Inter-professional education and training to build teams of the future – learning from the ECC transformational programme

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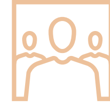
ECC Programme: Principles

Keep people well in their own homes



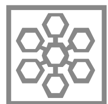
Provide services on a population basis

Provide primary care and GP services in the community

Link with other community services, voluntary and statutory bodies

Develop and provide access to specialist services in the community to targeted groups

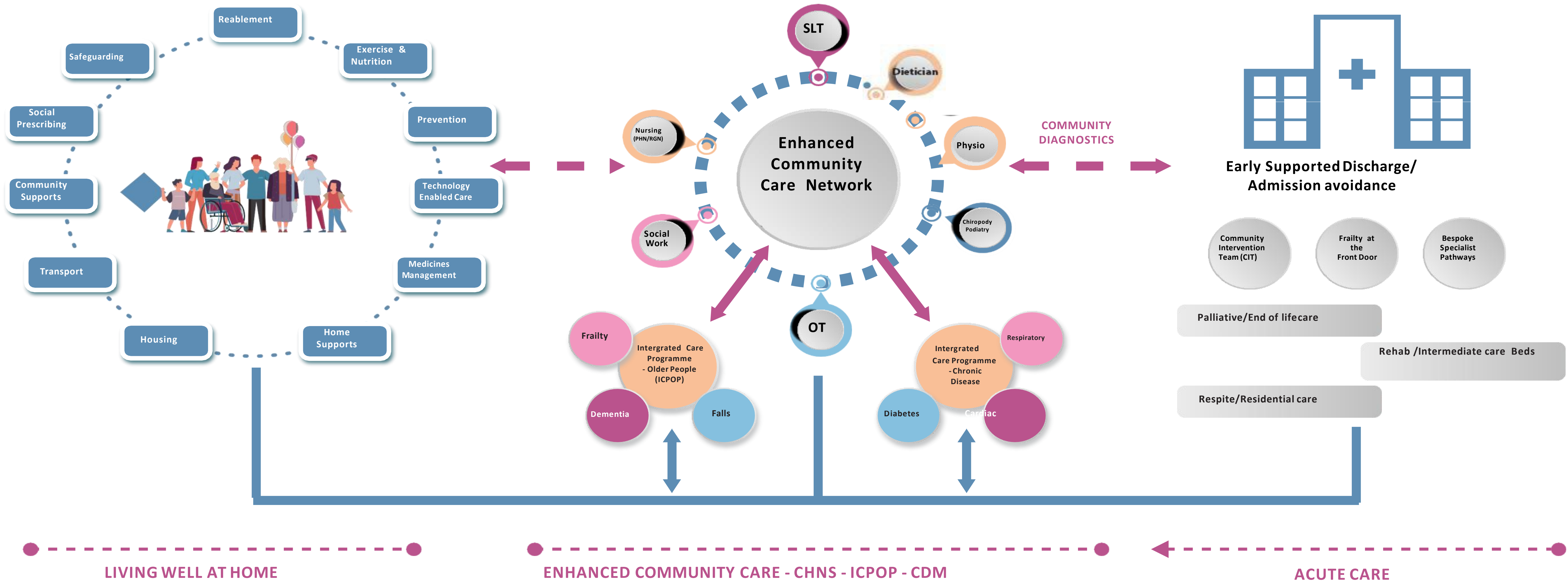
Ensure that discharge from acute hospitals is coordinated



End to end model approach enables the implementation of integrated care programmes

Apply resources intensively in a targeted manner to a defined population

Shift left of Resources & Activity

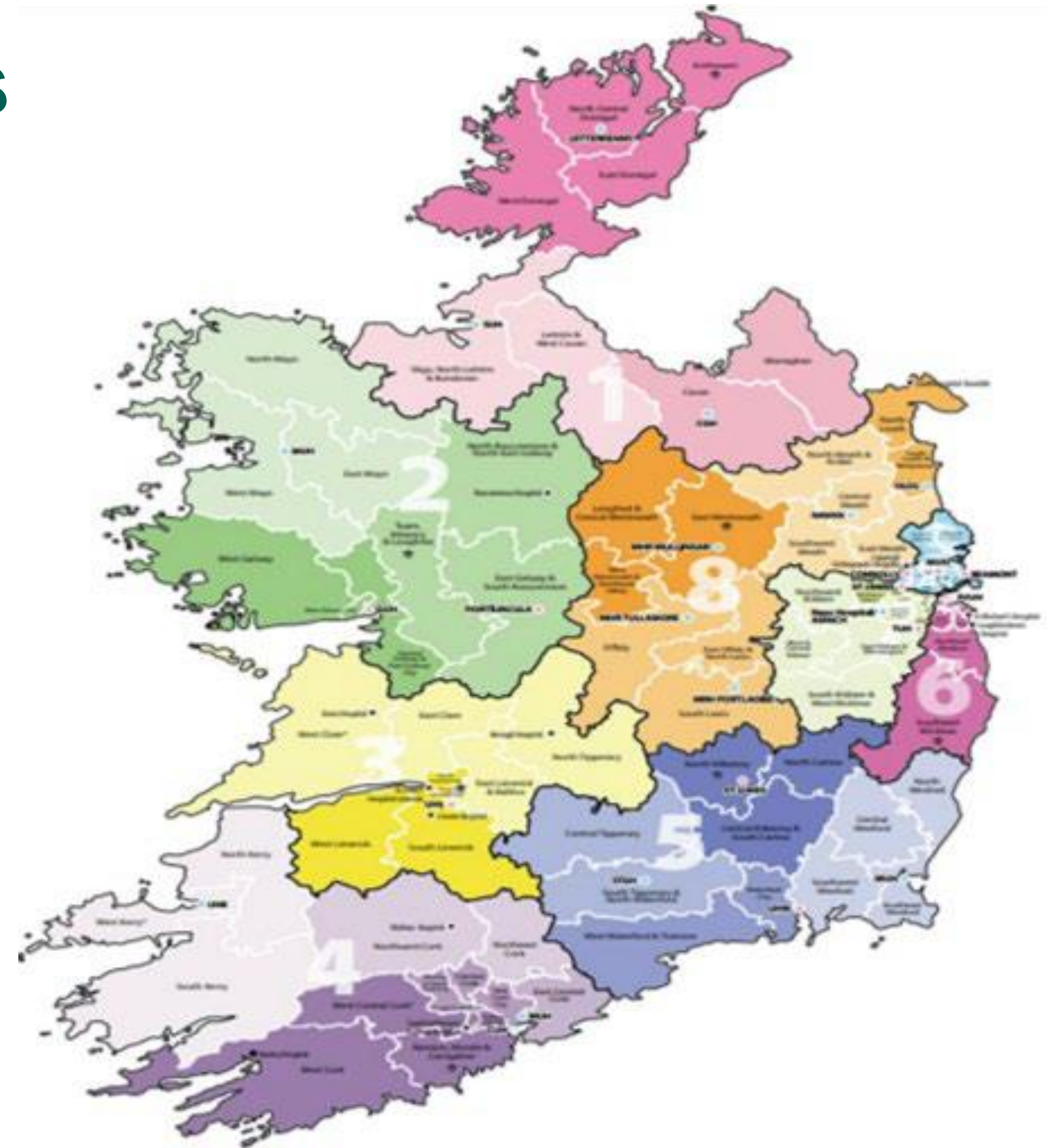


Community Healthcare Networks

Community Healthcare Networks

Through the implementation of the ECC Programme, we are establishing **96 Community Healthcare Networks (CHNs)**, providing the foundation and organisation structure through which integrated care is delivered locally at the appropriate level of complexity, with GPs, HSCPs, nursing leadership and staff, empowered at a local level to drive integrated care delivery and supporting egress in the community.

The 96 Networks, on average serving a population of 50,000, will implement a population need and stratification approach to service delivery and will improve integrated team working in primary care service, moving towards more integrated end-to-end care pathways, providing for more local decision-making and involving communities in planning to map identified health needs in their local area. The number of CHNs per CHO ranges from 8-14.



Community Specialist Teams

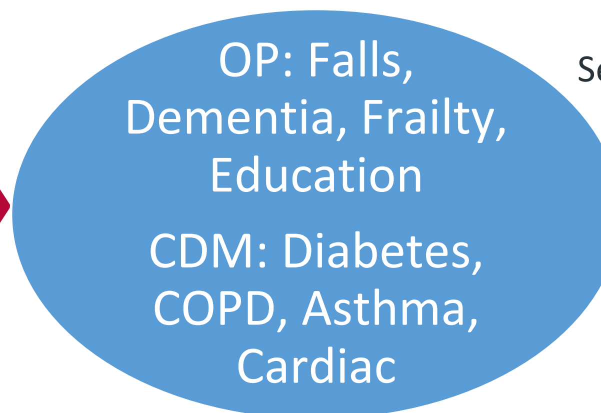
- 30 Community Specialist Teams for Older People & 30 Community Specialist Teams for Chronic Disease
- Supporting CHNs and GPs to respond to the specialist needs of the population, bridging and linking the care pathways between acute and community services - improving access to, and egress from, acute hospital services.
- Community Specialist Teams wil service an average population of 150,000 (3 CHNs).
- Teams wil be co-located together in 'hubs' located in or adjacent to Primary Care Centres reflecting a shift in focus away from the acute hospital towards general practice, a primary care and community-based service model.
- The services are fully aligned with the acute system with clinical governance being provided though the relevant model 4 or 3 hospitals, but with the services being delivered in the community setting.

Critical role of integrated interdisciplinary working

Population management and care pathway management

- Population Health profiling
- End to end pathways of care
- Managing populations of ~50k through Community Healthcare Networks
- Managing at risk of ~150k populations through CDM and ICPOP specialist teams
- Care closer to home as possible

Target Population/s



Dimensions of model

Self care management & support

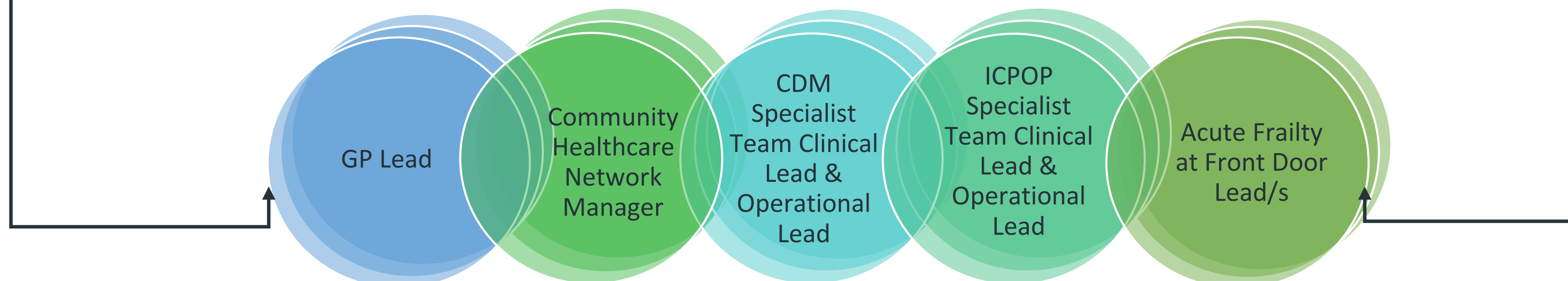
System design & delivery

Patient co-design

Integrated decision making

Enabled by Integrated clinical case management

Integrated interdisciplinary Team/s and Way of Working – Prepared, Proactive and Productive

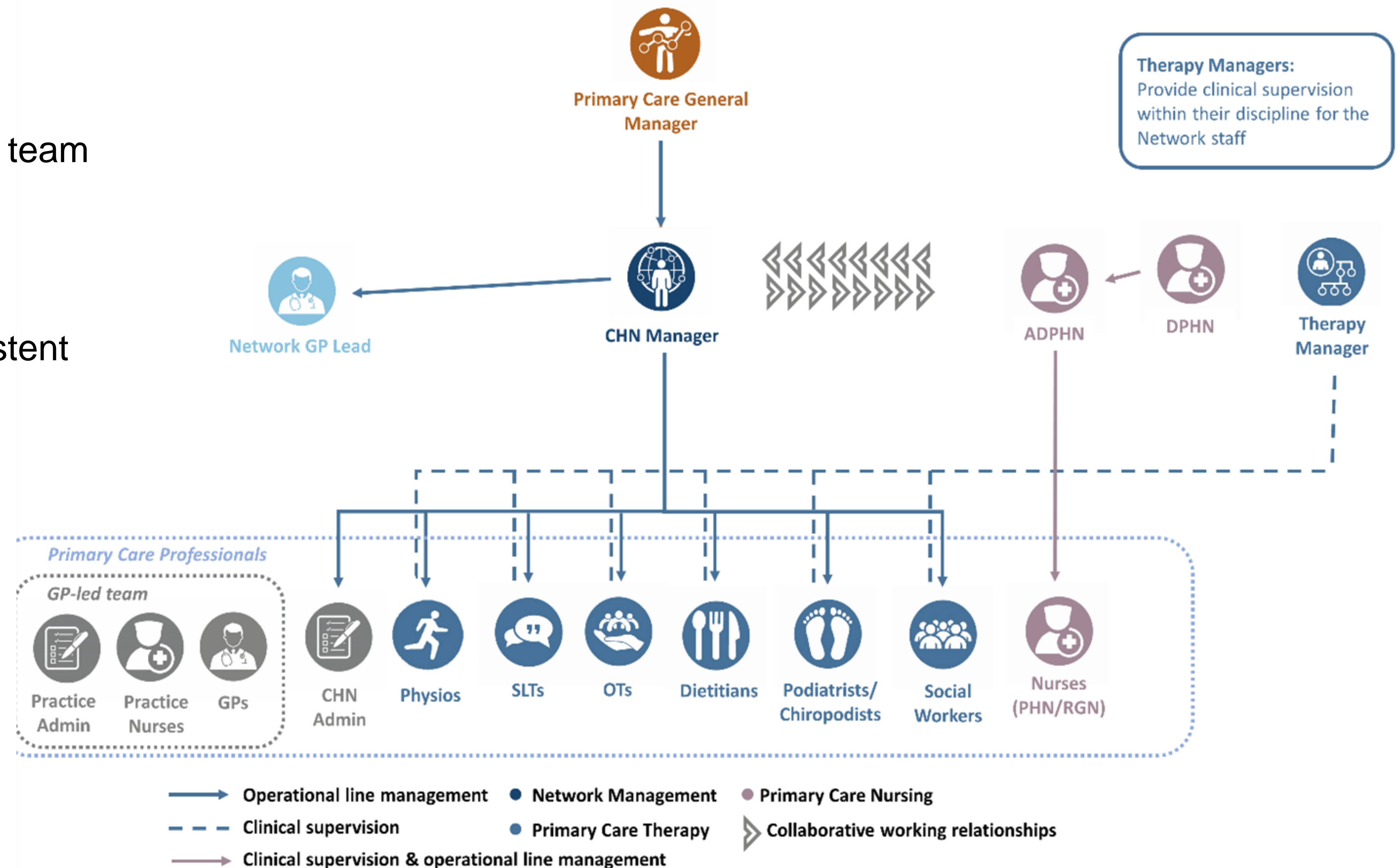


Underpinned and enabled by robust and effective clinical guidance, and inter-professional education and training

CHNs – from unidisiplinary to multidisciplinary Team working

Networks Aim to:

- Strengthen collaborative disciplinary team working in Primary Care
- Ensure more coordinated and consistent care for people using our services
- Improve integration with other community services
- Manage an deliver local services to a defined population



The role of Learning and Development- ECC/ CHNs

The HSE recognises the central role **Learning, Education and Development** plays in supporting good practice, and delivering safe and effective care whilst considering the development needs of all individuals.

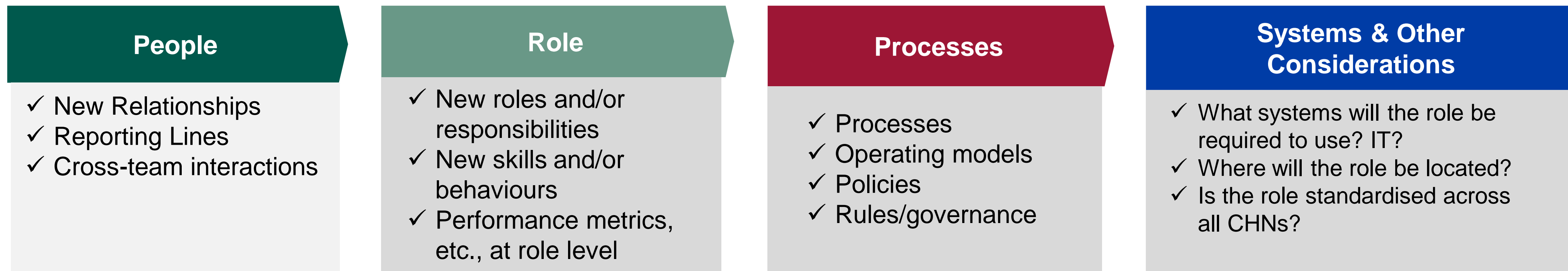
Learning and Development:

- Helps one improve or enhance their job performance
- Allows one to learn new skills and acquire new knowledge in order to take on new responsibilities, further enrich their role or advance their career
- Leverage their key strengths & identify areas for development

Learning & Development & Primary Care Learning Sites Implementation

Learning and development (L&D) is a key component of the Primary Care Learning Site Implementation process to ensure staff have the skills, knowledge and behaviours required to work within the Learning Site.There are a wide range of learning and development opportunities and resources available across clinical and non-clinical areas in the HSE which will be utilised and made available to those taking up new roles in the **Primary Care Learning Sites Implementation.**

L&D supports/resources will be available to all roles in the Learning Site however a key consideration in determining L&D supports for each role will be the level of change impact on the role **(High/Medium/Low)** across four key areas: **People, Role, Process, Systems & Other Considerations** which will be become apparent from the **Change Impact Assessment .** Key points for consideration for each of these areas are outlined below.

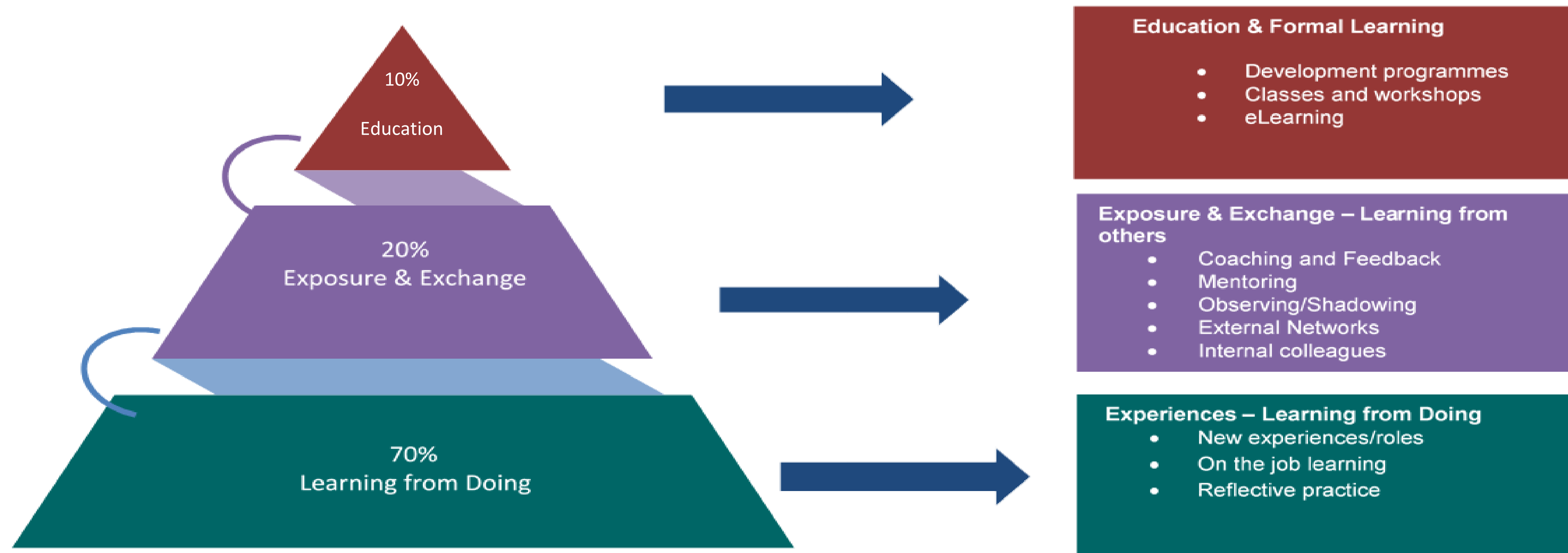


How Learning & Development is delivered in CHNs

Each of us must take personal responsibility for our own learning and development and supporting the learning and development of others. Learning and Development is recognised as a journey with many tools and techniques available to help us along the way.

A core principle of learning is adopting a **blended approach utilising the 70:20:10 model** and this model will be utilised as part of the L&D implementation process for all Learning Site role holders.

The **70:20:10** model recognises that **70% of** learning comes from **experiences** from **'on the job' learning**, **20%** comes from **exposure to others** and **exchange (i.e. coaching**) and **10% through education** such as **formal training programmes.**



Enabling integrated interdisciplinary working through education and training

Requires a broad range of supports to model and enable interdisciplinary working:

- Interdisciplinary development of pathways and guidance for clinical practice including co-design involving service users/patients and interprofessional team
- Education and training - includes roles of Higher Education Institutions, Regulators, Professional Bodies and Colleges (RCSI, RCPI, ICGP etc)
- Professional standards - includes roles of:
  - policy (DOH)
  - regulators (of professions - Medical Council, NMBI, CORU and services HIQA etc.)
  - professional bodies (ISCP, IASLT, IIRRT)

Examples of good practice education and training processes supporting integrated interdisciplinary working include:

- CHN Learning Site Process and associated support material
- ICPOP & CDM clinical guidance and associated support materials
- Buidling interprofessional approaches into CPD and funding; collaborations such as Spark Innovation across NDTP, ONMSD, HSCP; Clinical Leadership Competency Framework for Nurses, Midwives and HSCP; interprofessional practice based research informing practice.
- Interprofessional education approaches in several HEI. For example - UL has an IPE curriculum and most recently interprofessional practice placement. St James's in collaboration with TCD have Networking and Educating Students Together (NEST) involving 12 professions.

- Significant opportunity to enhance and enable the potential of interdisciplinary working through collaborative working with key stakeholders from across the health system

- This will be a critical factor in unlocking the potential of changing our healthcare system in Ireland