Joint Performance Summary: August 2010

Delayed Discharge as the census 15th July 2010:

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.

Argyll & Bute hospitals:

Delayed under 6 weeks = 10

Delayed over 6 weeks = 0

Exemptions code 9 = 1

Exemptions code 9/51x = 5

Exemptions code 9/71x = 2

A & B patients in Out of Area hospitals:

Delayed under 6 weeks = 1

Delayed over 6 weeks = 0

Exemptions code 9 = 0

Exemptions code 9/51x = 2

Exemptions code 9/71x = 0

Delayed Discharges over 6 weeks continue to be on target, at zero, both in Argyll & Bute and out of area, with the total number of delayed discharges (under 6 weeks and with exemption codes) falling from 26 in July to 21 in August. Whilst this is an excellent achievement in the reduction of delayed discharges, with the attendant benefits for patients, it is reasonable to expect that we will ultimately hit a plateau whereby further reduction will be dependent upon reduction of admission and re-admission to hospital.

Balance of Care for Older People:

The Outcomes Framework for Community Care 2009/10 requires us to move services closer to users and carers by achieving a shift in the balance of care, from institutional to 'home based' care.

Balance of Care targets for Argyll & Bute are 65% of people cared for in the community and 35% of people cared for in an institutional setting, these will increase to 70% and 30% respectively from 1st October 2010. A recent, short benchmarking exercise using annual data from Audit Scotland revealed that most partnerships routinely achieve a 70%/30% BoC and a few of the best performers achieve 75%/25% targets.

Balance of Care by Area:

Area	Clients cared for in the community	Clients cared for in an institutional setting	Trend
Helensburgh & Lomond	66.39%	33.61%	▲
Bute & Cowal	59.85%	40.15%	▼
Mid Argyll, Kintyre and the Islands	63.66%	36.34%	▲
Oban, Lorn & Isles	70.51%	29.49%	▼
Overall Delivery	64.73%	35.27%	▲
Target	65%	35%	
Overall RAG Status	Red	Red	▼

Source Pyramid: Joint Planning and Performance, August 2010.

The Balance of Care performance has improved overall this month. Amber RAG status has now been removed from Pyramid, so that any failure to achieve target attracts a red status. Overall totals are not calculated cumulatively, so one failure to achieve within any scorecard will result in an overall red status.

Helensburgh and Lomond are above target, with an upward trend.

Bute and Cowal are below target, with a downward trend.

MAKI demonstrates an upward trend, but is still below target.

OLI shows a downward trend, but is still above target.

From 1st October the targets are raised by 5%, based on current and recent performance only OLI are likely to achieve the new target. The planned overnight teams and re-launch of Telehealthcare should enable all areas to make progress towards shifting the balance of care in favour of care in the community.

NHS Continuing Care Bed Occupancy:

Hospital Code	Hospital Name	Designated CC beds as advised by Locality Managers July 2010	Occupied April 10	Occupied May 10	Occupied June 2010	Occupied July 2010	Occuoied August 2010
C101H	Argyll & Bute Hospital	**20**	15	15	10/15 tbc	10/15 tbc	10/15 tbc
C106H	Cowal Community Hospital	**0**	0	0	0	0	0
C108H	Islay Hospital	**0**	0	0	0	0	0
C113H	Rothesay Victoria Hospital	**0**	0	0	0	0	0
C114H	Rothesay Victoria Annexe	**16***	0	0	0	0	0
C121H	LIDGH	**2**	2	2	2	2	2
C122H	Campbeltown Hospital	**20**	5	5	3	3	2
H224H	Mid Argyll Hospital	**30 (20 dementia 10 frail elderly)**	23	21	22	20	20**
Total		**88**	**38**	**37**	**37/42**	**35/40**	**34/39**

Source Argyll & Bute CHP Information Services

** Of which 2 are Cowal patients, 1 is a Lorn patient and 1 is a Mull & Iona patient – all on Cara Ward, Mid Argyll Hospital.

Percentage Occupancy Actual 39% / 44% Target 30%

Work is proceeding well on the Cowal and Bute re-design, with all the Continuing Care beds in Cowal empty and resource Release plans under way. Similarly the re-design work in Bute is going ahead and is being used as the pathfinder for a model of care for the future.

NHS Continuing Care beds in Campbeltown and Lochgilphead remain in place, with no proposals to date, for further closures. Two of the 20 beds in Campbeltown are currently occupied by Continuing Care patients, whilst Mid Argyll and Argyll & Bute hospitals have significant numbers of Continuing Care patients.

- ***This figure had previously been stated incorrectly as zero – this was a typing error.***

Care home vacancies are detailed below for each area.

Social Care bed vacancies by area, 27th August 2010.

Area	**Permanent vacancies**	**Respite vacancies**
Helensburgh & Lomond	8	0
Bute & Cowal	13	1
Mid Argyll, Kintyre and the Islands	13	0
Oban, Lorn & Isles	15	2

Integrated Occupational Therapy Services:

Total active caseload.

Area	June 2010	July 2010	Aug 2010
Bute and Cowal	Data requested via Locality Managers	144	127*
Helensburgh & Lomond	Anne Stewart will provide data from July onward. This needs to be extracted from the ICT database	230	275
MAKI	Data requested via Locality Managers	175	198
OLI	237	237	231

Includes in-patient, out-patient and community work.

Additional data provided by Bute and Cowal indicates that there are 74 people in Cowal and 22 in Bute waiting for an OT service. Additionally 87 in Cowal and 56 in Bute are waiting for major adaptations to be carried out.

Occupation therapy input is a crucial element in the raft of services required to enable to continue to live well and safely in their own homes, to prevent hospital admissions and to facilitate discharge.

The figures supplied include all aspects of OT work.

In order to effectively monitor OT input and track unmet need we would require monthly data showing community caseloads, together with length and type of input and outcomes for the service user. This could then be linked to our key agenda issues, prevention of admission and facilitation of discharge. For IRF purposes it would be useful to monitor in-patient and out-patient cases in a similar manner.

This would require the OT services in each area to collect and collate in respect of each patient and provide this monthly for inclusion on Pyramid. At the present time the OT services have just begun to collate and provide total caseload figures on a regular basis and do not seem to have a system, or a designated worker, to provide any in-depth data.

Number of unallocated OT cases.

Area	May 2010	June 2010	July 2010	Aug 2010
Bute and Cowal	0	0	0	0
Helensburgh & Lomond	0	0	0	0
MAKI	11	12	12	5
OLI	0	0	0	0

Source Pyramid: Operational Services/Performance Framework

Number of OT assessments outstanding over 28 days.

Area	May 2010	June 2010	July 2010	Aug 2010
Bute and Cowal	1	0	0	0
Helensburgh & Lomond	0	0	0	0
MAKI	13	15	15	13
OLI	0	0	0	1

Source Pyramid: Operational Services/Performance Framework

There has been long term sickness in MAKI which has led to the delays in provision of OT services.

Integrated Care Teams:

Patients maintained at home following an acute incident or illness (MAH) would otherwise have been likely to be admitted to hospital by their GP.

Patients supported on discharge (SD) receive either a) intermediate care with no need for further services b) intermediate care at home prior to the start up of a CCP or c) continuing Physiotherapy, mobility or specialist post-discharge intervention. These interventions ensure that timely discharge takes place and delayed discharges are avoided.

Maintained at home.

Area	May 10	June 2010	July 2010	Aug 2010
Cowal (there is no ICT on Bute)	10	12	11	11
Helensburgh & Lomond	3	8	8	6
MAKI	6	10	8	6
OLI	14	15	16	18

Source Pyramid: Joint Planning and Performance

Supported Discharge.

Area	May 10	June 2010	July 2010	Aug 2010
Cowal (there is no ICT on Bute)	14	13	20	20
Helensburgh & Lomond	26	10	16	25
MAKI	9	14	10	10
OLI	9	3	8	9

Source Pyramid: Joint Planning and Performance

Providing support prior to emergency admission to hospital or care home:

Area	June 2010	July 2010	Aug 2010
Cowal (there is no ICT on Bute)	0	0	1 (prior to emergency placement in social care)
Helensburgh & Lomond	0	0	0
MAKI	0	0	2 (1 mid Argyll and 1 Kintyre)
OLI	0	0	0

Source Monthly Delayed Discharge Report.

The numbers maintained at home or supported on discharge appear to be those that impact on the agenda of prevention of admission or timely discharge. It is recognised that the ICTs do provide other service input, such as targeted rehabilitation, but it is not clear how this impacts on the agenda. A small number – usually a maximum of 1 or 2 per month, per area – of people will be diverted from A&E by the ICT input, this also prevents hospital admission.

In August 1 person had ICT in Cowal prior to emergency placement in a care home. 1 person in Mid Argyll and 1 in Kintyre had ICT input prior to hospital admission.

Integrated Learning Disability Service:

Total number of LD cases receiving a service.

Area	May 10	June 2010	July 2010	Aug 2010
Bute and Cowal	108	108	108	108
Helensburgh & Lomond	110	110	110	110
MAKI	78	78	78	78
OLI	98	99	98	98

Source Pyramid: Adult Services, Learning Disability

Number of LD cases with a PCP.

Area	May 10	June 2010	July 2010	Aug 2010
Bute and Cowal	33	33	33	33
Helensburgh & Lomond	88	88	88	88
MAKI	45	45	45	45
OLI	39	39	39	39

Source Pyramid: Adult Services, Learning Disability

Number of unallocated LD cases.

Area	May 10	June 2010	July 2010	Aug 2010
Bute and Cowal	1	0	1	1
Helensburgh & Lomond	0	1	0	0
MAKI	0	1	0	0
OLI	0	0	3	0

Source Pyramid: Adult Services, Learning Disability

Number of LD cases awaiting assessment for more than 28 days.

Area	May 10	June 2010	July 2010	Aug 2010
Bute and Cowal	1	0	0	2
Helensburgh & Lomond	1	0	1	1
MAKI	0	0	1	1
OLI	0	0	1	0

Source Pyramid: Adult Services, Learning Disability

Balance of care for LD service users.

Total LD service users	**Number in residential care**	**%**	**Number receiving community care**	**%**
324	37	9%	357	91%

Source Pyramid: Adult Services, Learning Disability

The number of LD service users is static, as would be expected with this service user group. The majority of service users are cared for in the community. Those in residential care are largely in specialist out-of-area establishments.

The numbers with PCPs varies across the areas. Although the PCP is the measure returned via eSAY, it is a specific tool used in life-changing events, such as a move to independent living, or the death of a carer and would not be a tool of choice for every service user.

The aim of this service, as with all others, is to move towards personalisation. This will be achieved through the use of a Personal Outcome Plan, regularly reviewed, which will ensure that every service user is being supported towards achieving his or her own desired outcome. Local monitoring of the use of Personal Outcomes Plans and some benchmarking with comparable authorities is planned for the near future.

Integrated Substance Misuse Services:

Data in respect of the integrated substance misuse services is currently only available on a quarterly basis. The data below relates to Financial Quarter 3 2009/10

Total number of substance misuse clients.

Area	FQ3 2009/10	FQ4 2009/10	FQ1 2010/11
Bute and Cowal	225	187	
Helensburgh & Lomond	57	63	
MAKI	78	63	
OLI	134	146	

Source Pyramid: Adult Care/Substance Misuse

Total Alcohol Misuse clients **240**

Total drug Misuse clients **219**

New referrals in the quarter.

Area	FQ3 2009/10	FQ4 2009/10	FQ1 2010/11
Bute and Cowal	32	37	
Helensburgh & Lomond	56	35	
MAKI	25	23	
OLI	43	40	

Source Pyramid: Adult Care/Substance Misuse

Number of substance misuse assessments outstanding over 21 days.

Area	FQ3 2009/10	FQ4 2009/10	FQ1 2010/11
Bute and Cowal	0	1	
Helensburgh & Lomond	0	3	
MAKI	1	5	
OLI	1	5	

Source Pyramid: Adult Care/Substance Misuse

Percentage of alcohol misuse clients offered treatment within 4 weeks of assessment.

FQ3 2009/10	FQ4 2009/10	FQ1 2010/11
90%	97%	

Source Pyramid: Adult Care/Substance Misuse

Percentage of drug misuse clients offered treatment within 4 weeks of assessment.

FQ3 2009/10	FQ4 2009/10	FQ1 2010/11
90%	96%	

Source Pyramid: Adult Care/Substance Misuse

Data for substance misuse is only collected on a quarterly basis. Accurate monthly data, spanning all services, would enable us to provide a more targeted and pro-active service.

There seems to be no data detailing the types of treatment being used, for example:

- Number of detox. Programmes commenced/completed
- Number of rehab. Programmes commenced/completed
- Numbers in substitute prescribing – commenced/retained
- Numbers receiving psycho-social interventions – commenced/retained

This data would support planning and commissioning of services in the future.

Harm reduction and reduction of the spread of blood-borne viruses is also a major issue in drug misuse, so monthly data in relation to this would allow us to estimate our success in maintaining safety levels amongst the drug using population. For example:

- Number of needles exchanged (pins in and out)
- Take up of BBV screening and vaccination
- Number of drug related deaths

Investigation into drug related deaths should also be undertaken and recorded.

The Treatment Outcome Profile (TOP) is now being used by the services we provide, to gain service user self-assessment of improvement and progress. This data is being collated by Joint Planning & Performance and will be built into Pyramid in the near future. Service Level Agreements currently being produced for third sector providers will include a requirement to apply TOP and to provide the forms to us for data collection purposes.

Data for FQ1 2010/2011 has not yet been entered onto Pyramid.