Developing a Community Nursing and Midwifery Response to an Integrated Model of Care

Consultation Document
March 2017
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<td>National Treatment Purchase Fund</td>
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Foreword by the Minister for Health Simon Harris TD

The Irish health service has seen many challenges in recent years. Our population demographics and the health problems we face as a society are changing. As more people live longer and manage several conditions affecting their health, we need services that support them to remain as well as possible for as long as possible within their own homes and communities. With the increasing complexities and acuity impacting greatly on an already stretched service, we need to be innovative in maximising the potential of the nursing and midwifery workforce to meet the population need and choice.

Our well-educated, highly skilled and experienced nurses and midwives are a valuable resource to our health service. We must ensure that this resource is fully utilised and appropriately applied to optimise patient outcomes and impact. We must create an environment that enables nurses and midwives to provide comprehensive care to individuals, families and communities. Our ambition is to create health services that are responsive to people’s choices delivering a positive experience and outcomes for patients and their carers. Our intention is to improve hospital avoidance, early discharge, patient flow and timely access to health services. One of our challenges lies in building the confidence of each nurse and midwife to develop additional competencies as well as embracing new ways of working and innovative methods of service delivery. This ensures the delivery of care in settings away from the hospital. Nurses and midwives are uniquely placed to work closely with patients and their carers during all stages of their lives. It is important that their point of view is fully reflected in the development of future health policy. This consultation paper has been produced based upon national and international evidence including contributions from professionals in community and acute health services, academic institutions, policy and senior management. It presents an eclectic model and pathway of care that recognises the vision of meeting the patient’s choice and delivery of care near to home. It offers the vision of utilising the primary care centre as the first point of nursing and midwifery contact. It promotes a proactive model of care that is both integrated and interdisciplinary allowing the patient to transit seamlessly between acute and community services.

This Government is committed to delivering sustainable and high quality health services and the Programme for Partnership Government (2016) proposes an ‘expansion of the PHN service with a greater administrative support’. This draft policy paper and the consultation now being undertaken, addresses this commitment. It is one of a suite of policy papers under development within the Chief Nursing Officer’s Office of the Department of Health. Following extensive development of the draft policy I am delighted to launch the consultation paper for national consultation and invite all stakeholders and service users to engage in the national process and to contribute to the development of world class future nursing and midwifery services.

Simon Harris TD
Minister for Health
A Message from the Chief Nursing Officer Dr. Siobhán O’Halloran

Community health nurses and midwives are involved in the delivery of care to service users of all ages and form an important link between primary and secondary care settings, and also between public, private and voluntary services. Following on from the Primary Care Strategy (2001), *Primary Care – A New Direction*, this draft policy proposes to maximize the potential for nurses and midwives to deliver patient services as near to the home as possible within an interdisciplinary team. This approach is based on an interdisciplinary model of integrated care built on pathways that support a holistic approach to patient and community needs.

A key aim of the draft policy is to ensure that all people in Ireland are able to access a community nursing and midwifery service that both promotes health and wellbeing and also provides appropriate care for those who require it.

Our vision is to deliver within the community all nursing and midwifery care that does not need to be delivered in a hospital setting. This integrated model of care will be based and managed within the community with referral pathways of care that transit seamlessly into a hospital setting to be used only when required. The consultation paper sets out how the draft policy can contribute to improving patient and family independence, maintaining well-being and reduce demand on acute services. It is our hope that this consultation process will, through contributions from all interested parties, support the development of a policy which meets service users’ choices and needs as close to home as possible, improve hospital avoidance and patient flow, and ensure timely access to services and early discharge.

The draft policy was developed from an evidence review, international literature, and expert consultation including contributions from such areas as practice, policy, education and management. It brings together what we have learned into practical, evidence based recommendations. The consultation paper on the draft policy should be viewed in the context of existing and emerging Government and Department health policy.

I would like to acknowledge the innovative thinking and hard work of Susan Kent, DCNO in leading the development of the approach set out. I would also like to thank all who have contributed to the development of the draft policy to date and look forward to the discussions that will take place during the national consultation process.

Dr Siobhan O’Halloran
Chief Nursing Officer
Department of Health
Chapter One: Introduction

1.1 Background

In today’s modern healthcare environment, the challenge for Government is to identify and provide an integrated model of care that can deliver an efficient, safe, equitable and cost effective healthcare service. This consultation document is intended to feed into a proposed policy which seeks to outline the key role that nursing and midwifery in the community can play in responding to the challenge of delivering such an integrated model of healthcare. It outlines the proposed model and pathways, as well as the associated governance and leadership, and education and regulatory factors. The ultimate aim of the policy is to contribute to the prevention of ill health and to maintain and promote health and wellbeing in the population.

The central vision of this proposal is for the community health nursing and midwifery service (CHNM) to maximise the delivery of healthcare in the home/community within the primary care team along the continuum of a person’s lifespan. It is envisaged that this delivery model will be facilitated by the reorganisation of the existing community nursing and midwifery workforce to provide proactive rather than reactive care.

The development of the proposed policy has been guided by two core principles:

1. Patient choice; and
2. Developing the nursing and midwifery resource in response to patient and service need.

Its core objectives are to:

- Ensure that the nursing and midwifery resource is equipped to respond to the dynamic health needs of the population in an integrated model of care with an emphasis on primary care; and
- Enable the organisation/re-engineering of nursing and midwifery services in the community to respond to the demands and needs of delivering an integrated care model.

The proposed policy reaffirms the primary care team as the first point of contact for the population in the community setting. The focus of primary care is on the provision of health services to individual patients with immediate health needs.
While no two models of primary care are the same, there is a set of common principles that have been identified, including:

- Improving the health of the nation;
- Individual and community inclusion and ownership;
- Strong clinical leadership to bridge interdisciplinary relationships, innovation programmes and structures; and
- Collaborative data sharing.

(Institute of Medicine (IoM), 2008; World Health Organisation (WHO), 2015)

The importance of primary care as an appropriate setting for the management of most healthcare needs was emphasised by the Department of Health and Children’s strategy document Primary Care: A New Direction (2001);

“...an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social well-being.”

(Primary Care Strategy, DoH, 2001, pg. 15)

Public health nursing shares a common goal with primary care in that it proposes to maximise the health of a community population.

1.2 Policy Aim and Objectives

The proposed policy provides evidence informed recommendations (see Chapter Four) to improve population health, assist in hospital admission avoidance, decrease lengths of stay, and improve patient flow, patient outcomes and satisfaction. It aims to re-strengthen the primary care team as the first point of contact for the population in the community setting. However, the realisation of these objectives demands substantial change to some of the operating assumptions on which health policy and health services are traditionally based, both systematically and system-wide.

This paper recognises both public health and primary care nursing and midwifery services and therefore the term Community Health Nursing and Midwifery (CHNM) is used. It is cognisant of the model of care that is already in place, and outlines an approach to strengthen the response of nursing and midwifery to further enhance care delivery.
It should be noted that this policy is reflective of the broader preferred model of care under development. Central to this broader model is the enhancement of a comprehensive community based health service and an improved integration of care across our health services.

1.3 Approach to Development of the Policy Paper

The Department of Health (DoH) recognises that any strategy for health service reform must be clearly based on population health needs. To that end, the DoH, commissioned a review of evidence to inform policy development on an integrated model of care for CHNM. A consortium of Universities (UCC, NUIG and UCD) led by the School of Nursing and Midwifery, UCC, undertook an evidence review (available at launch of finished policy document). In undertaking the review, national, international and local research and evidence was critically reviewed. Common to the evidence reviewed were the following:

- All countries had registered district nursing services that delivered acute interventions;
- Benefits were associated with the organisation and delivery of nursing and midwifery care centres primarily around preventative or curative care with a strong emphasis on ‘nurse-led’ interventions;
- No single overarching model of nursing and midwifery practice in the community that has been scientifically evaluated had emerged from the evidence review.

(Leahy-Warren et al, 2016)

Although no single overarching model of nursing and midwifery practice in the community emerged from the literature, what did emerge are evidence informed dimensions that can inform an effective model for the future. The essential components of a proposed model of nursing and midwifery in the community for consideration are:

- Right nurse or midwife providing the right care to the right people in the right setting.
- Use of generalist nurse/midwife to support the expertise of the specialist nurse/midwife service in providing care where patients at all levels require such service. The generalist nurse can maintain the patient in their home environment with the support of the specialist nurse when the patient requires additional intervention. This approach will ensure that clinical outcomes are meaningful, lasting and more sustainable.
- Operationalising a model for nursing and midwifery in the community demands a need for strong leadership and effective clinical governance.

(Leahy-Warren et al, 2016)
In reviewing the evidence it is significant to note that all the jurisdictions examined differ to Ireland in that they have dedicated district/community nursing teams that deliver acute interventions to the populations they serve. The title ‘community nurse’ is also used to imply a generalist although this is not always explicit. No variations of the title ‘midwife’ are evident.

Following the completion of the evidence review, further evidence was obtained from international literature and stakeholders. A first round, high level consultation process with key stakeholders was undertaken. Numerous discussions along with targeted workshops were held with stakeholders that identified key elements of synergy between community practice and integrated programmes (DoH units, HSE, academics, international experts, GP colleagues, nursing and midwifery colleagues).

1.4 Current context for change

Public health nursing services have been provided for many years based upon the requirements as indicated in the Health Act (1970). Attempts have been made to align the services with the health needs of the population. However, increases in patient numbers, acuity and complexities of illnesses coupled with reduction in staff and resources have caused the service, for the most part, to limit the original purpose of offering health prevention, protection and promotion (Phelan and Mc Carthy, 2016). We are now challenged further as the healthcare needs of the population change from an acute reactive and infectious disease focus to that of an ageing population with chronic disease. In addition, we face a nursing workforce and nursing leadership shortage (Keepnews, 2011; ONMSD, 2015; Phelan and Mc Carthy, 2016).

In January 2016, the then Minister for Health, Leo Varadkar TD launched the “Strategy for the Office of the Chief Nursing Officer 2015-2017”. One of the priority actions identified was the development of a policy to provide direction on the future provision of nursing and midwifery services in the community to support the overall health reform programme. The Programme for a Partnership Government (2016) proposed an expansion of the PHN service with greater administrative support. The Government’s intention is to provide a service in the community that will reduce the need for hospital attendance and stay. If hospital attendance is required, the duration of the stay should be for the shortest time possible and the transition between acute and community care must be well-managed so that it is effective, efficient and safe. This vision will require organisational restructuring that will include innovative methods of aligning funding with service provision.

Key to any policy development is an understanding and analysis of the current resources available, and their utilisation that will ultimately deliver the policy objectives in practice. Equally important, is an appreciation of the current and future changes that will impact on the capability and capacity of this resource to deliver safe, effective and efficient care.
The impact of an ageing population results in an increased dependency on others. Adding to this phenomenon is the reduction in informal care workers as necessity requires they become part of the workforce. This, coupled with the change in family dynamics affects the outcomes for older persons (World Health Organisation (WHO), 2016). Added to this issue and, witnessed globally, is the disparity of older persons living in rural settings as opposed to urban settings. This creates another dimension of complexity in the provision of services in both rural and urban settings.

The attention to the health of the young and the older population is significant to attain a healthy nation. With sufficient investment in nurses and midwives to focus on a population health approach and preventative focus, maximising the health of the nation can be achieved within the interdiscipli

The current composition of the community nursing and midwifery workforce is varied, with many roles delivering care in this context. A key finding of the analysis is the fragmentation and duplication of governance and accountability arrangements throughout the community settings. This is of substantial importance to the development of an integrated and seamless model of community nursing and midwifery care. In order to offer a safe quality service, reorganisation of this workforce (including governance structures) is necessary e.g. the varying governance arrangements that currently exist for the Community Nursing Units and Community Intervention/Response Teams would evolve to the development of a central point of nursing and midwifery governance and accountability.

In summary, disparities in service provision by nursing and midwifery professions in the community differ significantly in how they are delivered and coordinated. This is usually as a result of the funding and contractual agreements between service providers. Global populations have changed due to factors such as increases in life expectancy, increased ethnic and cultural diversity, advances in health, social and welfare contexts as well as greater care complexity. The combination of ageing populations and fewer younger carers, rising health costs of new treatment modalities and influential effects of technology are further compounding the complexity in service delivery. With concerns over the rising cost of complexities and chronic disease, a change in primary care structures will be required to underpin service provision at affordable levels. What is evident however is that currently there is a variety of nursing roles coupled with an underutilisation of the skills set and potential for optimisation of this workforce across this setting. There are limited if not absent development of advanced nursing and midwifery roles, coupled with a lack of development of advanced skills, such as nurse prescribing. These are central factors for consideration in the development and implementation of a community nursing and midwifery response to integrated care, where the shift in care is
planned from acute to primary health care, in an integrated manner. To realise this goal, the current development and re-organisation of the nursing and midwifery resource is vital.

Chapter Two: Developing the Nursing and Midwifery Response to an Integrated Model of Care

2.1 Evidence informed key principles to inform the development of the nursing and midwifery response

The vision for community health nursing and midwifery is to deliver healthcare in the home/community underpinned by the principles of health promotion, prevention and protection, through a selection of integrated models of care along the continuum of the life course within the interdisciplinary team. To deliver on this vision there is a number of evidence informed key principles that need to be considered.

These include;

- Care in the future will be required to shift from a ‘place’ to a selection of facilities interconnected through a robust infrastructure of shared technology;
- Interdisciplinary care is coordinated at a central point where patients and families can connect and control their own care (NHS Greater Glasgow and Clyde, 2014; Collins, 2016);
- Readmission to hospitals should only occur where required care cannot be delivered safely and effectively within the community setting (NHS Greater Glasgow and Clyde, 2014; DoH, 2016);
- Community health nursing and midwifery should be the first point of contact that patients will seek when accessing healthcare. From the point of first contact/self-referral, the nurse triage/rapid assessment team leader will assess the patient, prioritise and refer the patient to the most appropriate service/pathway. In addition to the primary care team (PCT) becoming the first point of contact, the patient also has the option to access the GP directly (New Zealand Nursing Organisation (NZNO) 2007; NHS Greater Glasgow and Clyde, 2014; Canadian Nurses Association (CNA), 2014);
- Community health nursing and midwifery will be delivered in a variety of settings defined either as home or as near to home as possible. Specialist and advanced nurse and midwife practitioners will be available in the community to offer safe, effective and high quality care (Carryer and Yarrwood, 2015);
- Community health nursing and midwifery services should meet the needs of the population by being accessible in an extended patient day over a seven-day period (NHS Greater Glasgow and Clyde, 2014);
The Irish **public health model of practice** is recognised as an example of good practice internationally across the public health nursing sector ([www.gnphn.org/2016](http://www.gnphn.org/2016)). This service should therefore continue to be provided;

To continue to meet the changing healthcare demands of the population, it is critical for nursing and midwifery to **respond where care is needed most**. This will have significant implications for the number, mix, distribution and education of the future community nursing care workforce (Leahy-Warren et al, 2016);

Models of care delivered by community health nursing and midwifery **should address service needs** (DoH, 2016; OECD, 2016);

The **scope of practice** by nurses and midwives must be maximised to optimise the health outcomes for patients (Nursing and Midwifery Board of Ireland (NMBI), 2010; NHS Greater Glasgow and Clyde, 2014);

A key element of the role of community health nurses and midwives is to **acknowledge the inverse care law** where those that need healthcare the most may not access the service (Marmot et al, 2012). Innovative approaches for the delivery of healthcare to disparate and marginalised groups should be developed;

Integration of services to those with a complexity of needs requires a dedicated nurse **key professional** and is essential for caring for families and patients in a holistic way (Begley et al, 2004; ONMSD, 2012; Queens Nursing Institute (QNI), 2013). This key nursing role brings in other disciplines and providers of care;

Proposed integrated governance between senior Community Healthcare Organisation (CHO) and Hospital Group (HG) nurse and management leaders within adjacent directorate structures will facilitate **shared funding models** to deliver bundles of care to patients. Pooling/sharing of funds will utilise resources in an effective and efficient manner (Collins, 2016; De Rossa Turner, 2012; Salford Trust [www.local.gov.uk](http://www.local.gov.uk), 2016);

Community health nurses and midwives should work in **interdisciplinary teams that are mobile** and operate in structures between the community and the acute setting (NHS Greater Glasgow and Clyde, 2014; Scottish Government, 2009);

**All undergraduate training should include elective placements in the community as part of the intern/4th year curriculum** (QNI, 2015). These placements will be supported by the Clinical Placement Co-ordinators attached to the academic partners;

Community health nursing and midwifery practitioners should obtain **prescriptive authority** as part of their skills enhancement (NHS NW, 2015);

**Rotation of community health** nursing and midwifery along the trajectory of the models of care (home to ward to home) should be developed to maintain skills but more importantly to offer continuity of care for patients (NZNO, 2007; NHS Greater Glasgow and Clyde, 2014; DH Scotland, 2009);

Community health nursing and midwifery practitioners should **become leaders** in community health practice (Leahy-Warren et al, 2016);
• The **credentialising of knowledge and experience** to become nurse specialists within their scope of practice should also be expanded (DoH, 2017a);
• The impact of the contribution of the nurse and midwife requires **tools that will measure and monitor** targets of health outcomes for the population (Bowler and Mann, 2008; QNI, 2013; Kings College London, 2013).

This international evidence and evidence review has contributed to the development of a vision for an innovative model of nursing and midwifery practice within community healthcare. Technology is essential for connectivity between structures and organisations for population-based planning. Funding models need to be delivered in new and innovative ways that demonstrate the best use of healthcare budgets (NZNO, 2007; DoH & HSE, 2013; QNI, 2013). The driver for national change should be the need to deliver **proactive rather than reactive care**. In this way, prevention and person-controlled healthcare should underpin community healthcare.

### 2.2 Proposed model for community health nursing and midwifery care

Integrated healthcare is...

“...the organisation and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money.”

(World Health Organisation Technical Brief No.1 May 2008)

The development of the proposed policy has drawn fresh attention to the large number of different nursing and midwifery roles currently delivering care to patients requiring primary, secondary and tertiary care in the community. What has also been highlighted are the relevant issues regarding the current shape and size of this workforce, its current relative underutilisation and under development, and the milieu of the future demands through changes in health trends fast approaching the health service. There is however, an opportunity, in the development of this policy, to harness, develop and re-organise this workforce to enable a community nursing and midwifery workforce, within the primary care team, to deliver an integrated model of care. The governance and leadership required to realise this potential is critical to the success of any model introduction and to ensuring a safe, effective and efficient provision and utilisation of the skill set for the benefit of the services.

There are also funding opportunities between the two organisational structures of the hospital groups and the community healthcare organisations that require exploration and development to ensure that patient need is met in a co-ordinated seamless pathway of care.
Of the many prerequisites for a future integrated model of care identified in the policy, the two critical dependencies for success are:

- **Change management leadership and governance;** the model proposed in this policy represents a substantial shift from the current method of care delivery in the community and acute hospital setting. The model requires a proactive rather than a reactive philosophy, along with a team rather than a lone worker philosophy. Strong leadership at senior nursing and midwifery level will be required to introduce the changes not only in practice but also within proposed funding streams which will allow eligibility to the service for all population groups that will be patient outcome focused (Douglas, 2010; Leahy-Warren et al, 2016); and

- **Technology to support ehealth and mhealth;** the available technology in addition to new technology is critical to the success of this integrated model of care and associated pathways (Kings Fund, 2015; NZNO, 2007). While technological developments have occurred in the acute hospital setting, there has been limited development in the community. Successful implementation will require - for example, the ability to offer online appointments systems, triage communication with staff, inter alia, tele-communication out of hours and virtual health.

It should however be noted that, while the proposed model of care and associated pathways refer to the nursing and midwifery component, it is accepted and expected that the nursing and midwifery services work as part of the primary care team, in an interdisciplinary way, where all skills within the wider team are optimised and utilised for patient benefit. Therefore, the reference to the CHNM model of care and associated pathways, is not designed in isolation, but are incorporated within the wider primary care team, and are delivered in an interdisciplinary way.

### 2.3 The Model of Care and Associated Pathways

The current model of care offers the individual, family and community the best choice. This will be further facilitated through reorganisation of the nursing and midwifery workforce to provide a proactive rather than reactive model of care. **The proposed model of care consists of four individual yet interconnected pathways.**

These are:

- First Nursing and Midwifery Response,
- Short Term Care,
- Continuing Care,
- Prevention, Promotion and Protection (PPP).

The individual pathways and how they operate within the model are further explained in section 2.3.1.

**Figure 1: Model of community health nursing and midwifery services for the delivery of integrated care**
2.4 The pathways explained

Integrated Care Pathways

The amalgamation of the nursing and midwifery professions within the acute and community services will strengthen and develop a proactive rather than reactive approach to healthcare delivery. In order to operationalise an integrated programme of healthcare, pathways must be established for deployment of resources to meet the patient’s needs. This section sets out proposed pathways within the overall model for community health nursing and midwifery (CHNM) care to deliver integrated care. Figure 2 below outlines the various pathways within the Model of CHNM care.

Figure 2: Patient Pathways within the Model of CHNM Care
2.4.1 First Nursing and Midwifery Response Care Pathway

First response care is when a CHNM has the first interaction with an individual following a referral from any source including self-referral. First Response aims to identify the patients’ health needs and deliver the required appropriate care, which may include onward referral, as appropriate. It is important that this first interaction with the CHNM services is a positive engagement to foster and develop the first point of contact within the community, as well as deferring the current reliance on presentation at emergency departments as the first line of treatment for care other than emergency presentations.

This element of care may include:

- Post-discharge care delivery for a defined episode, e.g. post-surgical wound care etc;
- Reactive care following trauma, incident e.g. cuts, sprains, fractures, etc. (Primary Care Team (PCT), National Ambulance Service (NAS) referrals or Minor Injury units);
- A holistic health assessment using appropriate tools available, e.g. for persons with dementia;
- Sharing information and accessing the wishes of individuals and families may take longer than routine visits i.e. in alignment to legislation e.g. Assisted Decision-Making (Capacity) Act, (Government of Ireland, 2015);
- Initialising the care planning, self-care plan and triage to the appropriate delivery of care as identified in the integrated model.

All first response care will include the capability of nurses and midwives to undertake a brief intervention assessment for mental health needs at the time of contact. The National Ambulance Service (NAS) is currently developing a strategy, Vision 2020, to promote alternative pathways for patients for treatment other than at the emergency department. Following a call to attend a patient, the NAS can triage and refer the patient for example, to a local injuries unit, GP practice or an appropriately resourced primary care centre (Vision 2020, HSE, Draft, 2016).

2.4.2 Short Term Care Pathway

There are two strands to this care pathway, intermediary and anticipatory care:

Intermediary care

One component of short term care delivery is where a specific episode of care is offered for a defined period of time. When care is no longer required, the patient is then discharged from the service caseload. An example of this in practice is where nursing care is required for a specific
period of time, to facilitate wound care or the administration of prescribed intramuscular medication, both for defined periods.

Intermediary care services aim to preserve and promote the independence of patients living in their own homes where they would otherwise face hospital or long-term care admission. Intermediary care health services (which includes re-ablement or rehabilitation nurses, community nurses, practice nurses or specialist nurse involvement) in practice have two strands that include:

- a step down area to develop independence as a transition to home; or
- a step up area to access a short episode of acute care that cannot be administered at home. This could include for example, administration of blood products for palliative symptom control that requires additional expertise/assistance.

Intermediary care may also be required to allow respite care for families. This short term respite care is of critical importance for family carers who have to manage a family crisis or significant celebration e.g. a family bereavement or a family wedding.

There are however, challenges to the facilitation of intermediary care, particularly where an individual requires care from the acute services. One significant challenge is the clarity of understanding and communication of patients’ care needs in the community particularly when care is required across the community/acute hospital chiasm. These are not however insurmountable. Through the availability of an integrated electronic health record and the mobility of nurses and midwives across the boundaries of acute and community settings these challenges can be overcome and indeed provide many additional benefits. For example, where the continuity of care enables the community nurse to integrate care within the Acute Medical Assessment Unit (AMAU)/Medical Assessment Unit (MAU), there are mutual benefits for both the patient and nurse. The patient receives the appropriate efficient care when and where it is required and the nurse is not only enabled to continue to care for the patient but will also benefit from maintaining their competence during the process.

**Anticipatory Care**

Firstly, in a primary preventative role this care is delivered to individuals, families and communities in anticipation of areas known to precipitate ill health. An example would include immunisation programmes to eradicate disease along the life course. It may also include a community health initiative, for example where an application is made for speed ramps/bumps in areas known to have higher risks of road traffic accidents, adjacent to where children play.

The second strand to this care pathway is the ongoing assessment by a CHNM of a patient in the community whereby a patient’s needs have altered significantly. Evidence demonstrates that the top two reasons for admission to hospitals are rehabilitation subsequent to a fall or chronic obstructive pulmonary disease (COPD). The response of the CHNM is undertaking
planned home visits to patients who are at high risk of emergency admission or as an extension of the current Health Service Executive (HSE) National Clinical Care Programme (NCCP) to avoid hospital readmission for a chronic disease. The CHNM service will monitor and carry out risk assessments e.g. falls risk, or deterioration in respiratory or cardiovascular conditions, assessing and educating patients and their families to manage their condition and promoting self-care. The CHNM service will also liaise with the most appropriate professional where they judge that further action/referral is required (www.hse/nccp.ie). That may be the GP, CNS or ANP within this clinical pathway. Increased use of ehealth and mhealth solutions to access information and to monitor patients will be required to enable this element of the model. The aim of this approach is to restore the individual to their normal state of health as soon as possible. This is episodic care and involves rehabilitative supports to return independence and self-care either by self or others.

2.4.3 Continuing Care Pathway (home/care home) (chronic/end of life/complex)

It is important that as we seek to transfer services from the acute to the community settings that we put in place integrated processes to enable continuing care for all patients who require long term continuous care services (home/care home). This will provide access to the following services through the PCT with the supports of GP/PN, CNS and ANP and acute services;

- Provision of an integrated approach to management of care. This includes the delivery of both anticipatory and intermediary care and is aligned to the HSE integrated care programmes;
- Chronic disease care plans and pathways of care which are currently in development should involve collaboration with integrated team members within a case management delivery of care;
- Self-care plans developed and monitored for individual, family and others involved in the care delivery;
- Discussion of the patient’s options and choices in accordance with disease management and legislation. This ensures the patient has an understanding and awareness of their condition and if not, to establish appropriate protocols relating to family responsibilities for care decisions;
- Development of integrated care pathways when exacerbation of the condition occurs. Proactive information sharing with all members involved in care delivery to provide a co-ordinated response;
- Ensure individuals and families comprehend the care delivery information sharing sessions;
- Access to a key professional most suited at each point of need for all complex continuing care patients. This person will function in the role of key professional as identified below;
- A supported continuing care pathway with first response and short term care options.
2.4.4 Prevention, Promotion and Protection Pathway (PPP)

This pathway of care signifies the cornerstone of the Irish Public Health Nursing model of care for which nurses qualify with a higher diploma in Public health nursing (NMBI, 2016). Based upon the evidence, in order to empower a population to refocus and take ownership of their healthcare and outcomes, a self-care model of public health is utilised across the continuum of the life course (Orem, 2011).

Whereas all nurses and midwives incorporate public health into their practice, the skills and qualifications offered by public health nursing ensures the provision of a healthy population along the continuum of health from birth to death inclusive of the working years of adults.

The public health nurse has a pivotal role in leading and coordinating delivery of public health interventions to address individual and population health needs. Upon registration, the public health nurse in addition to their nursing registration is sufficiently educated with critical thinking skills to; develop population focused initiatives; understand health and population focused legislation; collect and analyse data; use epidemiology to diagnose and treat a community (Stanhope and Lancaster, 2013); forecast for health needs in a geographical area through population profiling; understand how to lobby for funding and services that address the social determinants of health (WHO, 2010); empower a population in a community to improve health, self-care and build resilience along the life course; and to offer a protection role to the population in accordance with legislation.

Within the model, the public health role will be embedded in all of the care pathways. In alignment with the Programme for Partnership Government (2016), the role of the public health nurse has significant importance in offering every child the best chance in life along the trajectory of the life course.

The role in child health development and welfare remains a core element for the PHN and other nursing professionals. This policy will continue to support many policies (DoH, 2013; DCYA, 2015) including the review of the Best Health for Children Policy (HSE, 2005) and imminent implementation of the ‘National Healthy Child Programme’ nearing completion in the HSE.

The PPP role has significant value for the ‘working well’ population. These persons are members of the community who are not necessarily ill and do not access health services until they are in need of a service to meet a health deficit. The PPP pathway enables such individuals to access information and services to inform and support them to maintain wellness. One example of this in practice and demonstrated to be effective, is the role of PHNs in ‘brief intervention’ at the point of contact to their service. Many of the PHNs, for example, have
accessed training in ‘Ag eisteacht’ that will allow them to offer immediate support to any person in need when suffering stress (www.ageisteacht.ie).

The PPP role will cover all elements of prevention, promotion and protection and will, amongst others, address and meet needs in the areas of:

- Prevention - e.g. child and adult development and welfare, screening, immunisation programmes and management of infectious outbreaks (Scottish Government, 2007; Department of Health England, 2011);
- Promotion – e.g. behaviour change programmes in smoking cessation, community resilience building and empowerment for community groups (DoH, 2013; Fagerholt, 2009);
- Protection - e.g. child and older persons safeguarding etc. (DCYA, 2015; National Safeguarding Committee, 2016).

The role of the PHN in school health is for the most part, opportunistic. This is supported by the recent evidence by the Office of the Nursing and Midwifery Directorate (ONMSD, HSE, 2015), whereby it was identified that just 22% of Irish schools have a dedicated school nurse and the remainder rely on the PHN in practice to attend to the schools in the geographical caseload area. The role of the school nurse relates specifically to screening for audiology, ophthalmology and recently weight and height checks. Some are engaged in the primary school immunisation programmes however many of these practitioners are transient in the role (ONMSD, HSE, 2015). The school nurse role is vital and identified in many countries as valuable to the provision of care and offering every child the best opportunity in life.

2.5 The Team Leader (Triage/Rapid Assessment)

The role of the CHNM team leader is a multifaceted one. At a high level, the role is used to strategically and operationally organise the deployment of the nursing and midwifery teams in the community to deliver patient care activities. The role is also important as a central communication point for sharing relevant information amongst all of the people involved with a person’s care to achieve safer, effective and timely care. Any member of the community health nursing and midwifery team as identified in this policy and with the appropriate skills is eligible to perform this role. Indeed each member of the team, should be encouraged, facilitated and supported to develop their skills in undertaking this role. The team leader will also possess the skills to identify the best professional to meet the patients’ needs at each encounter. In this manner, the team leader is fulfilling the functions of triage on presentation at the health centre. While this currently occurs in practice, its implementation occurs in an ad hoc manner, with limited consistency in the application of triage decision making methods and processes. The main goal of this role within the team is to ensure that the health services best meet the
patient’s needs. This means the patients’ needs and preferences are known and are well communicated at the right time to the right people. A core element of this role is that it is both inward and outward facing. Therefore it is not just focused on those patients presenting to the community service, but has the ability to ‘reach in’ to the acute sector to identify those patients that can be discharged to the community service.

The team leader has a combined role of care and service coordination whose functions may include, some/all of the following:

- Receive and confirm referrals as the first point of contact;
- Source additional information;
- Triage the referrals – rapid assessment skills to prioritise and refer if necessary to appropriate services e.g. to GP/PN, CHNM, specialist nurse or acute sector as per integrated pathways;
- Provide brief intervention as required (e.g. www.ageisteacht.com);
- Monitor the caseloads to admit and discharge individuals to the services offered;
- Provide a clinical service. This includes availability of the midwife in the primary care centre;
- Allocate a named key professional to coordinate the care, as per the integrated pathways;
- Identify and meet eligibility to the services;
- Provide ‘in reach’ to the acute sector;
- Initialise the choice of model of care best suited at that time in consultation with the individual and family;
- Support the self-care plans of the individual;
- Be the central point of coordination of shared information between the integrated pathways relating to all areas of nursing and midwifery care;
- Provide feedback to the referrers;
- Predict and align resources to operationalise the care pathways;
- Utilise, manage and report on the work force and population health services. Align to technological reporting of information on care delivered;

Specialist nurses, often with a ‘specialist’ focus, should be integrated and coordinated alongside the nurses employed in generalist community nursing and midwifery roles. The role of the triage team leader will facilitate the integration of these roles.
2.6 The Key Professional

In many national and international reports the PHN/community nurse has been identified as the key coordinator of care in the community (National Council for the Professional Development of Nursing and Midwifery, 2005; DCYA 2012; International Family Nursing Association (IFNA) (2015)). Combined with their clinical expertise, they have a unique insight into a patient’s holistic needs, and can be adept at anticipating potential gaps between the needs of those they care for and the systems commissioned to deliver services. This places them in a key position to ensure that effective systems and services are in place throughout the patient’s journey.

The key professional is identified as the most appropriate professional with the set of competencies and skills to manage the patients’ needs. As the complexity of patient needs increases, it is expected that in order for the patient to be managed by a nursing/midwifery key professional, this would require appropriate specialist or advanced specialists. Development of a critical mass of advanced nurse practitioners and clinical nurse specialists offer optional choices for care delivery for individuals, families and communities. This model is supported by a larger cohort of community professionals as identified earlier. Ensuring the assignment of the appropriate key professional will avoid mishaps in practice that lead to missed care that affect patient outcomes (Phelan and McCarthy, 2016).

2.7 Synergy between this model and the existing HSE integrated model of care

There is a number of integrated clinical care programmes that have been developed by the HSE to respond to the growing demand for care, and in an effort to reduce the reliance on the acute hospital system. The programmes have been developed in a number of key areas, specifically in relation to chronic disease management and frail elderly. There are multiple synergistic opportunities, between these programmes and the model and associated care pathways proposed in this policy.
Exemplar 1: Respiratory Care

**Self-referral:** For the patient living at home with a chronic respiratory condition, nursing services at the PCT can be accessed through a self-referral system. At the point of contact with the PCT, the patient is assessed and triaged by the nurse team leader and offered the appropriate care, i.e., treatment in PCT by CHNM, Nurse Specialist, GP/PN or acute services. In this interaction the nurse team leader may consult with appropriate experts for further direction and advice of care needs.

**Referral by CHNM to CNS/ANP:** In caring for the needs of this patient in the home, regular monitoring is undertaken to maintain the patient in a wellness state. At signs of deterioration using the community early warning score (ICEWS) escalation tool, the CHNM can make referral directly to the nurse specialist, GP in the PCT to attend the clinic, perform a house visit or give advice on care needs.

Exemplar 2: Child Health

**Self-referral:** For many families, the need to access professional advice and raise concerns around their child’s health is often opportunistic and unplanned. In this model of care, the parents can access the nurse or midwife (in less than 6 weeks) in the PCT. When triaged by the nurse team leader the parents will get access to the appropriate professional to meet their needs and direct their care.

**Out of hour’s service:** For many families concerns around children are often raised outside of the traditional working hours of community services. On many occasions attendance at the ED either following a visit to the GP or attending directly is as a result of the absence of an alternative service. The presence of an out of hours service beginning with a telephone advice service can alleviate many concerns of parents and offer remedies to minor ailments experienced particularly in the evening, e.g. a ‘crying’ baby.

2.8 Concept of interdisciplinary versus multidisciplinary teamwork

Evidence has demonstrated that many of the community services are fragmented and work in professional isolation. Multidisciplinary (also known as multiprofessional) practice differs from Interdisciplinary integration. Whereas multidisciplinary is a team of individuals who may deliver their expertise in isolation from each other, the interdisciplinary team is a more sophisticated model that is capable of delivering true integration between professional groups within the acute and community settings. As a result, this team approach delivers what the patient needs and not just what the professional can deliver. The interdisciplinary team delivers
to the patient holistic, non-hierarchical coordinated care involving the active participation of the individual, family and community if required. There are, however, issues that would need to be considered when developing interdisciplinary teams in the community such as; funding models; blurring of the roles and accountability; structural barriers; lack of information sharing; and a need for very strong clinical leadership (Leahy-Warren, 2016).

2.9 New funding model for innovative community health nursing and midwifery models of care

A key component of several global funding models is the ability to offer the professionals an incentive to provide the service and remain within their budgets (Kings Fund, 2015). A full comprehensive service is delivered to the patient or outsourced as required, and paid in full by the service. In the Alzira model the Government offers funding per capita in a geographical area (www.kingsfund.org.uk). At year-end any profits made are distributed equally between the private partner and the service providers.

In order to change the cultural norm of depending on the acute settings to provide care, the provision of incentives should be considered (Naylor et al, 2015). These can be within blended models of funding that allow shared care practices between acute and community settings, with the patient at the centre and unaware of any separation of services. It is recognised internationally that incentives are aligned across systems and providers, physicians, advanced nurse practitioners (who may become independent practitioners) and where nurse and midwifery services are rewarded for better clinical outcomes financially and by peer/professional recognition (www.virgincare.co.uk; www.locala.org.uk).

One current example in Ireland, of a funding model for community nursing services is that of an ANP in Dublin, that currently delivers care to a cohort of patients similar to a GP/PN. This ANP is paid via the GP from the HSE/NCCP contract, for professional expertise and care. Payment obtained is then reinvested into the service as the ANP is salaried through the public service. Therefore, an optional funding pathway could see ANP services positioned in the PCT, with access to the service by the CHNM team and by patient through self-referral. This type of model is seen in systems of social enterprise and community interest groups (www.locala.org.uk) in the UK where services are paid for, reinvested and generate more services according to the population needs. A strong component of this model is the community involvement in decision making for the services required. In addition these models are favoured by professionals as they see reinvestment in their services.

These models demonstrate a different perspective on systems where integration, collective contracting, investment in leadership opportunities and robust ICT and electronic health record (EHR) systems have led to noticeable improvements in hospital readmission rates, better value for money and a higher focus on prevention and promotion initiatives. International evidence
identifies that nurse leaders are critical in managing financial budgets necessary for the success in the delivery of integrated nursing models (www.kaiserpermanente.org; www.srft.nhs.uk; Sherman, 2012; Rundio, 2016).

In the USA, funding the value of the nurse has seen an increase in the utilisation of the services when required in other disciplines. Many areas may require a nurse to undertake a clinical assessment of a person. Payment is not always offered to the service providing this care. However, the workload of the nurse increases with the amount of time required to undertake assessment. An example of this is completion of the common support assessment report (CSAR) form for Fair Deal. This can take approximately 90–120 minutes and may need several visits to complete. In a model developed by Welton and Dismuke (2008), nurses can track and report their hours of patient care in another fiscal area and with the assistance of a handheld device, generate a Nursing Intensity Database (NID) that can then adjust the health service payments to pay for the nursing time delivered to the person.

In two recent Irish systematic reviews examining the cost effectiveness of integrated models of care in the community (Hegarty et al 2015; Leahy-Warren et al 2016), findings demonstrated that while in some cases the cost of episodes of care as expensive, they were experienced by the patients as being of high quality care and satisfaction. These reviews also state that some random control trial (RCT) studies in older persons suggest that there was a reduction in adverse events (falls, acute events) and the service was more cost effective. Both reviews identify that ‘nurse-led’ services reduce the fragmentation of the service and improve patient satisfaction as well as outcomes (Hegarty et al 2015; Leahy-Warren et al 2016). What both reviews concluded was that there was insufficient evidence to confirm the cost effectiveness of integrated programmes in Ireland and further research and an evidenced informed approach is required to underpin the development of future services.
Chapter Three: Governance and Leadership

3.1 Governance

3.1.1 Quality, Safety and Accountability

Clinical governance is central to delivering safe, quality care and is a core expectation of nurse leaders. It is influential in assuring accountability for standards of practice, quality of care and the influence of evidence informed research on practice. Nursing and Midwifery governance has been associated with savings from reduced turnover of staff, restructuring and indirect revenue savings (Hess, 2004). Fundamental to delivering the Programme for Partnership Government (2016) vision for integrated models of care within the community will be a requirement that nursing and midwifery takes a lead function within any new structures. Nursing leadership must be seen throughout the structures, most particularly leading from the senior management level.

Quality and safety should be on an equal footing to financial benefits and productivity. Those that know what care looks like are best placed to lead and take full responsibility for delivering on these safe, quality services (Francis, 2013). Community practice in this enhanced, integrated model of care requires arrangements for clear professional leadership in accountability. Development of audit and performance frameworks to measure the quality and effectiveness of the service are essential to reassure the public that services are safe (www.hse.ie/eng/about/Who/qualityandpatientsafety/Clinical_Governance/2016). In the absence of nursing and midwifery leadership, many reports have identified that the inevitable outcome is poor care standards, inadequate response to care needs and an insufficient knowledge base within the services (O’Neill, 2006; Francis, 2013; Kirkup, 2015).

In a recent paper published by The Health Foundation (Hudson, 2016), on integrated accountability for integrated care, the issues of determining priorities, allocating resources, monitoring progress, ensuring delivery and learning lessons are key outputs from an accountability framework. While the paper discusses key principles for effective accountability, it notes the substantial implications of poor governance structures, not least poor quality care and poor value for money. Notwithstanding that the key principles outlined in this paper are targeted at national level, the principles are no less transferable to the local context.
The principles must be:

- Comprehensive and joined up, spanning quality and finance;
- Economical of time and money;
- Clear and transparent;
- Rigorous where it matters but encouraging towards innovation;
- Stable over time and consistently applied; and
- Robust to the real world.

Accountability is the core of clinical governance. Nurses and midwives are accountable to their professional regulator and accountable to their peers, their organisational authority and of course to the patients served.

Meeting the governance requirement of any model that transcends different care areas which include acute and community, public and private sectors, will be challenging. As seen in the international models, the success in the delivery of integrated models occurs when nursing leadership manages the services for a population across the sectors, e.g. the Salford Royal Trust (see the following example).

**Exemplar 3: Salford Royal Trust**

This particular model has been piloted within the Salford Royal Trust, Manchester (www.local.gov.uk/April 2016). The Salford Royal Trust piloted a collaborative model based on a forecast of integrated budgets. The Trust identified a cohort of 35,000 patients, aged over 65 years to pilot the model of care. They provided an integrated budget that pooled finances from several sectors across health and social care equating to £98 million in 2015, around £2,000-£3,250 per person. The budget has been rebased in 2016 to around £112 million which represents £3,200 per person. A £4.5 million investment was provided upfront to develop the model over 18 months across the acute and community setting. The sectors then agreed to set up an Integrated Care Organisation through a prime provider model that acted as a tool to facilitate integrated care. The integrated care pathway is expected to produce £2 million savings for each of the next four to five years totalling between £8 million and £10 million. The care delivered is person-centred and person-controlled. Clear governance arrangements were developed at senior nursing levels to ensure a robust method of testing, impact and commitment. (Salford Trust, 2016)
3.1.2 Quality Assurance and measurement

One mechanism to provide assurance is through the measurement of Performance Indicators (Draft policy paper in DoH, 2017b). In collaboration with the HSE a number of metrics/indicators for Primary Care have been agreed, however, in a similar manner to the National Healthcare Quality Reporting System (NHQRS), these are primarily focused on GP practice, physiotherapy, occupational therapy, orthodontics methadone treatment, substance misuse, homeless services and traveller health screening (DoH, 2016).

There is however a necessity to develop nursing and midwifery specific performance indicators that will demonstrate and measure the effectiveness of the nursing and midwifery contribution to integrated care in the community within an overall Performance Assessment Framework that includes population health outcomes. This is particularly important in light of this proposed policy, which recommends the consolidation and integration of nursing and midwifery services within the PCT. Therefore these performance indicators are critical to measure the impact of these changes (DoH, 2017b).

3.2 Leadership

Leadership in practice to drive integrated care was identified as essential for a seamless service for patients in both of the recent Irish reviews (Hegarty et al 2015, Leahy-Warren et al, 2016). With the diversity of services offered in the community setting, the leadership focus is on ensuring proficiency as a transformational leader (Underwood, 2010; Canadian Nurses Association (CNA, 2014). Leading integrated models of care requires nurses and midwives to collaborate in the governance and accountability of providing a selection of models of care applicable to meet the patients’ needs at different episodes of their care trajectory. In the provision of holistic care, nurses and midwives practice to their code of conduct (NMBI, 2015). The practice of community nurses and midwives needs to be based on discipline specific competencies, professional regulatory standards, values and principles, policy, and a theoretical foundation.

Within the CHO structures, the HSE should implement a leadership, governance and reporting framework that will reinforce and proactively drive this model of care.
3.2.1 Proposed Governance Structures

Some proposed potential options for the governance structures are set out at 3.2.2. These are in no preferential order. As new models of healthcare delivery emerge, governance arrangements may need to be modified or revised. The future governance structures proposed may be a combination of those set out below or other structures that may arise during the consultation process or be established in response to the development by Government of future models of care. One arrangement may emerge as the preferred option, equally one or a combination of arrangements may emerge as a stepping stone to the preferred option.

a) New position of a Senior Nurse Manager at the senior executive level of the Community Health Care Organisations that will work in collaboration with the Group Director/s of Nursing on integrated service delivery in a CHO area. This option would function as a shared governance model of integrated care delivery.

b) Overall governance of the Acute Hospital Group and the CHO nursing and midwifery services by the Senior Nurse Manager role. This role and function would operate similar to the Senior Nurse Manager Role outlined 3.2.2.

c) Overall governance of the CHO and Acute Hospital Group areas of nursing and midwifery by the Group Director of Nursing. This role and function would operate similar to the Senior Nurse Manager Role outlined 3.2.2.

d) Integrated Nurse and Midwife Director. This role will manage a geographical area and a population group within the acute and community settings. This role and function would be similar to the Senior Nurse Manager Role outlined 3.2.2.

Regardless of which governance arrangement emerges, the focus of the roles should be as 3.2.2.

3.2.2 Senior Nurse Manager Role

In light of the approach outlined at 3.2.1 above, the proposed policy recommends that a post of Senior Nurse Manager operate in each CHO area. The appropriate workforce will have the necessary governance and strategic leadership arrangements in place to develop and implement the model of care outlined in section 3.2.1.
The purpose of the Senior Nurse Manager post is to provide strong professional and clinical leadership for all work practices of nursing, midwifery and support staff within the CHO area. The role would deliver on four interdependent areas of governance which are:

- Clinical governance;
- Financial governance (relating to nursing and midwifery expenditure);
- Staff governance; and
- Information assurance.

The key objectives of the role would be to:

- improve the quality of nursing care and patient experience;
- deliver agreed Key Performance Indicators; and
- re-engineer a culture of integration that can increase the capacity of nursing to integrate services across acute, primary (community) and social care directorates.

The Senior Nurse Manager post would provide a clear line of overall accountability and responsibility between nursing services and general management. The Senior Nurse Manager would be a member of the CHO corporate management team and would have a key role in creating a climate and culture where excellence can thrive with strong interdisciplinary collaboration across the CHO and Hospital Groups. Establishing the Senior Nurse Manager post at this high level would put in place a governance function (incorporating clinical, financial and staff governance, and information assurance). Key elements of the role would include:

- developing strong collaboration with the Group Director of Nursing in the hospital groups in order to establish and develop integrated nursing services for the population;
- collaborating with other health clinicians to strengthen clinical leadership and expertise; and
- ensuring service delivery is developed within local and CHO areas and within national parameters, as well as promoting clinical involvement in service design and sharing decision-making and interdisciplinary working.

As a member of the management team, the Senior Nurse Manager would create the governing link between one of the largest workforces in the community with the other key stakeholders responsible for delivering community services, as a team.
3.2.3 Director of Community Nursing (DCN) (Currently the Director of Public Health Nursing (DPHN))

As part of the overall governance structures identified in section 3.2.1 and within the current CHO HSE structures (2014), the role of the Director of Community Nursing (DCN) would continue.

The title Director of Community Nursing (DCN) would replace the current title Director of Public Health Nursing (DPHN). The DCN would continue to offer clinical and professional leadership, management and governance. The DCN would report directly to the Senior Nurse Manager and collaborate locally with the network manager/s with responsibility for the area/s. The DCN would manage 5 networks or 250,000 population approximately, dependent on the landmass and geographical spread of the population in an area.

The DCN would operationalise the nursing and midwifery components of the senior management strategic plan. This plan would be operationalised through collaboration with Nursing/Midwifery managers in the Hospital Groups/Maternity services, and colleagues from the public, private, and voluntary sectors that are responsible for service provision and delivery.

3.2.4 Assistant Director of Community Nursing (ADCN) (Currently the Assistant Director of Public Health Nursing (ADPHN))

The current post of Assistant Director of Public Health Nursing (ADPHN) manages a 30-40,000 population and may also hold a service provision role. Some ADPHN posts have singular responsibility for service provision to include, amongst others, immunisation services and/or home support services.

The draft policy recommends that the title ADPHN be replaced by the title Assistant Director of Community Nursing (ADCN). Within the current CHO HSE structures (2014), the ADCN would be positioned within the Primary Care Network team and would manage the nursing and midwifery component of 5 primary care teams or one network of approximately 50,000 population. This arrangement would remain under the new recommendations.

Additional ADCN posts would be required to manage the service provision for children or adults aligned to a population of 250,000 or 5 Networks (similar to the size of the DCN population group).

Critical to a change in culture both within hospital and community care, is the development of practice and quality assurance functions. For this reason both these functions would be included in the role of the ADCN. A key focus here is to ensure community settings are
perceived by the population as a reasonable point of first nursing and midwifery contact for the provision of healthcare services.

The ADCN would be required to provide clinical and professional leadership, management and governance and would report directly to the DCN. The ADCN would have local collaborative relationships with the network manager and other service providers in the primary care team areas, including GPs and practice nurses.

3.2.5 Midwifery Governance

The National Maternity Strategy (2016) proposes a new model of maternity care and, with it, a requirement for strong and effective clinical leadership at national, maternity network, and individual maternity unit level. This will help to create and sustain a safe maternity service across the hospital, community, and into the home.

Strong clinical governance is necessary to safeguard high standards of care and to create an environment in which excellence in clinical care will flourish. Recent HIQA and DoH reports (2013; 2014) identified the need for midwifery leadership throughout clinical governance structures. This was highlighted as being necessary to ensure safe, quality care and services for mothers and infants. Such midwifery leadership will ensure appropriate oversight for the clinical management of women and infants, foster a culture of safety and quality, and provide strategic direction in terms of maintaining a balanced competent workforce.

The changing role of the midwife as lead professional for women within the maternity strategy, as well as the development of the hospital outreach community midwifery service, will require strong strategic leadership to develop a safe service in addition to the development of a midwifery workforce. The need to build capacity in the midwifery workforce is required not only in terms of numbers, but also in relation to capability to deliver the new model of service across the home, the community and the hospital settings. It is important that those who occupy critical leadership positions are supported to fulfil their roles and responsibilities effectively. Persons who hold responsibility and/or accountability must have the authority, the tools, capabilities, and sustained supports they require in order to carry out their responsibilities.

It is therefore recommended that, on an interim basis and subject to review, the development and governance of community midwifery services remain within the existing structures of the Directors of Midwifery appointed to each maternity unit within the hospital group structures. As the community service develops, the governance arrangements can be reviewed.
This will demonstrate a robust structure to govern, manage, implement and be accountable for clinical, professional and service deployment of nurses and midwives that will lead to maximum impact for health outcomes for the population.

Integrated delivery of care between the Senior Nurse Manager and the Group Director of Nursing (GDoN) is achievable through integrated funding models where a pool/shared budget is provided for the delivery of care to a cohort of the population whether this is children under 18 years or older persons over 65 years. This would bring together and integrate the services of the acute, community, primary care, mental health and social care services and other service providers like GPs and care homes as appropriate.

Governance over the midwifery services will originate from the Group Director of Midwifery (GDoM) and be delivered through the Directors of Midwifery in each of the maternity hospitals in line with the National Maternity Strategy. This will involve the placement and rotation of midwives from the tertiary to the community PCT and between maternity units within the hospital groups (www.doh/nationalmaternitystrategy.ie).

3.3 Education

Notwithstanding the issues in regard to the clinical learning environment in the community, a shift in policy and practice is needed to recognise the community as the primary setting for healthcare, as proposed in this model. Many areas related to education and deployment of nurses and midwives need to be developed in order to actualise the models of care in the community. This will take effort from the health providers, educational and regulatory bodies, professional organisations, population as well as nurses and midwives themselves. Post graduate education has been a route for further education for nurses and midwives educated to the pre degree nursing education. Ireland is quite unique in the world of nursing and midwifery because it has degree graduates with higher levels of professional critical thinking and understanding in practice. As a result proposals for evidence informed initiatives that can improve professional care and service provided should be enacted to support a 21st century service for the Irish population.

3.4 Making it Happen – Implementation of the Policy Paper

The proposed model and associated pathways outlined in this policy present a substantial opportunity to optimise the nursing and midwifery resources in the community to deliver an integrated model of care. As a novel concept, the recommended actions in this policy require testing, to ascertain their capability to deliver on their intended outcomes. Therefore undertaking demonstrator projects is a required step to inform national implementation.
A key action in bringing this policy towards national implementation is to undertake a demonstrator project. This requires two steps: (1) pre planning; and (2) implementation of the demonstrator project.

3.4.1 Pre Planning – Phase I

During this phase, a planning group of key stakeholders will be established. The purpose of this group will be to:

- oversee the planning and development of demonstrator projects to assess the intended outcomes that will include the resource implications arising from the policy recommendations;
- identify the demonstrator sites based upon alignment to the highest presentations at ED and the highest waiting list for OPD. (Based upon the evidence from NTPF and ED presentations, respiratory/COPD patients are one of the highest cohorts);
- identify the formal approach to evidence informed evaluation of the demonstrator projects; and
- seek approval to proceed to demonstrator projects implementation.

The planning group will consist of key policy representatives in the DoH and the HSE. The objective of this approach is to ensure integration and alignment with overall corporate policies.

3.4.2 Demonstrator Project Implementation – Phase II

Subsequent to approval to proceed to Phase II, an implementation group of appropriate members that can oversee the demonstrator projects development, implementation and evaluation will be established.

In addition, to support the project at local level, local implementation groups that can operationalise the recommendations for a specified cohort of patients in a defined geographical area will be established.

A critical outcome from this phase is to ensure that the project is evaluated with robust measurements, in order to test the capability of the project to deliver on the intended policy objectives.
3.4 Conclusion

In summary, the proposals for future structures for governance, leadership and management, in alignment with nursing structures in the hospital groups as described in this policy, will provide opportunities and ideas for nurses and midwives to develop new integrated ways of working across sectors and changing the traditional boundaries of where and how they work. Effective nurse and midwifery leadership will go a long way to eradicate the fragmentation of a service that could offer patients and families a seamless service through the trajectory of their healthcare needs. The strong defined leadership structures that align community and hospital group nursing and midwifery structures will assist in developing a more cohesive workforce and, in turn, attract nursing and midwifery professionals to this area of practice and help retain them.

Repurposing the community as the first point of contact means significant transfer of investment from the acute hospital setting to the community. The ability of nurse and midwife managers to collaboratively share the integrated budgets will enable them to make the right choices for patients and families. This will require a cultural shift for professionals and communities (Naylor et al, 2015).

Chapter Four: Recommendations, Actions, and Questions

4.1 Recommendations

These recommendations are set within the context of the proposed new model and the associated pathways of: First Response; Short Term Care; Continuing Care; and Prevention, Promotion and Protection (PPP); to enable the delivery of integrated care through the community nursing and midwifery resource.
**Specific Questions for Consultation**

The Department would be interested to hear your general views but would particularly like your views on the following questions.

1. **In order to shift the hearts and minds from delivery of care in the acute sector to first point of contact in the community setting, attention is urgently required for the development, enhancement, support and encouragement of the workforce required to deliver this model of care and associated pathways. This will be achieved by:**

<table>
<thead>
<tr>
<th>Actions</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>A</td>
<td>Aligning the nursing and midwifery resources within each PCT – within this model of care, to maximise the benefits for patients and communities.</td>
</tr>
<tr>
<td>B</td>
<td>Enhancing to the greatest extent possible, the full extent of the scope of practice skills of the community nursing and midwifery workforce to meet the population needs. For example medicinal and ionising radiation prescribing education.</td>
</tr>
<tr>
<td>C</td>
<td>Establishing a triage/rapid assessment nurse service in each PCT that will assess, prioritise and refer the patient to the most appropriate professional/pathway.</td>
</tr>
<tr>
<td>D</td>
<td>Equipping nurses and midwives with the appropriate education, skills, resources and tools to operationalise this model and associated pathways.</td>
</tr>
<tr>
<td>E</td>
<td>Supporting the nursing and midwifery resource by developing and implementing community early warnings score (iCEWS) that offers a safe and consistent assessment tool that can pre-empt, alert, and escalate deterioration in the patients’ condition.</td>
</tr>
</tbody>
</table>

**Questions:**

1. How will these actions benefit:
   a. The patient;
   b. The services; and
   c. Nursing and Midwifery practice?

2. What supports need to be in place to assist the implementation of Actions 1 A-E?

2. **In order to plan the nursing and midwifery services in response to population needs, future community service provision will be aligned to the model of care and associated pathways. This will be achieved by:**

<table>
<thead>
<tr>
<th>Actions</th>
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<tbody>
<tr>
<td>A</td>
<td>Ensuring that nursing and midwifery services in the community will deliver a full episode of care that is service driven and developed in accordance with population health needs.</td>
</tr>
</tbody>
</table>
| B       | Equipping all PCTs to support the HSE integrated care programmes with;
  - Access to National Integrated Medical Imaging System (NIMIS), Healthlinks |
and laboratory results;
- Access to diagnostic equipment appropriate for service provision;
- A review of the ICT and administration resources to identify the needs required to deliver the model of care and associated pathways;
- Utilisation of a nationally consistent personal held record to facilitate integrated care in the absence of electronic health records.

| C | Supporting points (A) and (B) above, by providing educational support mechanisms to mentor and precept nurses and midwives in community practice. |
| D | Developing the school health service up to 18 years of age by reviewing how best to deploy the nursing and midwifery resource to deliver on this model of care. |
| E | Reviewing the services of the practice nurse in the GP practice setting, in order to assess how best to deploy synergies of this resource to the maximum benefit for the patient. |

**Questions:**

1. What other areas may need to be explored to enable the provision of a first point of nursing and midwifery contact as near to the home as possible?

2. How do these actions align with compliance to national patient safety and quality standards?

| 3 | Robust governance arrangements are required in order to encourage, enable and support the safe and consistent development and implementation of the model of care and associated pathways. This will be achieved by: |

| Actions | A | Strong clinical nursing and midwifery governance within the policy will be a pre-requisite for delivering this model of care and pathways ensuring a safe, quality service for the population. |

As new models of healthcare delivery emerge, governance arrangements may need to be modified or revised. The future governance structures proposed may be a combination of those set out below or other structures that may arise during the consultation process or be in response to the development by Government of future models of care.

Potential options may include:

- a) New position of Senior Nurse Manager in each CHO area. This option would function as a shared governance model of integrated care delivery. This option would operate similarly to the Senior Nurse Manager Role outlined at 3.2.2.
- b) Overall governance of the Acute Hospital Group and the CHO nursing and midwifery services by the Senior Nurse Manager. This option would operate similarly to the Senior Nurse Manager Role outlined at 3.2.2.
- c) Overall governance of the CHO and Acute Hospital Group areas of
nursing and midwifery by the Group Director of Nursing. This option would operate similarly to the Senior Nurse Manager Role outlined at 3.2.2.

d) Integrated Nurse and Midwife Director. This role will manage a geographical area and a population group within the acute and community settings. This option would operate similarly to the Senior Nurse Manager Role outlined at 3.2.2.

Reporting Nursing structures will look like:

- Director of Community Nursing (DCN) (currently Director of Public Health Nursing (DPHN)) to manage approximately 5 networks/250,000 population reporting to the Senior Nurse Manager.
- Assistant Director of Community Nursing (ADCN) (currently Assistant Director of Public Health Nursing (ADPHN)) in each network area to manage approximately 50,000 population reporting to the DCN.
- Assistant Director of Community Nursing (ADCN) (currently Assistant Director of Public Health Nursing (ADPHN)) in each CHO area to manage child or adult service provision for 250,000 populations reporting to the DCN.

B Developing a central point of nursing and midwifery governance and accountability, for all nursing and midwifery roles, both public, private and voluntary must be developed to provide an integrated and seamless service.

C Developing a suite of Performance Indicators that demonstrates and measures the effectiveness of nursing and midwifery contribution to population health outcomes including hospital avoidance, early discharge, access and choice and improved patient flow.

D Continuing to support the Department of Health to employ evidence informed assessment tools and frameworks for the development of the nursing and midwifery workforce, including succession planning to develop an integrated approach to determine the service and workforce needs.

- This work will take account of the current work undertaken by the steering group for strategic integrated workforce planning (WFP); so that community integrated WFP optimises all of the skills and roles within the community.
Questions:
1. What are the beneficial changes of the proposed governance arrangements for:
   a. Patient needs and outcome;
   b. Service deliver; and
   c. Nursing and midwifery practice.
2. What are the challenges of the proposed governance arrangements offered?
3. What other options can be proposed to support the governance arrangements required?

Integrated care offers the patient a seamless service that is delivered on an interdisciplinary basis. The interdisciplinary team delivers to the patient holistic, non-hierarchical coordinated care involving the active participation of the individual, family and community if required. As a result, this team approach delivers what the patient needs and not just what the professional can deliver. This will be achieved by:

Actions | A | Enhancing existing community networks that are inclusive of all relevant health providers. Networks will have robust governance, role clarity, accountability and responsibility to further enhance collaboration and communication by:
   a) Enhancing the existing primary care network structures to become fully operational;
   b) Developing connectivity between networks in each CHO area to optimise and standardise provision of services; and
   c) Establish networks between the CHO areas and other healthcare providers at regional and national levels to optimise consistent integrated service provision.
   B | Enhancing and developing the interdisciplinary education of all healthcare professionals in undergraduate, post graduate and continuous practice.
   C | Reviewing the current standards and requirements for undergraduate nurse and midwife education programmes to take account of the requirement in this model, to practice across an integrated pathway of care that embraces competencies to work in the community.
   D | Ensuring that the new model of care and associated pathways are implemented in each CHO and HG within the context of robust evaluation and clinical governance.

Questions:
1. How will the interdisciplinary approach proposed in this policy affect patients/staff within public, private, and voluntary service provision of care?
2. How will this policy impact on current working relationships?
3. Please highlight any other enablers or barriers.
**Overarching Questions:**

1. What will the success of this policy look like?
2. From your experience, what would enhance this policy’s ability to achieve the core objectives of hospital avoidance, early discharge, improving patient flow and improving patient access?
3. What service level changes are required to achieve this?

<table>
<thead>
<tr>
<th>5</th>
<th>Making it happen will require a planning and action phase to assure the capability of the model of care and associated pathways to deliver on their intended outcomes. This will be achieved by:</th>
</tr>
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</table>

**Actions**

**Phase I Pre-Planning**

<table>
<thead>
<tr>
<th>A</th>
<th>1 Establishing a planning group* that will oversee the planning and development of demonstrator projects to assess the intended outcomes that will include the resource implications arising from the policy recommendations;</th>
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<tr>
<td></td>
<td>2 Identify the demonstrator sites based upon alignment to the highest presentations at ED and the highest waiting list for OPD. (Based upon the evidence from ED presentations, respiratory/COPD patients are one of the highest cohorts);</td>
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</tr>
<tr>
<td></td>
<td>4 Seek approval to proceed to demonstrator projects implementation.</td>
</tr>
</tbody>
</table>

| B | Establish an implementation group of appropriate members that can oversee the demonstrator projects development, implementation and evaluation. |

| C | Establish local implementation groups that can operationalise the recommendations above for a specified cohort of patients in a defined geographical area. |

| D | Ensure that the demonstrator projects are supported by sufficient resources and evaluated with robust measurements. |

The planning group will consist of key policy representatives in the DoH and the HSE. The objective of this approach is to ensure integration and alignment with overall corporate policies.
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