Health & Wellbeing Board

Progress Report August 2022

Introduction

The Ageing Well Programme in North & West Bristol draws from the national initiative, namely Urgent Community Response, Enhanced Health in Care Homes and Anticipatory Care. It is based in the Home First ethos, supporting our citizens to live well and as independently as possible in their own communities, avoiding unplanned admission to hospital.

There is a marked difference between the "inner" more affluent areas of North and West Bristol and the "outer" areas of social deprivation and the subsequent reduction in life expectancy, co-morbidities and quality of life. North and West Bristol also has the most care homes in the Bristol, North Somerset and South Gloucestershire catchment.

This paper gives a brief overview of North & West Bristol's ambition for the Ageing Well Programme. Full details are given in the forthcoming Vision document which will be available in early September 2022.

Urgent Community Response

- 2-hour response – to be defined further by system work and awareness raising
- 4-hour reablement – to be defined further by system work and awareness raising
- Discharge to Assess – to be defined further by system work, awareness raising

There is some further work to be done on ascertaining the current position on workforce, referrals and pathways as well as evidence of activity via robust data.

Enhanced Health in Care Homes

North & West Bristol will be in alignment with the national Enhanced Health in Care Homes Framework including the 7 elements of care. To this end, our discussions with Primary Care Network Clinical Leads on the Frailty Multi-Disciplinary Teams (MDTs) will help inform the design and delivery of the Care Home MDT approach. We will also continue to drive the delivery of Restore2 training in all care homes across North & West Bristol which will result in better quality care for residents, a reduction in unplanned admission to hospital and have a positive impact on the recruitment and retention of care home staff.

Anticipatory Care

The criteria for Anticipatory care are - people who will benefit from anticipatory care approaches are those with 2 or more long term conditions and for the first year of delivery, it is anticipated that systems should use the following criteria for selection of people from one or more of these cohorts:

- living with moderate or severe frailty
- experiencing health inequalities, defined as the top 20% most deprived populations and those within health inclusion groups
- people relying on unplanned care to manage their conditions, where integrated community-based support could better support individuals to manage physical and mental health needs

Module C (working together at Place to slow down the steep decline of health)

Module C focuses on Prevention initiatives (50- 70-year-olds, some mental health needs (depression/ anxiety and low multimorbidity). Working together at Place to slow the steep decline in health. Developing solutions for the 'whole person' with actions leading to potential impact for Place and system.

The project aims to develop a set of adult social care initiatives to curb the elevated non-elective spending amongst a particular cohort in the region. This cohort experiences higher rates of mental health problems and more limited multi mobility than others of the same age in the region. The project will enable members of the cohort, voluntary sector organisations, and members of the partnership to co-design the initiatives together.

We are working with the relevant community anchor VCSE organisations to assist the Locality in engaging and learning from this cohort. Engagement to gain valuable insight is expected to commence in September running through the Autumn period. We will then work with representatives of the cohort, communities, community anchor VCSE and partner organisations to co-design agreed interventions.

Next Steps

An Ageing Well Working Group has been established with representatives from all key partners and will be meeting again in September. Its aims and objectives are -

- BNSSG wide priorities: Urgent Community Response, Enhanced Health in Care Homes and Anticipatory Care
- BNSSG pilot projects – bringing those running in N&W into our programme (reporting, etc.)
- N&W priorities: informed from Population Health Data, link with partners priorities (i.e., Bristol Ageing Better), leg ulcer pilot, care homes focus, carers, dementia, prevention
- Asset mapping exercise: ageing well services available in N&W now, pilots/ service developments, estate
- Commence engagement work – design / development
- Reinstating MDTs in practices
- Ongoing refinement to programme structure – people/ representatives, GP lead, Terms of Reference, reporting mechanisms, etc.
- Prevention – module C piece, asset mapping, relevant pilots
- Anticipatory – MDTs, dementia, relevant pilots
- Frailty – urgent response (2 hours & 4-hour reablement), Enhanced Health in Care Homes, palliative care, dementia, relevant pilots

In order to inform all of the above, there will be a robust approach to data gathering.

Our longer-term plans will include an evaluation of our Ageing Well Programme; this will demonstrate whether the programme has achieved its health and care aims, what has worked well and where the challenges were, and opportunity mid-course to adapt/stop ineffective activities and provide evidence to justify retaining/ investing funding and, of course to support ongoing learning locally.