Health & Wellbeing Board

Improving outcomes for Frail Older People

Outcomes

Older People stay well at home longer	Older people with dementia and their carers feel supported to manage their dementia

Cross Cutting:
Reducing inequalities by tackling the wider determinants
Prevention and Early Intervention
Acting upon patient and customer experience
Safeguarding and ensuring high quality integrated services

There are around 20,000 people aged 75 years and above in Central Bedfordshire and approximately 1,500 are known to have dementia, thought to represent about 68% of the total number of people affected.

		Latest Data	Latest Data	Target	Current Status
...	Total non-elective admissions into hospital (general & acute) all-age per 100,000 pop (Monthly)	Aug 16	833	771	
...	Permanent Admissions of Older People (65+) to residential & nursing care homes (BCF)	Aug 16	161.0	485.3	
...	Proportion of 65+ still at home 91 days after discharge from hospital	Aug 16	90.3	95.5	
...	Emergency hospital admissions due to falls (65+) per 100,000	Mar 15	2,016		
...	Dementia diagnosis rate (65+)	Jun 16	56.1 %	58.7 %	
...	Social isolation-Adult carers who have as much contact as they would like	Mar 14	41.0 %		n/a
...	Delayed transfers of care (days) from hospital per 100,000 pop.	Jul 16	158.4	144.0	

▲Target missed by 10% or more ●Target missed by less than 10% ★Target achieved

Outcomes for improving outcomes for Frail Older People (many of which form part of the Better Care Plan metrics) show a mixed picture, with some being close to the target and others below target. This reflects the ongoing challenge of meeting the needs of an aging population with increasingly complex needs.

Permanent admissions of older people (65+) to residential & nursing care homes remain a focus of the Better Care Plan Schemes with a number of actions in place including scrutiny of packages of care to ensure that all alternatives have been explored to help people to remain in their own homes. The development of more independent living (extra care) accommodation will help to mitigate admissions into residential care.

The proportion of people aged 65+ still at home 91 days after discharge from hospital currently only reports on the Council's reablement service and as such the picture on the effectiveness of all reablement service is incomplete. An agreement has now been reached with the Community Health Services Provider (SEPT) for access to this data.

Emergency hospital admissions due to falls (65+) per 100,000 increased for the year 2014/15 which pre-dates some of the local initiatives put in place to prevent people being admitted to hospital after a fall and also to prevent subsequent falls. A Project for improving the Falls Service has been mobilised as part of the BCF Plan for 2016/17. Improvements will continue to be monitored by the BCF Commissioning Board.

Dementia diagnosis rate (65+) are improving but currently remain below target however the CCG are in the process of identifying a clinical lead to support the strategic planning in relation to dementia services. In addition East London Foundation Trust (ELFT) are currently reviewing the number of referrals made by GP practices and for those with low activity, will undertake some targeted work around understanding why the activity is low and to support with increasing the number of referrals into the Memory Assessment Service (MAS).

Delayed transfers of care from hospital is a summary measure of all local hospitals and therefore often masks high or low performing hospital trusts, this is expected to be rectified by the next scorecard. Work is currently underway to standardise the discharge process which would help reduce delays.