Guidance on local governance structures to support implementation of integrated service model

Establishing a local governance structure across health and social care (including the third sector) with senior sponsorship is a fundamental starting point on the journey towards integrated services for older people (ICP OP 2018)*. Slaintecare advocates the creation of an enabling environment to address implementation (figure 1)

Change approach  Figure 1

- Locally led transformation (clinically and operationally led)
  - Clinically and operationally led through engagement with frontline staff so that the approach is culturally embedded.
- Local improvement approach
  - Local Acute Hospitals and CHO’s own the change/improvement initiatives and work collaboratively within local structures to implement them across the local care pathway.
- Models of care will be delivered collaboratively across Hospital Groups and CHO’s.
  - Adopt a philosophy that shares resources and benefits.
  - Local governance will pursue a population approach whereby the resources available are mobilised to support the delivery of the service model.
- A structured programmatic approach
  - The proposed governance provides a mechanism for accountability for implementation which is locally owned and nationally enabled.
  - There is clarity on a tiered approach to escalation to allow decisions to be made at the appropriate organisational level.
- A national service model, centrally enabled
  - The national system will provide a clear roadmap and support for delivering the model. This will attend to key enablers (ICT, HR, Data, Finance).
  - There will be a consistent focus and clear communication around goals and a commitment to shared learning across the system.
  - There will be a clear approach to addressing Capacity and Enabling supports over an agreed timeline.

It is often the case that examples of governance are already well established in many areas, for example Area Crisis Management Teams or Winter Action Teams in the context of COVID or for specified purpose (e.g. discharge planning). The proposed governance builds on local informal professional and managerial networks. In the context of facilitating the change/reform agenda (Winter/NSP 2020/21 and corporate plan) the key function of the local governance group is to enable integrated service development to provide bespoke care pathways for older people/chronic disease. The governance group membership must be made up of senior decision makers and so membership must have sufficient seniority within their respective areas of responsibility to facilitate the implementation of the service model (figure 2). They will focus on 5 key areas;

1. Provide operational oversight of service change.
2. Integrate service developments and exiting services into 1 coherent model locally (reflecting Fig 2).
3. Provide senior leadership on servicing integrated pathways (exemplified by shared resources/personnel).
4. Support clinical and operational leadership in implementation of discrete service elements (e.g. Ambulatory Hub, FFD)
5. Facilitate delivery of enablers, particularly data collection in order to drive service improvement.

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The leadership of the change process is critically important. The leadership group are primarily representative of and attend to key service developments. Professional requirements (e.g., WTE resource is addressed as part of the HR/Project Management component). The ‘appointment’ of a clinical lead and operational lead in each local health economy (CHO/AH) is essential.

- **Programme sponsorship**
  - Chief Officer/CEO (AH)

- **Local Implementation Group Leadership**
  - Social care/Primary Care Lead/GM (AH)/Clinical Lead/Head of Service (CHO)/Nursing lead/NGO lead
  - Project Management Support

- **Working group workstreams**
  - Inpatient pathways chaired by Clinical Lead/GM (AH)
  - Ambulatory care pathways chaired by Clinical Lead/Head of Service (CHO)
  - Data (operational)
  - ICT
  - HR
  - Finance
## Example of tasks for local implementation group/working group

<table>
<thead>
<tr>
<th>Area of focus</th>
<th>Examples of key members</th>
<th>Key tasks</th>
<th>Data to be collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living well with support</td>
<td>Service User Representative, Local Authority Age Friendly Programme Manager, NGO rep, Third Sector Organisations, Health and Wellbeing Senior Management</td>
<td>Asset Mapping of resources (e.g. mobilised during COVID), Focus on wider health ecosystem supports, Participating in Frailty/Falls Prevention, Communications and awareness raising</td>
<td>Service Improvement Projects co-designed with service users, Referrals to preventative interventions</td>
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<tr>
<td>Ambulatory Care pathways</td>
<td>Clinical lead, Primary Care Senior Management, Social Care Senior Management, GP Representative, Senior PHN Representative, HoD lead, Home care lead, CIT lead</td>
<td>Demand and capacity planning (profiling population by CHN), Profiling services (directory), Develop the hub as the primary point of access, Develop liaison/linkages between ambulatory hub/specialist community team acute hospital and primary care, Develop opportunistic case finding, Define specialist roles within the integrated care team e.g. CNS, ANP to service pathways, Define and develop priority care pathways on falls, frailty, dementia, Define Ambulatory HUB (SoP)</td>
<td>Register of at risk older adults in CHN, No. of people with complex care needs identified and managed within the CHN, Number of patients on a caseload, The number of patients on the MDT caseload during the reporting Period with:</td>
</tr>
<tr>
<td>Inpatient pathways</td>
<td>Community Therapy/Rehab Management, Clinical Lead, AH Managerial Lead Integrated services, HoD leads, Senior Nursing lead, Patient Flow Lead, General Manager</td>
<td>Adopt a Home First Focus, Plan pathway based on demand and capacity planning (use ICP DP dashboard), Develop Frailty at Front Door Function, Cohort capacity for maximising flow, Address early supported discharge component between care settings</td>
<td>No. of cohorts beds, PET Times for &gt;75’s, No of patients screened positive for frailty, No. of CGA’s completed, AvLOS for &gt;75’s with complex needs, No. of patients discharged to MDT with care plan</td>
</tr>
</tbody>
</table>

The scope of the local implementation group would also address the following:

- To ensure the project remains aligned with the national service model and 10-step framework
- To ensure the project remains within scope, is implemented within agreed timelines and within allocated budget.
- Set up working group teams as required managing elements of the project work.
- To oversee the development and operation of the integrated care MDT teams and to ensure that dependencies between individual work streams are managed and their work remains aligned with the model of integration described in the Older Persons Service Model.
- To ensure the project makes the most of existing resources.
- To escalate emerging issues which need to be addressed by the governance group.
- To ensure that national education programmes relevant to the care of older adults are offered to key staff locally (e.g. National Frailty Education Programme)
Examples of local governance structures (Galway)

- **Governance Structure**: Galway Older Persons' Hub (GICOP)
  - **Sponsor**:
    - Saolta Group: Dr Ramona McLoughlin
    - CHW: Elaine Prendergast

- **Steering Committee**

- **Working Group**
  - **Work Streams**:
    - Inpatient/Intermediate Care
    - Ambulatory Care HUB/CHN
    - Supports to Live Well
    - Research/Innovation

- **Pathways**:
  - Pathways from ED/MAU
  - Pathways to CNUs/Short Stay Beds
  - Pathways to and from Rehab

- **Additional Working Group Activities**:
  - Initiation of Phase 1 Hub Recruitment of Staff Mapping Existing Services Linkage with CHN learning site Development of Spokes
  - Social Partnerships Home Help/Carers Age friendly Ireland/GCOCO
  - Links with Healthcare Innovation Hub QI research Frailty/Older Adult Health Research

*PJ Harnett, Des Mulligan, Jennifer Hardiman September 2020*
References:

2. ICP OP (2020); Making a start in Integrated care for older persons – A practical guide to the implementation of integrated care programmes for Older Persons at www.icpop.org