Lead Responsibility	Project title	Description	Anticipated Outcome	Cost
West Dunbartonshire Council	**Additional Assessment Capacity**	We will use this funding to employ an additional Social Worker to assist with preventing admission and reducing discharge times. This costs £35,000 per annum (in addition to existing Social Workers doing this kind of work) and assists the Council to achieve the Local Improvement Target of reducing delayed discharges in line with Scottish Executive targets over 2006/07 and 2007/08. Data on average assessment times is collected for quarterly analysis. Data on numbers of clients affected by Delayed Discharge of more than 6 weeks is collected on a monthly basis. Data on numbers of avoided admissions is collected on a quarterly basis. Risks are that the resources allocated overall in the assessment of need (including this additional post) are insufficient to meet high levels of clients being presented for discharge or approaching potential hospital admission.	Contributes to 1,2, 4 and 6	£35,000

West Dunbartonshire Council	Care Home Places	Expenditure incurred in placing clients in Care homes who are placed there from a Delayed Discharge bed or as a means of avoiding hospital admission. By accepting people into Care Homes this reduces admission to hospital and allows an earlier release from hospital that would otherwise have been possible. Data on numbers of clients affected by Delayed Discharge of more than 6 weeks is collected on a monthly basis. Data on numbers of avoided admissions is collected on a quarterly basis. Risks to the success of this lie in availability of Care Home places and the ongoing financial effect of accepting such clients into a Care Home. At present the ongoing cost of such cases for West Dunbartonshire is £1.2m per year. The more of such clients who remain in a care Home after leaving hospital, rather than returning home then the bigger the financial burden on the Council becomes. At present there is clear evidence that in most cases once a client is admitted to a Care Home they are staying there and producing an ongoing commitment for the Council which is in excess of the	Contributes to 1,2,3, 4 and 6	£180,000 from Delayed Discharge funding

		delayed discharge funding available.		
Susan Spicer Joint Future Development Manager	Lomond Care Team (LCT), including • Extension to weekends • Overnight Nursing	Developments to the Integrated Care Team which is an inter-agency, multi-professional team, responding rapidly to: • Prevent unnecessary admissions to hosptial • Support early supported discharges from hospital • Provide additional weekend interventions (in partnership with District Nursing teams) • Referal and outcome data is collected. Numbers of prevented admissions and supported discharges are reported monthly for collation to LA's for SEHD rapid response returns. Annual report to Joint Partnership. • The team has been successfully responding to the referrals as stated; there is an unknown element this year due to the NHS systems changing practice, with	For West Dunbartonshire (Lomond) population we would expect the teams in their entirety to deliver in line with last year's figures *(ie. The outcomes are not merely produced from the additional funds):* • Prevent approx 298 admissions to hospital per annum • Support approx. 179 early supported discharges from hospital • Weekend interventions approx 64 per annum • Overnight approx 137 prevented admissions per annum.	£114,000 from Delayed Discharge funding

		some services being delivered from different sites and cross boundary changes which may or may not have an effect on referrals.		
Lynne McKnight	Intensive / Augmented Homecare packages	• Alternative to residential care placements (limited residential placements availability within council area) • Recording through social work information system • Reported on quarterly basis	Anticipate working in partnership with health colleagues to contribute to overall reduction in delayed discharges and increased volume of prevention of admission to hospital	£91,080
Lynne McKnight	Intensive home care places in conjunction with Step Up Step Down facilities	• Prevent unecessary hospital admission. • Facilitiate support on discharge from hospital • Support client during carer emergency • Reported on quarterly basis	Improved success of speedy dischages and prevention of admissions providing intensive support during crisis period and supplemented carer support	£37,030
Lynne McKnight	Overnight care in the community Home carer working partnership with Overnight Nursing Service	• Prevent unecessary hospital admission. • Facilitiate support on discharge from hospital • Support client during carer emergency • Weekly returns from timesheet • Reported on quarterly basis	Anticipate 137 admission prevented per annum Support 52 discharges per annum	£25,000

Total				**£482,110**

ⓘ Tab through table to create more rows