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Ageing With Intellectual Disabilities and Complex Age-Related Conditions in Ireland: In Search of a Model of Care

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ABSTRACT

Improvements in health care and supports for people with intellectual disabilities have resulted in greater longevity, with more people living into older age. This is a positive development, but it has seen the occurrence of age-related issues that were theretofore quite rare in this population. It has become clear that some of these issues present a level of complexity, requiring a coordinated, timely, and individualized response. That response has been challenging for intellectual disability services in Ireland, where there has been no clear model of care for older people with intellectual disabilities with complex age-related health needs. The authors, having undertaken a review of the literature to identify extant models and finding none, seek in this paper to bring together key concepts and aspects to propose a model of care to support older people with intellectual disabilities as their needs become more complex.

1 | Introduction

Intellectual disability services in Ireland developed historically according to a quasi-medical model, with the institution modeled on the classic hospital and the service provided via health personnel. The work of these health-care staff (nurses, nurses' assistants, and doctors) was eventually complemented by the creation of a multidisciplinary team of health specialists (psychologists, occupational therapists, physiotherapists and speech and language therapists, for example) providing essentially a private health service for the residents of those services, focused around managing their intellectual disability and more recently care workers focusing on person-centred care and participation in the community. People lived and died in these services, surrounded by their fellow residents and service personnel.

The move away from congregated service provision in Ireland, heralded most notably by the Health Service Executive's (2011) policy document *Time to Move on From Congregated Settings*, affirmed an already shifting service paradigm away from a health-focused model to one grounded in social care. The staffing model changed too, with a move towards employing social rather than health workers as the community-based options became increasingly focused on employment and community engagement. Embedded in the transition to community-based living was an assumption that mainstream healthcare services in the community would be accessed on a basis similar to that of the general population (McCallion et al. 2017). The emergent view of health and healthcare was grounded in a desire to break away from medical models and to celebrate opportunities to be healthy rather than focused on illness and health needs.

Recent decades have also seen an increase in the number of adults with intellectual disability reaching older age (Egan et al. 2022; Dolan et al. 2021; McCarron et al. 2017), largely due to improvements in health and social conditions (Bigby and Haveman 2010). This welcome increase in longevity has given rise to new challenges, as demographics became increasingly diverse, with needs and health issues varied and complex (McCausland et al. 2021; Hatzidimitriadou and Milne 2005). The growth and development of intellectual disability services in Ireland was historically predicated on meeting the needs of a population who would have a shorter lifespan. With the proportion of older people in the intellectual disability services increasing and with unexpected age-related complexity, respondents in a recent Irish study overwhelmingly reported (93.3%, $n=28$) a corresponding increase in complexity for provision of service to older people with intellectual disabilities (Sheerin et al. 2023). This complexity presents as "multidimensional health and social care needs in the presence of a recognized medical condition or where there is no unifying diagnosis. [These] are individual and contextualized, are continuing and dynamic, and are present across a range of settings…" (Brenner et al. 2018, 1647), and requires care that is similarly, individually oriented and dynamic (Borghmans et al. 2024). Although age-related health conditions are akin to those of the general population, they are more likely to go unrecognised and people with intellectual disabilities are more likely to experience inequality in healthcare delivery (Doyle et al. 2021; Liao et al. 2021) with health and social care systems ill-equipped to meet those needs (García-Domínguez et al. 2020; Burke et al. 2019; McCarron et al. 2018; Haveman et al. 2011). The range of unmet health and social care needs (Bigby et al. 2014) is further compounded as people with intellectual disabilities are more likely to manifest premature ageing and increased risk of age-related health conditions (Alftberg et al. 2021; Haveman et al. 2010); and people with Down Syndrome, for example, have a higher risk of developing Alzheimer's disease at younger ages (Bigby 2008; Janicki and Dalton 2000). Furthermore, healthy ageing interventions have generally not been aimed at people with intellectual disabilities (Santos et al. 2022), and healthcare inequalities have been implicated in avoidable excess mortality in this population; with inequality of access to palliative care for people with intellectual disabilities described as "an urgent international priority" (Adam et al. 2020, 1007).

This paper draws together the available Irish and international literature and seeks to present an argument for the development of a model of care for this population in Ireland. Furthermore, it attempts to identify the key components and aspects inherent in such a model.

2 | Model of Care

A model of care aims to ensure that people receive the "right care, at the right time, by the right team and in the right place" (p. 3) defining the way health services are organised and providing guidance on the delivery of best-practice care and services for a person or population as they move through their health journey (New South Wales Agency for Clinical Innovation 2013). Such a model should be guided by core components and principles that sit within a structured framework which guides the implementation and evaluation of care (palliAGED 2021).

Models also facilitate the provision of a service across various settings. Thus, for example, Jokinen et al. (2013) describe a number of scenarios within which adults with intellectual disabilities and dementia may find support: for example, (1) a private home with a family or other caregiver; (2) living alone or with a housemate; (3) a group home or apartment; (4) a specialised dementia-capable residence; and (5) day service. They suggest that the appropriateness of any model can only be considered in the light of the assistance and support that is required by the individual person (Jokinen et al. 2013). Furthermore, a model of care should incorporate a continuum of service types to meet individuals' diverse needs (Watchman and Janicki 2019). Any model of care relating to persons with intellectual disabilities should also be cognizant of the obligations embedded in the United Nations (2006) Convention on the Rights of Persons with Disabilities (UNCRPD), thus ensuring that all people with disabilities are treated as people with rights, with the capacity to claim those rights, make decisions for themselves, and participate as active members of society.

Despite the limitations in specific evidence in respect of a model of complex-age related care for people with intellectual disabilities, it may be possible to glean some insights from the literature into the key aspects of such a model of care. Upon examination, it was noted that these aspects centred on areas encountered in non-age-related models and frameworks, including palliAGED (2021), Health Service Executive (2016), Genio (2016), New South Wales Government (2016) and National Health Service (2015). These are used in Figure 1 as structural components (integration, planning, workforce, networking) to support discussion of the literature-based evidence.

3 | Search Strategy

A scoping review of literature was conducted in two phases to identify models of care that support older people with intellectual disabilities and complex age-related conditions. The searches, which were overseen by a subject librarian, were run across the databases CINAHL, Medline, Embase, Web of Science, ASSIA and PsycINFO keyword strings derived from database thesauri. Three key concepts, 'Intellectual Disability', 'Older Person' and 'Complex Care' were used in full and truncated form along with synonyms (Table 1). A double-strand search strategy was employed, running *thesauri* terms first and then keywords. These two searches were then combined using the OR operator. This method was repeated for each concept and finally these were combined using the AND operator.

Finally, focussed searches were conducted for non-review information that provided a contextual backdrop for the review. Given the challenges associated with securing translations, literature was restricted to those in the English language. A comprehensive search methodology was undertaken for unpublished (grey) literature through extensive grey literature retrieval mechanisms. Study design delimiters were not employed, thus increasing the likelihood of finding relevant studies irrespective

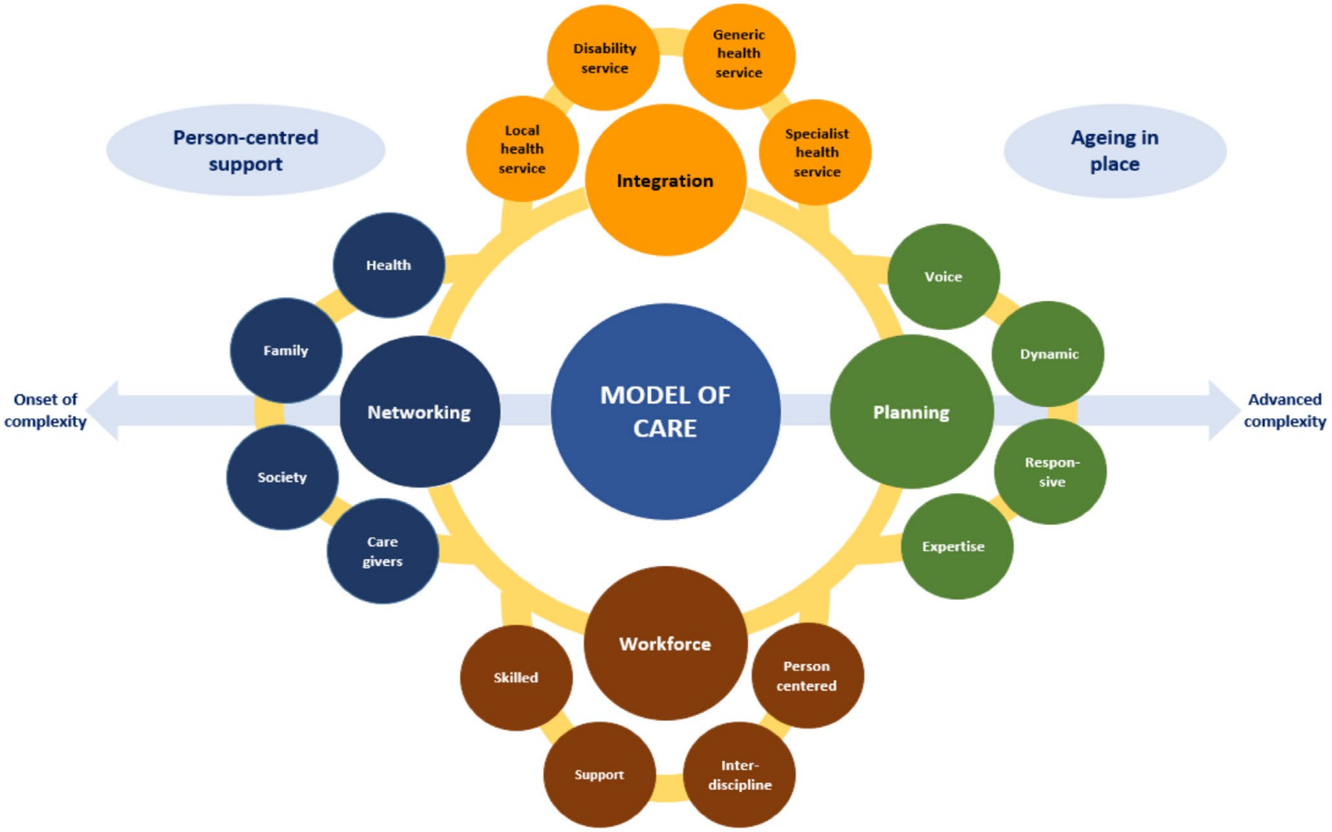

FIGURE 1 | Components of a model of care for older people with intellectual disabilities and age-related complex needs (Sheerin et al. 2023).

TABLE 1 | Exemplars of synonyms used for the search.

Key concept	Intellectual disability	Older person	Complex care
Exemplars of synonyms (database specific)	Learning disabilities Mentally disability Mental retardation Developmental Disabilities	Aged 80 and over	Terminally ill Critical illness Catastrophic illness Chronic illness

of design. No start date was applied, and literature was searched to March 2023.

Selection of relevant studies and other documents was conducted independently by two reviewers. This involved initial screening of titles and abstracts, followed by full text screening. Conflicts were resolved through discussion. Two reviewers carried out independent assessment of risk of bias/methodological quality on all included. If there were any discrepancies, consensus was reached through discussion. A total of 7448 records were retrieved in the initial searches, during 2020 and 2021, leading to the identification of 27 relevant records. Subsequent searches conducted in March 2023 resulted in the full text review of 52 records and the addition of 12 additional records to the review. Thus, 39 records were included for the overall review. Further literature is included where it provides useful context.

Key concepts arising in the literature pertain to integrated care (McCarron, McCallion, Fahey-McCarthy, and Connaire 2010; McCarron, McCallion, Fahey-McCarthy, Connaire, and Dunn-Lane 2010), planning (Bekkema et al. 2015; Schepens et al. 2019; Voss et al. 2020; Wark et al. 2017), networking (McCarron, McCallion, Fahey-McCarthy, and Connaire 2010; Johansson et al. 2017; Schepens et al. 2019), and workforce (Jenkins 2012; McCarron, McCallion, Fahey-McCarthy, Connaire, and Dunn-Lane 2010; Voss et al. 2020; Wiese et al. 2014). Furthermore, such a model would be grounded on key principles or values, such as dynamic person-centered support (McCarron, McCallion, Fahey-McCarthy, and Connaire 2010; Schepens et al. 2019) and aging in place (McCallion et al. 2017; Patti et al. 2010; Chapman et al. 2018). These key values are considered in the following sections.

3.1 | Person-Centered Support

Person-centeredness is considered to be a prerequisite for the achievement of quality care and is based around the provision of individually determined responses to the person's needs, informed by the desires and decisions of the person themselves (Dowling et al. 2006; Department of Health 2017). Underpinned by the valuing of people as individuals (Coyle and Williams 2001; Edvardsson et al. 2010), person-centered support involves starting service planning from the perspective of the person instead of that of the service, resulting in a movement away from rigid, institutional structures towards ones that are adaptable, dynamic, and changing (Brooker 2003; Schepens et al. 2019; McCarron, McCallion, Fahey-McCarthy, and Connaire 2010) according to the needs and preferences of the users (Tilley et al. 2023; Dowling et al. 2006). It is argued that this approach offers a better opportunity for independence and quality of life (Tilley et al. 2023; Heller et al. 1998).

White et al. (2008) have suggested there to be six dimensions of care: personhood; knowing the person; autonomy; comfort care; support for relationships; and a supported environment. Many of these are noted by de Silva (2014) who includes the need for employing a holistic approach to assessing needs and providing care and recognizing individuals' expertise in their own care. The enactment of person-centered support places significant demands on a health service, hence the need for it to be fully embedded in the model of care (Mansell and Beadle-Brown 2012). This is further challenged by the presence of complexity (National Institute for Health and Care Excellence 2015) and requires that staff be adequately trained in both person-centered support and the specialist techniques pertinent to the nature of that complexity (Mansell and Beadle-Brown 2012).

3.2 | Ageing in Place

There is much discussion in the literature regarding the location in which people with intellectual disabilities should reside as their age advances. The scope of such literature extends across a wide range of complex age-related health issues, including end of life (Bekkema et al. 2015), palliative care (McCarron, McCallion, Fahey-McCarthy, and Connaire 2010; Tuffrey-Wijne et al. 2008), dementia (McCarron, McCallion, Fahey-McCarthy, Connaire, and Dunn-Lane 2010; Chapman et al. 2018), nutritional concerns (Forbat and Service 2005) and the need for complex medical interventions (Forbat and Service 2005). All are agreed, however, on the basic premise that, where possible, older people with intellectual disabilities should be supported to remain in the home of their choice for as long as possible with the caveat that this is sometimes only possible if appropriate supports and resources can be put in place on a 24-h basis (Schepens et al. 2019, Bekkema et al. 2015; Tuffrey-Wijne et al. 2008; Health Service Executive 2012). Older people with intellectual disabilities often experience a greater number of significant life events than do their counterparts in the general population (McCarron et al. 2017) and relocation out of one's own home may exacerbate functional decline, as it constitutes a significant life event (Patti et al. 2010). Where transitions are necessary, they should be based on proactive planning to optimize the potential for successful relocation (Tilley et al. 2023). Thus, the model of care should build on the principle of providing care/service in the person's home of choice, drawing on staff and other resources through person-centered planning and integrated support that draws on familial (Baumbusch et al. 2017; Forrester-Jones et al. 2017; Voss et al. 2020; Patti et al. 2010), social (Johansson et al. 2017) and health service networks.

Whilst acknowledging the principle that a person should remain at home for as long as possible, and that their complex age-related needs should be met in that location, the concept of a ‘specialist ageing facility’ alludes to a need for an alternative location where, at some point, complex care may need to be provided away from the person's home. This may be particularly pertinent when a person is ageing in a family home. In this case, family choice, and their capacity to support as they themselves age, must be considered. The Specialist Geriatric Services Model of Care (Health Service Executive 2012) sets out the vision for such a response in the Irish health service. While it does refer to the fact that ‘residential care beds/nursing home beds…are required to care for a frail older person when their medical, nursing and biopsychosocial needs can no longer be met in their own home’ (p. 15), it is clear that specialised care is viewed, not as a facility but, rather, a service that can respond in multiple settings. This echoes the perspective of Jokinen et al. (2013). It may, therefore, be better to consider the concept of a ‘specialist ageing service’. Such an approach is inherent in the Irish Health Care Executive's (2012) model of care which envisions specialist ageing services having a footprint in emergency, hospital, outpatient and primary care, as well as reaching out to long term residential settings. This view is also shared by the British Geriatrics Society (2021). However, for people with intellectual disabilities past histories of exclusion via specialized services, the differences in age between someone in the general population and a person with an intellectual disability with a similar late onset health profile has raised concerns about the reliance on such models (McCallion et al. 2017).

Age-related health issues do not occur in isolation and have a broader impact on the physical, mental, and social wellbeing of the adult with intellectual disabilities; hence, there is a need for multidimensional specialist service. Schepens et al. (2019) and Rowe (2016) propose that, irrespective of where the person is living, the aim should be to create a health focus where health risks and age-related issues can be identified early, through screening and assessment, with developing issues managed in an integrated and planned way, through appropriate and timely interventions, including, where needed, palliative care and end-of-life decision making (Haveman et al. 2009). Ageing years are not only health and infirmity years, so provision also must respond to quality of life and community engagement concerns. It will be through building upon a foundation of key values, attention to key care needs, and the preservation of what has been gained in the lives of people with intellectual disabilities that must be the basis for a model of care for older people with complex age-related needs.

3.3 | Key Components for a Model of Care

3.3.1 | Integration

A number of Irish policy documents have identified the importance of integrated care (Health Service Executive 2019, 2018, 2021a) seeking to address the fragmentation of services for older people with intellectual disabilities by focusing on the creation of seamless care pathways (Chapman et al. 2018) which integrate care, drawing on services to respond to the needs of the person when and as they develop. Such pathways may relate to particular areas of complexity, including dementia (Chapman et al. 2018) and palliative care (McCarron, McCallion, Fahey-McCarthy, and Connaire 2010). Optimal services for older people with intellectual disabilities should have seamless interfaces with other local generic and specialist services, with immediate availability of specialised support and advice to facilitate responsiveness to the changing reality of the person's needs (McCarron, McCallion, Fahey-McCarthy, and Connaire 2010; McCarron, McCallion, Fahey-McCarthy, Connaire, and Dunn-Lane 2010; Chapman et al. 2018) as they progress along the life course (Baumbusch et al. 2017). This also promotes the possibility of the person ageing in place (Johansson et al. 2017).

3.3.2 | Planning

The interface between intellectual disability service and specialised health services has been difficult to navigate for many people with intellectual disabilities (McCarron et al. 2018; Health Service Executive 2021b). Generic health services, community care and palliative care have often been inaccessible, highlighting the need for coordinated and 'clearly managed pathways for health care' (McCarron et al. 2018, 75). In response to McCarron et al.'s (2018) report, there have been moves, in Ireland, towards redressing this situation, through the instigation of liaison roles between disability and health services.

Successful implementation of specialist service has a resource implication (Johansson et al. 2017). Inherent in such resources is that service recipients will have access to staff who are knowledgeable and skilled in the issues related to age-related care, and to appropriate equipment to facilitate timely recognition of physical and cognitive decline (Tilley et al. 2023; Johansson et al. 2017), emerging age-related illnesses or pain (Tilley et al. 2023; Haveman et al. 2009; McCallion et al. 2012), and impending end of life (Voss et al. 2023; Todd et al. 2020; Bekkema et al. 2015). Less explored is the expectation that all practitioners have a level of readiness to work with people with intellectual disabilities as they age in ways that are similar to expectations that practitioners be ready to serve other groups.

In this context, therefore, planning, within a model of care, must be responsive to the needs and preferences of older people with intellectual disabilities (Schepens et al. 2019). Thus, it is crucial that the model of care draws on the voices of the people who are recipients of that care (Bekkema et al. 2015). This harmonizes with the person-centered approach but also supports the concept of self-determination, which Schepens et al. (2019) suggest lends itself to positive aging, manifesting in their relationships, physical and mental health, and satisfaction. They also propose that self-determination contributes to a positive process for planning (ibid.), through active engagement of the person in making decisions about their own lives (McCallion and Ferretti 2017; Wark et al. 2017). Recent legislation in Ireland on mechanisms to support Active Decision-making both highlights the concerns and provides mechanisms to ensure that people with intellectual disabilities themselves are active participants in their healthcare and other decision-making. This is particularly pertinent as complex care issues will inevitably develop, which may require decisions to be made that will have important consequences for the person's care and their quality of life in older years. In the context of legislation such as the Assisted Decision-Making (Capacity) Act 2015 (Government of Ireland 2015) and the Mental Capacity Act 2005 (United Kingdom Government 2005), there is also a need for supported decision-making, which may include a decision-making assistant or proxy. Engagement between the person, family, and caregivers can provide space for discussions on issues such as advance care and end-of-life planning (Voss et al. 2020; Wiese et al. 2014).

Planning must also be interdisciplinary in nature (McCarron et al. 2018). Interdisciplinarity relates back to the previous discussion on integration but implies that person-centred support must be able to draw on the appropriate specialisms in a timely manner. This requires that there should be a proactive interdisciplinary approach aimed at identifying issues early and responding in a timely manner (Chapman et al. 2018). As noted, the development of integrated care pathways may be useful in bringing together the relevant expertise (Chapman et al. 2018; Tuffrey-Wijne et al. 2007). An example of interdisciplinarity in planning between services may be seen in McCallion et al.'s (2012) account of disability and hospice services working together for end of life and palliative care. Access to such services is vital but the sharing of knowledge and skills across the various aspects of care complexity is equally important (Jenkins 2012; Schepens et al. 2019) and raises the issue of workforce planning, which will be addressed anon. It should not be forgotten that *interdisciplinary expertise* should not mean that the input of the person themselves, their family and of care workers in their homes should be given less weight.

3.3.3 | Workforce

The move away from congregated service provision in Ireland, heralded most notably by the Health Service Executive's (2011) policy document Time to Move on From Congregated Setting, affirmed an already shifting service paradigm away from a health-focused model to one grounded in social care. This model, however, did not often link in with specialized aging-related services (e.g., palliative care), which remained difficult to access for people with intellectual disabilities. The timing of this was notable as it occurred as increasing numbers of children with intellectual disabilities and life-limiting conditions were surviving and greater longevity was being reported in older people with intellectual disabilities (McCarron et al. 2018). The staffing model changed too, and there was a move towards employing social rather than health workers. McCallion and McCarron (2014) argue that the higher rates of avoidable deaths from manageable health conditions point to the need for more concerted and skillful health care delivery for people with intellectual disabilities and for health services to support integrated care within community services as well as between the community and hospital services. The prioritization of social inclusion and decongregation led to the reduction of residential places within intellectual disability services, thereby inadvertently increasing the transition of people with developing complex needs into other long-term community services (Egan et al. 2022). As the numbers with complex health care needs increase, this is not a reason to again rely upon medical model services but is rather a challenge to find new ways to provide health supports while continuing to value chosen community lives.

It has been suggested that the removal of health skills among the workforce has meant that, in the face of new age-related complexity, older people with intellectual disabilities are not able to age in place and are more likely to be relocated to a 'nursing unit'; something confirmed by Patti et al.'s (2010) retrospective study and in literature reviewed by Tuffrey-Wijne et al. (2007). That said, the emergence of small group home approaches, such as those described by (Janicki et al. 2005; Jokinen et al. 2018) offer alternatives to a health-focused approach, drawing on flexible staffing (numbers and skillsets), with programmes and environments that can be modified according to and in-step with the needs of individuals.

It is proposed that, as people with intellectual disabilities age, they should do so in the home of their choice and relocation should be avoided as much as possible (Patti et al. 2010). Many authors note that, to achieve this, staff must have the prerequisite knowledge and skills to provide the support required (Voss et al. 2020; Jenkins 2012; Johansson et al. 2017; McCarron, McCallion, Fahey-McCarthy, Connaire, and Dunn-Lane 2010). Furthermore Kåhlin et al. (2016) argue for specific policies to support a formal culture within disability services that addresses old age and intellectual disability. The intention is not to recreate a health-focused staffing model, but rather to ensure that those who provide care and support to older adults with intellectual disabilities receive education and training so that they can continue to respond to the age-related complex needs presented by, for example, dementia and palliative care. Specialist nursing roles may assist in creating a bridge between specialist services, generic healthcare including hospitals and disability support (McCarron, McCallion, Fahey-McCarthy, and Connaire 2010; McCarron, McCallion, Fahey-McCarthy, Connaire, and Dunn-Lane 2010; Jenkins 2012). Similarly, training of caregiving staff in a variety of preventative and basic health care, social and other skills may facilitate flexibility and responsiveness among those working in providing service to older people with intellectual disabilities (Janicki et al. 2005). Such training is not only pertinent to the management of complex age-related health conditions (Tuffrey-Wijne et al. 2007), but may also encourage staff to facilitate healthy ageing, in the physical, mental and social domains (Johansson et al. 2017), as well as embedding capacity to support end-of life conversations that are so important to advance care planning (Wiese et al. 2014; Voss et al. 2020).

Staff do not, however, work in isolation, as aging in place carries with it an expectation that people with intellectual disabilities should remain connected to family and society. This final component of a model of care will now be addressed.

3.3.4 | Networking

It has been noted that there is a need for the integration of disability, social, community, and health services to facilitate appropriate and timely responses to the older person's needs and preferences. It is, however, also important that social interaction and community engagement are addressed, and that the social network and community activities, which are part of ageing in place in the community, are supported and nurtured too (Johansson et al. 2017). This was explored by Sheerin et al. (2015) in their evaluation of a community living initiative which, while not focused on complexity in ageing, did identify the loneliness and disconnect experienced by some older people with intellectual disabilities in the absence of social integration. A significant aspect of that study was the importance of peer interactions, and this is also noted by Schepens et al. (2019) and Forrester-Jones et al. (2017). In many ways, the concept of networking brings together two underpinning values in the model, including ageing-in-place (family involvement) (Baumbusch et al. 2017) and person-centeredness (staff training/focus) (Voss et al. 2020).

3.4 | Implications and Recommendations

As the proportion of older people in the intellectual disability services increases and as care needs become more complex, there is a need for a model of care to support the adequate and appropriate provision of such care. Ageing may be a dynamic period in a person's life and, notwithstanding the absence of an extant model of care, several recurrent concepts are apparent and have been explicated above. However, it is also evident from the literature that there are many challenges posed for services in meeting these needs including those relating to the workforce, integration, networking, and planning. Fundamental to many of the challenges is the current practice of per capita funding which may, in fact, be "congregated" to the overall cost of providing a service for older people living in a particular setting thereby limiting the possibility of individualized service responses (Sheerin et al. 2023). Resources should be made available to ensure that supports for people with intellectual disabilities are tailored to meeting their needs. This includes education and upskilling of professional staff and caregivers as required, as well as adaptations to living environments where feasible.

With this in mind, the following are recommended:

- Service provision should be underpinned by a clear, structured, and integrated model of care, underpinned by the principles of person-centeredness and taking cognisance of their rights, wishes, and changing needs.
- Services should have integrated such that mainstream health and social services are accessible to people aging with intellectual disability.
- Funding should follow the person and be flexible in addressing the dynamic nature of needs and wishes to age in place, where appropriate.
- Where it is no longer feasible for a person to age in their own home, alternative accommodation should be provided by specialist intellectual disability services in a place that is geographically accessible for family and friends.

The above can only be achieved if there is a coherent approach to designing an overall model for care. It is the authors' opinion that this should represent an overarching conceptualization and plan which can guide the delivery of services for people who are aging with intellectual disability. The responsibility for such developments in the Republic of Ireland has traditionally rested with the state agency which oversees and resources the delivery of health and social care, the Health Services Executive, but considering the importance of person-centeredness and rights, the authors consider it crucial that the voices of all stakeholders, especially those of people with intellectual disabilities, are central to its development.

4 | Conclusion

There is limited evidence in respect of models of care related to the support of older people with intellectual disabilities and complex age-related conditions. However, a number of recurrent concepts central to the provision of service are apparent in the literature, namely models of care should be underpinned by the fundamental principles of person centredness support (Brooker 2003; Schepens et al. 2019; McCarron, McCallion, Fahey-McCarthy, and Connaire 2010) and ageing in place (Schepens et al. 2019, Bekkema et al. 2015; Tuffrey-Wijne et al. 2008; Health Service Executive 2012) and key components pertaining to integrated care (McCarron, McCallion, Fahey-McCarthy, and Connaire 2010; McCarron, McCallion, Fahey-McCarthy, Connaire, and Dunn-Lane 2010), planning (Bekkema et al. 2015; Schepens et al. 2019; Voss et al. 2020; Wark et al. 2017), networking (McCarron, McCallion, Fahey-McCarthy, and Connaire 2010; Johansson et al. 2017; Schepens et al. 2019), and workforce (Jenkins 2012; McCarron, McCallion, Fahey-McCarthy, Connaire, and Dunn-Lane 2010; Voss et al. 2020; Wiese et al. 2014). These recurrent concepts can be synthesised into a nascent structure which, it is proposed, may provide a basis for developing a model of care and which may be represented graphically as in Figure 1 above. Furthermore, and importantly, this model is grounded on a number of key principles or values, such as dynamic person-centred support (McCarron, McCallion, Fahey-McCarthy, and Connaire 2010; Schepens et al. 2019), and ageing in place (Patti et al. 2010; Chapman et al. 2018).

Conflicts of Interest

The authors declare no conflicts of interest.

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