Practice Guidance for Older Person
Multi-Disciplinary Teams

National Integrated Care Programme, Older Persons
Foreword

We are delighted to support the publication of this guidance document on Multi-Disciplinary Teamwork. The guidance is important in the context of the implementation of the Enhanced Community Care Programme under Slaintecare. This programme represents the single biggest transformation of community services in decades and Multi-disciplinary teams are one of the central pillars of this.

Whilst the content of this guidance reflects the design and implementation of a new service model for older persons, the insights are universal and reflect good practice in MDTs irrespective of location or focus. We welcome this important publication as part of the reform agenda.

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The implementation of Slaintecare, as it embodies major policy changes to health and social care delivery in Ireland, is significantly dependant on high functioning multi-disciplinary teams (MDTs). Much of the research that supports the content of this guidance has its origins in foundational work by community based multidisciplinary teams in mental health. Insights into how best to organise and sustain these teams has evolved over the past 30 or more years. Working in MDTs poses professional and organisational challenges and therefore merits attention. Challenges associated with governance, operational service models, community delivery of care etc are all important and complex issues. Meeting all of these challenges are necessary in order to deliver new, age attuned, user friendly health and social care models. We are confident however that working in this way will enrich the working lives of staff and improve outcomes for service users.

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(on behalf on National Integrated Care Programme, Older Persons)
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Executive Summary

The policy shift towards enhanced community care delivery in Ireland (Slaintecare 2018), is significantly dependant on high performing interdisciplinary teams. The older persons service model design is founded on an end-to-end, integrated care pathway between various multi-disciplinary teams (MDTs) within Community Health Networks, Specialist Community Teams (Older persons), Front Door and inpatient teams in Acute Hospitals. The overarching aim of multi-disciplinary teams is to enable an integrated way of working across disciplines and settings, which improves the quality of care and outcomes for older people and enhances professional working and staff satisfaction.

The challenges associated with the organisation, governance and internal processes for MDTs, as well as the competencies required for interprofessional collaboration are addressed in the four sections of this guidance document.

This guidance seeks to inform the establishment and operation of MDTs and to outline the core principles and processes contributing to high functioning teams. This draws on evidence over the past 30 years and has universal application to any MDT working across healthcare disciplines and environments.

The document introduces fundamental principles and models of MDT working and highlights how high functioning MDTs demonstrate distinct behaviours and unifying principles:

- Commitment to a common purpose or cause – shared goals
- Collective/Distributed leadership – shared leadership roles
- Culture of continuous improvement - measurable processes and outcomes
- Accountability to one another – clear roles and mutual trust
- Personal meaning and connection to a higher purpose
- Open, authentic and honest team environment - Psychological safety

The document also focuses on key MDT functions and internal MDT process specifically.

- Targeting key populations in Community Health Networks
- Understanding demand and capacity of MDT - assessing service utilisation (demand) as well as team turnover (capacity) to ensure target population is reached.
- Clinical Case Management based on comprehensive assessment, ensuring a shared MDT case management approach
- Integrated pathways across primary care, specialist community care and acute care and dedicated primary care liaison function.
- Team shared roles including referral management, triage, assessment, care co-ordination and case closure
- Caseload management including Allocation of cases, Caseload capacity, Case discussion and Case closure
- Accountability and governance including professional, clinical and operational accountability.
- Involving service users and carers in local service design and improvement in tandem with local older person governance groups

Finally, the document addresses Team Development Education and Training and proposes competencies for interprofessional collaboration with recommended training resources.

We are confident that MDTs who follow the principles, processes and competencies outlined in this guidance document will ensure meaningful, productive and effective working lives for staff, whilst improving outcomes for patients and for service users.
1.0 Introduction

1.1 Background

Health and social care systems are recognising that sustainable strategies lie in a population-based health approach which includes a focus on older persons as a key cohort (Curry and Ham, 2011, Farmanova et al 2019). At the heart of this is the need for systems to move from acute, episodic care to longitudinal, coordinated and integrated care models as reflecting the growth in multi-morbidity and complexity of care needs. The development of end to end, integrated and person centred older person pathways of care is integral to Slaintecare (GOI 2021), the National Service Plan (HSE 2021) and HSE Corporate Plan (2021-2024).

The combination of policy and strategic plans to give effect to age attuned, longitudinal and integrated care have been accelerated by the impact of COVID-19 and informed by the Capacity Review (DoH 2018). This has now resulted in substantial investment in community oriented care models, funded through the Enhanced Community Care Programme. This guidance document is written in this context and specifically written for clinical practitioners, clinical leads, operational leads, front line managers, project leads (PMO) and professional heads of discipline. The aim of this guidance is to ensure fidelity to and consistent implementation of the Older Person Service Model in order to deliver the outcomes required of the investment.

A key tenet of the older person service model is the establishment of community based or facing multidisciplinary teams (MDT). These teams are comprised of health care workers from different disciplines working together with older people to help manage identified problems. A MDT structure helps to bridge professional boundaries by breaking down the barriers of cultural and organisational differences that interfere with a seamless (integrated) service experience. Whilst MDTs are recognised as enhancing professional sense of purpose and reward in one’s role, MDTs operating on an interdisciplinary basis will inevitably raise issues associated with authority and accountability and the need to avoid professional silos. In response to that the purpose of this is guidance is twofold;

1. To highlight important internal issues that can enhance the work of MDTs
2. To offer guidance on the principles of good MDT working for Specialist Older persons teams based on the evidence on MDT Operational Practices.

In doing so, it seeks to enhance and harness the best of interdisciplinary practice, whilst respecting the professional obligations and unique contribution of each discipline. This is intended to optimise outcomes for service users, carers and staff. In particular, the guidance draws on a collaborative research initiative between the National Integrated Care, Older Persons Programme (NICPOP) and UCD. This identifies and provides practical guidance on developing core competences for interprofessional collaboration, working in multidisciplinary teams providing integrated care to older people.
1.2 Context

The shift towards models of community care, especially in mental health and intellectual disability services, has long underpinned the need for community based multi-disciplinary teams. This was driven by changing models and associated ideology, consumer preference, efficient use of resources, improved access, co-ordination and team satisfaction (Patmore and Weaver 1992, Audit Commission 2002). Early research into MDTs indicated higher job satisfaction, lower rates of burnout and greater effectiveness (Harper and Minghella, 1997, Onyett et al 1995). Alongside this, challenges associated with multi-disciplinary teamwork were highlighted (Peck and Norman, 1999). Despite early evidence of effectiveness (Simmons and Coid 2001), MDTs in action had been the subject of ongoing debate amongst professional disciplines (Onyett et al 1994) which centred on loss of professional identity and autonomy, unclear governance and muddled team objectives. In the intervening period, greater insights into MDTs have ensured that these early pitfalls can be avoided (Onyett et al 2006, Byrne and Onyett 2010, Onyett 2011).

This guidance seeks to inform the formation and development of MDTs working within the National Integrated Care, Older Persons Programme and funded under the Enhanced Community Care Programme. The guidance is structured into three main sections covering Principles of Multi-Disciplinary Team Working, MDT Internal Processes and Team Development Education and Training. It addresses discrete aspects of MDT functioning in order to ensure that MDTs are productive, enjoyable to work in and effective.
2.0 Principles of Multi-Disciplinary Team Working’

2.1 What is a Multi-Disciplinary Team?

Recruiting a range of disciplines and locating them together does not automatically confer team status on an MDT. Onyett (2011) observed. ‘Teams that do not have at least weekly, well-attended and highly participative clinical team meetings do not warrant the title of ‘team’.

The process of becoming a team therefore needs to be attended to and within that are some key fundamentals such as;

- Having agreed on shared vision, values and goals
- Have generic (common) functions as well as distinct, complimentary roles
- Respect and understand the competencies of others
- Need to learn from other disciplines and respect their different views and perspectives.
- Share competencies and knowledge
- Undertake collective leadership functions based on expertise
- Have authority to act collectively and autonomy to act independently

2.2 Why Multi-disciplinary Teams?

In essence MDTs improve patient outcomes including satisfaction with care. In particular the evidence on improved outcomes for people with complex care needs have underpinned the logic of establishing MDTs (Krishnan et al 2008, Buggy and Moore 2017, Clarke 2013). The evidence underpinning MDTs involves harnessing the skills and expertise of multiple disciplines to manage complex care. This involves deliberately sharing knowledge, leveraging individual and collective expertise, avoiding sequential assessment and duplication, having a common purpose and improving staff satisfaction. MDTs are especially prevalent in mental health, palliative care and oncology where much of the research on MDT functions and roles have been explored (Taylor et al 2013, Chinai et al 2013).
2.3 Behaviours of High Performance Teams

Achieving and maintaining high performance in teams is the subject of substantial interest in sport and business (Blackhall et al, 2013). These characteristics are universal and have applicability in health and social care teams. Successful teams deliberately adopt the following behaviours;

1. commitment to a common purpose/cause
2. distributed leadership
3. a culture of and commitment to improvement (personally and collectively)
4. accountability to one another
5. connect personal meaning to a higher/greater purpose.
6. authentic, honest and open team environment (Psychological Safety)

2.4 Models of MDT working

For the purposes of this document the terms Multi-disciplinary, Interdisciplinary and Trans-disciplinary will be used interchangeably where appropriate and reflecting the stage of implementation of the Older Person Service Model and the stage of maturity of teams. It is anticipated that teams will evolve over time reflecting a Trans-disciplinary approach and this guidance is intended to support this process of team evolution. This will be internally negotiated as teams mature, reflecting contemporary research.

A summary of the difference in terminology is as follows:

**Multi-disciplinary Teams** allow for each discipline to independently contribute its expertise to a patient's care. Typically the Consultant Physician prescribes the contribution of others in the team and team members work in parallel.

**Interdisciplinary Teams** are organised to work on a common set of complex problems. Each discipline contributes their skill set in order to augment and support others in the team whilst taking account of that person's contribution. Members retain specialised roles and functions whilst communicating actively with one another.

**Trans-disciplinary teams** can share common functions and team members are sufficiently familiar with others roles in the team such that roles can be deliberately blurred in order to benefit patient care (e.g. assessment and care co-ordination).

2.5 Integrative team based healthcare

Team structure varies by situation, and is determined by the needs of the patient, the availability of staff and other resources. Team function has been described as ‘a spectrum running from parallel practice, in which clinicians mostly work separately, to integrative care, in which the interdisciplinary team approach is pervasive and non-hierarchical and utilizes consensus building, with many variations along the way’. For MDTs to function in an integrated way, it is essential that they adopt a unifying set of principles that embodies effective teams based on research evidence, (Mitchell, et al 2017, 2021). These principles are:

**Shared goals:** The team including the patient and, where appropriate, family members or other support persons works to establish shared goals that reflect patient and family priorities, and can be clearly articulated, understood, and supported by all team members.
Operational Guidance for Older Person Multi-Disciplinary Teams

Clear roles: There are clear expectations for each team member’s functions, responsibilities, and accountabilities, which optimise the team’s efficiency and often make it possible for the team to take advantage of division of labour, thereby accomplishing more than the sum of its parts.

Mutual trust: Team members earn each other’s trust, creating strong norms of reciprocity and greater opportunities for shared achievement.

Effective communication: The team prioritises and continuously refines its communication skills. It has consistent channels for candid and complete communication, which are accessed and used by all team members across all settings.

Measurable processes and outcomes: The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team’s goals. These are used to track and improve performance immediately and over time.

2.6 Team Culture & Leadership

Team effectiveness and performance is dependent on more than having the right combination of personalities and skills working together. Wooley (2010) concluded that in tandem with other authors referenced in this guidance, that components such as dependability, structure and clarity, meaning and impact are essential for effective teamwork. Wooley particularly emphasised that Psychological safety was the single biggest predictor of team success.

Psychological Safety

Psychological safety describes a team climate characterised by interpersonal trust and mutual respect in which people are comfortable being themselves and have confidence to speak up. The climate of psychological safety involves practices that are deliberately attended to including:

- Fostering respectful and compassionate interactions
- Participative safety to safely challenge assumptions and beliefs
- Peer supervision to support teamwork
- Reflection on team functioning and performance
- Openness to innovation
- Collaborative interdisciplinary project
- Shared opportunities for learning (in-house education schedule)

Collective Leadership

Leadership is described as ‘the most influential factor’ in shaping organisational culture, with good evidence of links between leadership, culture, climate and outcomes in healthcare (West et al 2014). Leadership with a strong emphasis on hierarchy can inhibit a positive safety climate due to fear of blame and repercussions for reporting issues (D’Innocenzo, et al 2016, Hartmann et al., 2010). Collective leadership on the other hand predicts team effectiveness (West et al 2014) and is a better predictor of team performance than vertical leadership (Ensley et al., 2006).

Collective leadership is cultivated by the teams formal leadership and expressed in the interaction of team members by sharing leadership responsibilities. It is a dynamic leadership process in which a defined leader, or set of leaders, selectively utilise skills and expertise within a network, effectively distributing elements of the leadership role as the situation or problem at hand requires” (Friedrich et al., 2016).
3.0 Multi-Disciplinary Team Internal Processes

3.1 Key functions of Specialist Older Person Community MDTs

The logic behind establishing specialist multi-disciplinary teams is predicated on the evidence that MDTs improve outcomes for users/carers and improve staff working lives. As indicated, this is especially important where complex care needs are involved. A substantial investment has been made in specialist, older person MDTs designed to address the needs of older persons irrespective of location in the care ecosystem. The fundamental design is based on an end to end (integrated) care pathways between Community Health Networks, Community MDTs, Front Door frailty Teams in Acute Hospitals and in-patient pathways. The following functions are key design principles;

**Targeting key populations in Community Health Networks**
- Teams will utilise available business intelligence to proactively target population cohorts that require optimisation of care needs. This includes older people at home and in residential care.

**Understanding demand and capacity of MDT**
- Teams will utilise business intelligence to assess service utilisation to ensure target population is reached (see Appendix 4). This also means understanding the rate of service utilisation (demand) as well as team turnover (capacity). This involves an understanding of how many cases each member (and by extension the team) can safely manage and what turnover is required to maintain capacity (See Section 3.4).

**Case Management based on Comprehensive Assessment**
- As well as undertaking comprehensive assessment, MDT team members will case manage care until outcomes are optimised. This will include teams agreeing with other care provides (primary and secondary care) how meeting care needs are shared.
- The needs of people with complex care needs requires proactive care co-ordination, with MDT members sharing that function (referred to as assertive case management).
- Clinical management will be person-centred and may include enhanced management/interventions in peoples own homes or in other community settings.

**Integrated pathways and liaison function**
- MDTs need to adopt an agile stance, working with people where they present and ensuring access to team expertise. This involves adopting a flexible approach within the boundaries of the team role and functions. This function is undertaken through in-reach (e.g. to hospital pathways) and outreach (e.g. to residential care). These liaison functions do not substitute for the substantive responsibility service functions and ownership of the services in question.
- MDTs should nominate team members to undertake a dedicated primary care liaison function. This includes capacity building through consultation and education, advice on process (e.g. referral pathways) and guidance/education on discrete management of patients.
3.2 Ambulatory Care Hub Base

Teams will be based in and function from an Ambulatory care community hub and will adopt a deliberate stance of being accessible to community dwelling older persons. This will be reflected in their referral policy and associated response such as timely response at the point of referral.

- An Ambulatory Hub is referenced in the Older Person and Chronic Disease Service Model and associated publications (NICP OP 2020). The Ambulatory Care Hub can be located in a variety of physical locations depending on the availability of local infrastructure. This can include Primary Care Centres, Day Hospitals or other community locations. The fundamental functions are:
  > Provide an MDT base
  > Enable ease of access to service users/carers
  > Facilitate operational service delivery and strategic development
  > Act as a focal point of service co-ordination across integrated care pathways

- The purpose of the hub is to act as a single point of access to provide specialist secondary care to older adults with complex care needs and chronic disease, for a defined period of time. The multi-disciplinary team based in the hub will receive referrals from primary care or acute hospital teams based on specific referral criteria (refer to Appendix 1).
3.3 Team shared roles

To fully realise the benefits of an MDT, it is essential teams have shared essential, interdisciplinary and transdisciplinary functions. These typically include.

1. Triage

Central to the triage function is a single point of access. This is especially important with target groups that are hard to reach, require complex care, are already known or other need to refer when patients are unable to seek help (Watson et al., 2005).

Team members should rotate this function. Some teams may choose to operationalise this by having a triage rota. This could include a day or week on triage and where their primary function is to screen, work up and/or divert referrals as appropriate. A ‘duty week’ is where a team member assumes triage functions on behalf of the team for a working week. This has the advantage of being able to work up a referral and get background information over a few days. This allows referrals that are not appropriate for the team to be diverted safely.

2. Common Assessment

• A common assessment function has several advantages. It allows team members to develop competencies based on a common assessment function (e.g. using InterRAI). It also exposes team members to areas less familiar (e.g. Polypharmacy) and in turn improves intra team dialogue. It means that siloed professional functions are minimised and allows all to have a common purpose. This includes the formulation of a provisional care plan on behalf of a team.

3. Care co-ordination

• Team members, irrespective of discipline should undertake a care co-ordination function. The details of care co-ordination/case management are set out in Appendix 2. Whilst case management has a broad function, care co-ordination at a minimum involves proactively supporting patients to access services, avoid duplication and optimises outcomes. This is achieved by travelling the care journey alongside the patient and carer.

4. Patient Referral, Assessment, Case Closure Process

• The Patient Pathway including referral management, assessment and case closure, is illustrated in Figure 1. A detailed description of this pathway is given in Appendix 5.
Figure 1: Patient Referral, Assessment, Case Closure Process

ICPOP Specialist Ambulatory Care Hub - Patient Pathway

1. GP/PHN/HSCP or other health care provider involved
2. Residential Care facility
3. Patient or Carer (if known to service)

- MDT Duty members receive Healthlink referral alert and screen referral on receipt
- Patient attends appointment (f2f/virtually)
- Clinical involves MDT
- Case manager assigned - first contact family/carer
- Commence CGA (InterRAI)
- Make appointment
- Liaise with MDT colleagues

- Falls
- Frailty
- Dementia
- Other

- CGA and Care Plan completed by MDT (InterRAI)
- Patient referred via Healthlink
- Discharge to Primary Care/Home with supports

- Falls
- Frailty
- Dementia
- Other

- Patient referred via Healthlink
- Refer Patient to acute hospital

- MDT Duty
- MDT weekly Meeting

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3.4 Caseload Management

Teams need to clarify target group, associated functions and interventions offered. Once agreed, this provides the foundations of team processes. These team processes may take place collectively or individually. Some key issues that are important in terms of team include;

Allocations of cases

- Cases need to be allocated based on a number of factors. This should be not only equitable but based on expertise, skill set and capacity and whether the patient is already known to the team or individual team members. Ideally, a functional caseload capacity process will facilitate this. In the first instance the primary question to be addressed by teams are concerned with;
  - Is this the group we are established to serve?
  - Will our involvement optimise outcomes?
  - What (broadly) are we trying to achieve?

Caseload capacity

Teams have limited capacity. Clarity about target group, associated functions and interventions offered will substantially influence team caseload capacity. Clearly there is a need for case turnover and limit any waiting times.

The team will need to ascertain the capacity of each discipline treating the complex older person and which ‘strands’ of care will be delivered by the relevant disciplines. Things to consider:

- The service users’ potential and ability to engage, does this older person require support to make a decision? Note: Some people may need help to be able to make a decision or to communicate their decision. This does not mean that they lack capacity to make the particular decision.
  - In line with the Assisted Decision Making Act (Capacity) 2015 staff have a duty to make every effort to encourage and support the relevant person to make the decision themselves. Further information on how a person can be supported to make a decision can be found on the Decision Support Service website.
  - What are the key and high priority team goals for this older person?
  - Are these goals functional and achievable?
  - What are short term and long term objectives?
  - What is holistic, integrated and realistic based on a person’s needs, personal strengths, formal and informal supports & desirable but realistic outcomes.

It is advised that the teams adopt a caseload management system based on caseload weighting. This is typically based on Risk, Complexity, Time and other factors. This is essential to maintain team function and avoid individual professional burnout.

Caseload management/caseload weighting

Caseload management is essentially a key element of care integration for the most vulnerable patients. Frequently patients have high levels of cognitive impairment and social vulnerability. Some established tools are used by teams to monitor and manage team capacity in order to ensure safe and equitable distribution of caseload (Korasz et al 2018, Spernaes et al 2017). The active caseload management will therefore depend on a number of these variables. The capacity of case managers should principally be determined by complexity, risk, care co-ordination as well as the operational older demographics of a given area and the levels of socio-economic deprivation.
The tables below are a sample of caseload weighting for illustrative purposes only

### Table 1. Risk score

<table>
<thead>
<tr>
<th>Present risk</th>
<th>History of risk behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>High and imminent apparent risk and danger - 5</td>
<td>High - 5</td>
</tr>
<tr>
<td>High apparent risk but no immediate risk to others - 4</td>
<td>Moderate - 3</td>
</tr>
<tr>
<td>Medium or significant risk which is manageable - 3</td>
<td>Low - 1</td>
</tr>
<tr>
<td>Low apparent (risk which is manageable - 2</td>
<td></td>
</tr>
<tr>
<td>Very low risk - 1</td>
<td></td>
</tr>
</tbody>
</table>

### Table 2. Relapse score

<table>
<thead>
<tr>
<th>Occurrence of relapse</th>
<th>Inpatient stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>3+ in last 2 years</td>
<td>3+ admissions in last 2 years - 5</td>
</tr>
<tr>
<td>1-2 in last 2 years</td>
<td>1+ admissions in last 2 years - 4</td>
</tr>
<tr>
<td>3+ in last 5 years</td>
<td>1+ admission in last 5 years - 3</td>
</tr>
<tr>
<td>1-2 in last 5 years</td>
<td>5+ years since last admission - 2</td>
</tr>
<tr>
<td>None in last 5 years</td>
<td>Not previously admitted - 1</td>
</tr>
</tbody>
</table>

### Table 3. Needs score

<table>
<thead>
<tr>
<th>Client’s needs</th>
<th>Interference with daily living activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple needs, severe symptoms and chaotic lifestyle - 5</td>
<td>High - 5</td>
</tr>
<tr>
<td>Multiple needs and severe symptoms - 4</td>
<td>Moderate - 3</td>
</tr>
<tr>
<td>Multiple needs and moderate symptoms - 3</td>
<td>Low - 1</td>
</tr>
<tr>
<td>Low level of needs - 2</td>
<td></td>
</tr>
<tr>
<td>High level of functioning - 1</td>
<td></td>
</tr>
</tbody>
</table>

(Ref; Spernaes, et al 2017)
Case discussion

- In addition to informal consultation, time needs to be set aside (ideally weekly) to discuss complex live cases and to encourage collaborative problem solving, organising services around the user. This acts as an opportunity for sharing expertise, experience and skill sets for all MDT members. It also supports complex decision making and augments good team governance.

- Daily telephone or a video call “huddle” between team members is good practice for a maximum of 10-15mins, if not every day then at least Monday and Friday to review weekend out of hours activity or to anticipate potential adverse activity going into the weekend with a view to alerting backup services e.g. CIT. If family and carers are prepared with a clear plan of when and who to call out of hours they are less inclined to default to acute hospital care as the first option.

Case closure

- A clear process needs to be in place to safely close cases. This is addressed at a weekly meeting and allows teams to agree closure decisions. This is necessary to maintain capacity and to ensure speedy access. Case closure decisions are closely linked to and dependant on clarity associated with team role and function. The decision to close cases is taken in light of having optimised the teams' involvement. The concept of optimisation is important in that it sets a realistic aim for MDT input without necessarily addressing every need identified. Decisions should be ideally by consensus, although in exceptional circumstances, a process for resolving difference of professional opinion on a case needs to be agreed amongst appropriate professional leads. This may include agreeing a contingency plan beyond closure and include a plan regarding further management post closure and options for re-referral. A typical, high level process map is outlined in Figure 1 with process details outlined in Appendix 5 (Onyett S and Byrne M, 2010).

- Prior to closing a case, the team will need to consider if there are any individuals that are required to be “co-opted” on to the MDT discussion outside of the NICPOP team, e.g. specialist team reps such as chronic disease, palliative care professionals, carers or advocacy services, to enable a collaborative and safe case closure.

- Access to the range of community services, self-management/prevention, home visits, falls/bone health interventions should be explored and utilised?

- Consideration needs to be given to whether any other joint interventions between the MDT and other services such as Primary care need to continue and a decision made regarding the case closure status, is the case considered open while joint interventions between services continues?
3.5 Accountability and governance

Addressing tiers of governance within MDTs is fundamentally important. Good governance is about leadership, planning with clear goals and objectives, defining reporting lines and ensuring the systems/processes are understood by the stakeholders involved. Governance is not only about compliance it is also about performance. This generally operates at three levels;

- **Professional accountability** - There is a level of specialist competence unique to each health care profession. All team members retain their professional accountability, exercised through their governing body (e.g. CORU or NMBI) as well as accountability to their professional line manager. This includes functions such as professional support, development and supervision on professional competencies and skill sets. All professions must demonstrate working within their scope of practice and are liable professionally and legally for the consequences of their decision making. Practitioners are professionally accountable to their line manager, working within their scope of practice, within the limits of their knowledge, skills, competence, experience and are appropriately supervised.

- **Clinical accountability** - within MDTs various models operate.

  Clinical Governance is a framework through which healthcare teams are accountable for the quality, safety, and satisfaction of patients in the care they deliver (Mc Auliffe 2014). It is built on the model of the CEO/GM/Head of Service or equivalent working in partnership with the Clinical Director, Heads of Discipline and Director of Nursing/Midwifery. A key characteristic of clinical governance/accountability is a culture and commitment to agreed service levels and quality of care provided.

  Clinical governance is described as the system through which healthcare teams are accountable for the quality, safety and satisfaction of service users in the care they have delivered. For healthcare staff, this means specifying the clinical standards you are going to deliver and showing everyone the measurements you have made to demonstrate that you have done what you have set out to do (HSE, 2012a).

  Clinical governance helps ensure people receive the care they need in a safe, nurturing, open and just environment arising from corporate accountability for clinical performance. The benefit of clinical governance rests in improved patient experiences and better health outcomes in terms of quality and safety. This has resulted in the clinical governance approach being widely adopted internationally (HSE 2012b).

- **Operational accountability** - a clear operational policy, developed and agreed by team members and supported by the organisations executive governance is critical to outlining how the team operates. A matrix of accountability will outline how the dual (operational and clinical accountability mechanisms operate). A sample guide to an Operational Policy is offered in Appendix 3. Some prompts used to clarify transdisciplinary and interdisciplinary roles (HIQA 2012) include;

  > Who leads our team?

  > Who are the members of our team; do we all know each other and understand each other’s roles?

  > Are we clear about our team roles and responsibilities, who we report to, and our lines or communication?

  > What arrangements do we have in place, so that we know who is always the named consultant/clinician/key worker responsible for each patient’s care?

  > Are we meeting the code of conduct and expected behaviour of our organisation and professional bodies?
• **Integrated roles and governance**

The importance of good governance, organisational and clinical has been a recurring theme (NICP OP 2018) and cannot be overstated. In the context of scaling up older person specialist teams and associated service model, a central tenet of the NIPCOP engagement with sites referenced ‘servicing the care pathways’ as a priority over organisational boundaries and associated constraints. The philosophy and values underpinning this, focus on putting the needs of the patient and carers at the centre of the strategic planning and operational delivery (NICP OP 2019). In addressing this, it is recognised that the demands on new governance structures are multifaceted in that they need to attend to the requirements of staff, managers, patients and carers. In doing so, it simultaneously addresses safety and quality, efficiency and effectiveness, career progression, improvement and innovation. The work of Gullery (2014), set in the context of implementing integrated care, highlights the critical functions to be addressed by good governance. She describes governance working at multiple levels in order to meet all stakeholders needs and give the necessary assurance and incentives to mobilise implementation.

1. Strategic - Population focus, joint planning, integrated ICT, shared measurement
2. Organisational - shared resources, supporting innovation, change management.
3. Clinical - supporting new ways of working, professional development, interdisciplinary learning, new clinical models care pathways.

**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.).

<table>
<thead>
<tr>
<th>Local Change/ Improvement Structure</th>
<th>Bottom up transformation which is clinically and operationally led</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Strategic</td>
<td>Clinically and operationally led through engagement with</td>
</tr>
<tr>
<td></td>
<td>frontline staff so that the approach is culturally embedded.</td>
</tr>
<tr>
<td>2. Organisational</td>
<td>Local acute Hospitals and CHOs own the change/improvement</td>
</tr>
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<td></td>
<td>initiatives and collaboratively within local structures to</td>
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<tr>
<td></td>
<td>implement them across the local care pathway.</td>
</tr>
<tr>
<td>3. Clinical</td>
<td>Models of care will be delivered collaboratively across</td>
</tr>
<tr>
<td></td>
<td>Hospital Groups and CHOs</td>
</tr>
<tr>
<td></td>
<td>• Adopt a philosophy that shares resources and benefits.</td>
</tr>
<tr>
<td></td>
<td>• Local governance will pursue a population approach</td>
</tr>
<tr>
<td></td>
<td>whereby the resources available are mobilised to support</td>
</tr>
<tr>
<td></td>
<td>the delivery of the service model.</td>
</tr>
<tr>
<td><strong>Joint Approach to implementation</strong></td>
<td><strong>Programmatic Governance</strong></td>
</tr>
<tr>
<td></td>
<td>A structured programmatic approach</td>
</tr>
<tr>
<td></td>
<td>• The proposed governance provides a mechanism for accountability for implementation which is locally owned and nationally enabled.</td>
</tr>
<tr>
<td></td>
<td>• There is clarity on a tiered approach to escalation to allow decisions to be made at the appropriate organisational level.</td>
</tr>
<tr>
<td><strong>A national service model enables</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The national system will provide a clear roadmap and supports for delivering the model. This will attend to key enablers (ICT, HR, Data, Finance).</td>
</tr>
<tr>
<td></td>
<td>• There will be a consistent focus and clear communication around goals and a commitment to shared learning across the system.</td>
</tr>
<tr>
<td></td>
<td>• There will be a clear approach to addressing Capacity and Enabling supports over an agreed timeline.</td>
</tr>
</tbody>
</table>

![Figure 1. Change approach](image-url)
Operational Guidance for Older Person Multi-Disciplinary Teams

- **Supervision and Performance Management** - The Head of Discipline and the Director of Nursing will work closely with the ICP POP Operational Team Lead and will provide clinical assurance through supporting development of models of care, providing clinical supervision, supporting reflective practice and supporting professional development. Appropriate governance is assured by setting out clearly defined roles as well as the accountabilities and responsibilities for each of the roles. The matrix in Appendix 6 offers guidance for the role of the Head of Discipline and the Director of Nursing in providing clinical assurance. The Operational Team Lead, the Head of Disciplines and the Directors of Nursing will work collaboratively and with the integrated team to support service development and to ensure practices are evidence based.

### 3.6 Involving Service Users and Carers in local Service design and improvement

Designing and delivering integrated care for older people across local communities and hospitals is a multifaceted, collaborative process between providers, users and carers. It involves changing the way health and social care is planned and delivered whilst ultimately focusing on patient experience, outcomes and quality of care needs. The Positive Ageing Strategy *(DOH 2013)* recognises that all sectors of society - government, businesses, voluntary groups, service providers, and the general public - have a part to play in creating an age friendly society. City and County Age Friendly Alliances (AFI), involving senior decision makers from statutory, commercial and not-for-profit organisations, are already working on co-ordinating the work of all key players at a local level in putting the views, interests and needs of older people at their core*. The NICPOP has adopted a co-production approach to service improvement in a Memorandum of Understanding with AFI where the voice of the older person is placed at the centre and given equal importance with service providers in the design and implementation of service improvements within the NICPOP.

At a NICPOP team level, team members can strive to involve service users and/or carers at all levels – one to one, groups, community consultation and service development, improvement and design adopting the Nothing About You Without You principle. *(https://www.sageadvocacy.ie/media/1336/quality-standards-for-support-and-advocacy-work-with-older-people-final-061015.pdf)*. The approach adopted reflects Arnstein's Ladder of Participation *(Stewart 2013)* whereby citizen engagement reflects the philosophy of the DOH Slaintecare Implementation, Strategy and Action Plan 2021-2023 *(DoH 2021)*. The methods used typically include feedback forms, cc’ing service users on discharge letters, ensuring service users are consulted on every aspect of both their care beginning all assessments/contacts with What Matters to You?

The **first step** in the engagement process is for local older person governance groups (i.e. ICP OP/ECC Governance groups), to engage with their local Age Friendly Alliance and Older Persons Council. Engaging with the Age Friendly City and County Programmes enables co-production to be operationalised in the development of a holistic approach.

The engagement with the local Age Friendly structures provide an opportunity to;

- Create awareness of the NICPOP and the aims of the local project.
- Allow for a clear line of communication between the local steering group and older people.
- Facilitate the recruitment of local Older Persons Patient Champions.
- Facilitate the co-production to service improvement process as outlined below.

Full details of the approach involving HSE staff, older people, other state agencies and third sector organisations can be viewed on the NICPOP website here

[www.icpop.org](http://www.icpop.org)
4.0 Team Development - Education and Training

4.1 Competences for Interprofessional Collaboration

The European Competency Framework for Health and Social Care Professionals working with Older People (Dijkman et al., 2016) describes the outcomes that interdisciplinary care teams providing care to older persons are expected to achieve and demonstrate in their different roles (seven roles in total). However, there is limited guidance in the literature regarding how inter-professional collaboration could be fostered and sustained in the context of integrated care for older people. In order for interprofessional collaboration to be successfully integrated into contemporary older peoples’ health and social care, in Ireland and perhaps, internationally, there is a need for a commonly agreed upon competencies framework. Core competencies that focus on the process of bringing organisations, professionals and clients together, that implement a coordinated approach to shared decision making with the overall aim of improving outcomes for patients and service users through the delivery of integrated care.

An applied research partnership project funded by the HRB and the National Integrated Care Programme for Older Persons, HSE, was led by Dr. Deirdre O’Donnell at UCD, in collaboration with the NICPOP Interprofessional Working group, with the aim of co-designing a framework which would describe the core competencies for interprofessional collaboration within integrated care teams for older people (Anjara et al., 2020). The research has led to the development of a framework for the National Integrated Care Programme for Older People (NICPOP), entitled, “Getting Started in Developing Core Competences for Interprofessional Collaboration in Integrated Care for Older People: A Step by Step Guide” (O’Donnell et al. 2021).

The framework identifies and describes the core competences for interprofessional collaborative working in multidisciplinary teams providing care to older people and provides teams with a practical guide for developing and evaluating these competences. Three competency domains were identified from the co-design process which describe a total of six core competences (See Figure 2). Domain one, Knowledge of the Team, includes the competences; understanding roles and making referrals. Domain two, Communication, includes the competences; sharing information and communicating effectively and Domain three, Shared Decision-making, include the final two competences; supporting decision making with older people and collective clinical decision-making.
The domains of competence represented in the framework model (figure 2) are mutually exclusive but collectively they are exhaustive in their description of the competences required for effective interprofessional collaboration in the care of older people. The six competences are reciprocal whereby proficiency in one supports proficiency in the next. For example, when team members demonstrate an understanding of team roles, they are supported in making effective referrals which in turn supports sharing of information and so forth. In the model, domains are grouped by colour and reciprocity is illustrated through the use of cyclical arrows. The framework provides practical operational guidance to teams in getting started in developing and monitoring performance in respect of each of the six core competences.

### 4.2 Education and Training Resources

MDTs are tasked with the implementation of a national change agenda at the front line. They are required to focus on developing new ways of working that will improve patient pathways and experience, and create system wide benefits. They are tasked with creating clinical network hubs in their areas, working in an integrated way with primary care, community health networks and acute hospital colleagues as well as supporting older people to live well at home by engaging with the ecosystem of statutory and voluntary supports available.

Whilst the operational processes outlined in this document are the nuts and bolts of how a team will operate on a day-to-day basis, it is critical that multidisciplinary teams are supported to develop high functioning transdisciplinary team capabilities and build relationships and mutual understanding of each other’s roles, develop clarity of goals and effective feedback processes to maximise the impact and performance of their teams.
The following resources are available to support

- The UCD Co-Lead Toolkit is a series of modules designed to enhance collective leadership among multidisciplinary healthcare teams. The modules were developed from research undertaken over five years, “Collective Leadership and Safety Cultures”, sponsored by the HRB and the HSE. The modules take the form of group workshops, each lasting approximately one hour. There are six core modules, which should be undertaken first, to introduce the principles and outcomes of collective leadership, and provide tools to achieve them. Teams may then choose from thirteen targeted modules which focus on specific areas for improvement, based on what they feel is needed. The co-lead toolkit will be published shortly and circulated to teams/sites as soon as available.

- The Framework for the National Integrated Care Programme for Older People (NICPOP), “Getting Started in Developing Core Competences for Interprofessional Collaboration in Integrated Care of Older People: A Step-by-Step Guide”. It describes the knowledge, practices and skills required for demonstrating proficiency in six core competences for interprofessional collaboration. Furthermore it provides practical operational guidance for teams to get started on building and monitoring these competences. This guidance incorporates, among other things, the Co-Lead modules which are aligned to each of the six core competences contained in three domains: knowledge of the team; communication and shared decision-making.

- The “National Frailty Education Programme”, is a one-day education programme open to all healthcare professionals working with older adults. The aims of the programme are to provide healthcare professionals with an enhanced understanding of frailty and frailty assessments, ensuring early recognition of frailty, improved healthcare management and better health outcomes for frail older adults. The programme incorporates key research findings from TILDA, provides an overview of theoretical models underpinning frailty and frailty assessment tools. The programme is available online at www.hseland.ie. Face to face programmes are delivered by hospital/CHO frailty facilitator networks.
Special Purpose Award; Certificate in Principles of Integrated Care

A collaborative between the International Foundation for Integrated care (IFIC) and Munster Technological University (MTU) has resulted in the development of an online accredited award (level 9, 15 credits) in the Principles of Integrated Care. This programme was developed with practitioners, managers and policy makers as target audience. The programme recognizes that an increasing cohort of practitioners will occupy roles in community and primary care settings. This means that there is a further level of expertise required for practitioners who have more direct interface on a longitudinal basis with people who have ongoing needs. The SPA in Principles of Integrated Care will expose students to key tenets of integrated care as foundational module. In that regard, a heavy emphasis is placed within the module content on;

- Vision and values unpinning integrated care
- Engaging people and communities as partners in care
- Exploring new ways of working
- Addressing leadership and governance models
- Understanding the role of technology
- Improving outcomes for all

Detailed information about the programme can be found [here](#).
Appendix 1 - Referral Criteria to the Ambulatory Care Hub

The framework of the IPCHS, Integrated People-Centred Health Services (IPCHS, WHO 2016), describes the complex nature of care for those with multiple needs. The challenge is managing and delivering this services so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, co-ordinated across the different levels and sites of care within and beyond the health sector and according to their needs across their life course’ (WHO, P2, 2016).

The older person referred to the NICPOP specialist teams will be over 65 with complex care needs. The older person with complex care needs may have multiple chronic conditions and concomitant functional impairment (Wodchis et al, 2015) affecting >1 discipline domains (i.e. physical, mental and social), that at some point, require a co-ordinated case management by multiple, skilled disciplines (Ahmed et al 2021). The profile of older persons referred to the ambulatory hub/community specialist typically have a decline in cognitive and functional abilities, reduced mobility or recurrent falls, concomitant social vulnerabilities such as a collapse in care arrangements and co-morbid medical need. They will consequently be at risk of ED presentation/admission if an intervention is not undertaken and will require a comprehensive geriatric assessment (CGA) and time limited case management to optimise their outcomes. He/she is often stratified as high risk; at risk of falls, frailty, dementia, pain, disability and/or social social exclusion/issues. They require a comprehensive geriatric assessment (CGA), case management and access to bespoke frailty, falls, dementia, primary care, rehabilitation, palliative and/or outreach nursing home integrated care pathways as indicated.
Appendix 2 - Case Management

Case management function for older people with complex needs

Introduction

Case Management is a complex function that involves organising and coordinating care. It forms a cornerstone of a new way of working that proactively identifies (case finds) and delivers secondary care in the community for older adults with complex needs and long term conditions such as frailty. The flexibility and adaptability of case management models is a key strength as approaches can be tailored to suit a diverse range of settings and locations. Emerging evidence suggests that case management approaches have a key role to play in achieving improvements in clinical care, system level and patient-oriented outcomes. The benefits of this approach are most significant for individuals ‘at risk’ of hospitalisation and for those living with multiple health problems (ICP OP 2018). A case management function involves collaborative and multidisciplinary approaches to organising and coordinating care for the individual.

It typically comprises of a case finding, needs assessment, care planning, care coordination and case closure.

Clinical Case Manager for Older Persons

Case Management is “a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs, through communication and available resources to promote quality cost-effective outcomes.” (Case Management Society of America, 2008).

The prevalence of polypharmacy in particular requires the development of strong linkages as part of existing care pathways and future inclusion of pharmacists as core team members on Older Person Multi-disciplinary Teams. Case management necessitates collaboration internally and externally. In the case of managing pharmaceutical care need, MDTs are strongly encouraged to include a time commitment from or collaborate with a pharmacist at key stages of the patient journey (assessment in hospital or community, pre-discharge). This function will expand and become more integral to the core team as MDTs evolve.

The key functions of such an approach are to enable:

• Roles to become key points of access in the system when complex care issues / frailty emerge
• Older people and families navigate the care system across acute and community systems
• Co-ordinated care where multiple services are involved and have sufficient autonomy to guide how those services can be optimally delivered
• Development of care plans based on good quality comprehensive assessment which will anticipate and inform ongoing and likely future care needs over the short-medium term
It is recognised that impact on emergency hospital admissions and bed days are highly dependent on case managers having timely access to alternatives to admission including rehabilitation, community intervention teams, day hospital for older person and other ambulatory care services. A primary aspect of the function is that it operates at the patient interface whether in the community, acute hospital, community nursing unit or day hospital for older persons. The clinical case management function therefore operates most effectively within an integrated care pathway for older people (Stokes et al, 2017). In order for the role to function as designed, there is a need for;

1. A clinical training (to CNM2/HSCP equivalent or above) and have a background in older persons care or be willing to further enhance their training in same

2. Access to an MDT within a HUB to facilitate rapid access assessment of older people with complex needs

3. Have a reporting relationship clinically with the consultant geriatrician and function as part of a core integrated care team

4. Have a managerial reporting relationship to the ICP OP Operational Lead and have a working relationship with the Community Health Network Manager and manager of Older Person services in the network and /or the relevant Director of Nursing (Older Persons or Public Health) or HSCP Head of Discipline.

5. Have access to acute inpatient care records and patient records in the community

6. Be able to access respite and rehabilitation beds in the community in conjunction with an agreed plan of care with the MDT

7. Be able to access a direct route to acute hospital care through the geriatrician when needed

8. Be able to access services that support the older person in their home on an emergency basis including Community Intervention Teams, Public Health Nurse/ Community RGN and home care

9. Have a designated and managed caseload reflective of the acuity and complexity of a designated group of frail older people within a given community health network.
Appendix 3 - Operational Policy Guide

What is an operational policy and why is it important?

The challenge involved in implementing change in health systems is very substantial, especially in relation to integrated care. The change process involves challenges to well established philosophical perspectives, roles and responsibilities, organisational and clinical practices to name but a few. In that context, an Operational Policy serves a number of functions;

- To facilitate discussion on a shared vision of future service model
- To clarify objectives and to ensure coherence to emerging model
- To facilitate teams to think through the detail of their work
- To ensure all parties are clear and committed and act as a point of reference where views diverge
- To provide good governance and institutional clarity
- To address changes to ways of working reflecting current context (e.g. COVID) and emerging opportunities (e.g. Technology)

Local Operational Policies are a subset of local and national policies and fit into the governance structures associated with Quality and Risk.

Scaling up integrated care for older persons, involving a substantial investment of resources is a game changer and a once in a generation opportunity. As people are employed in operational and clinical leadership roles they will address this challenge whilst retaining fidelity to the older person service model. It’s also important to recognise that many services have initiated innovative and valued services. An operational policy is designed to ensure existing good practice and desired changes are successfully merged, that they can be understood and communicated and will be subject to ongoing review.

The following heading (areas) should be attended to;

1.0 Introduction/Purpose/aim of the team(service)

- Service overview (description HUB and blue diagram, etc)
- Brief Introduction/rationale for team (service)
- Define teams population (who does the team work with/target)
- What is the primary aims of the service (e.g. Per service model) (to provide care in the community, reduce/delay long term care admission. reducing avoidable admissions/re-admission, reducing avoidable ED attendees/re-attends)
- Philosophy/model of care(local pathways/model graphic)
2.0 Access

- Referral pathways (open referral system/map of referral pathway)
- Referral criteria (Urgent referrals/non urgent referrals)
- Intake structures and decision making (Duty worker)
- Referral management (feedback/diversion/incomplete)
- Triage, intake and screening process (duty worker/post triage process)
- Allocation processes within team
- Consent to engagement/assessment/Care Plan (capacity/advocate, sharing information).

3.0 Clinical Processes

- Team multi-disciplinary meetings (who is involved, what is their purpose, how often do they meet)
  > Shared team roles and responsibilities for case management (e.g. common assessment and intervention functions reducing duplication)
  > Single point of contact and co-ordination (avoiding sequential assessment)
  > Distinct and complementary roles and responsibilities (e.g. leading specific functions)
  > Collaborative working (e.g. CDM, MH, Pall Care Team, Third Sector)
  > Interdisciplinary screening and assessment process
  > Assessment tools (use of InterRAI)
  > Technologies in use and policy on same (telehealth, remote working, guidance on involving the carer, where the patient should be seen, how the team communicates to other agencies, electronic records)
  > Description of a common assessment with an agreed MDT care plan (frailty, vulnerability, deterioration, non-adherence to treatment)
  > Case management functions (define model of case management)
  > Discharge process (decision making on same)

4.0 Operational processes

- Working hours
- Out of hours management (anticipatory care planning), Out of hours cover and referral system
- Team/service base
- Location of care processes (i.e. Person centred work process, that defines here work gets done (home, clinic) based on balancing accuracy, need, safety, efficiency)
- Team structure and approach to leadership
  > Collective leadership model
  > Reporting relationships (appendix organogram)
- Supervision and leadership (who manages the team day to day and who provides supervision to which job roles)
• Team operational/business meetings
  > who is involved
  > what is their purpose
  > frequency
  > key areas of focus as per service model
  > metrics for strategic and operational improvement (structure and process)

• Shared team documentation
  > referral forms
  > assessment forms
  > care plans
  > additional assessment and planning tools
  > discharge summaries and correspondence

• Data management and returns
• Domicillary and lone working policy
• Virtual consultation management (criteria for use of virtual consultation)
• Safeguarding vulnerable adults (responsibilities of the team members, reporting arrangements, equality and diversity, access to interpreting services, access to faith services)
• Liaison with other teams/agencies (GP’s, Mental Health services, Acute Services etc).
• Inreach/outreach approach
• Caseload management (and weighting)
• Induction of new team members
• Sharing information/documentation

5.0 Quality and Governance

• Governance of quality, safety and performance monitoring and improvement
  > Key performance Indicators and actions,
  > Clinical Audit and QI initiatives
  > Complaints and incidents,
  > Implementation and monitoring of the operational policy
• Data management (responsibility for data collection and return)
• Patient and carer involvement and feedback (EQ5DL)
• Electronic records incident management
• Management of clinical case files (stored, transfer, GDPR)
• Health and safety policies
• Major incident procedure
• Risk register (clinical and operational risks)
• Supervision and Performance management
6.0 Education and research

- Undertaking MDT training common to all (e.g. understanding the effects and side effects of medications for older persons, case management, InterRAI, access to data)
- Team development (e.g. HSE Land facilities, HSE Change Guide, MDT working)
- Delivering training and education to others (e.g. falls, frailty, dementia)
- Educational structures (internal)
- Building team competencies and capabilities for integrated care
- Accessing education (to support team mission)
- Research activities (shared/individual)
- Innovation and learning

7.0 Appendix (what you could include)

- Appendix – references, organisational chart, due diligence document, diagram on how to refer, checklist on discharge, flow chart on how to contact staff, indications for seeking senior medical support, good practice guidance, other teams contact details (CMHT, Bed Manager,)
Appendix 4 - Example of Potential Demand/Capacity Planning

(example for Older Persons - click on document below for link)
Appendix 5 - Sample referral, assessment, closure process

1. A completed specialist older persons template referral form is submitted to the NICPOP team via healthlink.

2. The healthlink system is monitored at least twice daily by the administrator and NICPOP duty manager on call.

3. Administrator acknowledges receipt of referral with referrer and updates the electronic patient registration portal.

4. Duty manager* screens referral and either
   a. Accepts referral and adds to agenda for next huddle to update team
   b. Declines referral, contacts referrer, resolves any minor issues and signposts back to primary care or 3rd sector organisation
   c. Declines referral, contacts referrer and escalates referral to FFD team in ED if acute intervention required.

5. Administrator updates electronic patient registration portal with date of acceptance of referral.

6. Duty manager provides a brief overview of all new referrals received at next MDT daily huddle.

7. MDT huddle assign the most appropriate case manager dependant on patient need, MDT skillset and prior knowledge of patient.

8. Case manager makes contact by telephone with family/carer/patient outlines the service ethos and
   a. Commences the CGA (InterRAI)
   b. Makes an MDT appointment for the older person to be seen in the hub, or visits at home and provides virtual access to the wider MDT

9. Wider MDT see and assess older person and complete CGA (InterRAI).

10. Case discussed at weekly MDT to either:
    a. Agree initial care plan with on-going interventions from NICPOP team
    b. Discharge from NICPOP and refer onwards to specialist older person clinics or other specialist services
    c. Discharge from NICPOP and refer back to primary care with supports.

Duty Manager is an NICPOP team member. Each team member assumes the role of duty manager on a weekly rota system to screen incoming referrals. The working relationship and line of communication between the duty manager and the team administrator is key.
Appendix 6 - Matrix for Clinical Assurance for HSCPs working within the Integrated Care Hubs for Older Persons.

The delivery of high quality care within the Ambulatory Hubs for Older Persons will require close collaboration between the Head of Discipline and the ICPOP Operational Team Lead. Appropriate governance is assured by setting out clearly defined roles as well as the accountabilities and responsibilities for each of these roles. The below matrix has been developed as a resource to support the line management of HSCPs and to define the role of the Head of Discipline in providing Clinical Assurance. Clinical Assurance is provided by the Head of Discipline through a number of methods including supporting the development of models of care, providing clinical supervision, supporting reflective practice and supporting professional development.

This matrix can be used and adapted to support collaborative working between the Operational Team Lead and the Head of Discipline, to ensure delivery of high quality care to service users. Within the Matrix it can be recorded who has responsibility for the identified area, and when there should be consultation before making a decision. This Matrix can be reviewed after a number of months to determine if some fields need to be updated.

| Completed by: |  |
| Role/Job Title |  |
| Date: |  |
| Signature: |  |

### Clinical and Operational Meetings eg Discipline Specific Team Meetings, Discipline specific CPD

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Frequency</th>
<th>Areas identified that will require collaborative working</th>
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### Staffing

- Annual Leave/ Sick Leave/ Parental Leave
- Rotations/ Clinical placements
- Recruitment /Probationary Period/Induction/ Interviews/ Management of Vacancies

### Opportunities/Concerns:
### Operational Guidance for Older Person Multi-Disciplinary Teams

#### Maintenance of Staff Records - eg Management of CORU registration/ Study Leave
- **Record**
- **Comments / Agreed Actions**

#### Agreed Care Pathways and Service Development
- **Areas Identified for Collaborative Management**
- **Comments / Agreed Actions**

#### Training Requirements eg Study Days, Professional Development, Mandatory Training
- **Areas Identified**
- **Comments / Agreed Actions**

#### Opportunities/Concerns:

#### Quality and Patient Safety Frameworks
- **Areas Identified eg Audits/ Risk Register**
- **Comments / Agreed Actions**

#### Complaints / Incident Management

#### PPPGs - eg Clinical Specific / Safeguarding / Video Conferencing

#### Medical / Equipment Alerts

#### Service Planning and Performance Management
- **Areas Identified for Collaborative Management**
- **Comments / Agreed Actions**

#### Management of Aids and Appliance Requests eg Use of Contracts, Clinical Sign Off, Stock
- **Current Process**
- **Comments / Agreed Actions**
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