

Co-developing and unlocking Integrated Proactive Neighbourhood Teams in Gloucestershire to improve care for people living with frailty

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CONFERENCE ABSTRACT

Co-developing and unlocking Integrated Proactive Neighbourhood Teams in Gloucestershire to improve care for people living with frailty

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In Gloucestershire we are rightly proud of our strong track record in collaborative working across organisations in the wider health, care and wellbeing system. We are committed to the delivery of Integrated Neighbourhood Teams building on integrated care.

Across our partnerships we strive to continuously improve the care and outcomes for our people. However we are not without our challenges. While life expectancy continues to improve for the most affluent 10%, it has either stalled or fallen for the most deprived 10%. An ageing population means there's a growing demand and pressure on the system to remain sustainable.

The Working as One transformation Programme endeavours "to deliver quality, integrated care for the people of Gloucestershire to support the best possible physical and mental health outcomes, enabling them to lead the most happy and healthy lifestyles". One improvement cycle of the Prevention workstream of Working as One is the development of Integrated Proactive Neighbourhoods; Integrated Neighbourhood Teams focussed on proactive frailty. We know there are over 73,000 people in Gloucestershire over the age of 65 coded as frail within our GP clinical systems. If and when people in this age group attend our acute hospital emergency department, they are more likely to spend longer there than those aged under 65, and more likely than the younger age group for that attendance to lead to an admission. We are keen to prevent attendances where reasonably avoidable and where people can be proactively supported to remain in their own homes and communities.

We know a patchwork of interventions has developed for different cohorts of people living with frailty. This programme enables us; a system comprising teams of teams around specific populations; to collectively work better together to improve the health and care outcomes for our populations. It is an opportunity to systematise adoption of the most impactful evidence based interventions for people across our county by cohort and individual need and positively impact the wider system. We acknowledge that, whilst transformative in many respects, this is also an evolutionary change that builds on examples of already successful integrated working practices.

We're phasing our approach across fifteen neighbourhoods in Gloucestershire to collectively run improvement and change cycles. Importantly whilst system and senior strategic colleagues can provide the structure, conditions for change and permissions for this new way of working, it is the local health and care professionals, our vibrant voluntary and community sector and people in communities who hold the key to delivering locally appropriate adaptations of the model to meet local people's needs in a meaningful and sustainable way. Our work links most to pillars 1,2,3 and 6 of integrated care.

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Our key next step is convening a series of workshops to enable local teams the time and space to co-develop the integrated working in their neighbourhoods. With the support of our systemwide Improvement Community and strategic leaders, local teams will be enabled and empowered to work with people to continuously develop and iterate integrated care for, and with the people we serve.