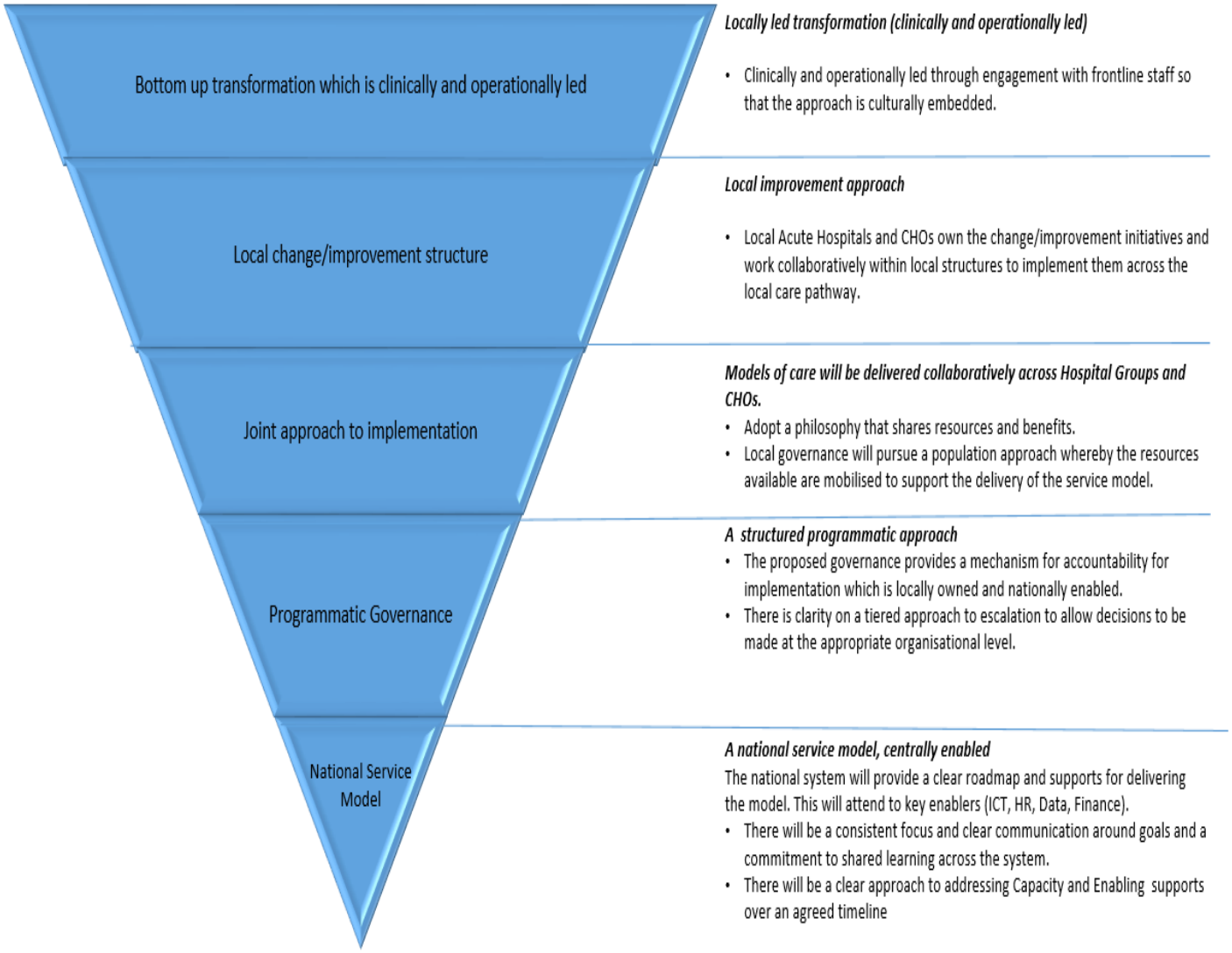
Guidance on local governance structures to support implementation of integrated service model

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*



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.

PJ Harnett, Des Mulligan, Jennifer Hardiman September 2020

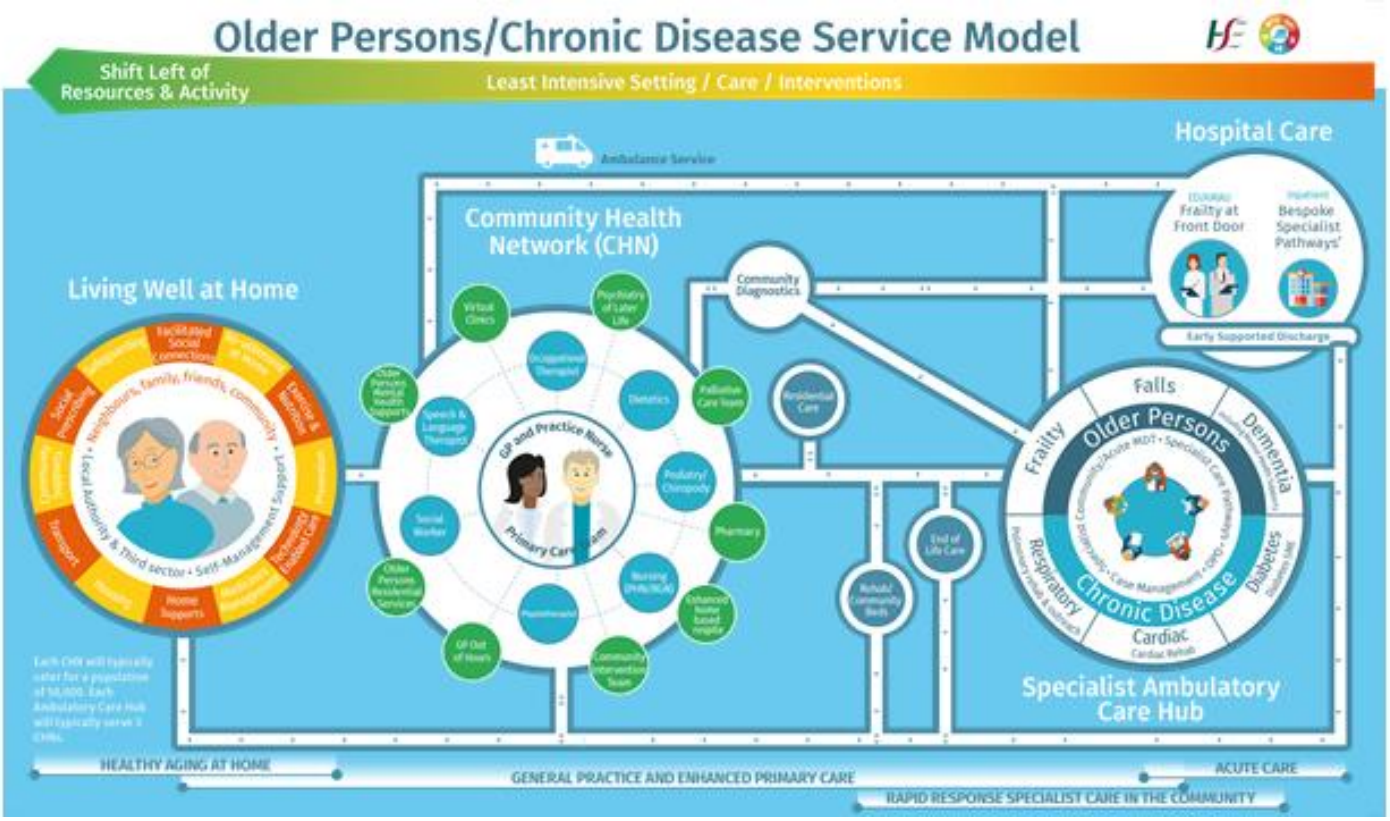
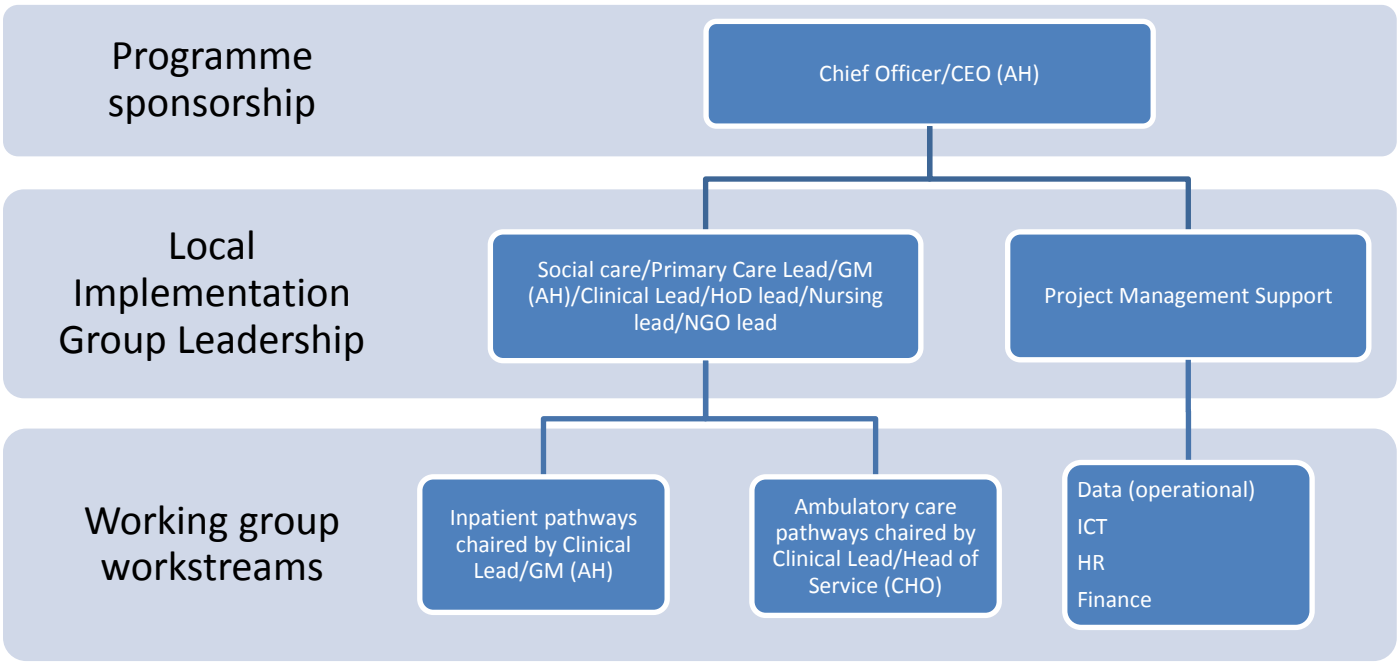


Figure 2. Older Person/Chronic Disease Service Model

Example of local governance leadership structure

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.



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Example of tasks for local implementation group/working group

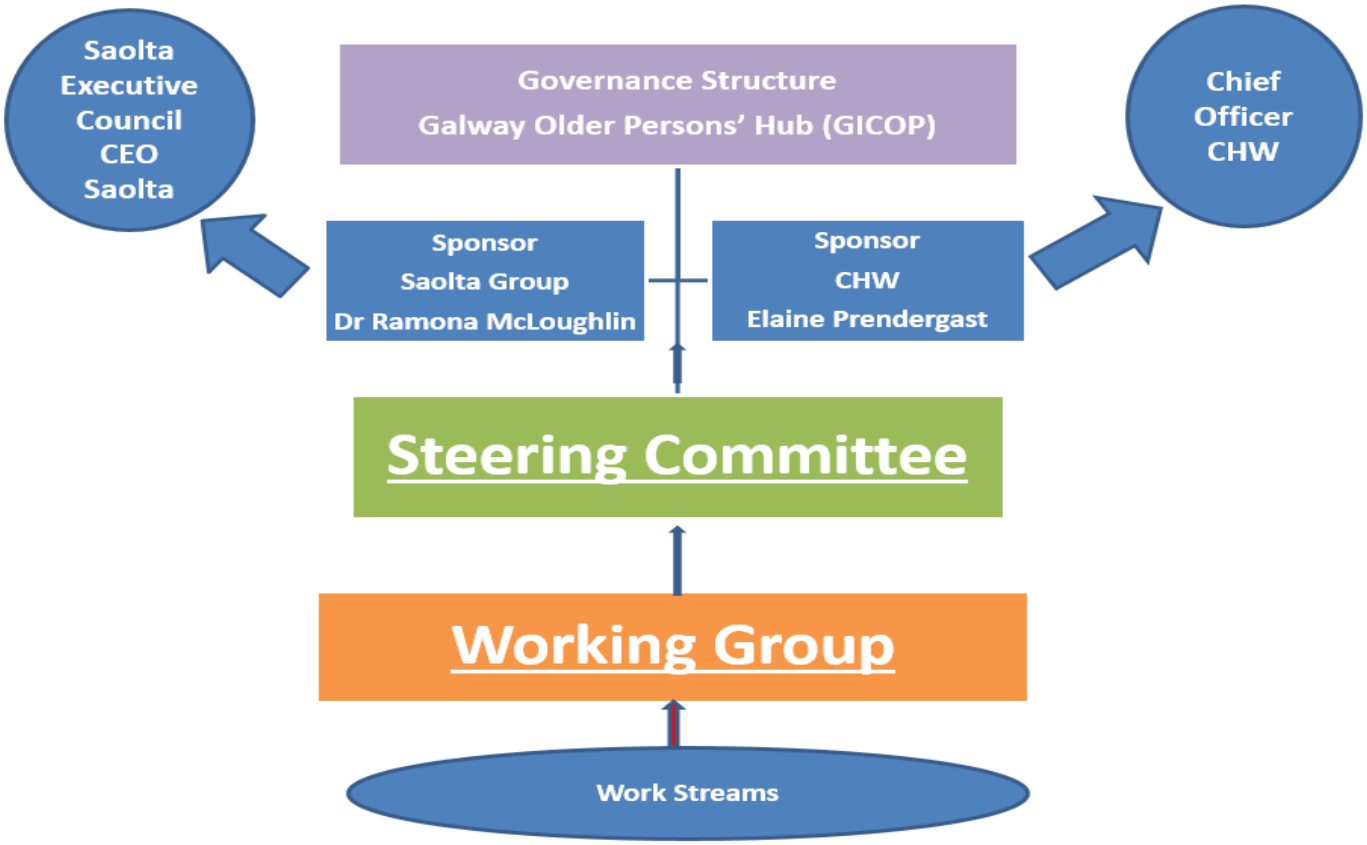
Area of focus	Examples of key members	Key tasks	Data to be collected
Living well with support	• Service User Representative • Local Authority Age Friendly Programme Manager • NGO rep • Third Sector Organisations • Health and Wellbeing Senior Management	• Asset Mapping of resources (e.g. mobilised during COVID) • Focus on wider health ecosystem supports • Participating in Frailty/Falls Prevention. • Communications and awareness raising.	• Service Improvement Projects co-designed with service users. • Referrals to preventative interventions.
Ambulatory Care pathways	• Clinical lead • Primary Care Senior Management • Social Care Senior Management • GP Representative • Senior PHN Representative • HoD lead • Home care lead • CIT lead	• 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)	• 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: High, Moderate, Low } Complex Care Needs • Total number of patients on caseload with a completed CGA
Inpatient pathways	• Community Therapy/Rehab Management • Clinical Lead • AH Managerial Lead Integrated services • HoD leads • Senior Nursing lead • Patient Flow Lead • General Manager	• Adopt a Home First Focus. • Plan pathway based on demand and capacity planning (use ICP OP dashboard) • Develop Frailty at Front Door Function • Cohort capacity for maximising flow • Address early supported discharge component between care settings.	• No. of cohorted beds • PET Times for >75's • No of patients screened positive for frailty • No. of CGA's completed • AvLOS for >75's with complex needs No. of patients discharged to MDT with care plan

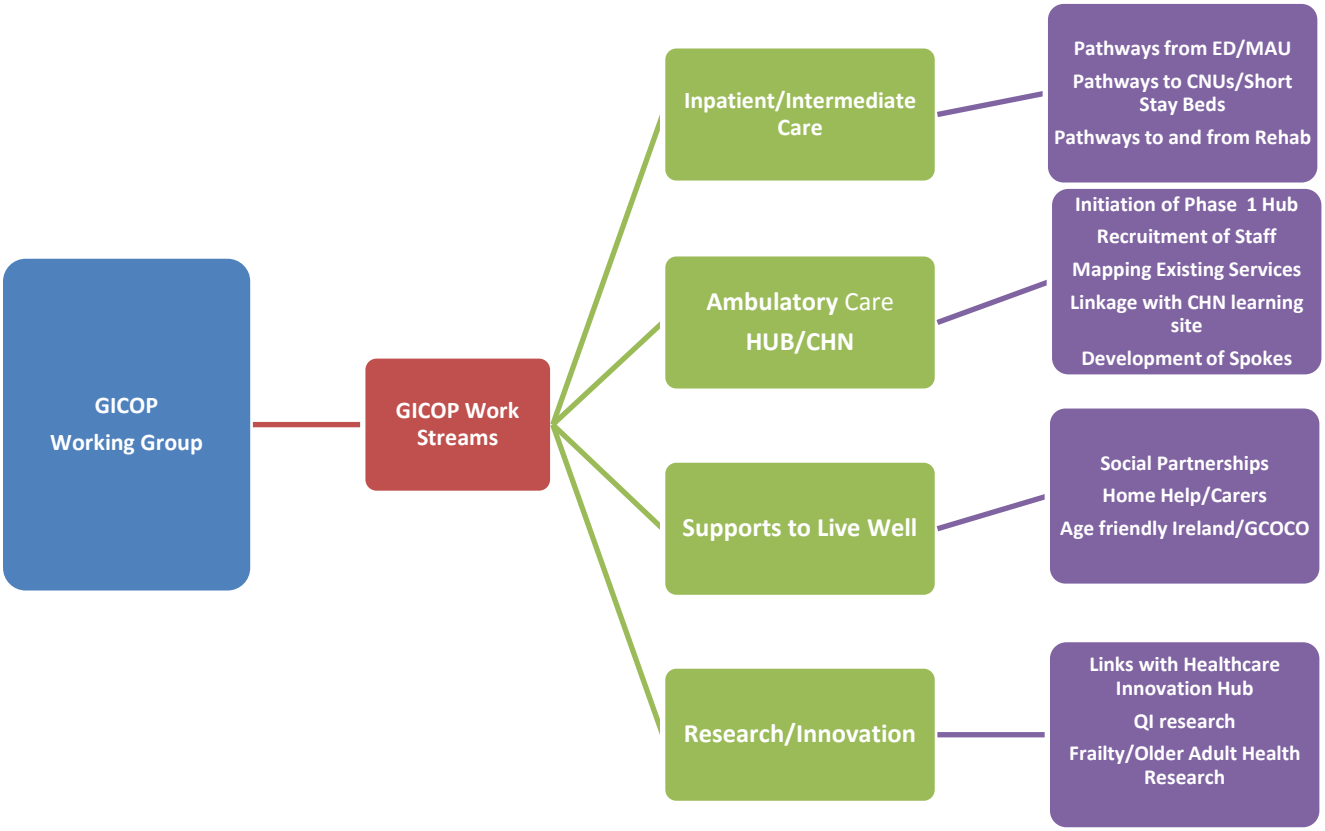
The scope of the local implementation group would also address the following;

- 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)

PJ Harnett, Des Mulligan, Jennifer Hardiman September 2020

Examples of local governance structures (Galway)





PJ Harnett, Des Mulligan, Jennifer Hardiman September 2020

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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)
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4. Nicholson, C. Jackson, C. Marley, J. (2013) A governance model for integrated primary/secondary care for the health-reforming first world. Results of a systematic review. BMC Health Services, Research, 13, 528.

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