t's about our life, our health,
ur care, our family and
ur community'

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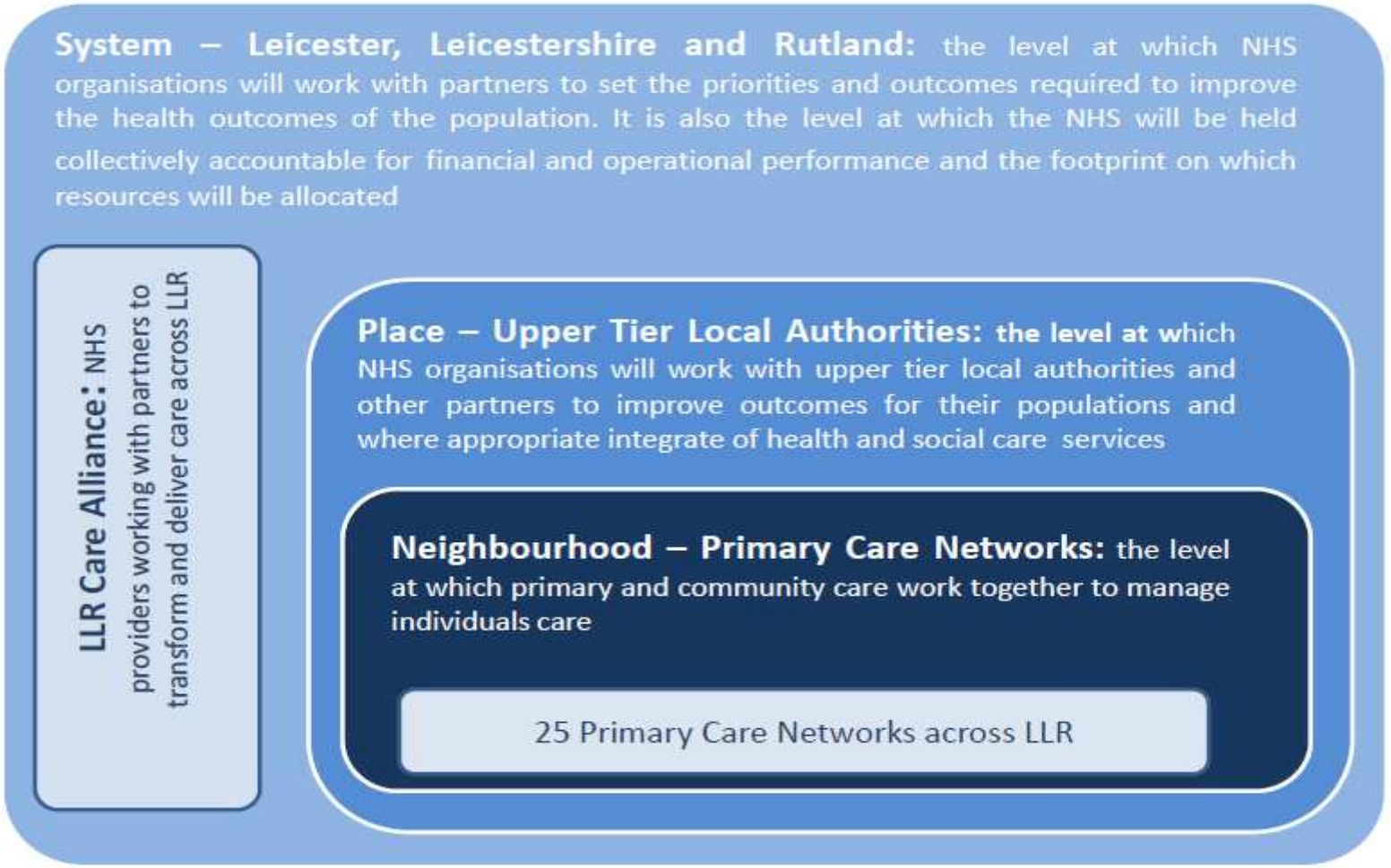
Integrated Health and Care in Rutland: Governance and recent progress

Fay Bayliss, Deputy Director of Integration and Transformation, LLR CCGs

Sandra Taylor, Service Manager - Community Support Services, RCC

LLR Integrated Care System



tland: putting Health and Care into 'Place'

nam Rugby Club, February 2020

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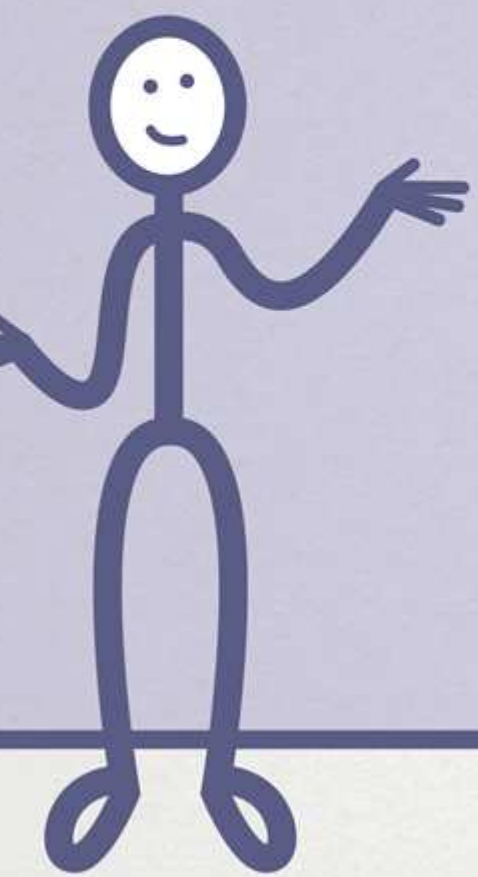


Approach

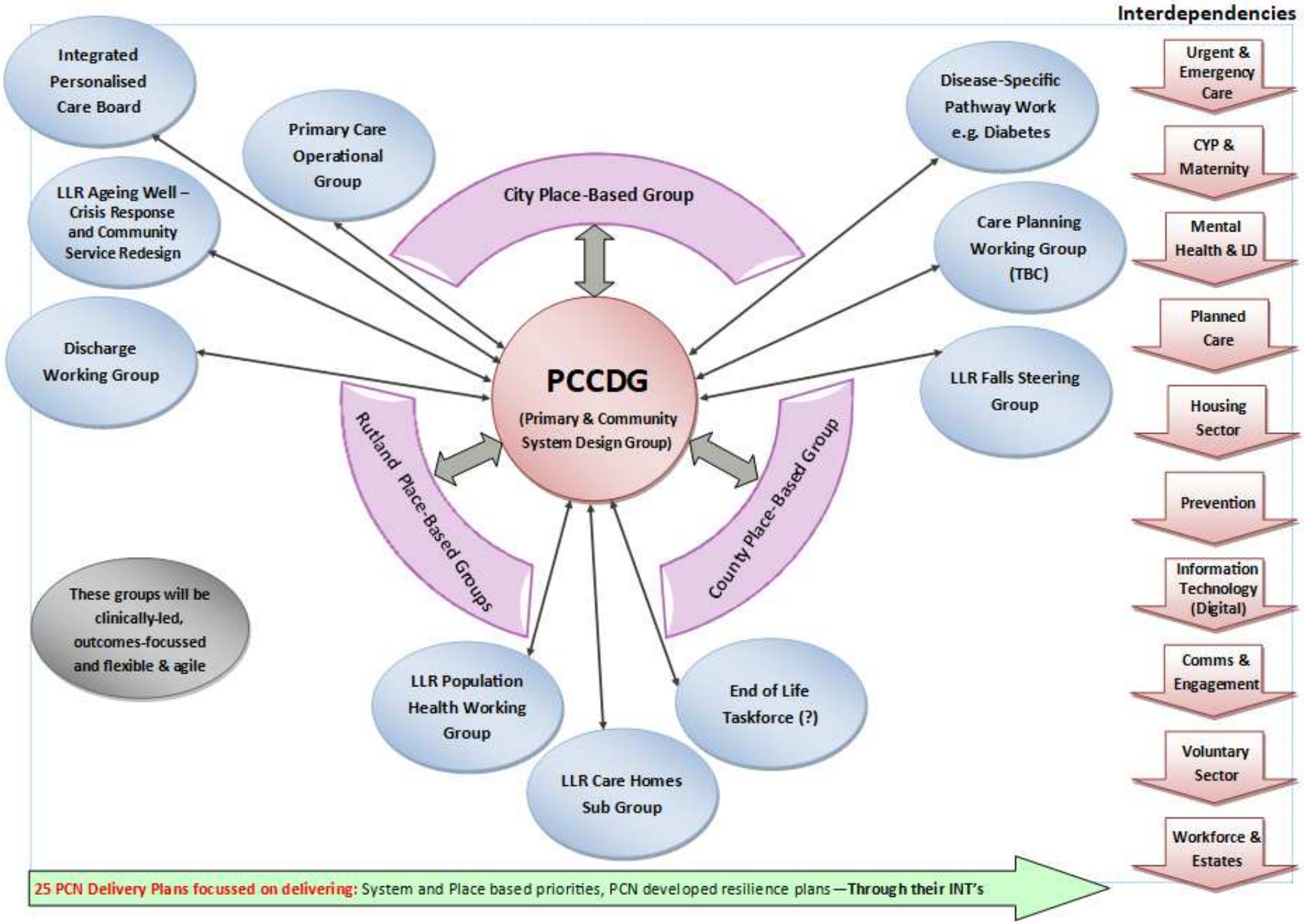
- Build on the strong foundation of integrated care in Rutland
- Put individuals at the heart of change – patient centred
- Create a vision 'in the round' – inter-related changes not stand-alone
- Involve and empower the public – what does this mean to me?

Making it happen

- Renew governance for change
- Deepen relationships between RCC, the CCG integration team, the Rutland PCN and other partners incl third sector to accelerate progress
- Align & streamline strategies, recognise geographic realities

Actions

- Match services to needs – population health management
- Whole population: boost prevention
  - Wider than health – everything that impacts on wellbeing
- Living with ill health: Multi-disciplinary working for coherent care
  - Best use of resources, care closer to home, real patterns of service use
  - Minimising escalation – step up & step down interventions
- Plan for Rutland – integrated care, outpatient offer, diagnostics, rehab, housing gro


Interdependencies
Integrated Personalised Care Board
Primary Care Operational Group
LLR Ageing Well – Crisis Response and Community Service Redesign
Discharge Working Group
City Place-Based Group
PCCDG
(Primary & Community System Design Group)
Rutland Place-Based Groups
County Place-Based Group
Disease-Specific Pathway Work e.g. Diabetes
Care Planning Working Group (TBC)
LLR Falls Steering Group
These groups will be clinically-led, outcomes-focussed and flexible & agile
LLR Population Health Working Group
LLR Care Homes Sub Group
End of Life Taskforce (?)
Urgent & Emergency Care
CYP & Maternity
Mental Health & LD
Planned Care
Housing Sector
Prevention
Information Technology (Digital)
Comms & Engagement
Voluntary Sector
Workforce & Estates
25 PCN Delivery Plans focussed on delivering: System and Place based priorities, PCN developed resilience plans —Through their INT's

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egration Delivery Group

of Reference

roup

- Locally: Reporting to Rutland Health and Wellbeing Board. Also Rutland Partnership Board for (Better Care Fund manageme
- LLR ICS: Reporting into the LLR Better Care Together Primary and Community System Design Group
- Virtual meetings, monthly

cope

- Under the oversight of the Rutland HWB, work together to shape and drive a coherent change programme in Rutland that de to the aims of a number of strategies/programmes
  - Rutland Better Care Fund, Rutland Health and Wellbeing Strategy, LLR Ageing Well/Home First programme
  - Turn principles/aims into actions
  - Commit or pool respective resources for common or coordinated solutions
- Use data/insight to inform action
- Progress significant work using design/test cycles (Plan Do Study Act), and reporting progress to the Group
- Monitor impact/measure success

NH

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tland Integration Delivery Group

ership

ay Bayliss, Chair, LLR CCGs
ohn Morley, DASS, Vice Chair, RCC
r Hilary Fox, Clinical Director, Rutland PCN
onna Bottrill, Community Nursing, LPT
at Wise, Discharge & Therapy change, RCC
el Rowland, Therapy change, LPT
evin Quinn, Transformation, VCF sector, RCC
athryn Packham, Public Health
andra Taylor, Health and Care Integration, RCC
udith Munson/Michelle Christie Smith, CCG Rutland Locality

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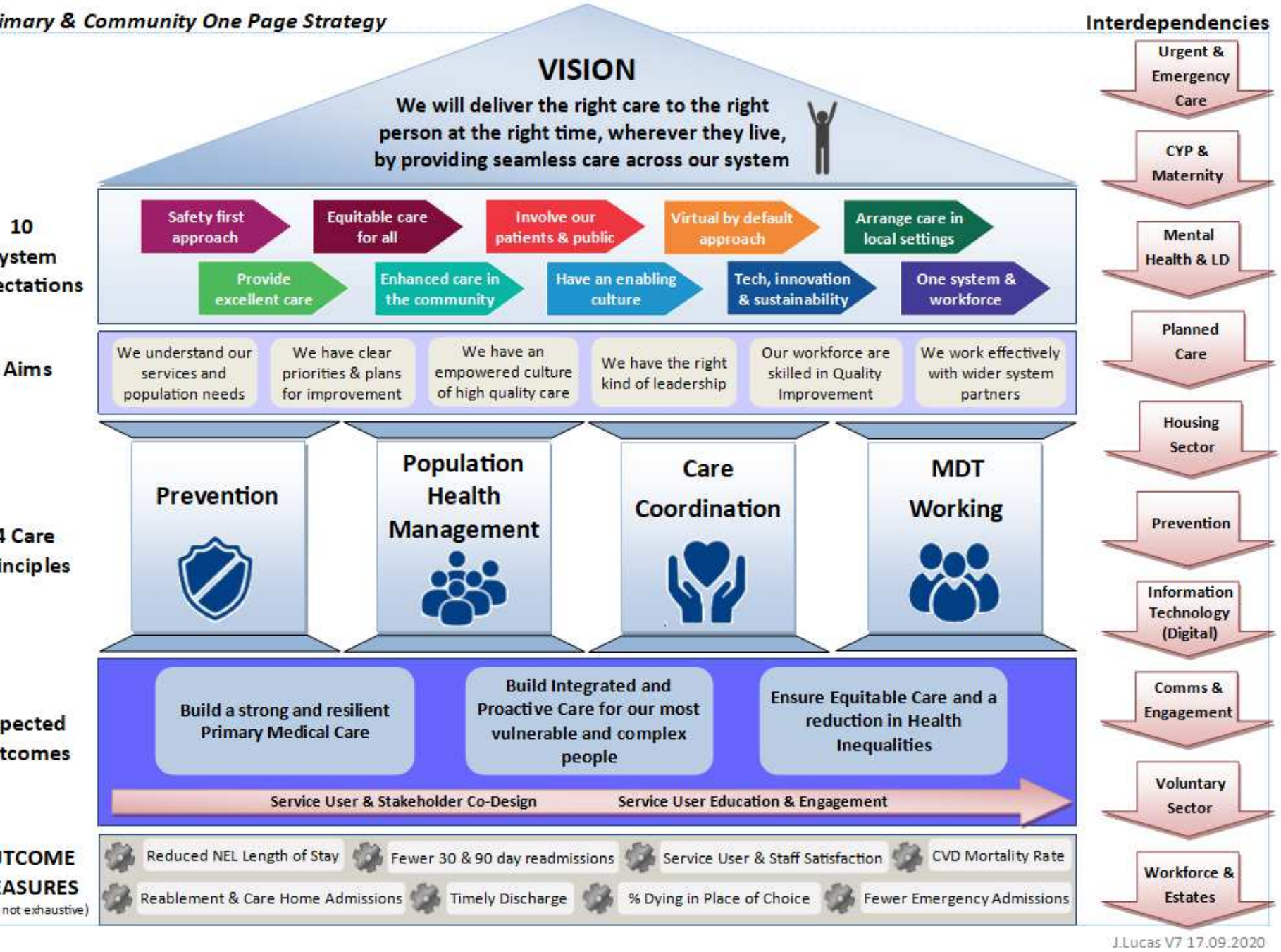


Questions

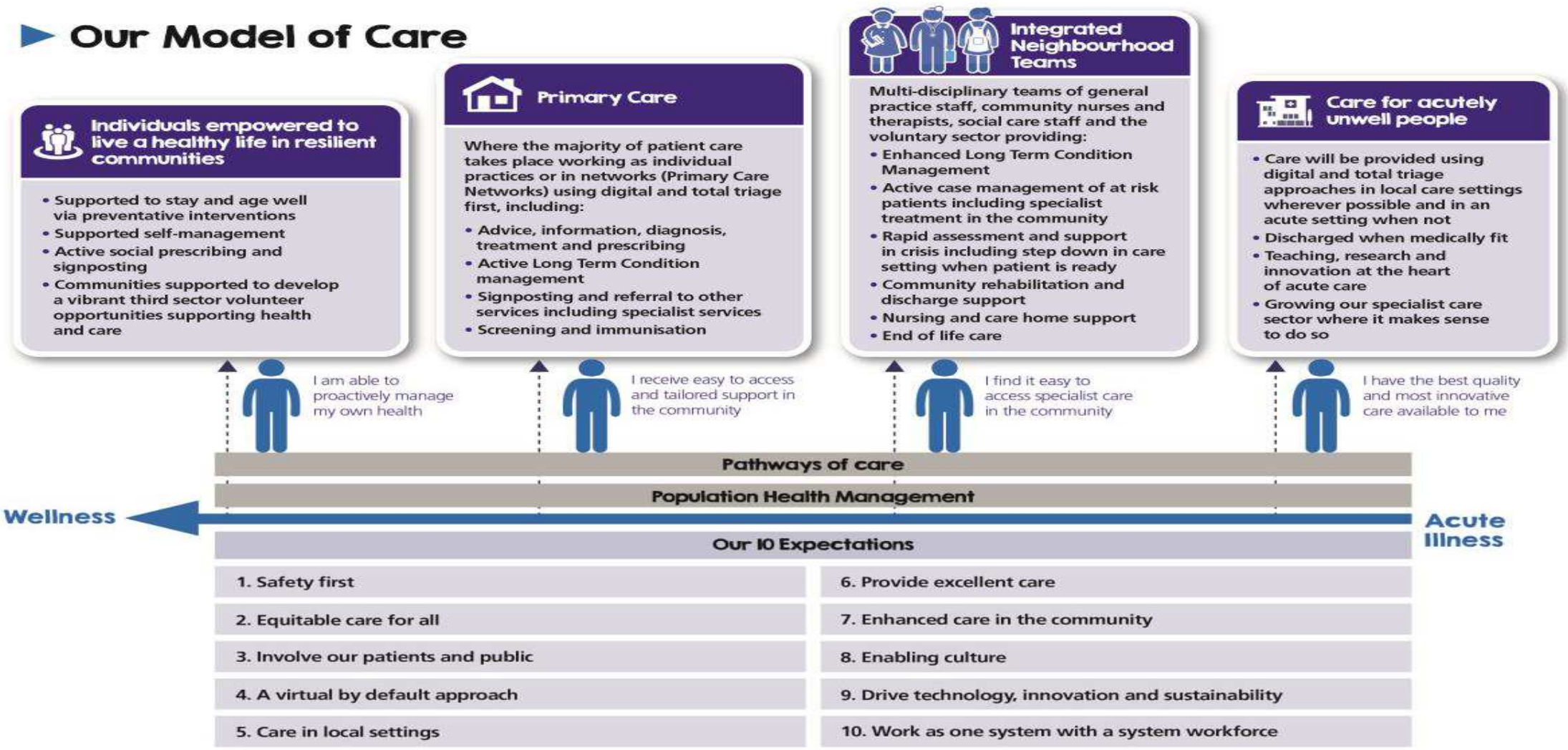
How does the Rutl system and situatio compare?

Feedback on the model?

Does this direction right for Rutland?

What needs to hap to move the vision forward in ways th are right for Rutlan

The LLR integrated model of care



erging model of integrated care for Rutland

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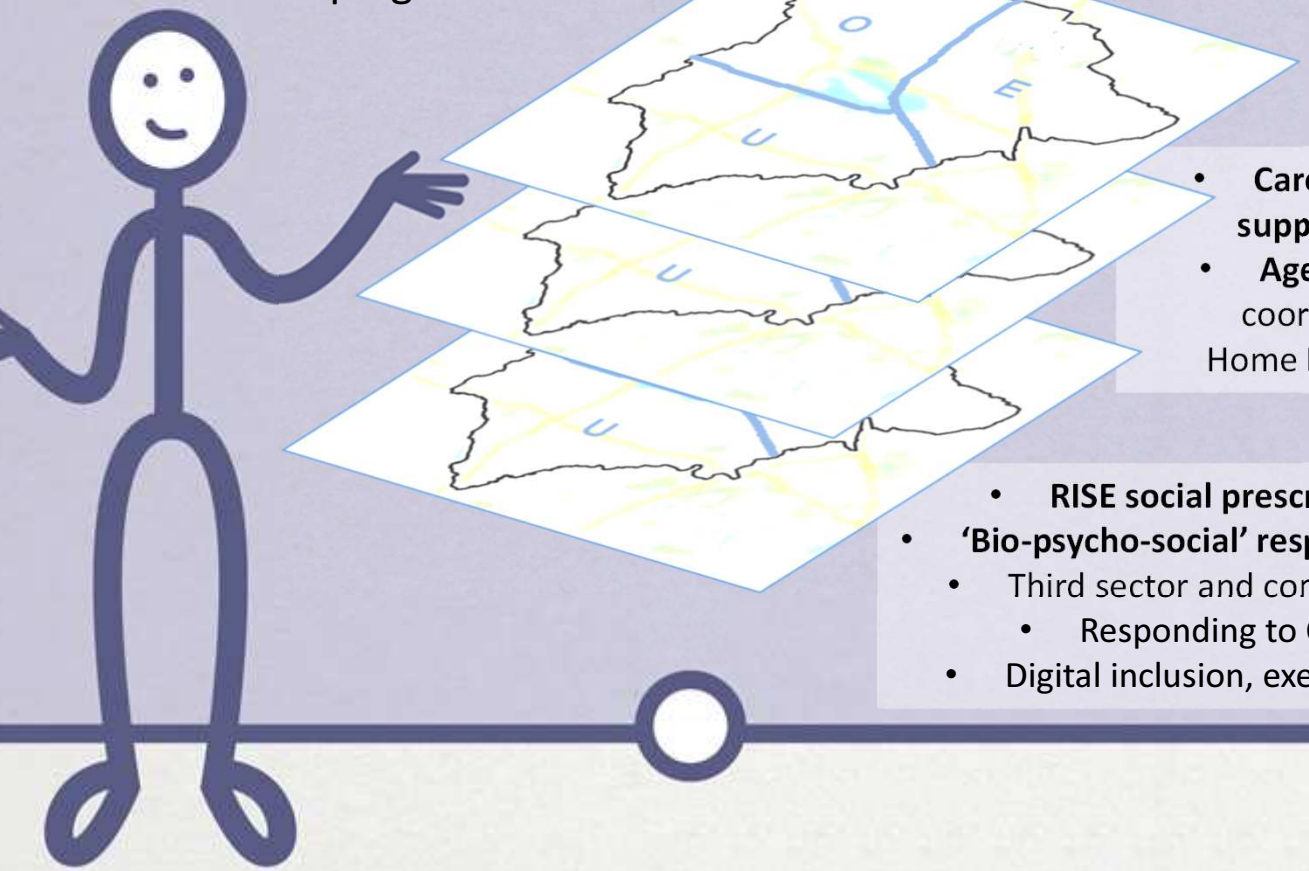
Rutland PCN - structure/geog to build integrated teams around

- Oakham/Market Overton
- Uppingham
- Empingham



- **Swift hospital step down – 'D2A'**
- **Micare 3 zones - aligned to GPs**
  - ASC – nursing – therapy
- **End of life care – care planning**
- Crisis support: step up services

- **Care home working – new role supporting GP/community MDTs**
- **Ageing well:** multi-disciplinary coordination around the patient, Home First, diagnostics, planned care

- **RISE social prescribing – RCC/PCN**
- **'Bio-psycho-social' response, health coaching**
  - Third sector and commissioned services
    - Responding to Covid-19 needs
  - Digital inclusion, exercise, mental health

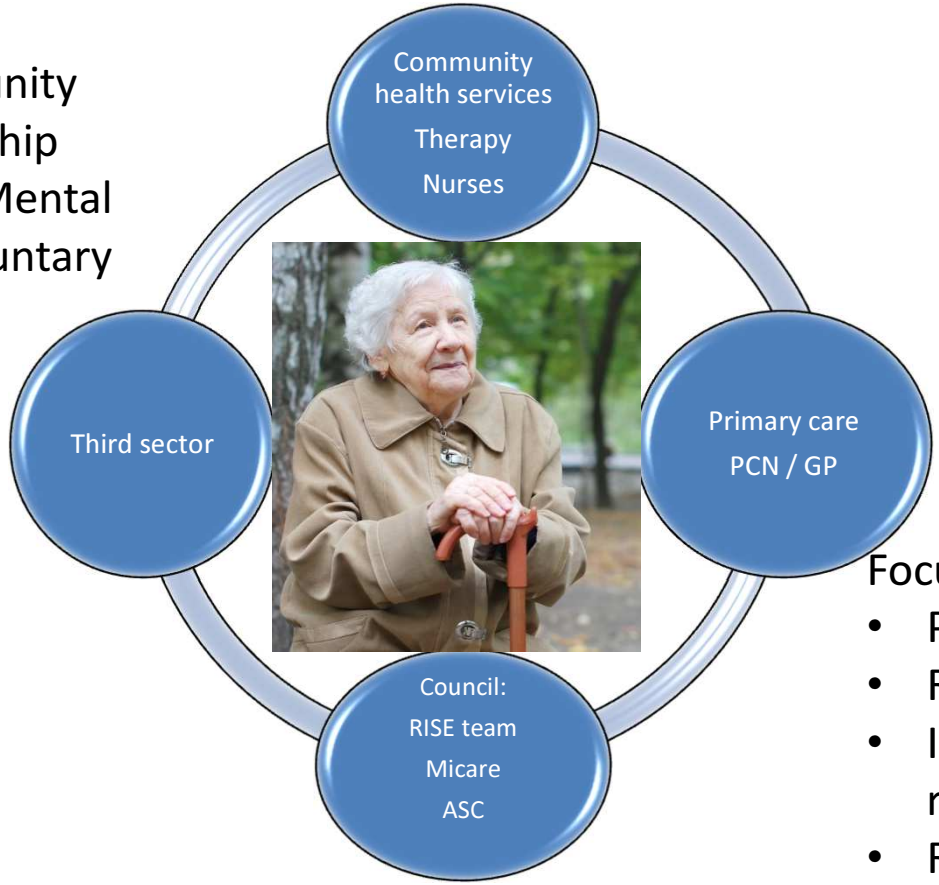
Acute needs

Multi-morbidity, Integrated teams for coordinated care

Prevention & self care

Rutland Long term plan for Ageing Well

- MDT Model
- Primary & community health in partnership with social care, Mental health teams, voluntary sector & others



Focused on

- Prevention
- Reducing health inequalities
- Interventions for identified risk and unmet need
- Reducing loneliness & social isolation
- Early identification of vulnerability and frailty
- Support at end of life

Preventative proactive model of care for complex and at risk patients in Rutland focussed on population health and well being

What we need to develop:-

- Identification of vulnerable populations
- Shared integrated care
- Shared workforce
- Integrated triage and assessment processes
- Integrated data and IT systems to enable flow of information

Meaningful outcomes for patient care which support people to stay well