AGENDA ITEM

12

Agenda Item: 12

Falkirk
Health and Social Care
Partnership

Title/Subject: **Delayed Discharge Progress Report**

Meeting: **Integration Joint Board**

Date: **5 October 2018**

Submitted By: **Chief Officer**

Action: **For Decision**

1. INTRODUCTION

1.1. Timely discharge from hospital is acknowledged as an 'important indicator of quality and a marker for person-centred, effective, integrated and harm free care' [Delayed Discharges in NHS Scotland – annual figures to March 2018]. Since the inception of the Health and Social Care Partnership continuous improvement on delayed discharge performance has been a focus of effort and investment of resources. This strategic priority had been reflected in an earlier Joint Inspection of Older People's Services report which pointed to the need for improvement on delayed discharge in Falkirk.

1.2. Improvement work on delayed discharge is overseen by the Delayed Discharge Steering Group. This report provides an account of work undertaken in the context of the Steering Group's action plan. The Board is asked to consider a recommendation that a refreshed action plan be presented at a Board Development Session, aligning future work on delayed discharge with related work on unscheduled care.

2. RECOMMENDATION

The Integration Joint Board is asked to:

2.1. note the improvement work which is in progress

2.2. note performance data highlighting improved outcomes in aspects of delayed discharge whilst highlighting where progress has been difficult to maintain

2.3. address future performance improvement priorities at a Board Development Session to consider a refreshed action plan combining action on delayed discharge and unscheduled care.

3. BACKGROUND

3.1. Being delayed in hospital can be harmful and debilitating – and in the case of older people, can often prevent a return to living independently at home. Older people may experience functional decline as early as 72 hours after being clinically ready for discharge and the risk increases with each day delayed in hospital. Scotland is

recognised internationally as having a very advanced system of reporting delayed discharge. There is a comprehensive and detailed coding system for reporting delayed discharges. A standardised approach to performance is to report all delays, followed by a breakdown into Standard Delays and Complex delays [which are known as Code 9]. Chart 1 provides a perspective on the position with delayed discharge over the past two years, covering all delays, total standard delays and code 9 delays.

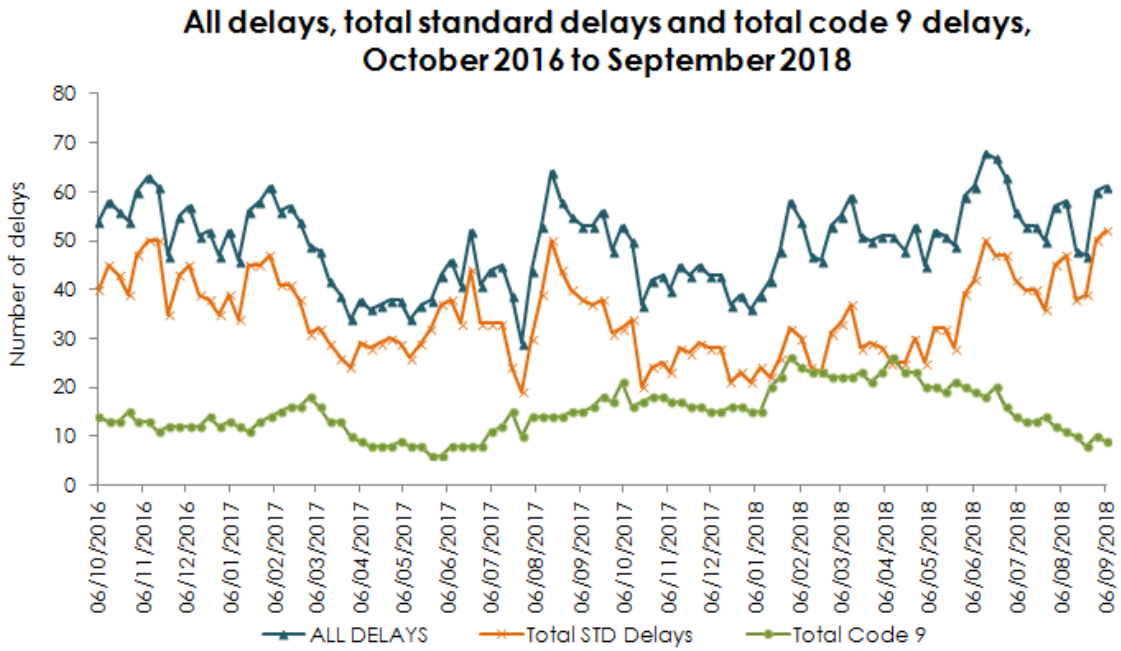

Chart 1

3.2. The key messages are that

- all delays and total standard delays tend to follow the same trajectory
- lowest number of all delays was 29 and lowest number of total standard delays was 19, both on 27th July 2017, followed immediately with a sharp increase in the number of delays.
- highest number of all delays was 68 on 14th June 2018
- highest number of total standard delays was 52 on the 6th September 2018,
- number of all delays and total standard delays has fluctuated over the period.

3.3. The above figures refer to census point data for numbers of delays. During the year 2017/18, compared with the year 2016/17 there was a slight reduction in the average number of delays reported over the year. This was also reflected in a decrease of 9.7% in the number of bed days lost year on year. In the current year 2018/19, there has been an early increase in the number of Code 9 delays, mainly related to Guardianship, and sustained high numbers of delays related to care home wait.

3.4. The strategic direction of improvement work on delayed discharge in Scotland is set in the report of the Delayed Discharge Expert Group. Published in 2012, this report remains the authoritative position statement on the approach required to achieve ambitious improvement in delayed discharge. The Expert Group's starting point was that the agreed outcome is to enable and support people to remain in their own home, as independently as possible, for as long as possible. When this is not possible, we should care for people in as homely a setting as possible, which will seldom be a hospital bed. In July 2015, Healthcare Improvement Scotland and the Care Inspectorate published the report of the Joint Inspection of Older People's Services in Falkirk. Their first recommendation was that the Partnership 'should put measures in place to meet the Scottish Government's delayed discharge targets and to make sure older people are discharged home or to a homely setting when they are medically fit to do so".

3.5. The present report describes a baseline of achievements on implementation of the Joint Inspection recommendation, and sets out a recommended future direction and focus for effort to create forward momentum across those areas which continue to challenge performance. These areas relate to the key themes that emerged from a recent seminar, facilitated by Brian Slater, Scottish Government Delayed Discharge Policy Lead. The Expert Group identified the causes of delays as being split into five broad, interpendent categories as follows:

- Pathways
- Process
- Systemic determinants
- Capacity
- Resources

These categories of causes of delayed discharge provide a framework for improvement action, forming the structure of Section 4 of this report.

4. REPORT OF ACTION TAKEN

4.1. PATHWAYS

4.1.1. At a national level, the Expert Group acknowledged that:

- too many people are admitted to hospital when there could be safe and viable alternatives;
- too many people are moved inappropriately around the hospital system
- too many people remain in hospital because there is a perceived 'risk' in discharging them.

4.1.2. Local action to improve pathways includes:

4.1.3. **Discharge to Assess**
Discharge to Assess was launched in December 2016 as a partnership project with NHS, SW and an external provider. The project proactively identifies individuals who, through reablement, can be discharged from hospital timeously or supported at home rather than be admitted to hospital. Since May 2018 the home care provision aspect of the reablement approach has been delivered by the in-house Falkirk Council Home Care Service.

4.1.4. The discharge to assess model is founded on the following principles:

- clear referral pathway and appropriate outcomes identified for individuals
- high quality initial screening/assessment by the right people at the right time
- working as a multi-disciplinary team to problem solve and ensure solutions such as telecare or equipment are explored
- responsiveness and flexibility
- ongoing and multi-faceted communication on a daily basis.

4.1.5. The approach targets reablement, homecare, and intermediate care resources towards those patients / service users where assessment shows potential for safe, early discharge from or prevention of admission to hospital. These resources span health and social care, including ReACH, the Council's occupational therapy services, domiciliary physiotherapy and home care services.

4.1.6. Chart 2 demonstrates the impact of the Discharge to Assess Model on delays in discharge due to packages of care. The chart shows significant reduction in the numbers of people who are delayed in their discharge awaiting arrangements for a package of care at any one time [census point]. In addition to a sustained reduction in the number of delays occurring at any one time, Discharge to Assess has made a contribution to reducing the average duration of the wait for patients who are delayed in their discharge pending the provision of home care services.

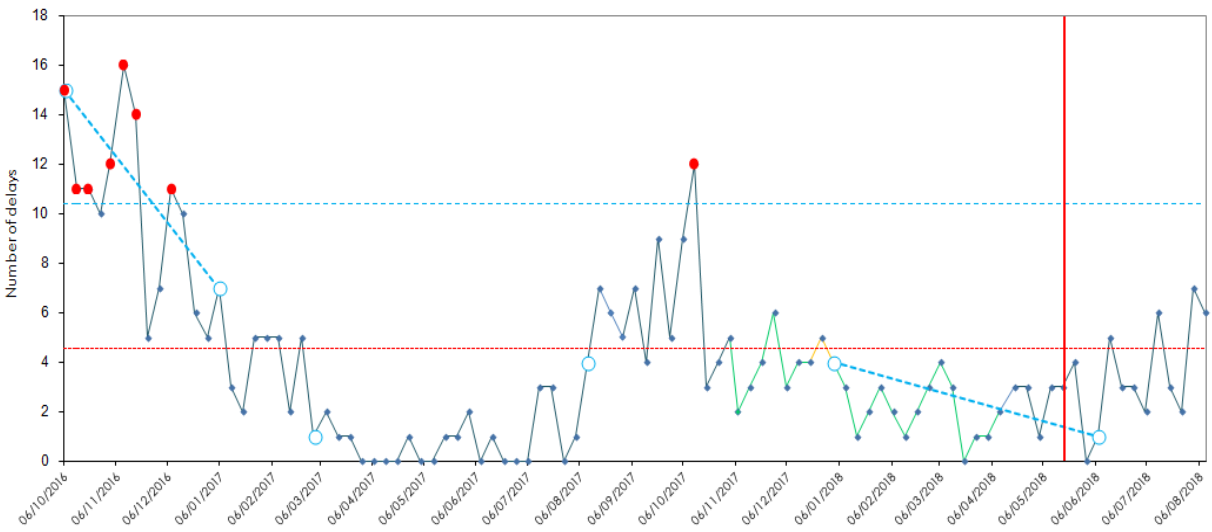

Chart 2: Delays due to Packages of care

4.1.7. **Intermediate Care**
Within the partnership Summerford Intermediate Care Service and Tygetshaugh provide intermediate care which provides a bridge between hospital and home for people who have experienced deterioration in their functioning. Intermediate care promotes a faster recovery from illness, supports timely hospital discharges and prevents unnecessary hospital admissions. Summerford and Tygetshaugh staff, in collaboration with staff from ReACH, Reablement Project Team (RPT) and the Closer to Home Enhanced Community Team (ECT) have adopted a reablement approach whereby individuals are encouraged to maximise their ability to live as independently as possible, relearn skills and increase self confidence.

4.1.8. Summerford has steadily increased its capacity over the lifetime of the IJB, from an original 5 beds to its current 20 beds and has a current occupancy rate of 83%.Tygetshaugh provides an additional intermediate care resource of 5 beds.

4.1.9. Over the past 18 months stakeholders from across the Partnership including social work, ReACH, RPT, ECT, Discharge Team, Liaison Psychiatry and Community Nursing, have worked collaboratively to enhance the model and strengthen partnership relationships. Developments including streamlined referral and access processes, enhanced staff development and introduction of outcome focussed /goal setting documentation have emerged resulting in improved person centred outcomes for individuals.

4.1.10. Chart 3 showing occupancy over time at Summerford and demonstrates growth in uptake of the bed based intermediate care pathway.

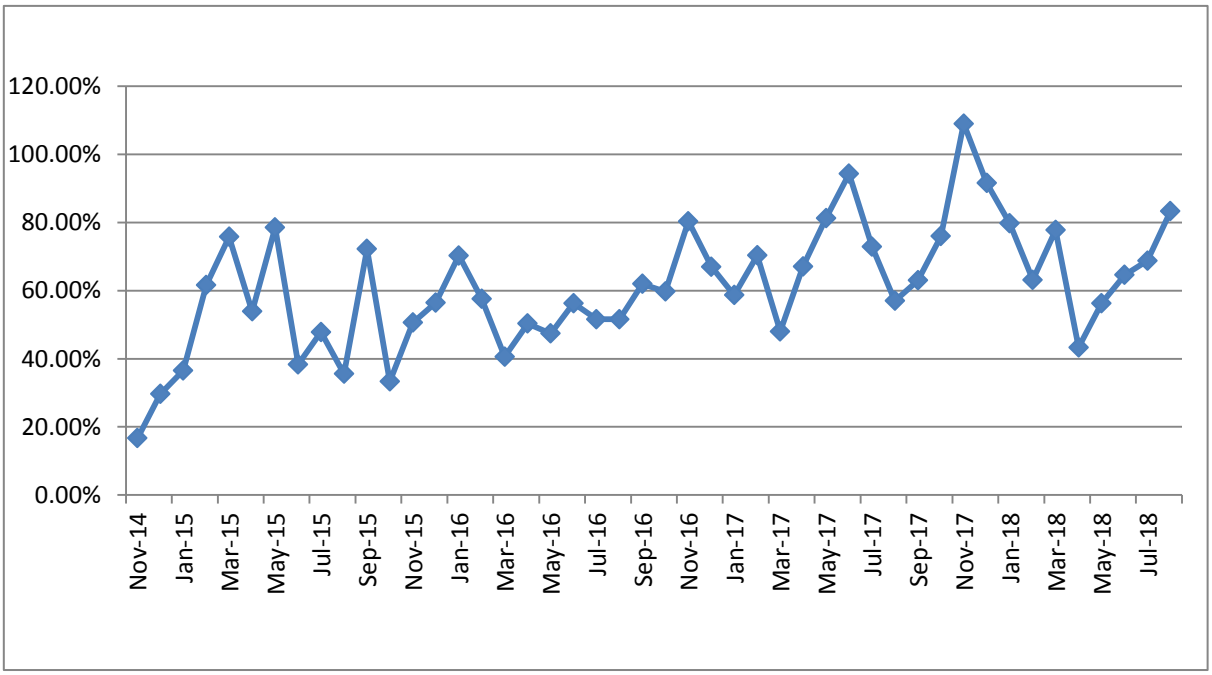

Chart 3: Summerford Reablement Occupancy

4.1.11. **Closer to Home**

The Closer to Home Team provides an enhanced community based service aimed at preventing admission of older people who become unwell at home or have an uninjured fall. The service can also support earlier discharge from hospital and consists of nurses with advanced skills, GPs (formally GP Fellows) and Allied Health Professionals.

The chart below shows current activity.

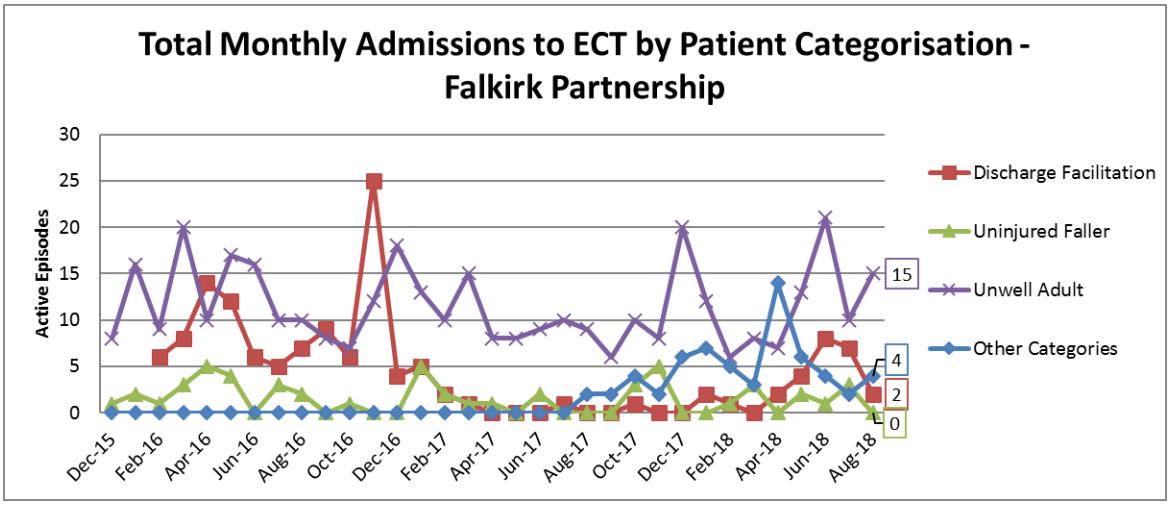

Chart 4: ALFY activity level (note data is FV wide rather than specific to Falkirk)

4.1.12. Opportunities to expand the service are being explored with pathways now in place for intermediate care including Summerford.

4.1.13. The Advice Line for You (ALFY) continues as at present providing both a public facing help line and an access point for district nursing as part of a test of change. Due to ongoing low public demand for the service, there is a recommendation that funding for this element of the services is not continued beyond end March 2019.

4.2. **PROCESS**

The Expert Group emphasised the need for effective processes to be designed and in place to ensure that discharge planning arrangements minimise delays. This includes those complex circumstances where patients lack capacity to make decisions for themselves.

4.2.1. **Adults with Incapacity**

In order to address the issue of high numbers of people delayed in their discharge from hospital as a result of the requirement for Guardianship, significant work has been undertaken in the area of process redesign. These delays form the greatest number of the category of delays known as Code 9s. The work strands presently ongoing include:

- implementation of dedicated Mental Health Officer time to monitor private Guardianship applications, support families and improve people's pathways

- standardised information regarding Adults with Incapacity (AWI) process to be distributed to individuals and families prior to AWI meetings
- development of a simplified process for solicitors /applicants to obtain timeous medical reports from Consultants to support Guardianship applications
- AWI flowchart with target timescales to be completed including recommendation about convening AWI meetings for all situations where use of AWI Act is being considered. This flowchart is shortly to be shared with local solicitors in order to convey the Partnership's expectations
- standardised letter to be issued, should progress with private Guardianship application not be demonstrated, advising of Falkirk Council's intention to progress application
- staff development focus on supportive decision making and risk management and ensuring least restrictive options are being used wherever possible
- power of Attorney be promoted more widely

4.2.2. Chart 4 shows the numbers of people who have been subject to delays which are complex in nature including those subject to a guardianship process. The downward trend on these delays since March 2018 tracks the implementation of the above process improvements.

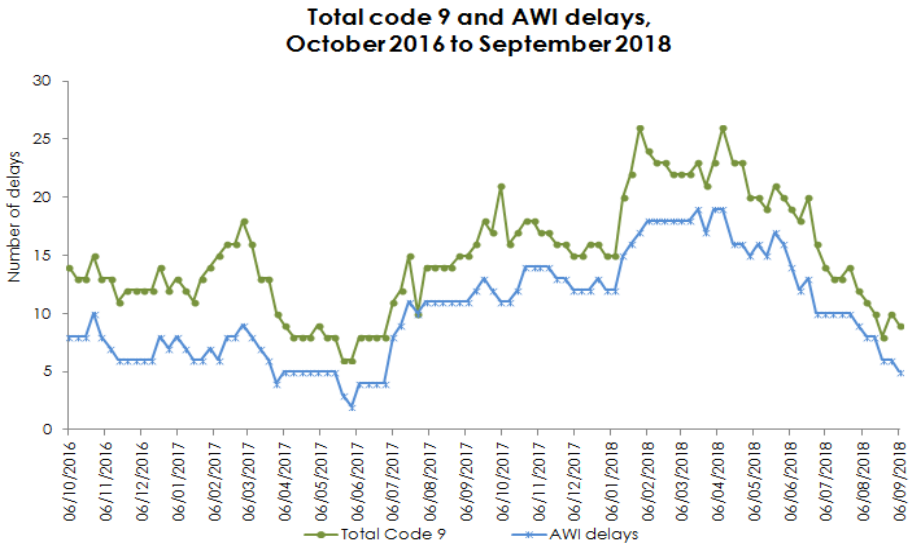

Chart 5

4.2.3. **Choice Policy**

Delays in hospital can be due to patients exercising their statutory right of choice, often over the destination of their ongoing care. The Scottish Government provides guidance on the policy to be followed when the choice of care home is not available. This includes the requirement to offer an interim care home place and an escalation process to the Medical Director should there be ongoing disagreement regarding discharge arrangements. Delays arising for this reason are reported under Code 67. The number of patients progressing through the Choice Policy in Falkirk fluctuates from week to week but numbers have been higher in recent months.

4.2.4. An audit of the choice escalation process was undertaken in 2017 and identified a number of areas for improvement including the timeframes for escalation through the process where there is ongoing disagreement. A follow up audit has been undertaken and the implementation of the Choice Policy remains a priority for continuous improvement work.

4.2.5. Chart 5 below shows Code 67 delays in Falkirk as a proportion of total delays in this category across Scotland.

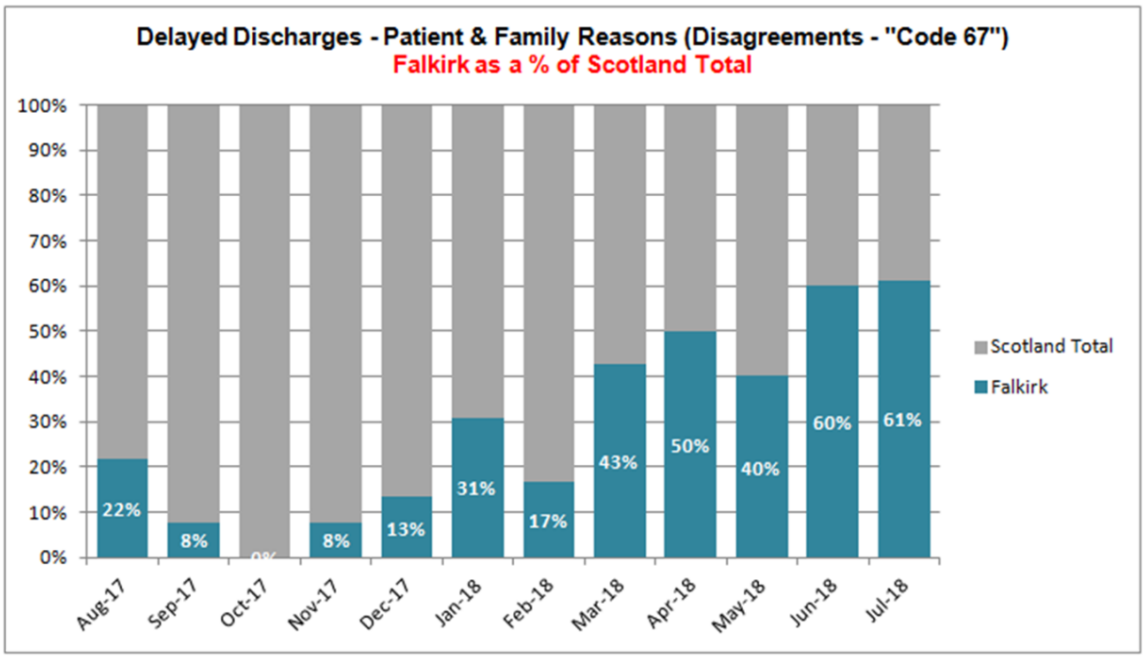

Chart 6

4.2.6. **Unscheduled Care Programme**
Under the auspices of the Unscheduled Care Programme Board, a number of workstreams are underway that will improve discharge pathways and over time, will impact positively on delays to discharge [see 4.2.6 to 4.2.8]. These include:

4.2.7. **An Integrated Discharge Pathway Group**
This is a task and finish group the key aim of which is "*to deliver safe person centred care to every patient without unnecessary waits, delays and duplication*" by:

- developing system wide processes to provide good patient flow that places the patient on the optimal pathway for their needs, and contributes to safe, person centred and effective care; and
- ensuring that every patient has the right care, at the right time, at the right place, every time.

4.2.8. **Dynamic Daily Discharge** is a proactive Multidisciplinary Team process which is being implemented in wards in both Forth Valley Royal and in Community Hospitals. This takes a proactive and systematic multidisciplinary approach to facilitating early and appropriate discharge plans and ongoing care.

4.3. CAPACITY – AVAILABILITY OF APPROPRIATE RESOURES

The Expert Group identified capacity as a key determinant of success with delayed discharge performance. The kind of care which the person has been assessed as needing has to be available to allow an effective, safe discharge plan to proceed. Chart 6 below illustrates trends in the relationship between delays in discharge and availability of appropriate resources.

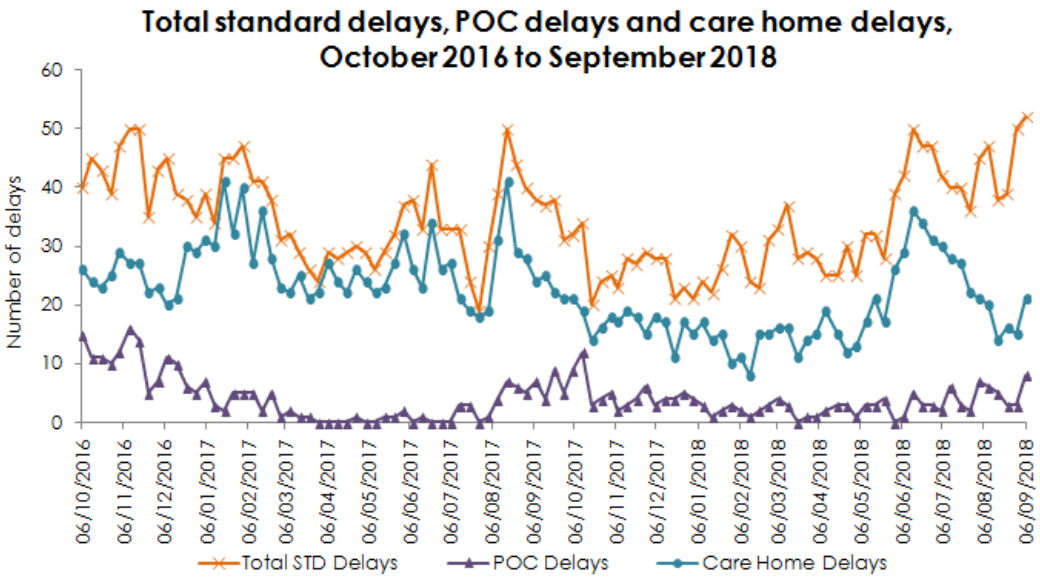

Chart 7

Total standard delays, Package of Care (POC) delays and care home delays:

- the majority of standard delays are due to care home delays. On average 65.6% of standard delays are due to care home delays over the period
- on average, care home delays from October 2016 to September 2017 were higher than care home delays from October 2017 to September 2018
- recently there has been a decrease in care home delays, from 36 delays on 14th June to 21 on 6th September
- POC delays have reduced significantly from previous years and generally remain low. The highest number of POC delays was 16 on 10th November 2016
- there was a spike to 12 POC delays on 12th October 2017.

4.3.1. Care Home Placement Availability

A significant proportion of people are delayed in their discharge in Falkirk as a result of available capacity in care homes. The above chart 7 depicts the impact of delays for people awaiting admission to care home, total delays closely tracking the trend for delays linked to care home placement availability. The majority of standard delays are due to care home delays, rather than waits for care at home.

4.3.2. The factors driving delay related to care home placement availability are manifold. The publicly funded rate for care home fees is agreed nationally as part of the

National Care Home Contract. Consistently, there is a shortage of availability of placements to which admission is accepted at the publicly funded rate, while there may still be locally available placements for which the care home enterprise is willing only to accept a much higher rate. A second factor is choice, with there sometimes being availability within the wider care home sector but not in the patient / service user's first choice of placement. This can and does lead to some delay and work on the implementation of Choice Policy is detailed at section 4.2.3.

4.3.3. The management of capacity in the care home sector requires there to be a strong focus on supporting and enabling more people to remain at home, in order that the available care home capacity is targeted towards those people who need that kind of provision.

4.3.4. **Care at Home Availability [package of care POC]**
Waits for a package of care at home have reduced significantly from previous years and generally remain low. There was a peak of 12 POC delays on 12th October 2017. In the past there was not only an issue with high numbers of people waiting for a package of care at any one census point, but also with the duration of that wait being protracted. Since then there have been very significantly reduced upper limits on duration of delay. This is a substantial achievement, closely linked to the introduction of the Discharge to Assess model and to redesign of in house and contracted home care provision. Work with the independent sector has included the implementation of a new tender and close work with specific providers to respond to demand at times of specific delayed discharge pressures. In external care at home provision there has been an increase to the period of time for which a person's package of care can be retained, with the external provider continuing to be paid, so that the discharge plan can proceed without delay at the end of the stay in hospital.

4.4. RESOURCES

4.4.1. The Delayed Discharge Expert Group highlighted the importance of resources as a potential factor driving poor performance on delayed discharge. At the time when the Expert Group were researching the delayed discharge field, some partnerships were in a position where people did not move to care homes because of lack of funding for their placement.

4.4.2. No placement in Falkirk has ever been delayed due to the exercise of a budgetary control over the resources allocated to care home placements, or to other forms of care such as contracted home care. The successful discharge programme from Lochview Hospital is a case study of the commitment of significant funded support to enable better personal outcomes for people affected by delayed discharge.

4.4.3. **Learning Disability Delayed Discharges**
There has been considerable effort ensuring that patients delayed in their discharge within Lochview Hospital are assessed and found a suitable, homely environment. In the last year there have been four patients from the Falkirk area who were delayed in their discharge from Lochview discharged successfully. None

of these individuals have been readmitted to hospital, enabling us to conclude that although these people have complex needs and the planning of their discharge had taken significant time, the multi-disciplinary team working together ensured they have a homely environment where they can be supported to live as independently as possible. This work is underpinned by close working with colleagues in Falkirk Council's Housing Service.

4.4.4. Falkirk HSCP (along with Aberdeen and Angus areas) took part in The Complex Needs Project that forms part of the Place, Home and Housing Programme which is funded by Healthcare Improvement Scotland (HIS) ihub. The aim of the project was to reduce delays in discharge from hospital for those with complex needs. A report written by the project in January 2018 stated that "The project has shown that solutions can be found for people with complex needs" and that, "the complex needs project is at its most advanced in Forth Valley – particularly Falkirk". To date Falkirk HSCP has committed £520,840 in resource spend each year discharging 6 people with the most complex needs from hospital into homely settings with support in the community.

4.4.5. **Mental Health Delayed Discharges**
Within the Mental Health wards there has also been a focus on Delayed Discharges across Forth Valley since January 2018. Within Falkirk there have been ten patients delayed in their discharge from the Mental Health wards of which eight patients have been discharged.

4.5. SYSTEMIC DETERMINANTS

4.5.1. The Expert Group report highlighted systemic causes of delays in discharge, highlighting the risk that the patient who is in hospital is considered to be 'safe' and ceases to be a cause for concern and focus for community staff who move on to the next crisis, reducing the priority of patient discharge. Here in Falkirk there has been a steadfast commitment to prioritising action on delayed discharge. The above account of continuous improvement work highlights some of the initiatives which have been undertaken. All of these enhancements to practice build upon a foundation of system wide effort by people working in services to deliver the best possible outcomes for people affected by delayed discharge. Current work on aligning work on delayed discharge with that on unscheduled care opens up a wider horizon for system wide improvement.

5. PLANNING FOR CONTINOUS IMPROVEMENT

5.1. Leadership and Governance

The Scottish Government Expert Group emphasised the importance of cultural change across the whole system to embed an approach to discharge planning based on "Home First". Avoidance of a blame culture, ensuring that all frontline staff and leaders across health and social care services are aligned to the Home First commitment and consistent communication with patients and families is considered to be critical.

5.1.1. These themes were picked up and developed in the review of delayed discharge undertaken by Brian Slater and in a positive and successful seminar with senior leaders across the Partnership which took place before the summer. The themes and priorities that emerged from the seminar are informing a review of the improvement plan and can be presented at the workshop in the proposed Board Development Session as recommended in section 2.3.

5.1.2. Current Partnership leadership arrangements are set out below:

- **Delayed Discharge Steering Group**: This is co-chaired by General Manager NHS FV and Head of Social Work Adult Services. It operates at a strategic level bringing together senior officers from across the Partnership to develop and implement improvements in delayed discharge performance.

- **Delayed Discharge Tactical Group**: This is a Forth Valley system wide group which brings together operational managers across both Health and Social Care Partnerships to address immediate issues impacting on discharge or to address system level challenges. This group has undertaken recent work to improve guardianship process and audit compliance with policy on choice of care home. The group is co-ordinated by the Discharge Team Manager.

- **Delayed Discharge Operational Group**: This is a weekly Partnership level group which reviews progress with all patients delayed in their discharge.

5.1.3. In addition there are daily and weekly huddles and multidisciplinary discharge planning meetings co-ordinated by the Discharge Hub. The Hub is managed by the Discharge Team Manager and plays an important role in supporting, co-ordinating and advising frontline health and social care staff in maximising discharges. The Discharge Hub also plays an important role in staff education and training, helping to embed cultural change in relation to “Home First” approach and in sharing issues preventing discharges on a daily, weekly and monthly basis. This has recently been improved by the development of the Delayed Discharge Dashboard and the implementation of the new delayed discharge database. These tools assist the work of the delayed discharge groups and facilitate shared ownership of targets and performance.

5.2. **Whole System Working: Locality Model Development**

Effective performance on delayed discharge is built upon integration at the frontline of service delivery, strong relationships between professionals at locality level, and high quality communication between the acute sector and the locality. Following a series of locality development sessions across the 3 localities, led by NHS and Social Work Service Managers, local multi-agency network meetings have continued. These meetings include GPs, Community Nursing, CPNs (older people), AHPs, Social Work, home care and carers’ centre. Local multi-agency networking allows opportunity to learn from situations in the community that have worked well to support a person to remain at home and prevent a hospital admission, or to identify where partnership working could be improved. Equally, when a person is ready for discharge strong local relationships and understanding of roles and

responsibilities can contribute to a timely and successful discharge, taking a reablement approach where possible.

5.2.1. Further work in relation to locality development is planned by NHS and Social Work Service Managers to begin work with specialist and integrated teams such as the Learning Disability Team, Adult Mental Health Team, Sensory Team and hospital Social Work Team. This work will focus on how these teams will most effectively link with core locality staff. This work will be essential to improving the opportunities to all Falkirk people, whatever their needs, to be supported in their locality area by a proactive team of staff working in collaboration with service users and their carers to prevent hospital admission or facilitate timely discharge.

5.3. **Improvement Targets**

Delayed discharge performance targets for the Partnership have been agreed with the Ministerial Strategic Group (MSG) as part of a wider suite of integration themes. This is reported within the Performance report at item 20 on this meeting's agenda. Set out below is the performance:

Falkirk Health and Social Care Partnership	**Delayed discharge bed days (18+ years)**
Baseline 2015/2016	All reasons **2015/16** – 13,306
Objective 2018/2019	Reduce numbers from current position with aim to get to 2015/16 or below **2016/17** increased to 18,523 **2017/18** decreased to 16,726
How will it be achieved	• Anticipatory Care Planning • Closer to Home – ECT, GPC, ALFY • Comprehensive Geriatric Assessment process • Daily Huddle • Delayed Discharge Action Plan • Discharge Hub • Discharge Tactical Group • Discharge to Assess • Falls prevention strategy • Frailty Pathway • Implement Reablement pathway • Night Nursing • Raise awareness of Power of Attorney and Guardianship • Support Carers

Falkirk Health and Social Care Partnership	Delayed discharge bed days (18+ years)
Progress (updated by ISD)	2017/18 is showing an improved position from 2016/17 although is currently below the trajectory to achieve the 2018/19 target.
Notes	Concern around the impact of demographic rises on figures.

5.3.1. Achieving the target of a year on year decrease in number of delays and in bed days lost remains challenging to address. In the early part of 2018/19, there have been sustained high numbers of delays related to care home wait and high numbers of guardianship applications, leading to Code 9 delays earlier in the year.

5.4. **Re-aligning Improvement Priorities**

The Partnership recently held a seminar, facilitated by Brian Slater, from the Scottish Government, to discuss the barriers to improving discharge performance and to identify key areas for improvement. The outputs from the seminar and the priority areas that emerged are now being translated into a revised improvement plan. This is being developed in collaboration with the Unscheduled Care Improvement Team to ensure alignment with the work of that programme and that discharge related work is co-ordinated.

5.4.1. The key areas for ongoing action and improvement work which emerged from the Seminar are set out below:

- **Adults with Incapacity**: Continuing the work to streamline the guardianship process and reduce unnecessary bed days lost. Supporting national media campaign to increase awareness of Power of Attorney.
- **Home First Approaches**: There are a number of related areas of work, some of which will be taken forward in collaboration with the Unscheduled Care Team and include:
    - Discharge to Assess
    - Implementation of the Reablement Pathway
    - Roll out and evaluation of Dynamic Daily Discharge
    - Roll out and evaluation of Frailty Model
    - Development and implementation of Community Front Door models aimed at preventing admission.
    - Sustained performance improvement will be built upon effective alignment of the above approaches with the development of the locality model and investment of effort in the following priorities:
        - **Staff Education & Training**: Ensuring consistency in communication within teams, with patients and families, and in the application of Home First approaches across all staff groups.
        - **Horizon Scanning**: Using data and information to track improvement, identity trends and support early action and intervention. Related to this is a recent test of change of a Predictive Discharge Tool. This

tool highlights individuals at the point of admission who may be at risk of being delayed in their discharge and is aimed at supporting early discussion regarding discharge planning.

- **Culture**: This includes clarifying the roles of key members of the multi disciplinary team, embedding a Home First ethos within teams and considering Realistic care/medicine approaches.
- **Community Hospital Review**: This will build on early discussions regarding the role of community hospital and intermediate care beds including reviewing pathways; developing enhanced rehabilitation models; and improved discharge processes including dynamic daily discharge and criteria led discharge.

6. CONCLUSIONS

6.1. The report describes those significant areas of activity which are being taken forward as part of the current Delayed Discharge Improvement Plan. The priority attached to the Delayed Discharge agenda is reflected in there having been no cap placed upon the resources allocated to discharge planning at individual case level, and considerable resources allocated to improvement initiatives, notwithstanding that the work undertaken has been delivered against a backdrop of resource scarcity and ongoing demographic change. On the other hand capacity, the availability of appropriate care solutions, and driving the Home First agenda, continue to present opportunities for delivery of improved performance. This report proposes further focussed work which has emerged from the recent seminar and which will form the basis of a revised Plan. This revised plan will be aligned and co-ordinated with the Unscheduled Care Improvement work and will be subject to in depth consideration at the proposed Board Development Session.

6.2. As the data demonstrates there are multiple factors which cause delays in discharge. Each causal factor needs to be addressed and continuously improved. A significant proportion of partnership funds have been committed to support wider initiatives to prevent hospital admissions, support discharge to assess, develop intermediate care and extend services and supports to sustain people at home. (see Appendix 1). The commissioning model for care at home has been reviewed and the internal care at home service is currently undergoing significant redesign.

6.3. There is still work to be done to ‘smooth out’ some of the predictable demands and hot spots. This requires a ‘whole system’ approach to ensure 24/7 access to care when it is needed through multi-disciplinary teams:

- work is underway to develop a predictive tool for delays in discharge to assist with planning
- discussions are underway with the Unscheduled Care programme manager re the development of a Home First model for both hospital and community referrals for care and support
- the development of integrated locality teams will support localised, coordinated support.

6.4. The proposed development session will provide an opportunity for in-depth exploration of all elements of the current system. There is an opportunity to develop a more cohesive integrated system underpinned by Home First principles and targeted partnership resources. The impact of each element of the whole system will be measured by a combination of appropriate outcome indicators to monitor and support improved performance.

Resource Implications
The resources of the Partnership continue to be prioritised to address the delayed discharge challenge. There continue to be no delays as a result of funding, and there is a commitment to continued investment in improvement initiatives supported by a strong evidence base.

Impact on IJB Outcomes and Priorities
Delayed Discharge is a key strategic and operational priority for the Partnership. All of the work undertaken on delayed discharge is driven by a fundamental concern for better personal outcomes for patients / service users for whom the aspiration must be that they are able to leave hospital as soon as they are clinically ready for discharge.

Legal & Risk Implications
Effective delayed discharge practice is essential to management of risk to patients / service users, both risk related to unnecessarily prolonged hospital stays and to poorly planned discharge. The work set out in this report is intended to address such risk.

Consultation
The present report reflects inputs from professionals working across the service system. As a progress update report, setting out a direction for future work, the present report has not been subject to public consultation.

Equalities Assessment
The present report does not set out policy change and is not subject to a requirement for equalities impact assessment.

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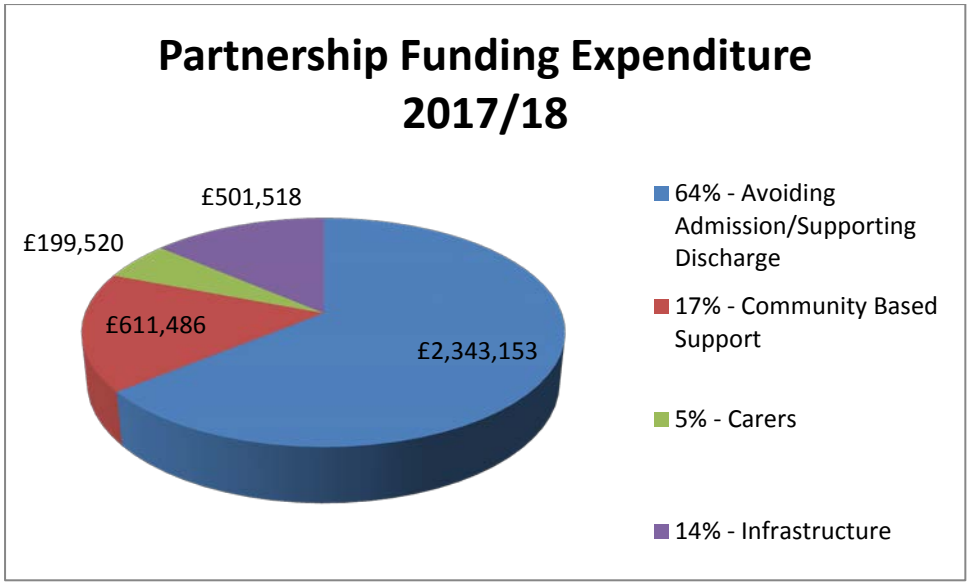
Approved for submission by: Patricia Cassidy, Chief Officer Falkirk HSCP

Author – Joe McElholm, Head of Social Work Adult Services
Kathy O'Neill General Manager

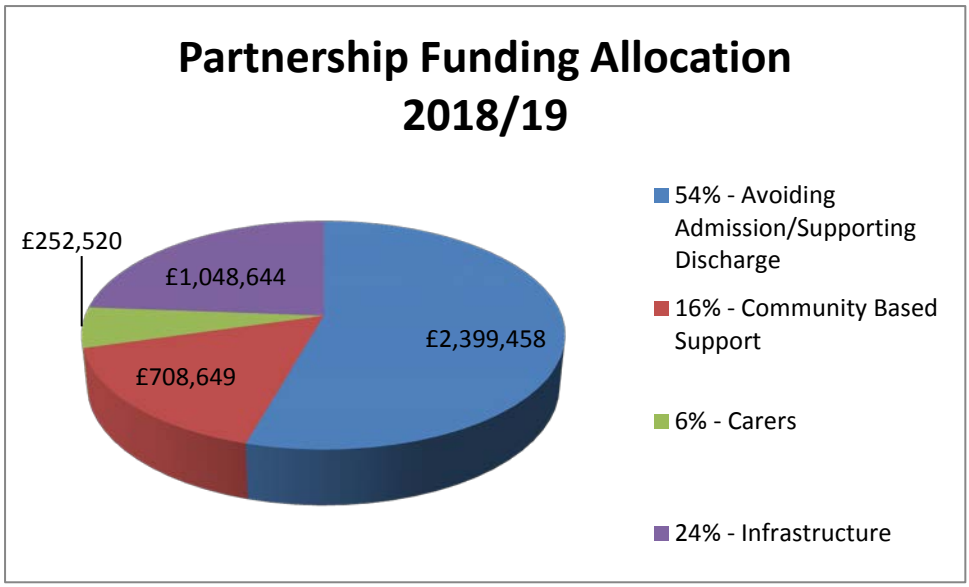
Date: 26 September 2018

List of Background Papers:
References:
‘Delayed Discharges in NHS Scotland: figures to March 2018’
https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/2018-09-11/2018-09-11-DelayedDischarges-Annual-Report.pdf

Report of Expert Group on Delayed Discharge 2012
https://www.gov.scot/Resource/0039/00397908.pdf



Partnership Funding Expenditure 2017/18	£		%
64% - Avoiding Admission/Supporting Discharge	£	2,343,153	64
17% - Community Based Support	£	611,486	17
5% - Carers	£	199,520	5
14% - Infrastructure	£	501,518	14
	£	3,655,677	100



Partnership Funding Allocations 2018/19	£		%
54% - Avoiding Admission/Supporting Discharge	£	2,399,458	54
16% - Community Based Support	£	708,649	16
6% - Carers	£	252,520	6
24% - Infrastructure	£	1,048,644	24
	£	4,409,271	100