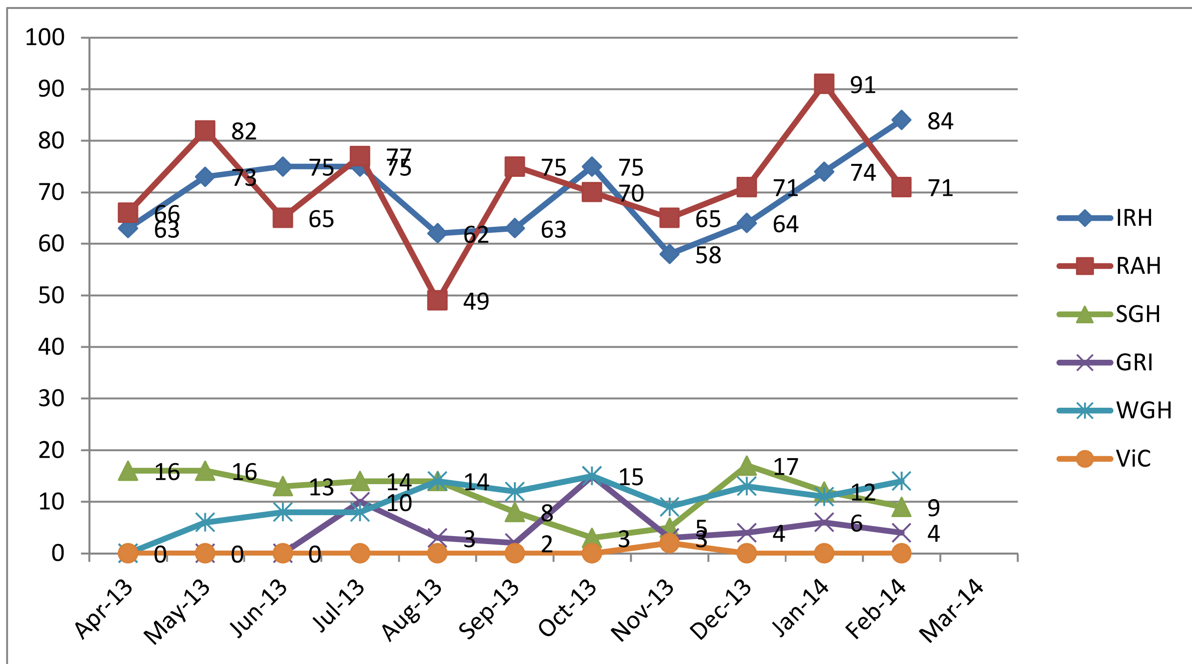
There were 210 unplanned admissions to Argyll & Bute and Vale of Leven hospitals during February 2014.

Table 1.2a *Total unplanned admissions 65+ – Argyll & Bute and Vale of Leven, showing 2012/13 comparators*



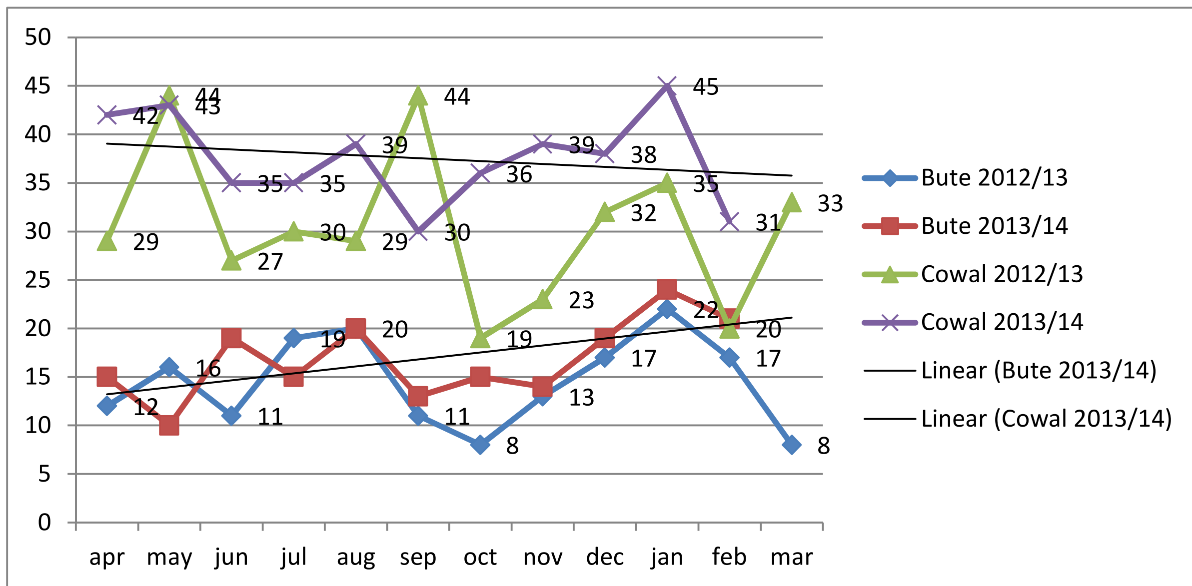
Total unplanned admissions in February 2014 remain at higher level than last year, with an upward trend. There were 210 admissions to Argyll & Bute and Vale of Level hospitals, with a further 182 admissions to the other Glasgow hospitals, giving a total of 392 unplanned admissions during the month.

Table 1.2b *Glasgow hospitals – 65+ unplanned admissions by month/financial year2013/14*



During February 2014 there were 182 unplanned admissions of Argyll & Bute residents aged 65+ to the Glasgow hospitals. The highest numbers were admitted to RAH and IRH, from the Cowal and Helensburgh areas.

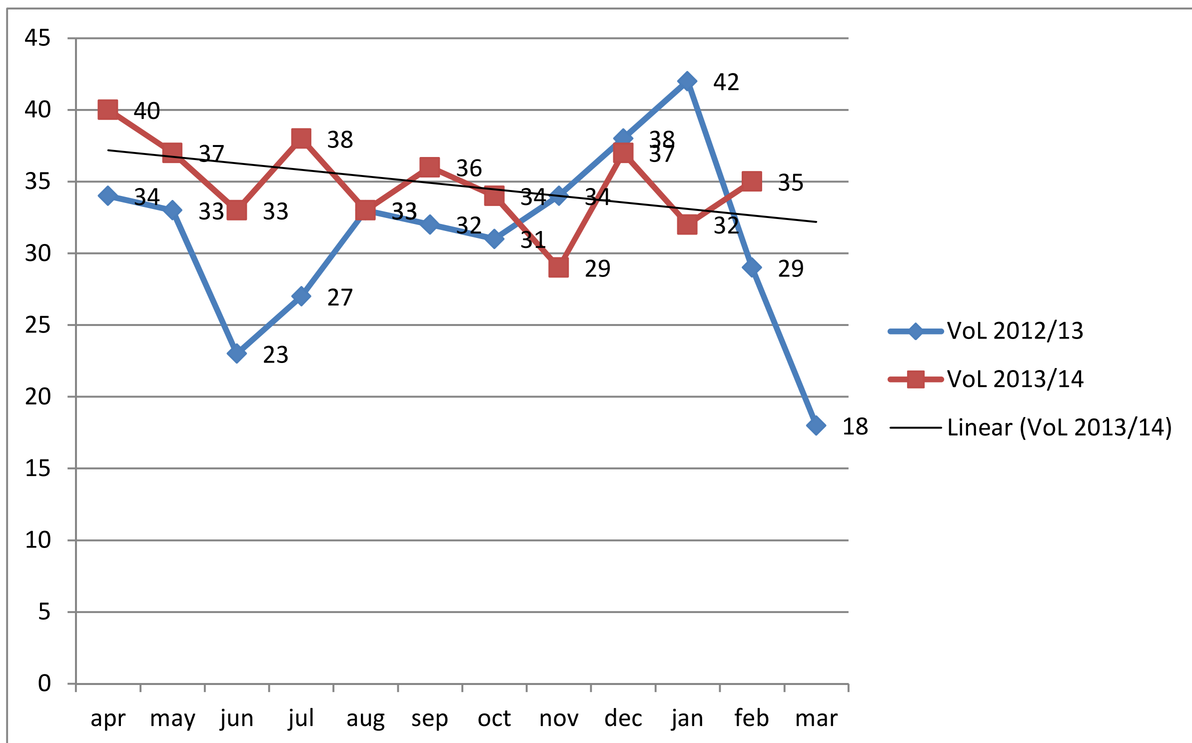
Table 1.3 *Bute & Cowal 65+ unplanned admissions*



There were 21 unplanned admissions in Bute during February 2014 and 26 unplanned admissions from Bute to Glasgow hospitals. The linear trend for Bute is rising across the year.

In Cowal there were 31 unplanned admissions, with a further 68 patients from Cowal admitted to Glasgow hospitals. The linear trend for Cowal is falling across the year.

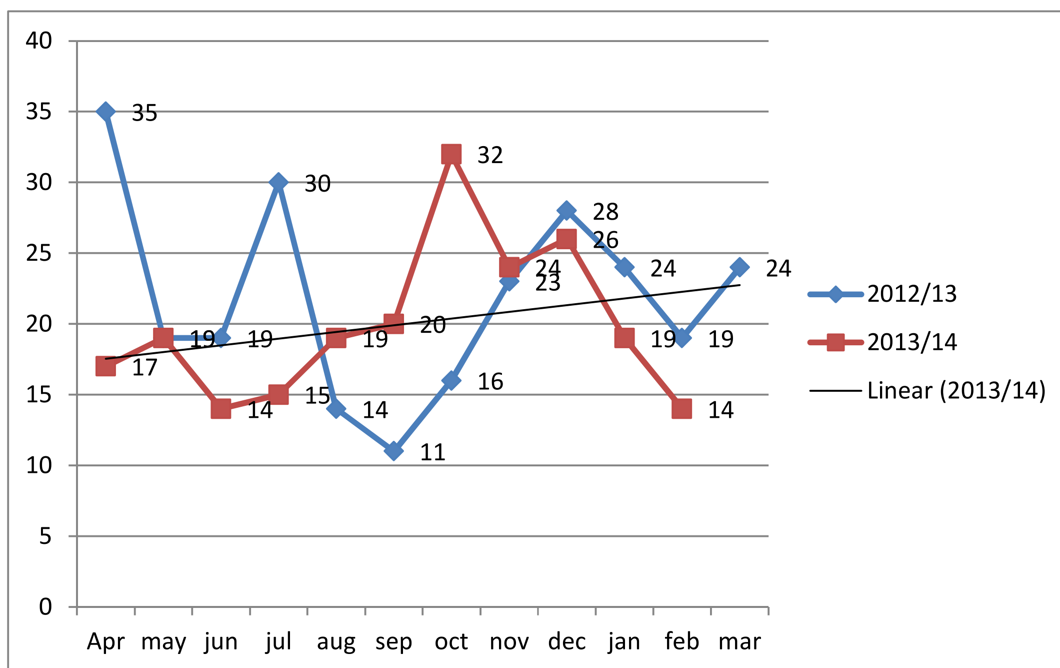
Table 1.4 *Helensburgh (Vale of Leven) 65+ unplanned admissions*



There were 35 unplanned admissions to Vale of Leven hospital during February 2014, plus 58 Helensburgh patients were admitted to other Glasgow hospitals, creating a total of 93 unplanned hospital admissions from the Helensburgh area during February. The linear trend for Vale of Leven hospital, across the financial year is downward.

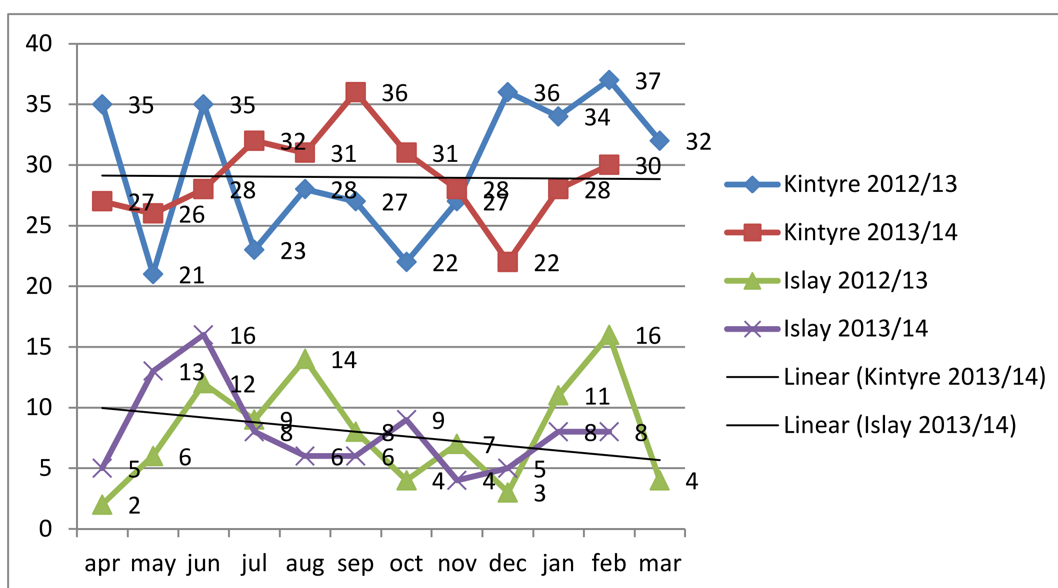
Table 1.5 *MAKI*

1.5a Mid Argyll 65+ unplanned admissions



There were 14 unplanned admissions in Mid Argyll during February 2014, there were 14 admissions from Mid Argyll to the Glasgow hospitals, giving a total of 28 unplanned admissions. The linear trend across the financial year is upward.

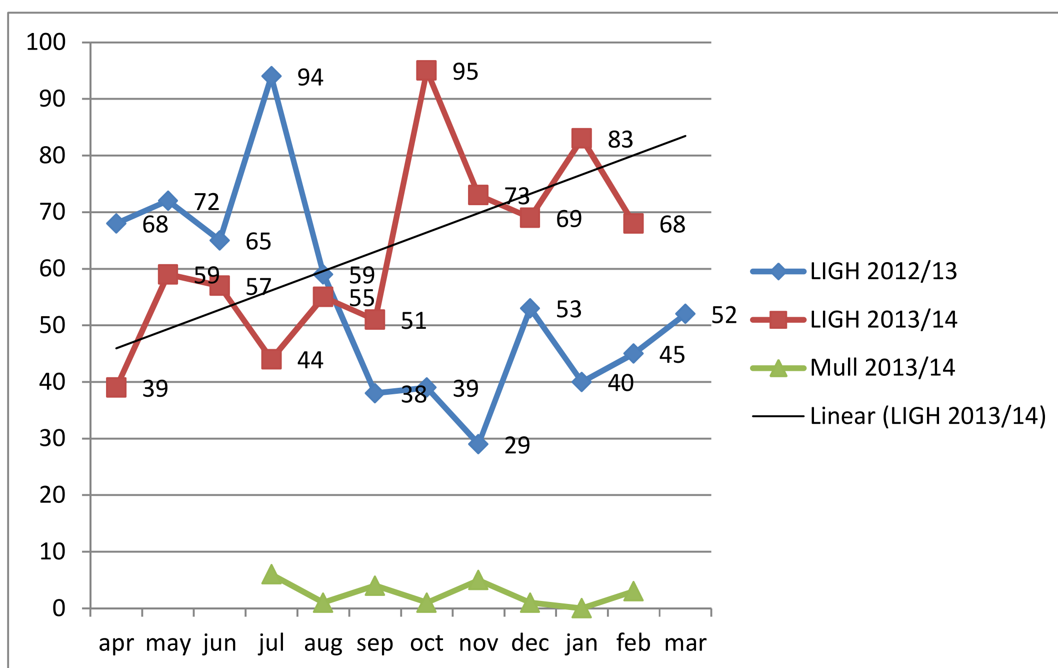
1.5b Kintyre & Islay 65+ unplanned admissions



There were 30 unplanned admissions in Kintyre, plus 6 to the Glasgow hospitals during February 2014. The linear trend across the financial year is slightly down.

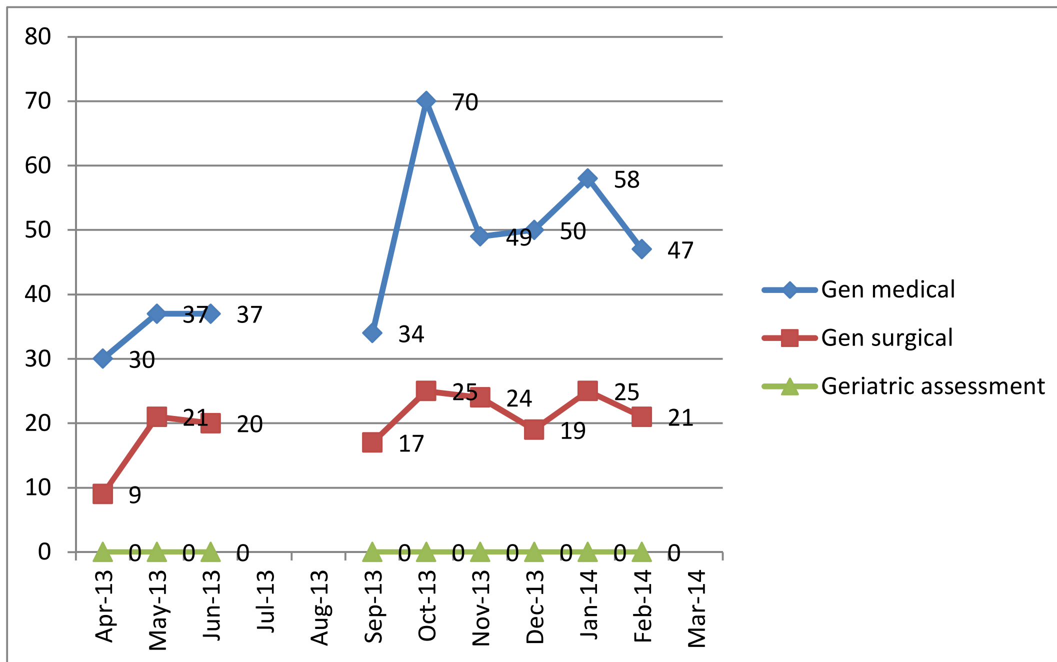
There were 8 unplanned admissions to Islay hospital during February 2014, plus 2 to the Glasgow hospitals, giving a total of 10 unplanned admissions. The linear trend across the financial year is downward.

Table 1.6 *OLI 65+ unplanned admissions*



There were 68 unplanned admissions to L&IH during February 2014, with a total of 21 patients admitted for surgery. There were 3 unplanned admissions on Mull. There were 12 unplanned admissions from OLI to Glasgow hospitals, giving a total of 96 unplanned hospital admissions from the OLI area (including Mull and Tiree) during February. The linear trend across the financial year is sharply up.

Table 1.7 Lorn Admissions by specialty:



POINTS FOR DISCUSSION:

- Argyll and Bute is one of the better performing partnerships in Scotland overall in relation to numbers of emergency admissions to hospital
- We have set a challenging 10% reduction target for unplanned admissions in Argyll & Bute and an aspiration to reduce unplanned admissions to the Glasgow hospitals. The reduction target is not being met during 2013/14.
- The CHP Lead Nurse is heading up a scrutiny group to look at the numbers of emergencies in the community and identify those people admitted to hospital who could be looked after elsewhere.
- Clinical Services Managers (CSMs) will provide emergency admission data from each area, to be analysed by Joint Planning & Performance Officer.
- Action plan under development to improve the levels of anticipatory care planning and intensive case management for those at highest risk of admission/readmission – focussing on readmissions in the first instance
- Linear trends are now only shown for the current financial year. For clarity this purely reflects the trend in the current year. Comparison with the last financial year needs to be made using the graph data.

Table 1.8 *Total Emergency Re-admissions – Rolling 12 month period to February 2014*

Area	Total patients re-admitted as emergency in the last 12 months	Aged 65-74	Aged 75+	Admitted from care home	Admitted from Sheltered Accommodation	Admitted from own home	Total compared to last month
Bute	44	10	34	1	2	41	-1
Cowal	123	26	97	13	0	110	+7
Helensburgh & Lomond	0	0	0	0	0	0	-1
Mid Argyll	78	54	54	0	3	75	0
Kintyre	79	53	53	6	4	69	-8
Islay & Jura	29	21	21	0	0	29	0
Lorn	149	118	118	11	18	120	-3
Mull & Iona	28	19	19	0	2	26	+7
Colonsay	0	0	0	0	0	0	0
Tiree & Coll	0	0	0	0	0	0	0
OOA/not know to SW	118	64	54	0	0	118	-3
Totals	**648**	**198**	**450**	**31**	**29**	**588**	**-2**

Within this reporting system Helensburgh & Lomond rolling re-admission data shown relates only to admissions to Argyll & Bute hospitals, not to Vale of Leven hospital.

Table 1.9 NHS Continuing Care Bed Occupancy:

NHS Continuing Care (CC) beds are available in Oban, Campbeltown and Lochgilphead, with Mid Argyll Hospital accepting dementia patients from other areas.

Hospital code	Hospital name	Designated CC beds at Aug 2011	Occupied November 2013	Occupied December 2013	Occupied January 2014	Occupied February 2014
C101H	Argyll & Bute Hospital	**0**	0	0	0	0
C106H	Cowal Community Hospital	**0**	2*	2*	2*	2*
C108H	Islay Hospital	**0**	0	0	0	0
C113H	Rothesay Victoria Hospital	**0**	0	0	0	0
C114H	Rothesay Victoria Annexe	**0**	0	0	0	0
C121H	LIGH	**2**	2*	2*	2*	2*
C122H	Campbeltown Hospital	**14**	2	2	2	2
H224H	Mid Argyll Hospital	**20**	9	10	10	10
Total		**36**	**15**	**16**	**16**	**16**

**Patients placed in Mid Argyll hospital, but shown in their home area.*

POINTS FOR DISCUSSION:

- There are political pressures related to closing any Continuing Care beds and the negotiation process requires time and sensitivity.
- The 20 beds in Mid Argyll are specifically dementia beds, which are available to patients from any area of Argyll & Bute. Whilst we do have some specialist dementia care homes, there are patients whose needs challenge their capacity and who need to be accommodated in a hospital setting.

Table 1.10 *Social Care bed vacancies, by area as at 28.02.2014*

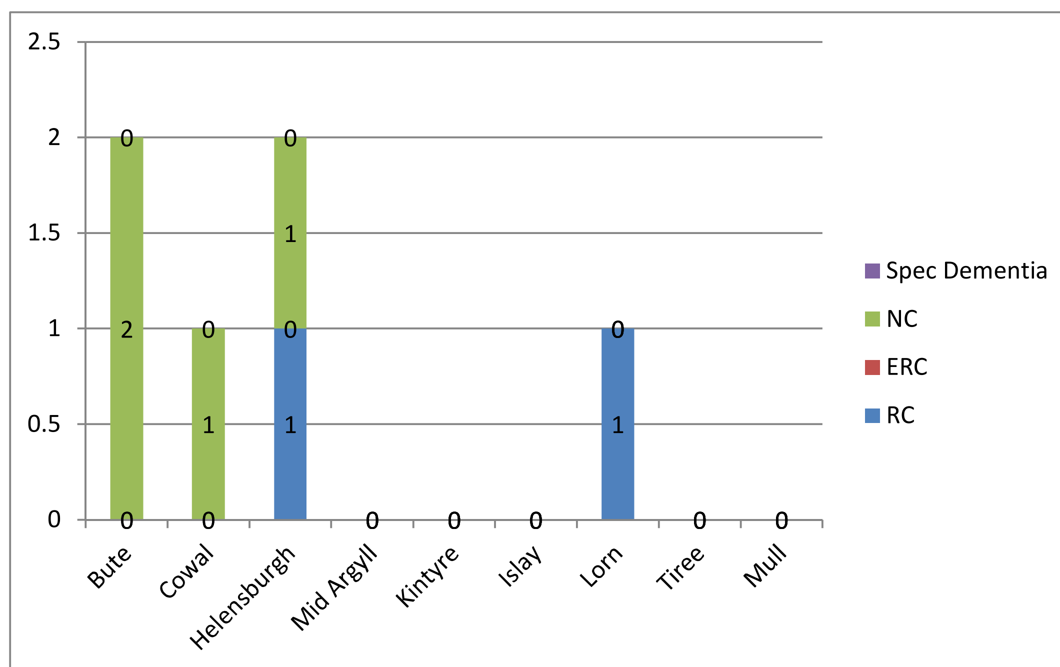
There were 80 social care vacancies across the area, plus 5 respite vacancies.

Vacancies					**Bed capacity**			
Area	**Residential vacancies**	**Nursing vacancies**	**Single Care vacancies**	**Area vacancy total**	**No. of residential beds**	**No. of Nursing beds**	**No. of Single Care beds**	**Total capacity**
Local authority								
Bute & Cowal	0	0	2	**2**	0	0	21	**21**
MAKI	0	0	3	**3**	0	0	32	**32**
OLI	3	0	5	**8**	25	0	12	**37**
LA Total	**3**	**0**	**10**	**13**	**25**	**0**	**65**	**90**
Private sector								
Cowal	23	0	15	**38**	64	0	97	**161**
Bute	1	0	1	**2**	8	0	16	**24**
Helensburgh	0	2	2	**4**	16	35	98	**149**
MAKI	0	0	11	**11**	0	0	64	**64**
OLI	2	0	10	**12**	26	0	62	**88**
Private Sector Total	**26**	**2**	**39**	**67**	**114**	**35**	**325**	**474**
Total vacancies	**29**	**2**	**49**	**80**	**139**	**35**	**390**	**564**

Total A&B vacancies 80
Respite vacancies (not included in table above) 5
% of permanent beds available in A&B 14.18 %

In total there were 80 care home vacancies in Argyll & Bute – 29 in Residential Care, 2 in Nursing Care and 49 in Single Care.

Table 1.10 *Planned admission to a care home by care category: February 2014*

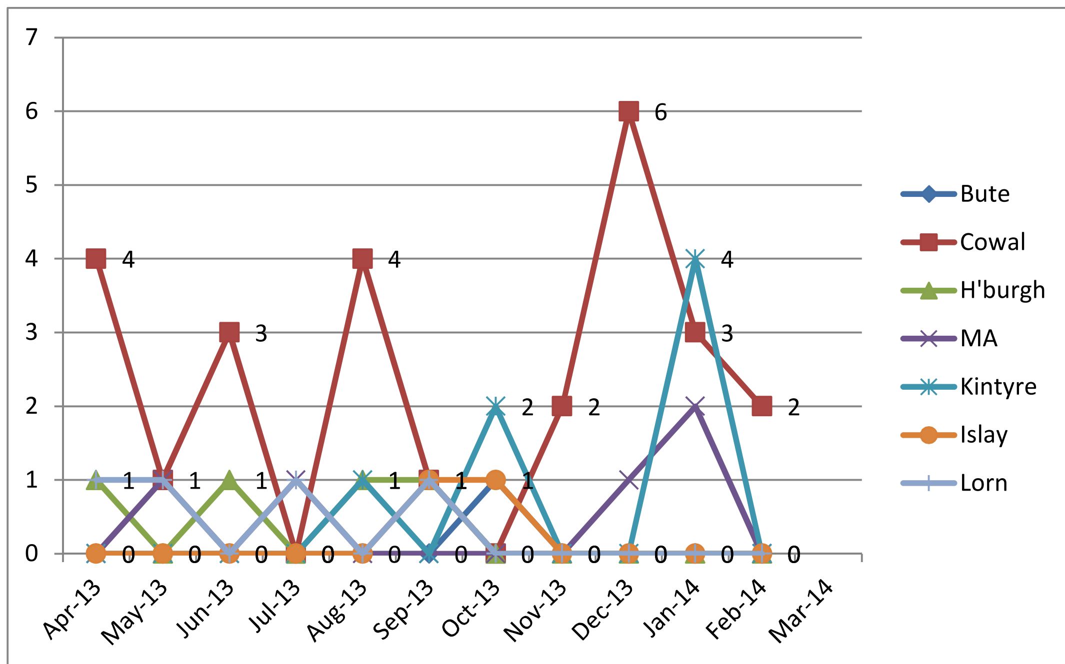


There were 6 admissions to care homes during February 2014. 4 of the admissions were to nursing care and 2 to residential care.

POINTS FOR DISCUSSION:

- Many people requiring care home placement wish for that to be in their local area.
- People being admitted to residential care homes are likely to have higher levels of need than people at the point of admission a few years ago.
- We have numerous care home vacancies, but in some areas we may not have availability of the type of care we need. For example we need to be in a position to offer Progressive Care, Nursing Care and specialist dementia care in more areas across Argyll & Bute, to respond to demographic changes. The emerging Joint Commissioning Strategy will address these issues.
- Joint Managers in MAKI have raised concerns about the length of time it takes for a care home to assess prospective residents; the absence of managers with the power to make decisions about acceptance and the lack of deputised powers; the reluctance of care homes to accept some referrals, even when the prospective resident falls within the parameters of their registration.
- In Lorn one of the large care homes, Lynn of Lorn has restricted admissions due to recruitment difficulties.

Table 1.10a Emergency and Temporary admissions to care homes 2013/14



Emergency and temporary care home placements have predominantly been made in Cowal, with 26 placements in the year to date. Year to date placements in the other localities remain in single figures (range 1 to 7). There have been no emergency or temporary placements on Mull & Iona, Colonsay or Tiree & Coll and these areas are excluded from the graph. There were 2 emergency admissions to care homes during February 2014, both were in Cowal.

POINTS FOR DISCUSSION:

- What community services are available in other localities, but absent in Cowal that would enable a greater number of emergency situations to be managed in the community?
- Can existing community support be used to better effect in Cowal, are there learning points to be taken from other areas?

Delayed Discharges at the December 2013 census date. (15th February 2014)

Delayed discharges are patients who are deemed to be medically fit for discharge from hospital, but who remain in a hospital bed for non-medical reasons.

A local target of zero delays at 2 weeks has been applied from April 1st 2013, with the national target of zero delays at 4 weeks being implemented simultaneously. Discharge at 2 weeks is a challenging target, which will be implemented nationally from April 1st 2014.

At the February census date we had a total of 11 delayed discharges. Of these 7 were non-exempt patients and 4 were adults with incapacity.

There were zero delays at 2 weeks and 4 weeks.

Argyll & Bute Council's Business Process Re-Engineering Team are currently reviewing the whole process to assist us in maintaining a high performance level, as the zero delays at 2 weeks target, applied from April 1st 2014 imposes an ever greater challenge on service delivery.

Exemption Code 9 are complex cases: the 51x suffix indicates an adult with incapacity (AWI), the 25x suffix indicates a patient awaiting a complex care package in order to return home, the 71x suffix indicates that the desired placement is not available and that an interim placement would be unreasonable.

Exemption code100 – detained MH patients who require reprovisioning/recommissioning of services.

Table 1.11a

Description	Delayed under 2 weeks	Delayed 2 - 4weeks (local target 0)	Delayed over 4 weeks (national target 0)	**Total**
A&B no exemption code	4	0	0	**4**
A&B Exemption 100	0	0	0	**0**
A&B Exemption 9/51x	0	2	2	**4**
A&B Exemption 9/71x	0	0	0	**0**
A&B Exemption 9/25x	0	0	0	**0**
Out of area no exemption code	3	0	0	**3**
Out of area Exemption 9	0	0	0	**0**
Out of area Exemption 9/51x	0	0	0	**0**
Out of area Exemption 9/71x	0	0	0	**0**
Out of area exemption Code 100	0	0	0	**0**
Total delayed discharges	**11**			

Table 1.11b Adult with Incapacity Patients- Length of Delay February 2014

Area	Hospital	Patient	Length of Delay in days	Discharge Destination
Campbeltown	Campbeltown Hospital	B	82	Nursing Care
Mid Argyll	Glassary Ward	J	31	Residential Care
Mid Argyll	Glassary Ward	J	24	Nursing Care
Mull	Mull	D	22	Residential Care

Table 1.1c Total delayed discharges, financial year 2013/14

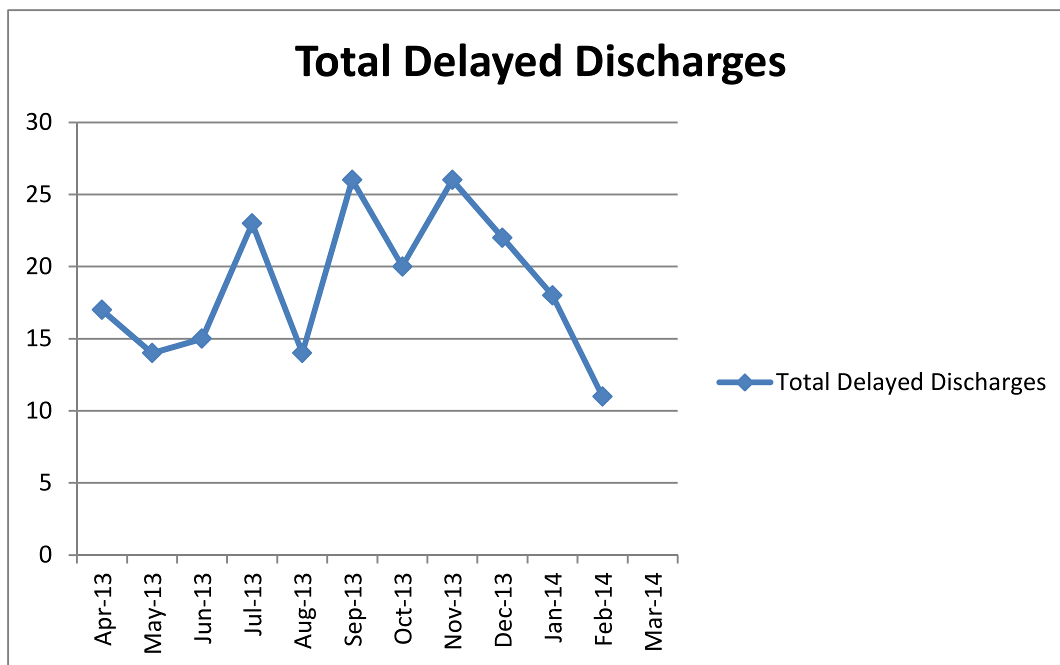
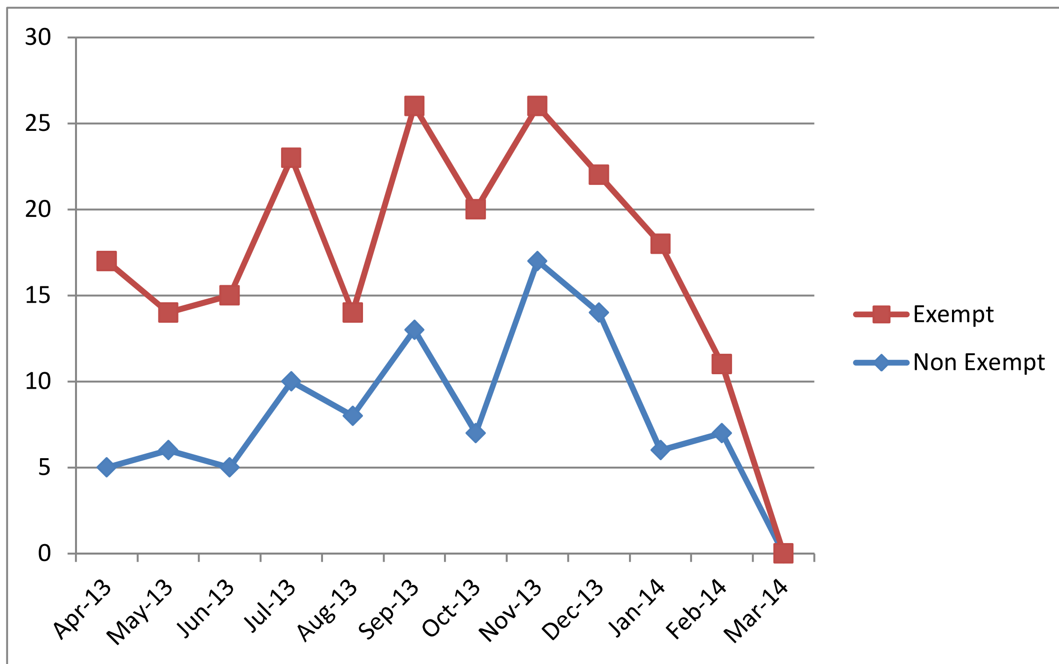


Table 1.1d delayed discharges exempt/non-exempt, financial year 2013/14



POINTS FOR DISCUSSION:

- We applied the 2 week target locally in April 2013, but using our current systems we have had difficulties meeting the target, for a variety of reasons.
- There is a need for greater collective urgency in planning and initiating timely discharge from hospital – there is still a sense that people are safe in hospital even when they have been assessed as medically fit for discharge.
- Shared local ownership of the Delayed Discharge agenda is needed, with local managers having knowledge of each person delayed in hospital and the actions needed to facilitate discharge
- We need to review the assessment process and understand the reasons for delays in completion of assessment in a timely manner
- We need to understand the reasons for delays in getting people moved to care homes
- There has been difficulty in some areas getting home care packages started in time, due to lack of availability of staff. Creative local solutions are required.
- Process mapping of the assessment process will be carried out in OLI to identify where the delays are in the system – learning from this will need to be applied throughout Argyll and Bute
- Action plan is under development to identify key priorities for 2014 in managing and reducing the number of Delayed Discharges across Argyll and Bute

Balance of Care for Older People:

The Outcomes Framework for Community Care 2009/10 required us to move services closer to users and carers by achieving a shift in the balance of care from 'institutional' to home-based care. The Reshaping Care for Older People work builds on this requirement by providing additional funding, until 2015, to enable and support the shift towards care in the community, through a partnership approach.

The Balance of Care targets from April 2013 are 80% cared for in the community and 20% of people cared for in an institutional setting. The measure represents people aged 65+ who receive a funded service from the Partnership. This target recognises that a small percentage of people will have care needs that require specialist equipment, or levels of care that cannot be provided safely in the community.

The overall Balance of Care shows people aged 65+ who receive formal (funded) care from the Partnership. The target increased to 80% of people cared for in the community on April 1st 2013.

Care in the community includes Homecare, Integrated Care Teams ICTs/Enhanced Community Care Teams ECCTs, Overnight Teams, Extra Care Housing, and Delayed Discharges awaiting a homecare package. Meals on Wheels, respite care, daycare and Telecare are not currently included.

Work with the Lead Nurse, to establish ECCT reporting has resulted in the receipt of reports from all areas except Bute and Tiree & Coll. Total referrals have been included to maintain the integrity of reporting i.e. in line with previous ICT reporting, for the remainder of this financial year. It is recognised that this has an element of double counting and from April 2014 a Pyramid revision will ensure that ECCT data in Balance of Care will exclude people who also have a homecare package, in order to eliminate double counting. Reporting will ultimately be via MiDis.

Care in an institution includes permanent and temporary/emergency stays in a care home and NHS Continuing Care. Delayed Discharges awaiting care home provision are also included in the Balance of Care calculation.

Table 1.12 Overall Balance of Care by area, February 2014:

Area	Clients cared for in the community		Clients cared for in an institutional setting		Trend for CiC
	Number	%	Number	%	
Helensburgh & Lomond	418	78%	117	22%	→
Bute & Cowal	585	76%	185	24%	↑
Bute	176	79%	46	21%	→
Cowal	409	75%	139	25%	↑
Mid Argyll, Kintyre & The Islands	415	78%	115	22%	→
Mid Argyll	148	74%	51	26%	↓
Kintyre	146	74%	51	26%	→
Islay & Jura	121	90%	13	10%	↑
Oban, Lorn & The Isles	328	75%	108	25%	↓
Oban	249	72%	95	28%	↓
Colonsay	3	100%	0	0%	→
Mull & Iona	67	92%	6	8%	↓
Coll & Tiree	9	56%	7	44%	↓
Overall delivery	1746	77%	525	23%	↑
Target	80%		20%		

Source: Pyramid, Joint Planning & Performance

Table 1.13 In-year Balance of Care by area, February 2014:

Area	Clients cared for in the community		Clients cared for in an institutional setting		Trend for CiC against previous month	March 2012/13 Totals (for comparison)	
	Number	%	Number	%		CiC	Inst
Helensburgh & Lomond	184	79%	50	21%	↓	80%	20%
Bute & Cowal	344	83%	70	17%	↑	74%	26%
Bute	65	77%	19	23%	→	73%	27%
Cowal	279	85%	51	15%	↑	75%	25%
Mid Argyll, Kintyre & The Islands	251	81%	60	19%	↑	79%	21%
Mid Argyll	84	78%	24	22%	→	75%	25%
Kintyre	80	71%	33	29%	↑	82%	18%
Islay & Jura	87	97%	3	3%	↑	82%	18%
Oban, Lorn & The Isles	117	77%	35	23%	↓	72%	28%
Oban	98	75%	32	25%	↑	69%	31%
Colonsay	1	100%	0	0%	→	100%	0%
Mull & Iona	16	94%	1	6%	↑	90%	10%
Coll & Tiree	2	50%	2	50%	↓	66%	34%
Overall delivery	896	81%	215	19%	↑	77%	23%
Target	80%		24%			80%	20%

Source: Pyramid, Joint Planning & Performance

The In-Year Balance of Care data shows the people aged 65+ who have started an episode of care funded by the Partnership, within the financial year. The right hand columns provide March 2012/13 percentages for comparison.

Care in the community includes Homecare, ICTs/ECCTs, Overnight Teams, Extra Care Housing and Delayed Discharge patients awaiting a care package. Data for Extra Care

Housing in all areas has now been included. Meals on Wheels, respite care, daycare and Telecare are not currently included.

Some people are supported on an on-going basis by Community Nurses, within ECCTs, now working into the evening in most areas. Evening availability varies across areas, some finishing at 8pm and others between then and 10pm. As a result there is a service gap, of varying length, between this provision and Overnight Team availability, which commences at 11pm.

Work with the Lead Nurse, to establish ECCT has resulted in the receipt of reports from all areas except Bute and Tiree& Coll. Total referrals have been included to maintain the integrity of reporting i.e. in line with ICT reporting, for the remainder of this financial year. It is recognised that this has an element of double counting and from April 2014 a Pyramid amendment will ensure that the ECCT data in Balance of Care will exclude people who also have a homecare package, in order to eliminate double counting. Reporting will ultimately be via MiDis.

Care in an institution includes permanent and temporary/emergency stays in a care home and NHS Continuing Care. Delayed Discharges awaiting care provision are also included in the Balance of Care calculation.

Individual data for each area and type of service can be found on Pyramid, on the In-year Balance of Care scorecard. The overall Balance of Care stands at 77% of people cared for in the community, but falls short of the 80% target applied since 1st April 2013. Performance against this indicator was 67% of people cared for in the community in February 2012, rising to 77% in February 2014, an effective rise of 5% per annum, if this performance level is maintained the target will be exceeded in 2014/15.

The in-year Balance of Care shows only people new to services since April 2013, in line with the new financial year, it is currently above target at 81% of people cared for in the community. By area Helensburgh and OLI are below target this month.

POINTS FOR DISCUSSION:

- The overall Balance of Care is a measure that changes slowly over time, it is unlikely to meet the 80% target for some time yet, as there are no short term actions that impact this measure.
- We need to establish regular and accurate data collection from ECCTs in all areas.
- At present all referrals to ECCT have been included and can be found in the ICT section on Pyramid, this has given a false increase to the percentage performance in some areas. From the start of the new financial year Pyramid will be amended for ECCT data and the Balance of Care section will only show service users who have no other service input. This will avoid double counting with Homecare.
- The Health and Social Care Report section of Pyramid will capture ECCT work that complements a homecare package.

2. Integrated Community Based Services.

Integrated Occupational Therapy (OT) Services:

Table 2.1 *OT Active Caseload*

Area	Active caseload November 2013	Active caseload December 2013	Active caseload January 2014	Active caseload February 2014
Bute & Cowal	139	129	139	129
Helensburgh & Lomond	Not provided	Not provided	Not provided	Not provided
MAKI	114	193	194	176
OLI	247	247	247	247

Source: Local Teams

Table 2.2 *OT Waiting list for assessment*

Area	Waiting list November 2013	Waiting list December 2013	Waiting list January 2013	Waiting list February 2014
Bute & Cowal	16	28	32	24
Helensburgh & Lomond	Not provided	Not provided	Not provided	Not provided
MAKI	25	26	26	30
OLI	36	21	36	32

Source: Local Teams

Table 2.3a *OT Service Users awaiting major adaptations*

Area	Awaiting major adaptations November 2013	Awaiting major adaptations December 2013	Awaiting major adaptations January 2013	Awaiting major adaptations February 2014
Bute & Cowal	81	58	41	58
Helensburgh & Lomond	Not provided	Not provided	Not provided	Not provided
MAKI	80	74	84	87
OLI	29	59	43	41

Source: Local Teams

Overnight Care Teams. The overnight care teams are provided by Carr-Gomm in 8 areas – Bute, Dunoon, Lochgilphead, Campbeltown, Islay, Helensburgh, Oban and Mull. They also offer a service to people in outlying areas, whenever this is possible to fit within their existing planned work.

The service aims to prevent hospital admission and support discharge, the range of tasks includes response to community alarms and enhanced Telecare systems; responding to GP calls for support during the night to prevent hospital admission; diverting people back home from A&E; supporting with planned visits post discharge and providing temporary support at home to prevent hospital or care home admission. The teams work from 11pm, to 7am every day. In most cases they can provide a rapid response within 20 minutes of receiving a call, although travel time can be longer to more remote areas.

Table 2.4 *Service Users/Number of visits February 2014:*

Area	Number of service users/visits – under 65s	Number of service users 65-74	Number of service users 75+	Number of visits to service users aged 65+
Bute	0	2	24	239
Cowal	1 clients/57 visits	2	15	191
Helensburgh	1 client/1 visit	2	17	346
Mid Argyll	2 clients/5 visits	5	22	519
Kintyre	2 clients/98 visits	5	14	355
Islay	0	0	10	180
Oban	3 clients/57 visits	4	15	449
Mull	1 client/32 visits	1	6	251

All areas use the service to provide temporary care at home, to maintain the person at home and prevent admission to hospital or a care home.

All areas also use the overnight teams to respond to Telecare alarm calls, this supports informal carers by ensuring they can have undisturbed sleep and feel confident that the person they care for is receiving a skilled response during the night.

Table 2.5 *Service users aged 65+, Purpose of visit February 2014:*

Area	Prevent hosp. adm.	Return from A&E	Support dis-charge	Temp. care at home	Resolved alarm activity	Unable to resolve alarm activity & referred on	Respond to enhanced T'care system	Support assessment
Bute	0	1	1	15	9	0	0	0
Cowal	0	2	0	9	6	0	0	0
H'burgh	0	0	0	10	9	0	0	0
M. Argyll	0	1	0	21	5	0	0	0
Kintyre	0	0	0	11	8	0	0	0
Islay	0	0	0	9	1	0	0	0
Oban	0	0	0	13	6	0	0	0
Mull	0	0	0	7	0	0	0	0

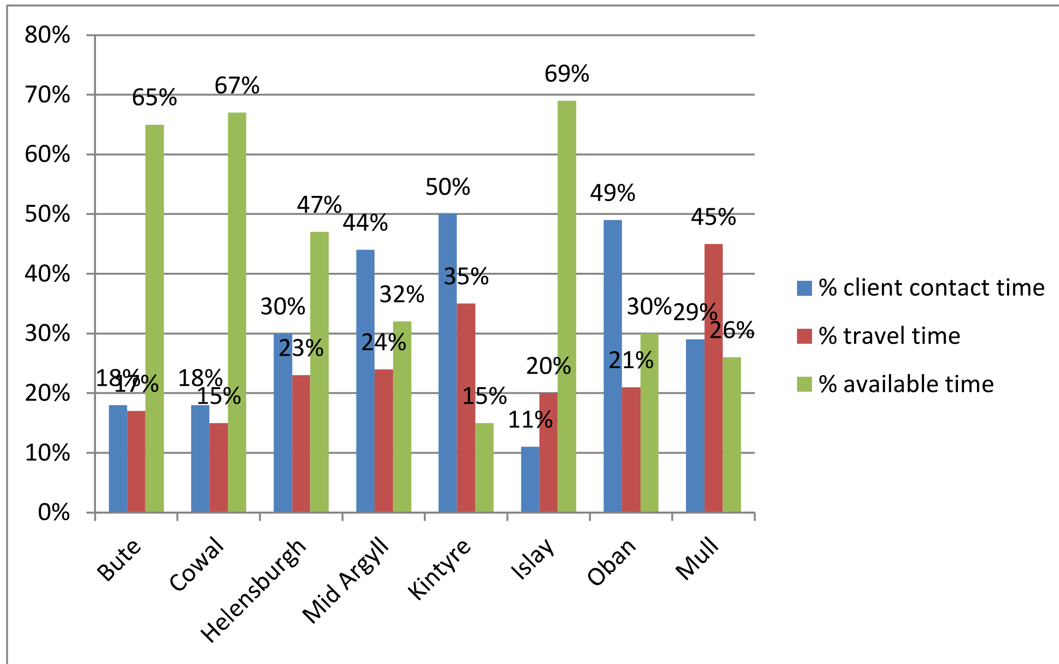
Table 2.6 *Service users aged 65+, Referral source February 2014:*

Area	Ambulance or Police	GP	Hospital	District Nurse/ CPN	ECCT	SW/HCO	Alarm Calls/Other
Bute	0	0	3	1	0	13	26
Cowal	0	0	2	0	0	9	17
H'burgh	0	0	0	0	0	8	19
M. Argyll	0	0	2	3	1	15	27
Kintyre	0	0	1	0	0	9	19
Islay	0	0	0	0	0	9	10

Oban	1	0	0	1	0	12	19
Mull	0	0	0	0	0	7	7

Source: Carr-Gomm monthly report

Table 2.7 *Percentage use/capacity of Overnight Teams, January 2014*



All of the teams were active 28 days during the month. The service has significant unused capacity in all areas except Kintyre. In all other areas the overnight teams have high levels of unused capacity, although local managers report that the teams decline to extend working practices outside of the 10 mile radius.

There is identified need for extension of the overnight service into the Inveraray area.

Service provision and reporting are to be reviewed by the Service Manager, Resources, working with Carr Gomm.

POINTS FOR DISCUSSION.

- Use of the overnight service needs to be reviewed in terms of the type of work carried out and the geographical areas covered, to maximise value from the service.
- Island provision needs to be examined to ensure that minimum travel and maximum client contact can be achieved.
- The teams have capacity to prevent unplanned hospital admissions and return people from A&E but there is little evidence that they are used for this purpose.
- GPs need to be reminded of the availability of the service on a regular basis.
- Reporting on this service needs to be discussed with Carr Gomm and updated to provide an indication of how their work impacts the strategic outcomes.

3. Integrated Learning Disability Services.

The aim of the Learning Disability Service is to move towards personalisation, through the use of a Personal Outcomes Plan, regularly reviewed, which will ensure that every service user is being supported towards his or her own desired outcome.

Table 3.1 *Balance of Care for LD service users. February 2014*

Total active LD Service Users	Number in residential care	%	Number case managed in community	%
353	32	9%	321	91%

Source Pyramid: Adult Services, Learning Disability

The Learning Disability Service is actively working to modernise day services, with a move away from the traditional Resource Centre model for some people, in favour of a more person-centred, community based approach.

4. Mental Health Services.

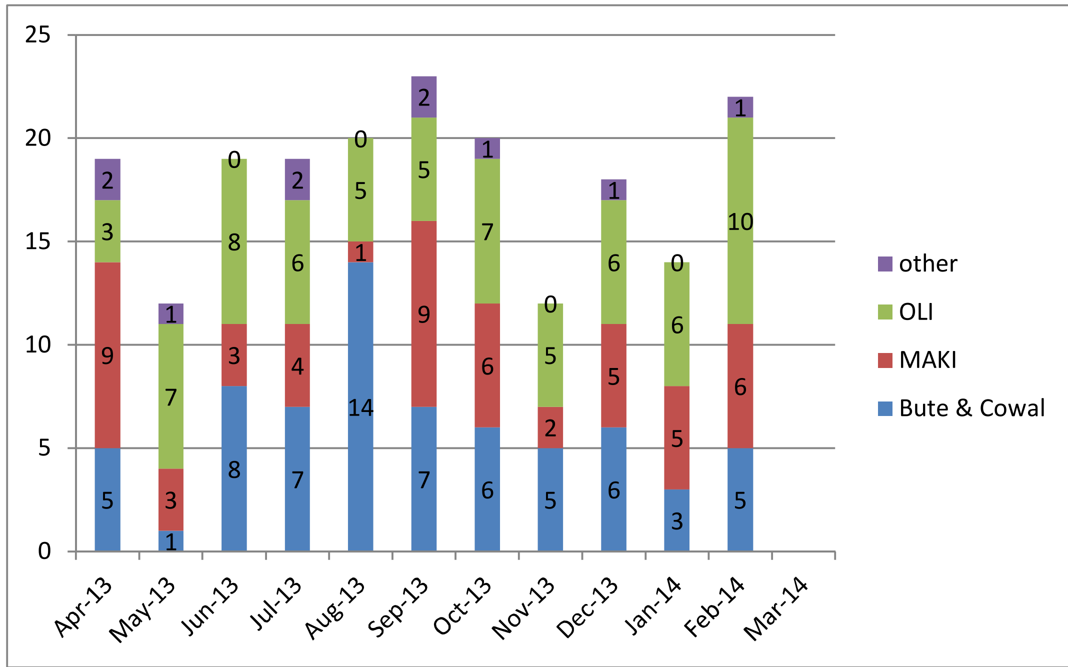
Table 4.1 *Balance of Care for MH service users, February 2014.*

Total MH Service Users	Number in residential care	%	Number case managed in community	%
237	2	1%	235	99%

Source Pyramid: Adult Services, Mental Health

The majority of Mental Health service users are cared for in the community, as opposed to residential care.

Table 4.2 *Mental Health unplanned admissions (totals), by area– Financial year*



2013/14

Table 4.2 shows unplanned admissions of all ages (adults) by area of origin. All admissions are to Argyll & Bute Hospital in Mid Argyll, where patients are received from Bute & Cowal, MAKI, OLI and other, non-specified areas, a category often relating to homeless or itinerant people and Gypsy/Travellers. One patient from Helensburgh was admitted to Argyll & Bute Hospital in February 2014. A breakdown by age is shown in table 4.3

Table 4.3 *Mental Health unplanned admissions by age group – Financial year 2013/14*

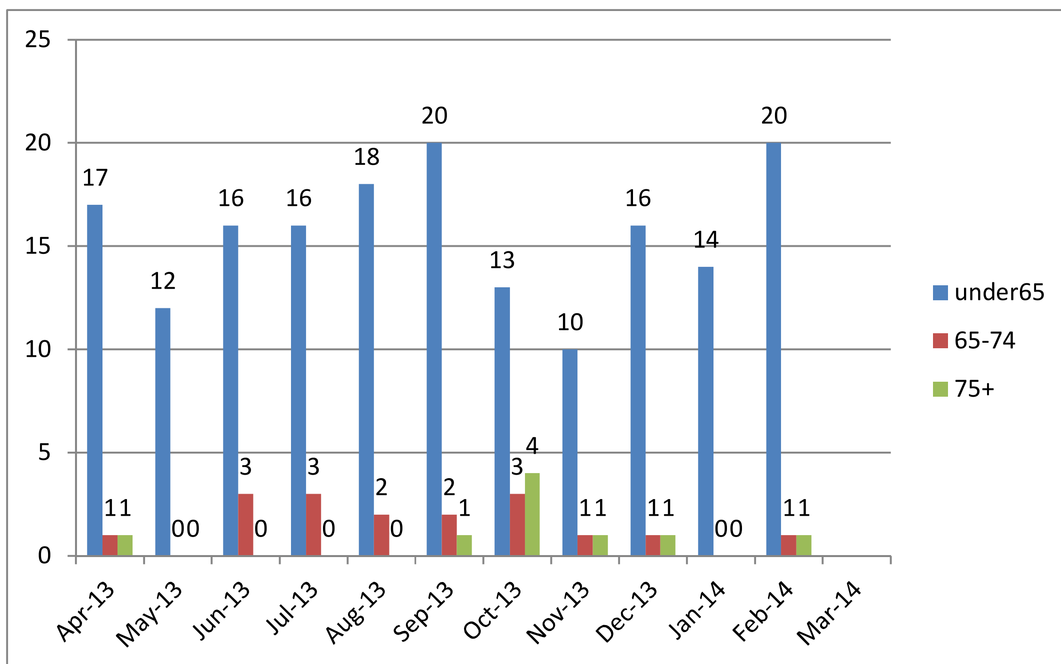


Table 4.4 *MH unplanned admissions – supporting data, Financial year 2013/14*

Month	Total admissions	Re-admissions	Percentage re-admissions
April 13	19	6	32%
May 13	12	3	25%
June 13	19	6	32%
July 13	19	4	21%
August 13	20	11	55%
September 13	23	9	39%
October 13	20	4	20%
November 13	12	8	66%
December 13	18	2	11%
January 14	14	4	29%
February 14	22	8	36%
March 14			

5. Integrated Substance Misuse Services.

The Argyll and Bute Alcohol and Drugs Partnership (ADP) Co-ordinator and Area Manager, Service Development will work to establish regular provision of data that will provide insight into the entirety of the work the Partnership is undertaking in response to addictions. The ADP Co-ordinator has advised that this piece of work should be commenced when the strategy document is complete, as the success measures should fall out of the strategy. Until that time reporting on this section is suspended.