Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Clinical Strategy and Programmes Division

CSPD Reform and the establishment of Integrated Care Programmes Charter

Draft (16th March 2015)

Version 1.0

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1. DOCUMENT PURPOSE

This document is intended to set out the Programme of work for the reform of the Clinical Strategy and Programmes Division including the establishment of the Integrated Care Programmes.

The development of the Integrated Care Programmes is a major element of reform to the health and social care system in Ireland. The Clinical Strategy Programmes Division (CSPD) is forming five Integrated Care Programmes (ICP's) to support a fundamental requirement of the *Future Health* strategy, to deliver better, more integrated and responsive services to people in the most appropriate setting. The Integrated Care Programmes will work with, and build on the success of, the existing clinical programmes. The intention is that they will have a benefits focus to ensure not only a clinically sound design but also that the results are fit for implementation across the system. To that end the CSPD will be positioned as the Clinical Design Authority for clinical reform with responsibility for directing that changes implemented by the five operating Divisions are consistent with the Integrated Models of Care. Each Integrated Care Programme will develop a Programme Initiation Document to articulate the scope, workstreams and structure for delivering its vision and benefits.

The objectives of this document are to:

- Provide a background and introduction to the Programme
- Clearly articulate the Programme vision and benefits
- Describe the programme governance with clear decision making powers
- Define the reform approach and key workstreams
- Describes the high level plan with key milestones
- Describes the communication and engagement approach
- Develop a mechanism to monitor Programme risks and issues
- Provide an outline of the Programme reporting methodology
- Describes the resource requirements for the Programme.

This charter will form the basis for the management of Clinical Strategy and Programmes Division reform and establishment of Integrated Care Programmes.

2. BACKGROUND/ CONTEXT

The Quality Patient and Safety (Quality improvement division since Nov 2014) and Clinical Care Division was established in the HSE in 2009 and then subsequently divided into the Quality and patient safety Division and Clinical Strategy and Programmes Division (CSPD). CSPDs strategic role is to develop a national, strategic and co-ordinated approach for the design of clinical service improvements to deliver improved patient care, improved access and better use of resources. The Division is responsible to the Director General of the HSE, who is in turn accountable to the Secretary General of the Department of Health. National Clinical Programmes are agreed, scoped and resourced under the remit of the CSPD and report to that Division on their deliverables via the respective National Clinical Leads.

CSPD's role is to improve the patient experience and quality of care through the design of standardised models of care throughout the health care system by bringing together clinical and management disciplines and enabling them to share innovative solutions to deliver greater benefits to every user of our health services. This is achieved by designing and specifying standardised models of care, guidelines, pathways and associate strategies for the delivery of evidence based integrated clinical and social care. The implementation of these strategies has been outside the scope of the National Clinical Programmes, although the programmes do provide clinical leadership to support local implementation teams where needed.

The first phase of National Clinical Programmes has been based around developing excellence in individual specialties, specific diseases and stages of care, such as acute medicine and elective surgery. The Clinical Programmes have been instrumental in driving improvements in clinical care in Ireland and it is the vision for establishing the Integrated Care Programmes and that these individual National Clinical Programmes will remain the "engine room" of the clinical reform programme.

In November 2012 the Department of Health issued *Future Health: A Strategic Framework for Reform of the Health Service 2012 – 2015*. *Future Health* states that "*The current hospital-centric model of care cannot deliver the quality of care required by our people at a price which the country can afford. For this reason the Government is determined to create a new integrated model of care that treats patients at the lowest level of complexity that is safe, timely, efficient and as close to home as possible. The aim of increasing integration is consistent with initiatives in other countries that seek to shift the emphasis from episodic reactive care to care based on needs which is evaluated as to its impact on outcomes.*"

3. OVERARCHING SCOPE

To best meet the recommendations set out in Future Health the CSPD must reform to position itself as the Clinical Design Authority, building and incorporating the current clinical programmes the CSPD is establishing Integrated care programmes to enable the delivery of integrated models of care in Ireland. The CSPD have identified an initial five ICPs, which meet the defined principles of an ICP however for the avoidance of doubt all clinical services provided through the Health Service as part of the scope for consideration for delivering integrated models of care.

These ICP's will be established on a phased basis and are as follows:

- Integrated Care Programme for Patient Flow;
- Integrated Care Programme for Older People; and
- Integrated Care Programme for the prevention and management of Chronic Disease.
- Integrated Care Programme for Children;
- Integrated Care Programme for Maternity;

These ICP's will seek to work with the existing clinical programmes and other key enablers such as Finance, HR and ICT to ensure that they are aligned and can support the delivery of seamless patient centric services.

It is the intention of the CSPD that new ICP's are identified and prioritised in the future. The agreed working definition of an Integrated Care Programme is one which outlines a framework for the management and delivery of health services which ensure that patients receive a continuum for preventative**,** diagnostic, care and support services, according to their needs over time and across different levels of the health system. The supporting models of Care will incorporate cross service, multi-disciplinary care and support which will facilitate the **maintenance of health** and the delivery of appropriate high quality, evidence based care, delivered in a co-ordinated manner which feels seamless to the user. The ICPs will be underpinned by **proactive management of interfaces** between stakeholders to reduce barriers to integration and allows for cohesive care provision across a continuum of services.

The following principles have been developed to help identify potential ICP's:

- Disease or condition currently affects significant population;
- Potential to reduce burden of illness is high;
- Potential to alleviate service pressure points/ waiting lists/ delays is significant;
- Vulnerable groups (socially deprived/ young/ old / those with disabilities) are greatly affected by their condition;

- Outputs will result in appropriate care delivered closer to preferred location and at an appropriate level of acuity;
- The model should result in better quality of care;
- The theme is considered appropriate by patient advocacy representatives;
- Potential to obtain better value for money within health budget is high;
- The services delivered by at least 3 Operating Divisions would feature in the associated Model/ Framework;
- The Programme would require multi- disciplinary care planning; and
- Benefits would be tangible and measurable.

4. INTEGRATED CARE - VISION AND BENEFITS

4.1. WHAT IS MEANT BY INTEGRATED CARE?

Integrated care, as set out in Future Health, can be defined as "*care that improves the quality and outcome of care for patients and their immediate families and carers by:*

- *ensuring that needs are measured and understood and that;*
- *services are well co-ordinated around these assessed needs;*
- *it is preventative, enabling, anticipatory, planned, well-coordinated and evaluated; and*
- *it is a system of care that critically looks at the impact on health and wellbeing of the patients concerned.*

Understanding integrated care means looking at processes and outcomes of quality safe care rather than at structural and organisation issues."

Integrated care is an approach characterised by a high degree of collaboration and communication among health professionals. Integrated care delivery can occur in multiple settings to benefit individuals across the lifespan of the care they receive. These settings include: primary care, specialised medical settings, long-term care settings, and community-based health and social service sites. The integrated care team often functions differently according to the setting. However, mutual respect and communication are critical at all sites.

The World Health Organisation defines Integrated Care as "*a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency"*

The vision for CSPD and the establishment of the Integrated Care Programmes is set out on the following page in figure 1.

4.2. CSPD Reform through the establishment of Integrated Care Programmes - Vision and Benefits

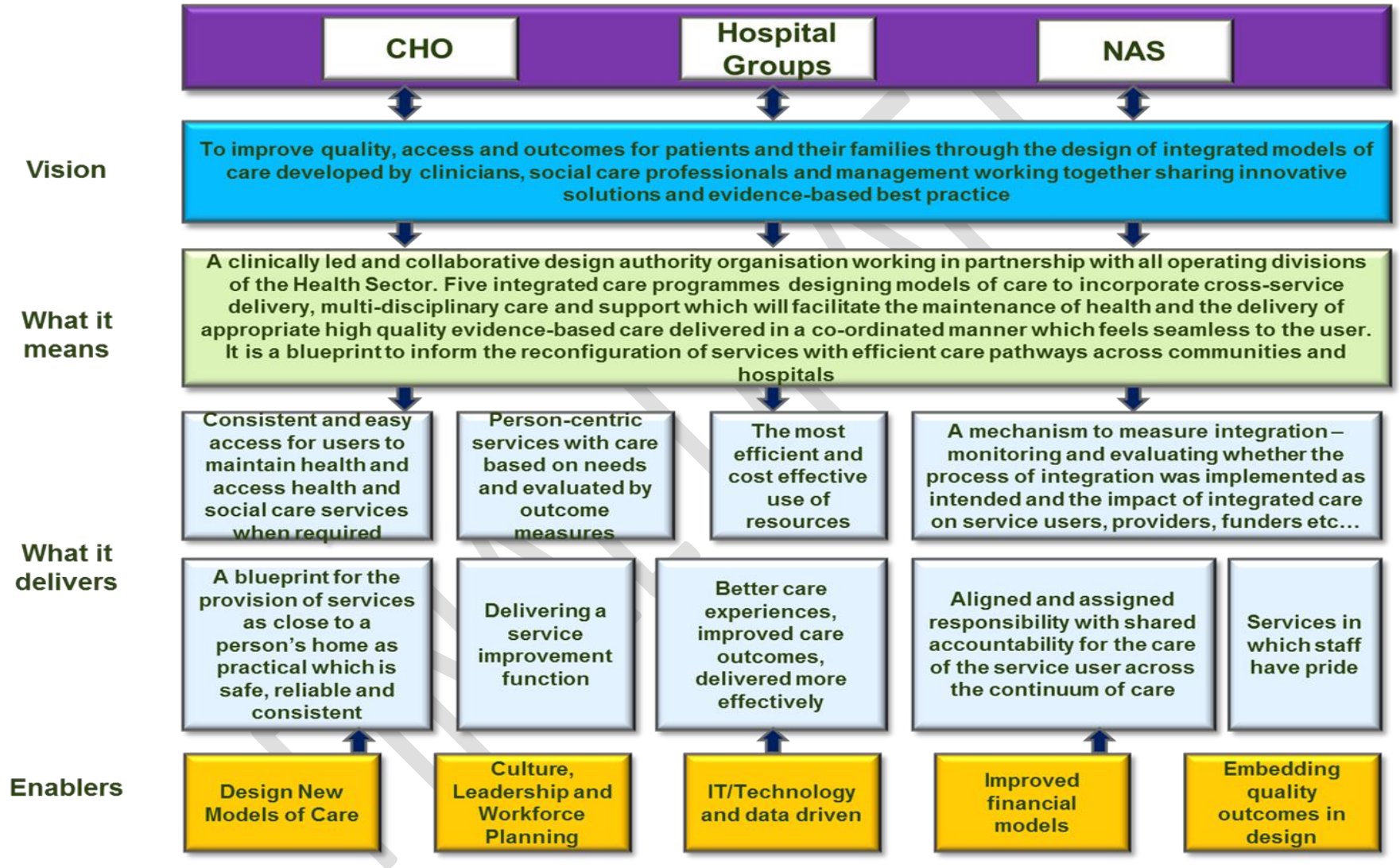

Figure 1 – CSPD Reform through the establishment of Integrated Care Programmes

4.3. Integrated Care Programmes

An Integrated Care Programme (ICP) outlines a framework for the management and delivery of health services. The framework ensures that patients receive a continuum of diagnostic, care and support services, according to their needs over time and across different levels of the health system.

An ICP is underpinned by the principles of illness prevention, patient empowerment, multi-disciplinary cross service care planning and delivery.

Supporting integration does not mean that everything has to be integrated into one package. Instead services can work together to provide a flexible network of care responsive to the changing needs of patients and their families.

4.4. Key features of establishing the Integrated Care Programmes

The Integrated Care Programmes will adopt the following key features to promote the vision of developing the health service of the future for Ireland:

- Designed by clinicians, with formal structures agreed with the Medical Colleges for input and sign-off; and developing similar structures with Nursing & Midwifery and with Health & Social Care Professionals
- Take a cross-organizational view – basing the models and pathways around the needs of the patient rather that organizational structures
- Each Integrated Care Programme will be chaired by an executive with deep knowledge and experience of the challenges of implementation of integrated services.
- Each programme will utilize best available evidence for the design of models of care; within each programme specific workstreams will be prioritised for immediate work

The vision for each Integrated Care Programme is set out on the subsequent pages:

4.5. PATIENT FLOW INTEGRATED CARE PROGRAMME – VISION AND BENEFITS

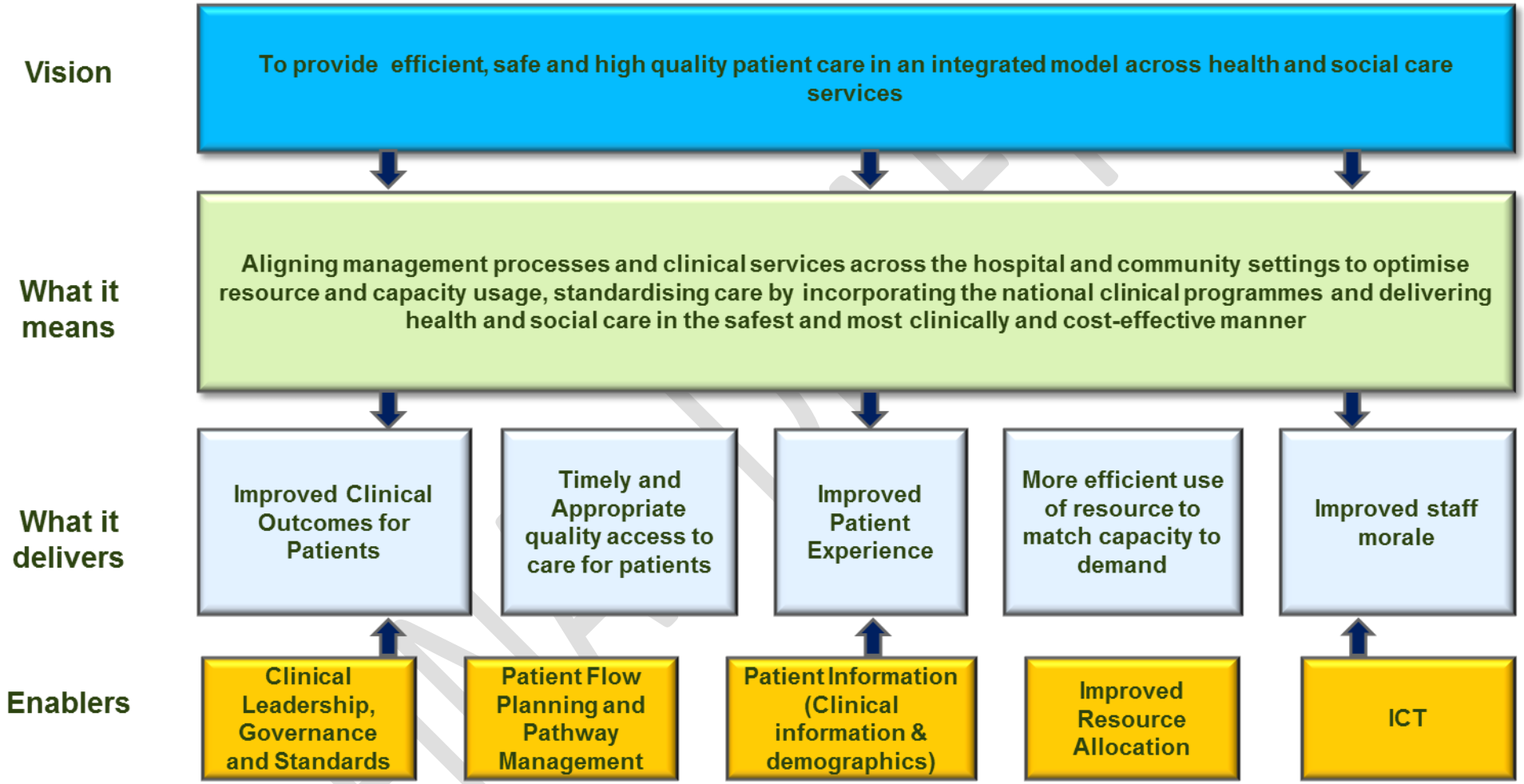

Figure 2 – Patient Flow Integrated Care Programme – Vision and Benefits

4.6. Older Persons Integrated Care Programme – Vision and Benefits

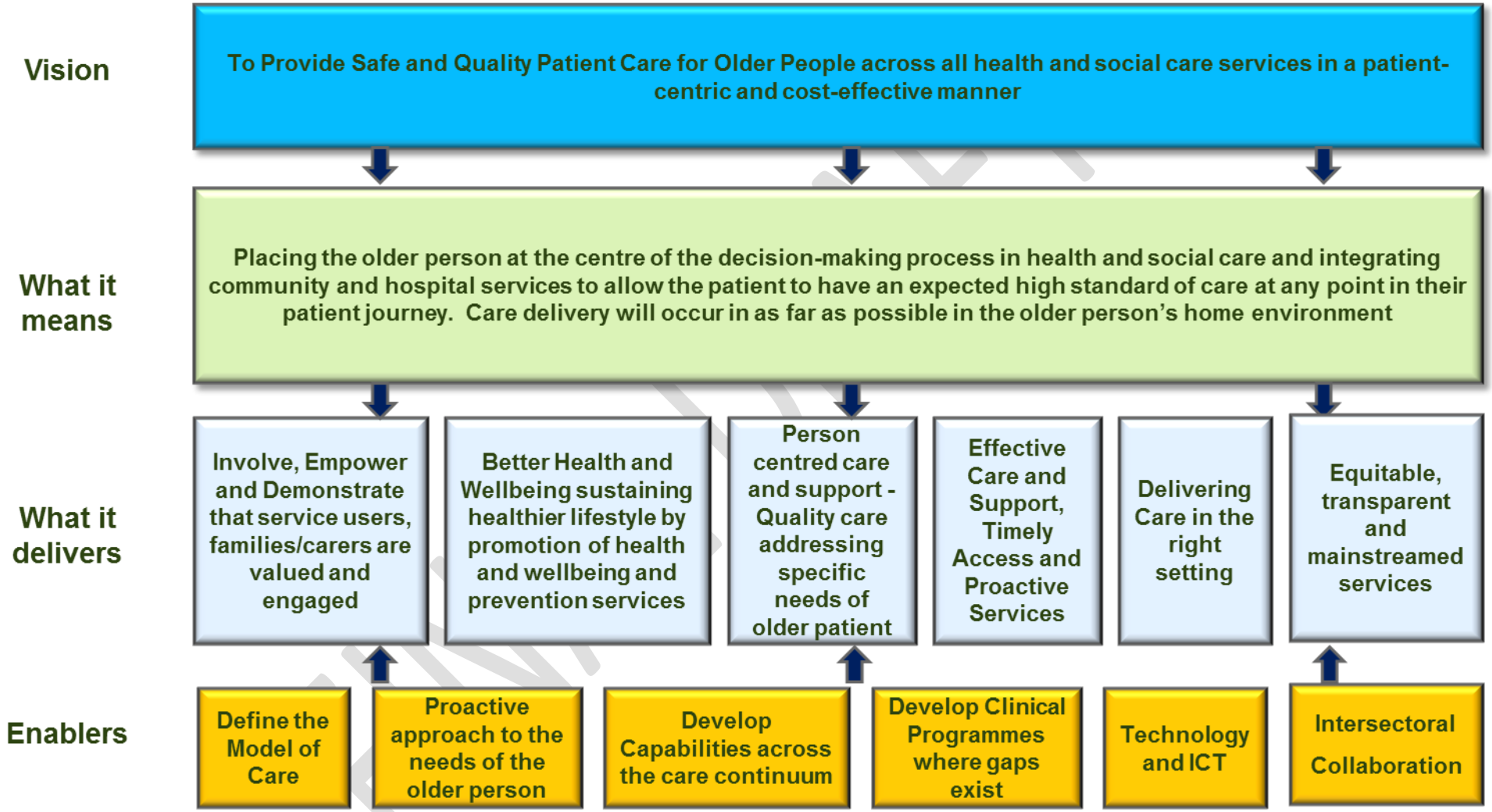

Figure 3 –Older Persons Integrated Care Programme – Vision and Benefits

4.7. Chronic Disease prevention and Management Integrated Care Programme – Vision and Benefits

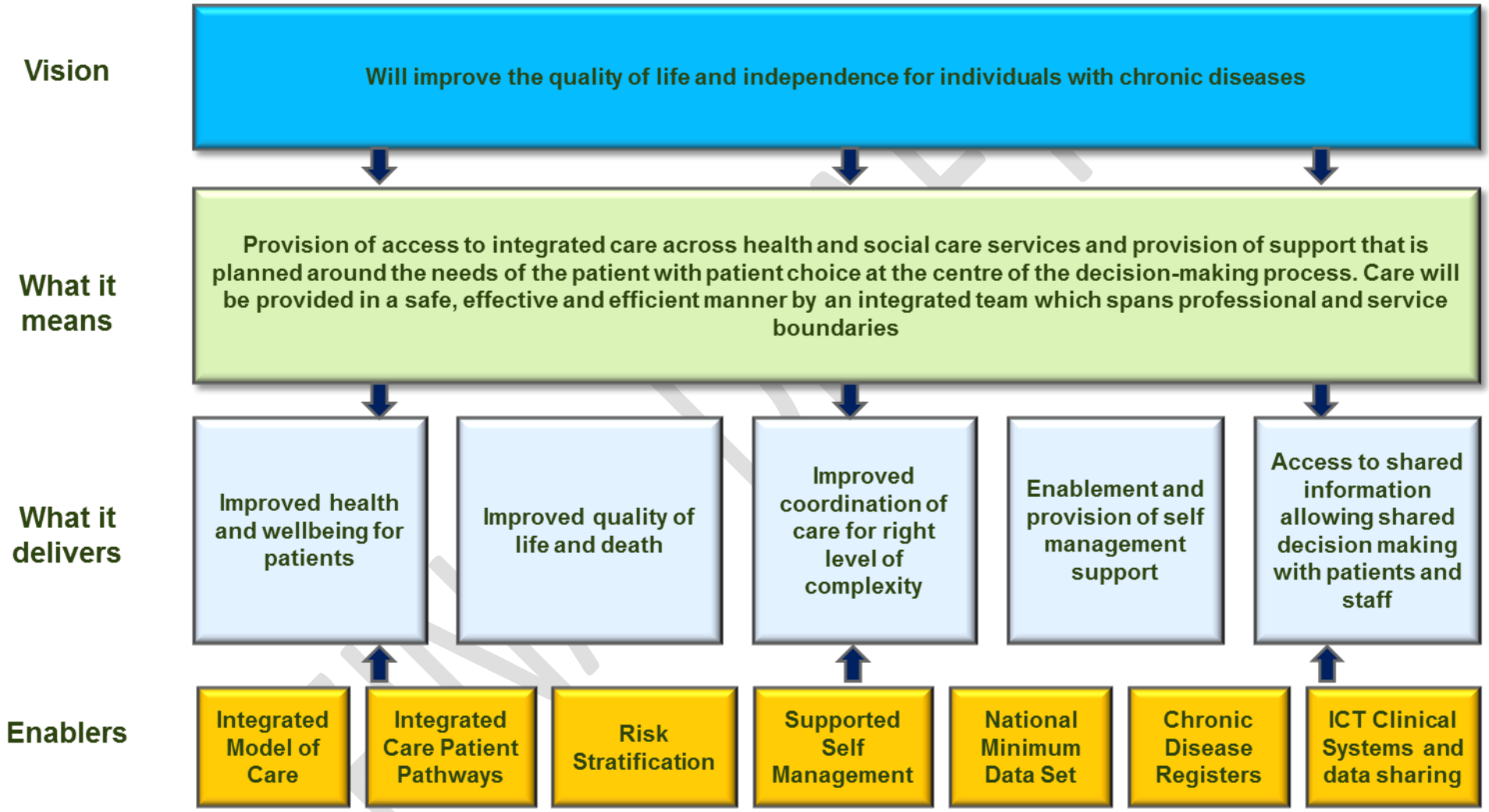

Figure 4 – Chronic Disease Prevention and Management Integrated Care Programme – Vision and Benefits

4.8. Children's Integrated Care Programme – Vision and Benefits

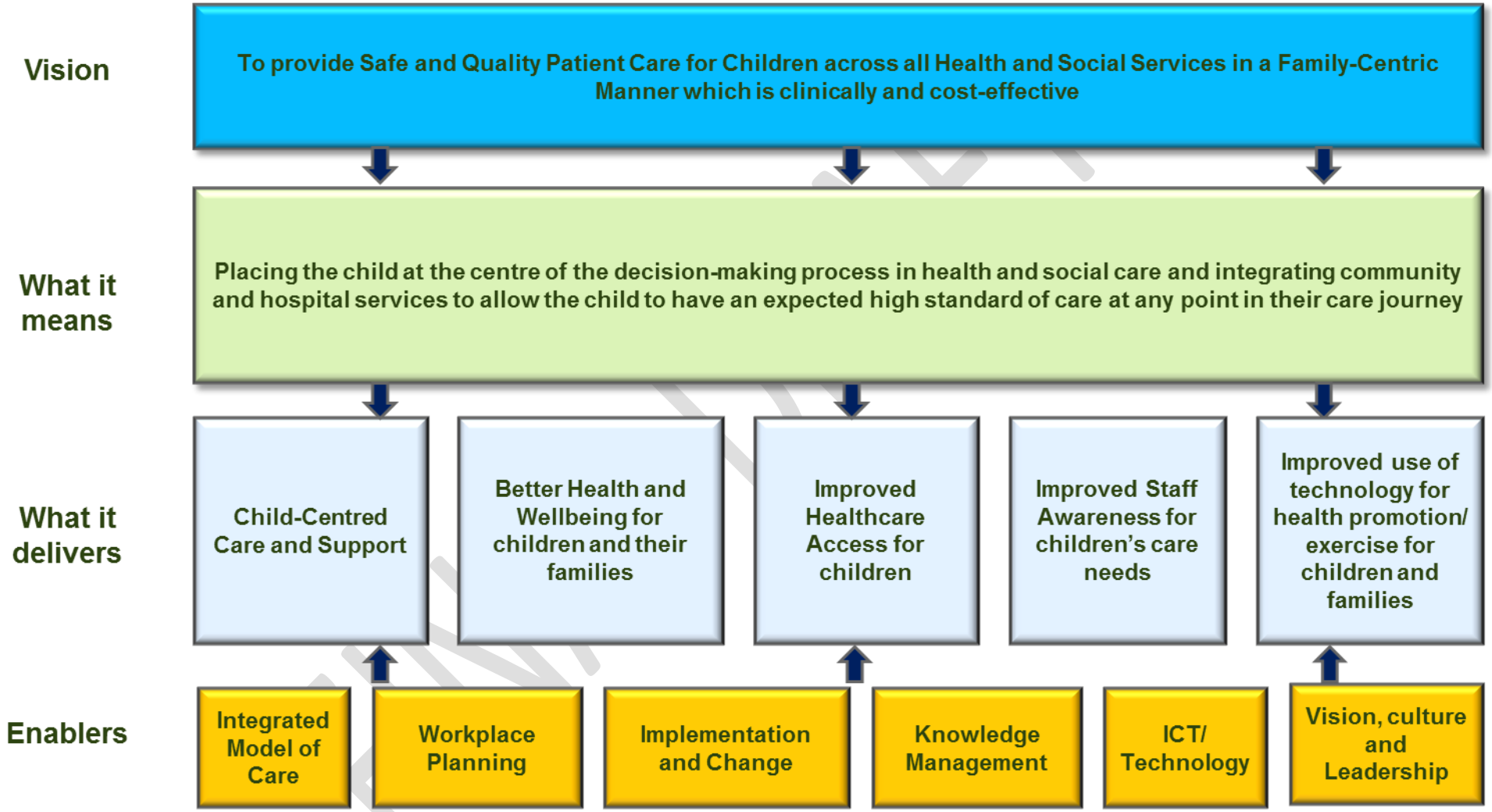

Figure 5 – Childrens Integrated Care Programme – Vision and Benefits

4.9. MATERNITY INTEGRATED CARE PROGRAMME – VISION AND BENEFITS

The benefits workshop needs to be conducted to draft the appropriate vision and benefits for this Integrated Care Programme.

5. GOVERNANCE

Given the complex nature of Integrated Clinical reform, ensuring that the appropriate governance is in place is vital at all levels of the portfolio of programmes and projects. This section sets out the governance arrangement, including roles and responsibilities to deliver on the portfolio and programmes of work to ensure that all key stakeholders understands their roles and responsibilities in delivering the programme and provides a clear decision making framework. The proposed governance model is outlined on the diagram below.

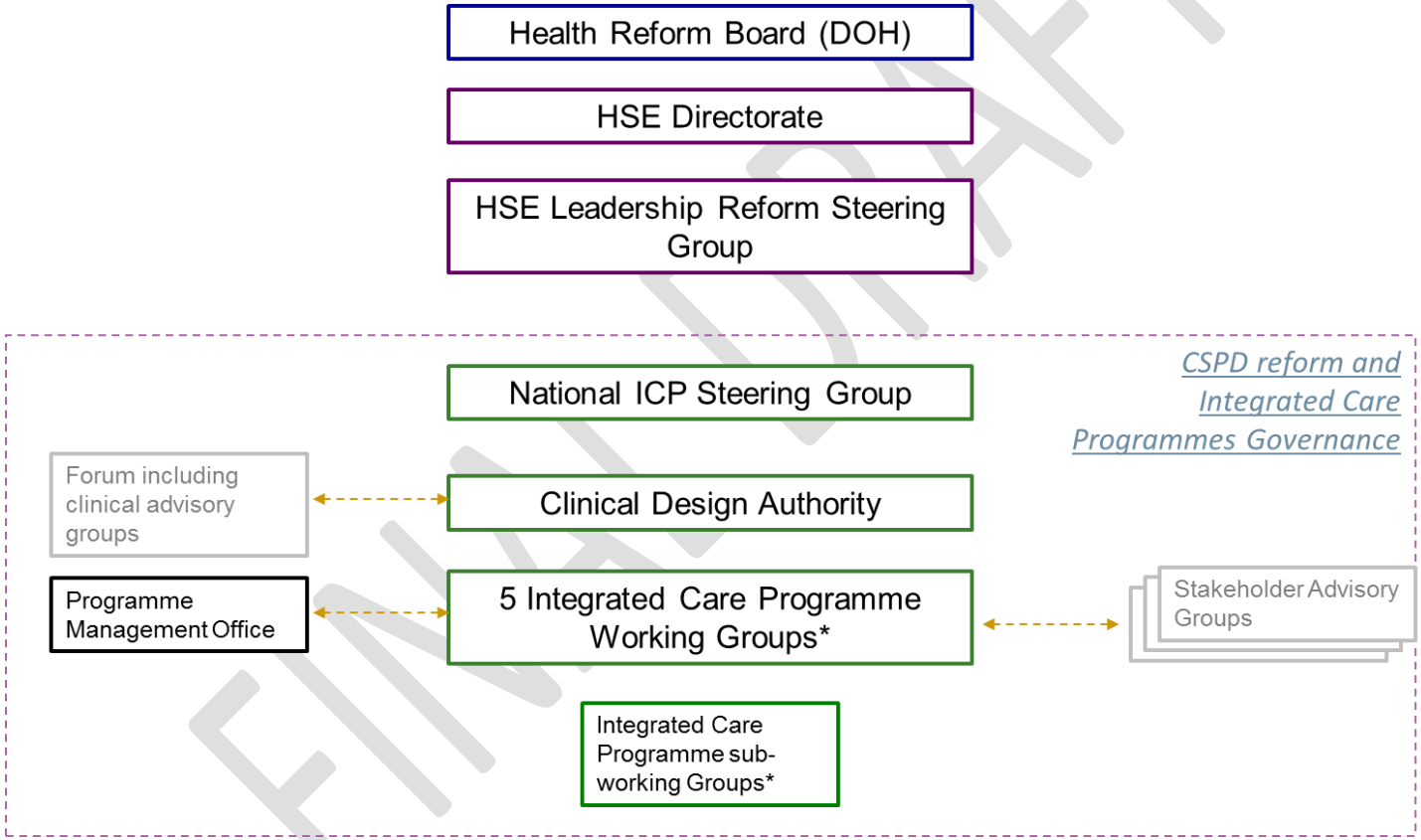

Figure 6 –Proposed Governance Model

Building upon the principles of the System Reform Governance the governance shall include the following key levels:

- CSPD Reform Steering Group, accountable for the successful reform of the Clinical Strategy and Programmes Division
- Clinical Design Authority, providing assurance of the clinical design for implementation of the ICP's
- Core CSPD Reform team, responsible for the day to day management and delivery of reform within the CSPD
- PMO to provide guidance and control for the Integrated Care Programmes and national clinical programmes
- Integrated Care Programme teams to deliver implementable integrated models of care supported by:
    - Integrated Care Programmes Working group (multidisciplinary group providing expertise from across the health system)
    - Stakeholder Advisory Groups to assist with the formal structures for input and sign-off with the Medical Colleges and similar developing structures such as Nursing & Midwifery and with Health & Social Care Professionals.

Proposed CSPD Reform Steering Group (meet every 6-8 weeks)	
The membership of the Steering group has been selected to promote alignment between the CHO and Hospital Group programmes. It is envisaged that the steering group membership will evolve through time. The proposed membership is as follows: – Dr Aine Carroll, ND Clinical Strategy & Programmes (Programme Sponsor & Chair) – Mr Pat Healy, ND Social Care – Dr Stephanie O'Keeffe, ND Health & Wellbeing – Mr John Hennessy, ND Primary Care – Ms Anne O'Connor, ND Mental Health – Mr Liam Woods, ND for Acute Hospitals – Mr Patrick Lynch, ND Quality Assurance – Dr Philip Crowley, ND Quality Improvement – Mr Richard Corbridge, CIO (Clinical Information) – Mr Ian Tegerdine, Interim ND Human Resources – Mr Stephen Mulvany, CFO – Senior DOH representative, to be nominated – Mr Damian McCallion, National Director Ambulance	Role of the steering group will be to: – Approval of the models of care – Account for the successful reform of the Clinical Strategy and Programmes Division including the establishment of an Integrated Operating Model – Agree and approve the vision, scope and benefits of the CSPD – Agree and ensure alignment of organisational change effort – Ensure alignment with the strategy and delivery of the CHO and Hospital Groups Programmes – Ensure that there is meaningful involvement of key enabling stakeholders in this reform programme – Ensure that the appropriate programme governance and management structures and processes are in place to deliver and to maintain appropriate oversight across the programme – Resolve escalated issues raised by the Clinical Design Authority – Address strategic and directional issues between the CHO programme and other inter-dependent programmes within the HSE Reform Portfolio. – Provide progress reports through the Reform Portfolio report to the HSE Leadership Steering Group and ensure that critical issues and risks are escalated appropriately through the overall reform governance structure.

Clinical Design Authority (meet every 4 weeks)	
The membership of the Clinical Design Authority is as follows: – Dr Aine Carroll, ND Clinical Strategy & Programmes (Programme Sponsor & Chair) – Assistant National Director of CSPD – National Clinical Advisor for Social Care – National Clinical Advisor for Primary Care – National Clinical Advisor for Acute Hospitals – Director of Nursing & Midwifery Services – National Clinical Advisor for Mental Health – National Clinical Advisor for Health and Wellbeing – Director or nominated representative for the key divisions: **Finance**, **HR**, **ICT** and **Quality**. – ICP Chair Representative(s) (agreed nominations from the Chairs of the ICP's) – Health and Social care professionals (as required)	Role of the Clinical Design Authority will be to: – Ensure that the work of the integrated care programmes is firmly aligned to the vision and strategy of the CSPD – Be accountable for approving the design of the integrated models of care and guidance developed by the Integrated Care Programmes – Agree and approve the vision, scope and benefits for the Integrated Care Programmes – Understand and where necessary resolve issues related to the complex set of interdependencies between the Integrated Care Programmes and clinical programmes – Ensure alignment of the models of care with the CSPD strategy and delivery within their respective organisational division/ department- – Help identify make resources available for the planning and delivery of the integrated care programmes models of care – Provide progress reports to the National ICP Steering Group and to ensure that critical issues and risks are escalated appropriately through the overall reform governance structure.

5 *Integrated Care Working Groups (meet every 2- 4 weeks)	
The membership of the Integrated Care Working Group(s) is as follows: – ICP Chair (Integrated Care Programme Sponsor & Chair) – Integrated Care Programme Manager – Primary Care representative – Acute Hospitals representative – Mental Health representative – Health and Wellbeing representative – Social Care representative – Nursing representative – NAS (required for patient flow WG) – Advisors for the key enablers, **ICT**, **HR**, **Finance** and **Quality** (Note – It maybe pertinent to have a workstream in the respective reform programmes dedicated to the Integrated Care programmes to ease resource demands and promote cohesion between the reform programmes thereby inputting into the design of the models of care and the respective corporate strategies) – Other agreed roles pertinent to specific Integrated Care Programmes	Role of the Integrated Care Working Group(s) will be to: – Be accountable for the design of the integrated models of care and guidance developed by their specific Integrated Care Programme – Set up relevant working groups to enable the design aspects of the programme and to advise the Working Group as appropriate – Sign off on key deliverables – Resolve key issues within the Integrated Care Programme and escalate as required to the Clinical Design Authority – Provide guidance, recommendations and inputs to deliver the required outcomes for the integrated models of care – Ensure that their respective sectors are informed and have an input into approving the models of care e.g. Primary Care Lead liaising with ICGP – Help identify resources required to deliver the workstreams and demonstrator projects. – Provide progress reports to the Clinical Design Authority through the Programme Management Office and ensure that critical issues and risks are escalated appropriately through the overall reform governance structure.

Integrated Care sub-working Groups (as defined for specific tasks)	
Each ICP may convene sub-working groups to consider and make recommendations on specific issues or deliver the workstreams identified for each programme, as and when required. These will comprise the relevant experts and stakeholder representatives for the particular issue being considered.	Each sub-working Group's terms of reference will be approved by the Integrated Care Programmes Working Group

Key Roles

Programme Director and CSPD Reform Team	Integrated Care Programme Chair
– Day to day management of the overall reform programme; – Drive overall the overarching reform programme plan and direction; – Monitor overall progress of Programme and all key interdependencies; – Manage overall programme risks and issues and escalate to Programme Steering Group where appropriate; – Meet with Project Leads on a regular basis and review plans and provide direction where needed; – Assess key deliverables to ensure they align with Programme objectives and benefits; – Develop the Programme Management Office updates and provide to the Clinical Design Authority and Steering Group as required; – Embed agreed SRG tools/standards across the overall Programme. – Agree transition to "business as usual" for the CSPD in operating the delivery of integrated and clinical programmes	Key role of the ICP Chair includes: – Work with nominated ICP Programme Manage to ensuring successful delivery of their ICP's; – Provide and coordinate the service expertise required to progress the ICP; – Provide overall direction and coherence to the ICP within the remit of the working group; – Work with the Programme Director and ICP Manager to ensure appropriate governance and that resources are in place to deliver on the required capabilities; – Meet at least on a 4 weekly basis with the Programme Manager as part of the Programme Reference Group to provide a forum for knowledge sharing, problem solving and overall Programme of work; – Represent the ICP at meetings of the Clinical Design Authority.

Senior Programme Managers for Integrated Care
– To develop, agree and drive the individual ICP plan, within specific timeframes that deliver on the agreed targets with the Clinical Design Authority and Steering Group; – Identify the critical workstreams and processes necessary for delivering and implementing the agreed plan and maintain an issue log to record all associated issues/risks; – To coordinate and commission the delivery of workstreams or work packages with the identified resources (including the current national clinical programmes) to deliver on the ICP plan; – Establish the core ICP team to deliver specific elements of the plan; – To provide leadership and direction to all staff in relation to the ICP; – To provide drive and challenge to achieve the change objectives as quickly as possible. Embed agreed SRG tools/standards across the overall Programme.

Programme Management Office

Given the complex environment within which the integrated and clinical programmes will be operating (involving multiple teams, working groups and stakeholders), there is a fundamental need to ensure consistency and quality of approach and management information relating to those programmes.

This is compounded by a number of factors:

- The complexity of the programmes and hence the need to co-ordinate/integrate activities across the programmes to deliver a fully integrated approach.
- With the large number of diverse but interrelated programmes, resources and processes, conflicts will be inevitable therefore having the means to support and direct these programmes is essential.
- Given the demand on resources within the HSE there is a need for a single view, in order that priorities may be set and conflicts identified and resolved ASAP will be required.

- To limit the degree of uncertainty and the need to provide flexible information flows to facilitate rapid, well-informed decision making and ensure effective communication
- Effective issue and risk management to ensure guidelines and models of care are delivered efficiently and effectively.

The establishment of a discrete PMO function for the reform programme working directly with the integrated programme teams and in conjunction with the CSPD and the clinical programmes should provide the consistency, support and guidance to direct integration.

6. PROGRAMME OUTLINE PLAN

6.1. PLANNING

6.1.1. High level Plan

There will be a 3 phased approach to provide a controlled environment to establish the Integrated Care Programmes and transition to the new CSPD Operating model with Integrated Care Programmes can be constantly reviewed and enhanced if necessary. The 3 phases are:

Phase I: **Initialisation (3 months)**: Short-term actions to be taken establish and resource the Integrated Care programmes:

- Agree and sign off the CSP vision and the vision for each ICP
- Establish the governance structure;
- Establishment of the PMO;
- The design and sign off of an Integrated Programme Framework
- Fill identified resource gaps for the CSPD and Integrated Care programmes;
- Assess the work plans Clinical Programmes and alignment with the Integrated Care programmes;
- Develop the Programme Initiation Documents for each Integrated Care Programme
- Development of the communication strategy for CSPD and the Integrated Care Programmes
- Development of the target organisational and performance model for CSPD and plan for transition to this model
- Plans for stakeholder communications;

Phase II: **ICP Planning and Delivery**: Medium-term actions to be taken during **2015**;

- A fully developed ICP framework and principles for steering reform;
- Plans for delivery and implementation of new Integrated models of care with tangible milestones, clear benefit plans;
- Appropriate governance structures and stakeholder engagement at overarching and ICP level;
- Further delivery of clinical reform aligned to the integrated care programmes through demonstrated projects against agreed outcomes and KPI's;

- Development of the key principles for change, implementation and mainstreaming of integrated clinical reform; and
- Development and agreement on the Integrated Operating Model to deliver the implementation and mainstreaming of the integrated models of care.

Phase III: **Implementation and Mainstreaming**: Long-term actions to be taken during **2016**;

- Implementation of Integrated Care initiatives with mainstreaming;
- Monitoring of the impact and outcomes of initiatives against agreed KPI's.
- Identification of further innovation to deliver improvements in healthcare in line with strategic goals for improved outcomes

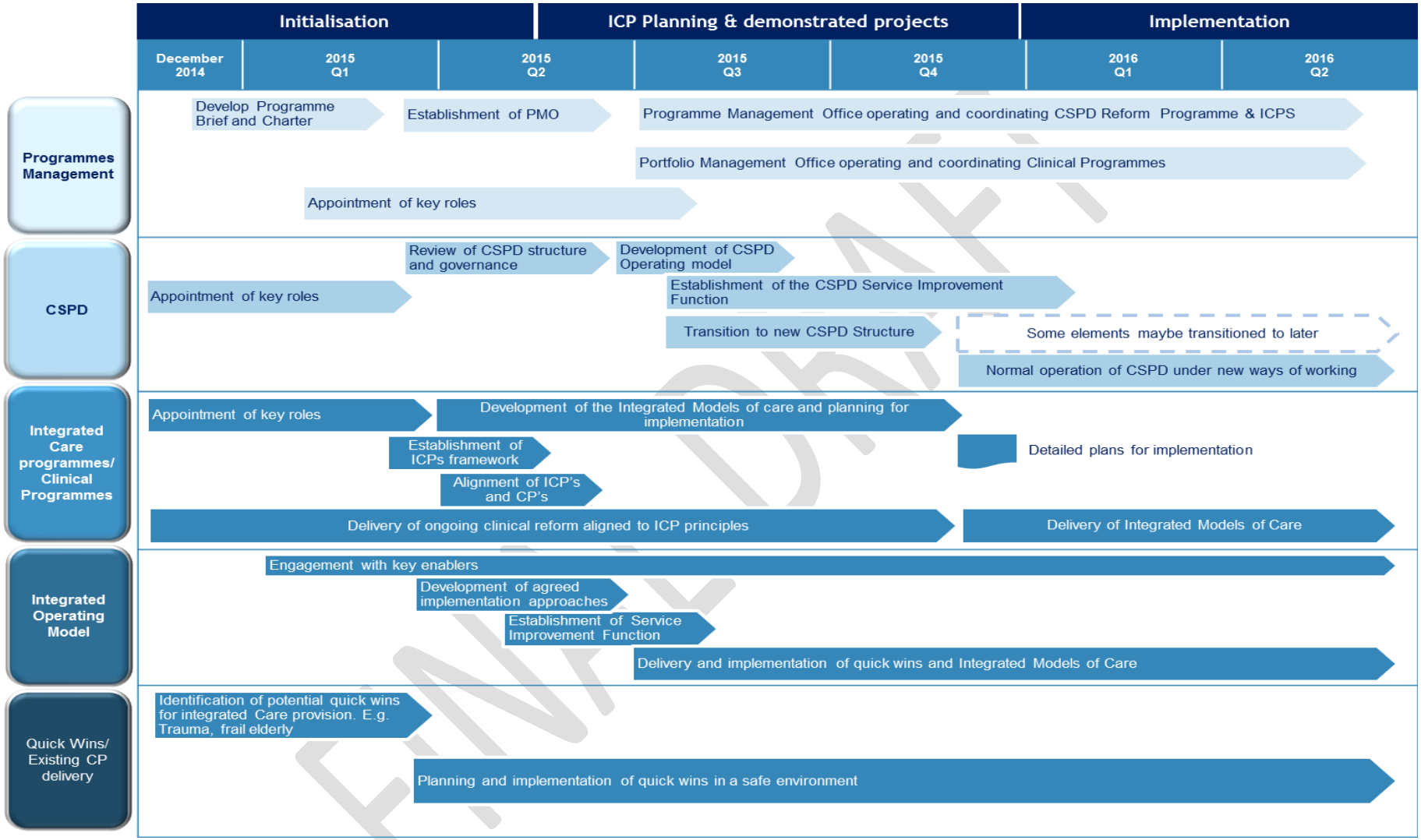

Figure 7 –CSPD reform and the establishment of Integrated Care programmes – High Level Plan

7. OUTLINE SCOPE FOR EACH WORKSTREAM

To support the overarching Programme Vision (as set out in section 3) 5 programme workstreams have been identified. The workstreams are set out individually in the following pages. (Responsibility for each project or work stream will need to be defined against each one).

The following workstreams are set out in this section:

- Project Management Process
- Clinical Strategy Programme Organisation Structure and Performance
- Establishment of the Integrated Care programmes
- Establishment of the Integrated Operating Model
- Delivery of existing CP's and Integrated Care quick wins

The diagram below outlines how the core workstreams will support the move towards the development of integrated services for healthcare:

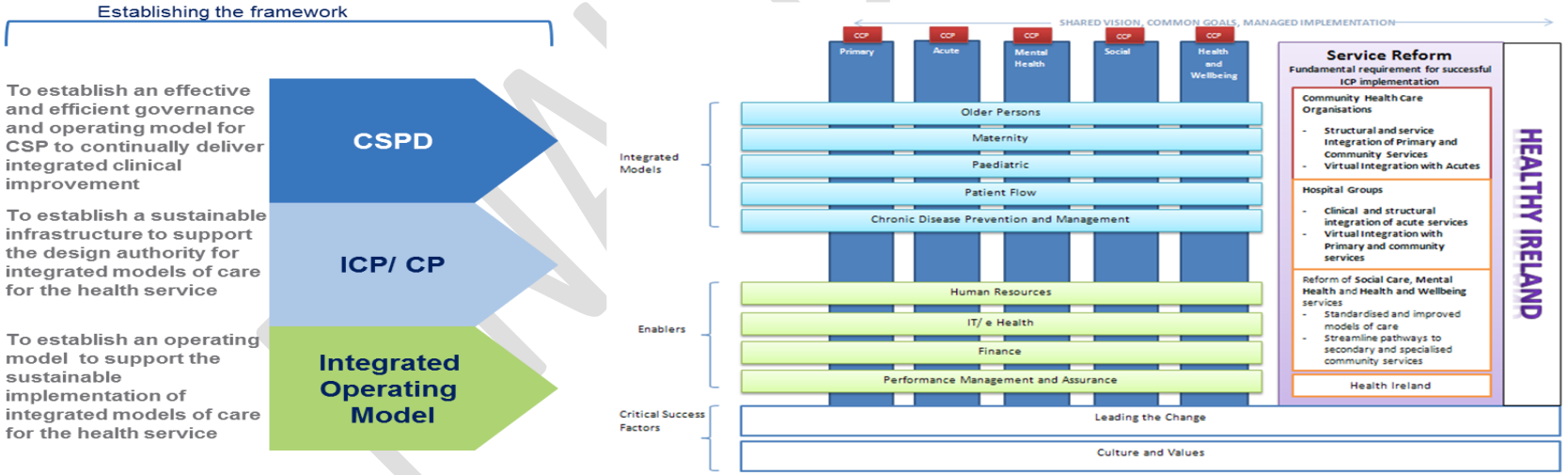

Figure 8 –Programmes major workstreams and the move towards integrated services

7.1. Programme Management Process

Objective

The objective of this work stream is to establish a clear governance structure and accountability to support the reform programme and through the establishment and transition to delivering integrated care programmes.

Critical Success Factors

- Appropriate governance structure to meet the needs of the programme
- Involvement of key stakeholder representation in the decision making process
- Resource availability to complete programme
- Appropriate funding to meet the needs of the programme
- Appropriate metrics and reporting for the programme

Key Decision points

- Steering Group membership
- Identification of Programme Management and Project Management resources

Key Deliverables

- Programme Charter
- Programme governance structure agreement
- Detailed programme and project plans
- PMO Risks and Issues Register
- Resource requirements
- Secure funding to complete programme

Key Risks

- Delay in appointment of membership to Steering Group
- Resources unavailable
- Funding constraints
- Failure to recruit appropriate staff

Key Dependencies

- Alignment with other strategic reform programmes primarily the CHO and Hospital Groups programmes
- Resource availability (both financial and human)

7.2. Clinical Strategy Programme Organisation Structure and Performance

Objective

The Clinical Strategy and Programmes Division is committed to supporting the development of a strong system of integrated corporate and clinical governance within the National Clinical Programmes. As the new Integrated Care Models for Health and Social care are developed the CSPD needs to have the right governance and management structures, processes, outcomes and ways of working and people, in order to ensure that it can carry out its functions effectively in guiding the full integrated clinical reform for Ireland. This operating model will seek to build on the current model aligning with the Divisions of care within the HSE Directorate whilst providing the foundations and support for the both the ICPS and NCPs.

Critical Success Factors

- Appropriate organisational structure to support the enhanced delivery of services
- A governance model that is efficient and supports the objectives of the function.
- Required resources available with expertise within the business
- Adequate and appropriate KPI's to measure the delivery of models of care and initiatives based on outcomes

Key Decision points

- Agreement and sign off on strategic priorities and vision of the CSPD for Integrated Care and from the National ICP Steering Group/ HSE SMT?
- Agreement on appropriate KPIs to for the effective operation of CSPD
- Resources made available to carry out the functions on behalf of the CPSD and Integrated Care Programmes
- Agreement and sign-off on the target operating model for CSPD including processes for capturing innovation, performance and decision making

Key Action Points and Deliverables

Operating model, governance and roles

- Establish the operating model for the CSPD senior management team including:
  - revised terms of reference;
  - management process and meetings;
  - reporting;
  - governance;
  - action; and
  - performance management.
- Development plan for the senior leadership team to promote continual improvement at a team and individual level;
- New key roles have been identified within the CSPD core team and need to be recruited as soon as possible. These roles include:
  - National Clinical Advisor and Group Lead for Primary Care;
  - National Clinical Advisor and Group Lead for Social Care;

  - Assistant National Director
  - General Manager for CSP.
  - ICP Programme Managers and Programmes Director
  - In addition the appointment of new Clinical Leads is required to continue the work within the Clinical Programmes;
- Establish/review staff roles and provide greater clarity. In addition identify potential opportunities for future roles; and
- Provide for shift in service priorities in response to healthcare crises

Communication and Stakeholder Engagement Strategy

- Development of the Communication Strategy and Plan– immediate focus on communication with National Clinical Leads, Programme Managers, Clinical and Management Stakeholders and Clinical Directors including formalised engagement with:
  - Clinical Stakeholders – the Forum of postgraduate medical training bodies (the forum), Nursing and PBAI, professional bodies outside of PBAI, including appointment of liaison. (This will include MoU and support for PBAI.);
  - Patients and patient organisations;
  - Department of Health; and
  - Hospital Group Programme and CHO Implementation Programme

Planning and Outcomes

- Development of a prioritised work plan for the short, medium and long term;
- Development of clear and realistic outcome measures with the appropriate mechanism for measuring both:
  - Patient outcomes; and
  - The success of the implementation.

Key Risks

- Insufficient key resources
- The transition from the established model of running clinical programmes will require careful planning, monitoring and time to effectively transition to the Integrated model

Key Dependencies

- Ongoing reform within the Health system including appropriate alignment with the CHO and Hospital Groups
- Key stakeholders available to perform role on the steering group
- Adequate funding available to implement objectives

7.3. Integrated Care Programmes/ Clinical Programmes

Objective

The key aim for this workstream is to establish a sustainable infrastructure to support the design authority for integrated models of care for the health service. This clinically-led, multi-disciplinary, cross-organisational, design authority for patient-centred, integrated models of care will ensure that all clinical programmes which meet the criteria for integrated care programmes deliver the best outcomes in an integrated manner to deliver the right outcomes for patients and the health service in Ireland.

Critical Success Factors

- Development of an effective Integrated Care Programmes framework
- A "commissioning" model for integrating the Integrated Care Programmes with the Clinical Programmes
- Delivery of early demonstrator projects as proof of concept of the Integrated model
- KPI's to measure outcomes and the impact of integrated initiatives

Key Decision points

- Agreement and sign off on each ICP Programme Initiation Document from the National ICP Steering Group
- Appointment of key resources such as the ICP Programme Manager(s) and Executive Lead(s)
- Resources made available to carry out the activities within the identified ICPS

Key Action Points and Deliverables

Mobilisation of the Overarching CSP Integrated Care Programme

- Define and implement governance and management and reporting structure for Integrated Care and Clinical Programmes
- Develop the compelling case to clearly articulate the real value of the integrated care and clinical programmes;
- Definition and establishment of the Integrated Care Programmes management Office
- Development of the overarching ICP Programme Charter;
- Ensuring the correct alignment with existing system reform programmes including the work being undertaken in relation to the process redesign support for Acute. (Particularly important for Patient Flow);
- Develop the overarching Programme Framework for assessment of ICP's;
- Ensure the ICP's are appropriately aligned with the following:
    - Programme for Government;
    - Future Health ;
    - Healthy Ireland;
    - Visions for Change;
    - National Standards for safer and better healthcare
    - DoH priorities; and
    - National Service Plan (2015).

For each ICP

- Review the existing clinical programmes and the existing Models of Care to develop the new focus within the overarching programme and within each integrated care programme to ensure that the principles underpinning Integrated Care are adopted. It is essential to ensure that the National Clinical Programmes are adopting the appropriate integrated approach for delivering health care;
- Stakeholder and communication engagement plan including consideration of public, clinical, academic, economical stakeholders;
- Development of the workstreams and related project plans for each Integrated Care Programme including resourcing plans;
- Prioritisation of workstreams with a particular focus on quick wins;
- Development of the appropriate roles and responsibilities to ensure that clarity is provided between the ICP and its related CP's. This should include clarification between roles such as "National Clinical Advisor and Group Leads", Chairs, Programme Managers etc… and will be captured in a responsibility matrix;
- Development of the required and expected outcomes with the appropriate measurement mechanisms to consider the outcomes for the patient, the service and the success of the implementation; and
- Develop prioritised Integrated Models of Care.

Key Risks

- Insufficient key resources
- The transition from the established model of running clinical programmes will require careful planning, monitoring and time to effectively transition to the Integrated model (to be able to commission the current clinical programmes as appropriate into the planned Integrated Care programme workstreams.)

Key Dependencies

- Ongoing reform within the Health system including appropriate alignment with the CHO and Hospital Groups
- Key stakeholders available to perform roles on the steering group
- Adequate funding available to implement objectives
- Support of the key stakeholders and current clinical programmes

7.4. Integrated Operating Model

Objective

To ensure that the desired outcomes are achieved the optimum operating model to support the sustainable implementation of integrated models of care for the health service needs to be established. It is therefore essential that the critical enablers for successful implementation of integrated models of care are aligned appropriately during design, implementation and ultimately mainstreaming.

Critical Success Factors

- Establishment of an integrated model that enables the ICP's to design and implement integrated models of care within the constraints of the Health System
- Establishment of an effective service delivery function
- The ability to help shape the strategies of the key enablers (e.g. ICT, HR, Finance, Quality Improvement Division) to help drive positive changes in the delivery of integrated healthcare (the alignment of the key enablers strategies with the needs of the ICP in both the design and implementation phases)
- Establishment of the appropriate KPI's and metrics

Key Decision points

- Agreement and sign-off of the full integrated operating model with service divisions and key enablers
- Agreement on appropriate KPIs and metrics for measuring the both ability to change and the patient outcomes
- The model for delivering service improvement

Key Action Points and Deliverables

Describe approach to design and deliver the change

- Define link to and interactions with Service Divisions – operating model;
- Define link to and interactions with Hospital Groups and Community Healthcare Organisations;
- Define and implement a Service Improvement function to develop the capability (national/local), including governance link between HG/CHO. Requires clear responsibility and roles for central programme team and Service Improvement teams;
- Embed key enablers into design of models of care including:
  - Human Resources (workforce planning; training & development);
  - ICT (supporting systems influence strategy);
  - Finance;
  - Performance Indicators; and
  - Quality indicators/measures.
- Embed key enablers into implementation of integrated models of care including:
  - Human Resources (recruitment; contractual);
  - ICT;
  - Finance;

  - Performance Indicators; and
  - Quality indicators/measures.
- Description of the implementation strategy, how, who and outcomes? (also evaluation tool for audit); and
- Create link to Innovation (Enterprise Ireland) and Research (Health Research Board).

Key Risks

- Engagement with the key enablers who also embarking on significant reform programmes
- Insufficient key resources
- Ongoing reform within both the HSE and health system in Ireland means that the environment is consistently changing and that resources required to deliver the transformation are scarce

Key Dependencies

- Ongoing reform within the Health system including appropriate alignment with the CHO and Hospital Groups
- Alignment with the reform plans and future strategies for ICT, HR and Finance
- Adequate funding available to implement objectives

7.5. Delivery of existing CP's and Integrated Care Quick Wins

Objective

To ensure that the current clinical programmes continue to deliver the desired outcomes and to promote the move towards the design and delivery of integrated health & social care though identified quick wins such as the Frail/ Elderly initiative.

Critical Success Factors

- Identification of integrated initiatives within each ICP
- Support during the transition to Integrated programmes for the Clinical Programmes through the establishment of the PMO
- Establishment of the appropriate data capture to identify the desired outcomes and impacts for each initiative.

Key Decision points

- Agreement and sign off on the initiatives
- Transition and alignment of the clinical programmes to the ICPS

Key Action Points and Deliverables

- Establishment of the PMO and processes to advise, guide and align current clinical programmes
- Identification of the early innovations (demonstrator projects) for integrated care
- Delivery of these initiatives including the measurement of impact and outcomes to patient populations

Key Risks

- Resourcing to support the planning and delivery of these initiatives
- Coordination with other groups driving improvements such as SDU

Key Dependencies

- TBD

7.6. Resourcing Plan for CSPD REFORM and to establish the Integrated Care Programmes

It is envisaged that the following resources shall be required during the Initialisation phase of the reform programme and in the establishment of the Integrated Care Programmes:

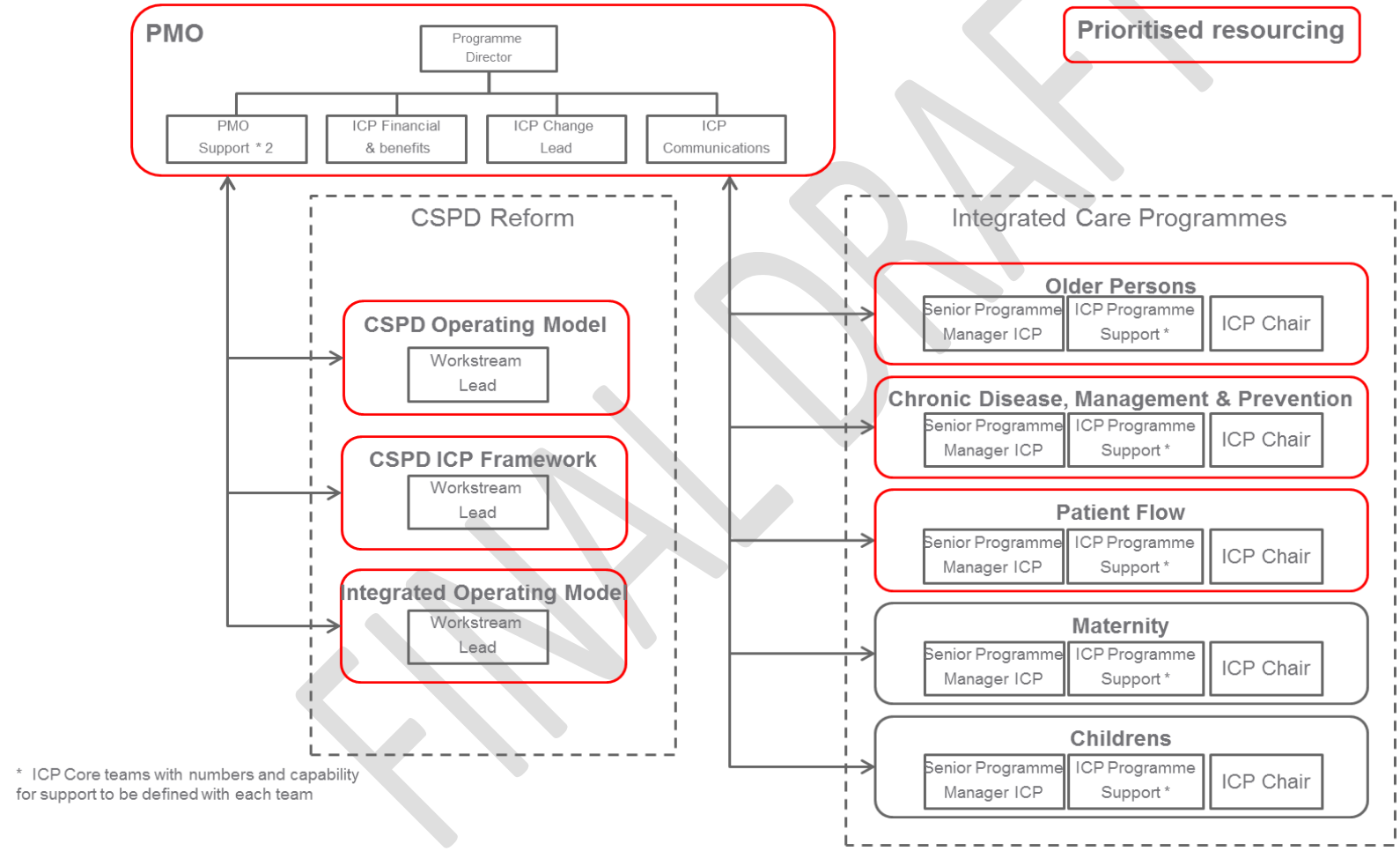

Figure 9 –Initial Resources required

7.6.1. The Programmes Management Office

The PMO should be established in a single location operating with the core ICP teams to provide the Integrated Care Programmes with a hub which promotes integration at all levels. In order to provide the right mix of support and control for the ICP's and the reform programme the PMO needs to focus more often on driving the right capabilities and behaviours as wells as programme processes & controls as highlighted below:

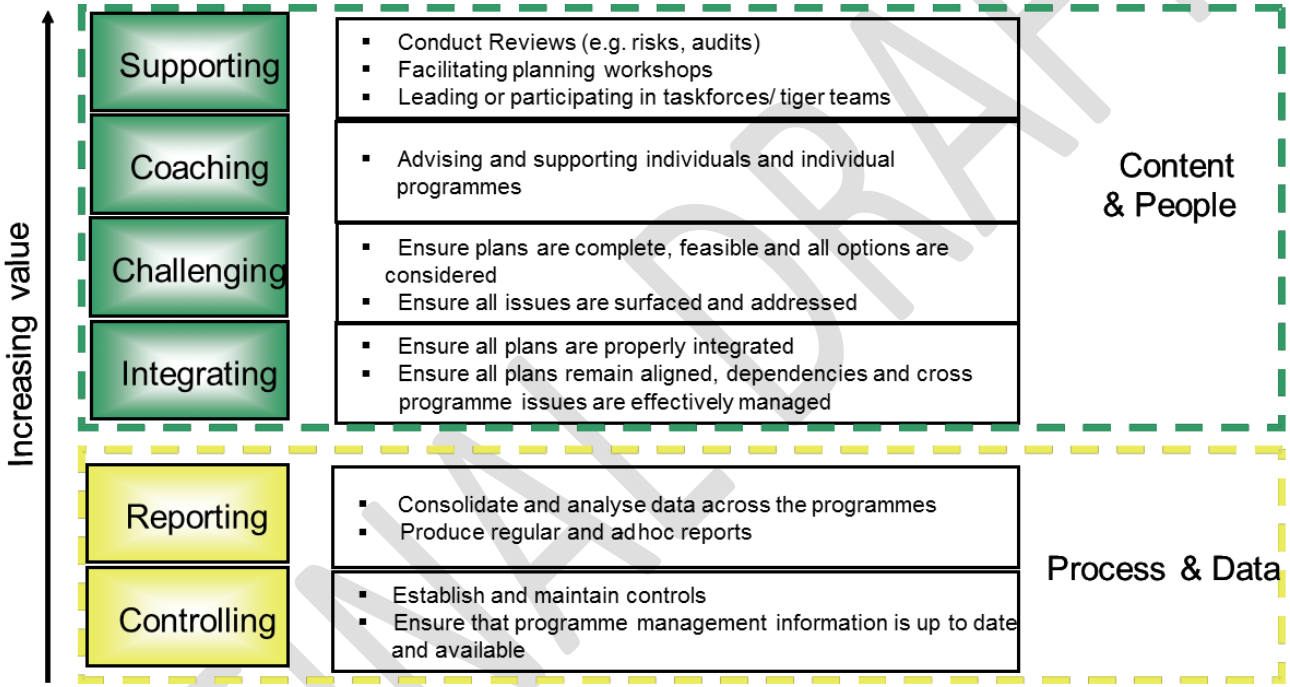

Figure 10 –Proposed PMO capabilities

8. STAKEHOLDER ENGAGEMENT AND COMMUNICATION

Major transformation programmes that succeed usually set clear stretch targets, develop a clear structure and pathway, maintain interest and involvement throughout and finally but critically have strong and visible leadership. In relation to the last two key criteria re interest/involvement and visible leadership, it is critical that the communication of vision, goals, aspirations, themes/initiatives, milestones on the journey etc. are effectively communicated to all stakeholder to ensure they are aligned with and support the goals of the reform programme and in particular the development of integrated models of care to enable and to facilitate change that can and will happen at all levels.

Hence if change is to happen it is critical that there is a planned approach to communication and engagement with staff and that this is built into the Programme plan and the various initiatives required. The aim will be to deliver on a consistent and frequent communication and engagement process in order to:

- Gain support and buy-in /understanding for transition/change;
- Ensure accurate messages are circulated and information is available;
- Understand stakeholder requirements;
- Minimise uncertainty for staff and provide timely information as to how roles will be affected;
- Identify roles and responsibilities in relation to action plans.

The following diagram sets out a communications and engagement approach and an initial programme communication strategy will be drafted in due course for this programme.

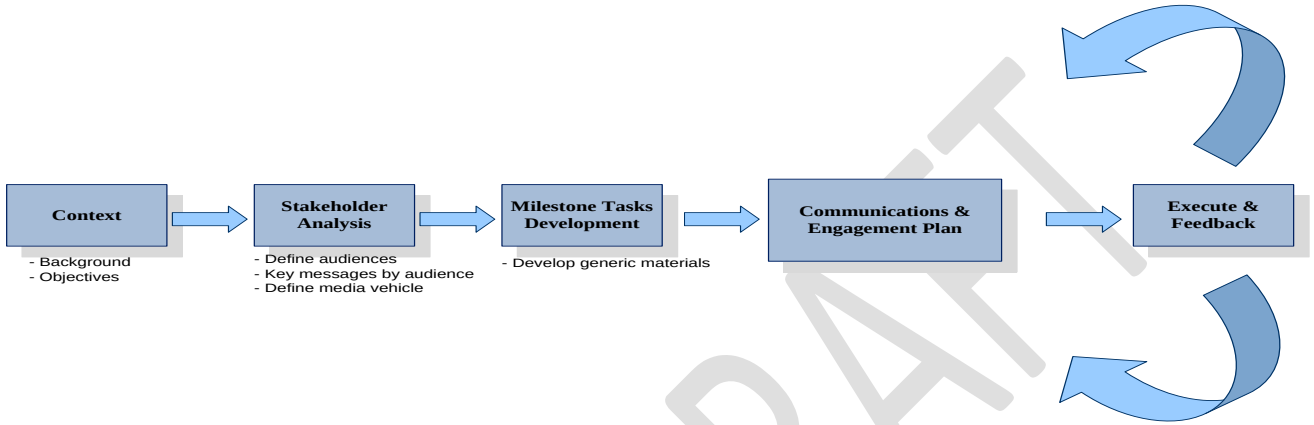

Figure 11 – Strategic communications and engagement approach

9. RISK AND ISSUE MANAGEMENT

9.1. RISK MANAGEMENT

Being able to identify and quantify risk is crucial to the delivery and success of the Integrated Care Programmes. Initial Programme risks will be identified with the CSPD and integrated care programme managers upon their appointment and will then be monitored on a regular basis by the Programme Manager(s), Programme Director and PMO.

Figure 12 Risk management approach

Risks will be discussed with the working groups, updated and maintained by the Programmes and escalated through the governance model for the appropriate level of attention. The Registers at clinical reform and ICP programme level will be managed through the Programme Management Tool (Project Vision) which is being used across the HSE Reform Portfolio.

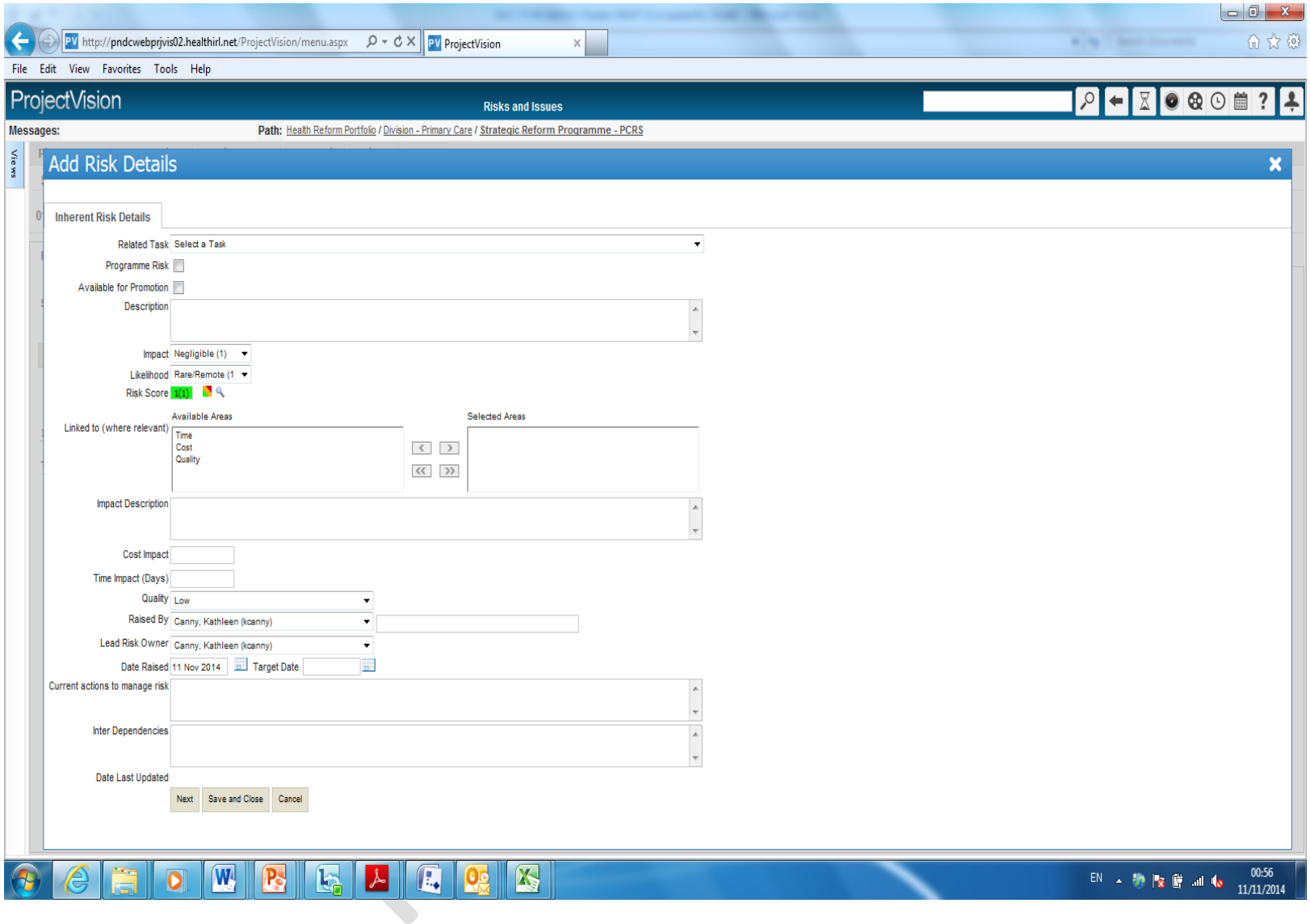

Figure 13 – Project Vision screen for recording risks

9.2. Issue Management

An issue related to a documented concern or known problem that is linked to an individual project or the overall programme. It is critical that these are resolved as quickly and as early as possible. Sometimes issues will need to be escalated for discussion at a higher level and ultimately the overall Steering Group. This type of escalation process is set out in the section on 'escalation of decision' in the section 9 and as with risk, the issue management process itself will be managed through the Project Vision Programme Management Tool.

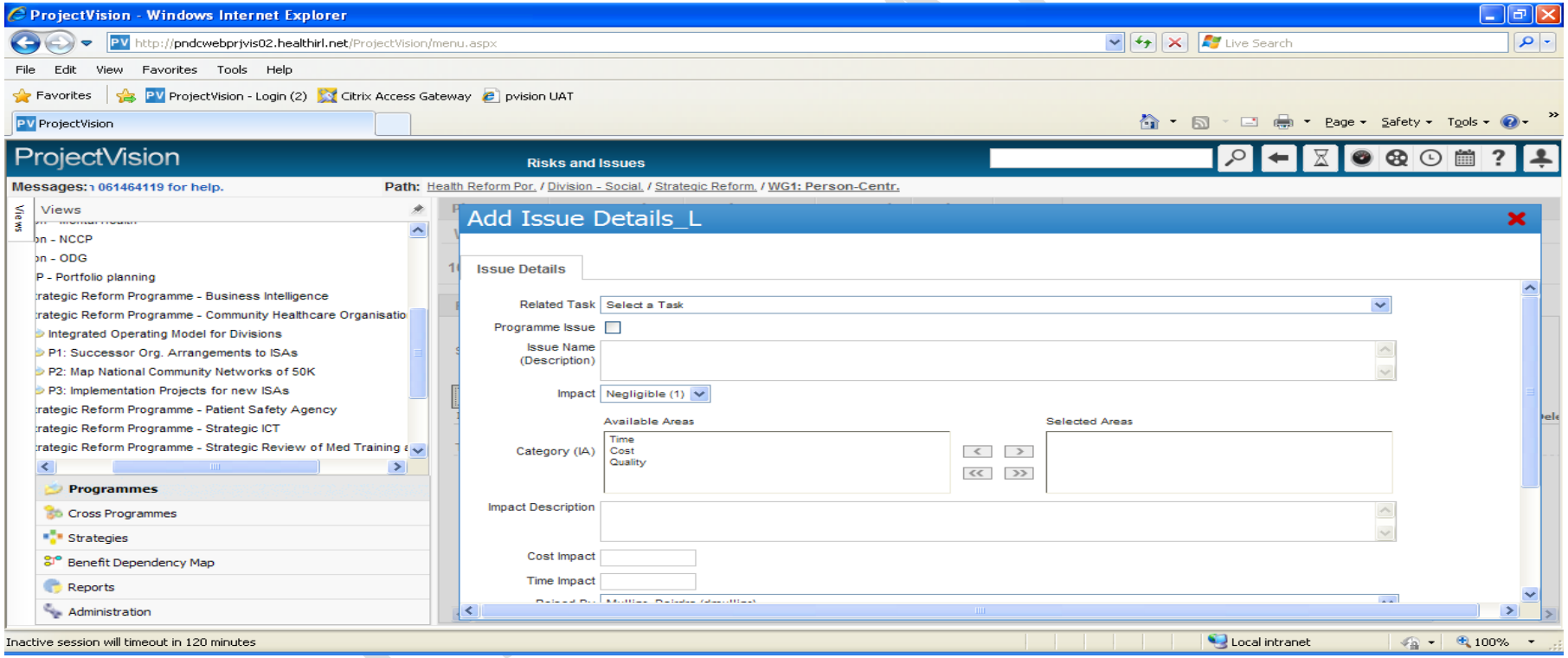

Figure 14 – Project Vision screen for recording issues

10. REPORTING

A key element of management for the CSP Reform Programme and the establishment of ICP's will be to ensure that progress is regularly monitored against the baseline plan. ICP Programme Managers will produce a monthly report, in the Project Vision system. (Section 11.1 sets out an example of an individual project summary report (please note that this report is a sample only and not complete). To set up projects on Project Vision, some initial information including scope, deliverables with associated timelines, risks, issues and dependencies are required. Following this initial piece of work monthly status updates and a quick review of deliverables/ risks and issues, the system will automatically provide an up to date report for each project and programme.

The Programme Director will collate these monthly reports into a monthly Programme dashboard to formally assure delivery and report progress on programme/project success, risks and issues to the Clinical Design Authority and ICP Steering Group. A dashboard format will enable and facilitate effective decision making by providing absolute clarity on programme performance and milestone achievement or slippage. The Programme Director in the first instance will decide which, if any, ICPS it wishes to receive individual written or verbal reports from. This reporting will be undertaken in line with the Steering Group Chair's attendance at the System Reform Steering Group.

10.1. SAMPLE PROGRAMME REPORT FROM PROJECT VISION

Health Reform - Programme report
Strategic Reform Programme - Finance Operating Model

Programme Manager	Joe Sheeky	**Programme Sponsor**	Tom Byrne
Programme Status		**Division**	Finance
Programme Start	01 Jan 14	**Programme Overview Doc Completed**	
Programme Finish	22 May 15	**Route Map Completed**	
Duration (Days)	507	**Resource Requirement Doc Completed**	

Key Progress This Month

N/A

Key Progess Planned next Month

The focus of the programme o er the next period will e on:
-Alignment of projects D1, E1, And F1 and further progression of project C5
-Development of cost-benefit analysis fir te business case
-Finalisation of current state findings for Enterprose Structures
-Completion of Portfolio Review

Project Summary

Project	Status	PM	Sponsor	% Complete
A1 PMO Set up and Mobilisation	G	Gillian Smith	Tom Byrne	1.77 %
A2 Portfolio Review	A	Jim O'Sullivan	Tom Byrne	0.00 %
B1 Interim Performance Reporting		Jim O'Sullivan	Tom Byrne	0.00 %
A3 Communication and Engagement	A	TBC	Tom Byrne	38.14 %
C1 Procurement of new Financial Management Systems		Eddie Hogan	Tom Byrne	0.00 %
C2 Business Case Development	G	Andrew Dowie	Tom Byrne	25.86 %
C3 Technology - Requirement Specifications	C	Ed Parker	Tom Byrne	100.00 %
C4 Technology - Design of Chart Of Acounts and supporting coding structures	G	John Needham	Tom Byrne	44.51 %
C5 Organisation Design	A	Joe Sheeky	Tom Byrne	25.96 %
D1 MFTP - Blueprint for Financial Management		Maureen Cronin	Tom Byrne	20.00 %
E1 Hospital Group Implementation		Ian Carter	Tom Byrne	0.00 %
F1 Community Health Organisations Implementation		Pat Healy	Tom Byrne	0.00 %

Figure 15 – Sample programme report from Project Vision

10.2. Sample Portfolio Report from Project Vision

Health Reform - Portfolio report
Health Reform Portfolio

Portfolio Status		**Portfolio Manager**	Leo Kearns
Portfolio Manager	Seamus Woods	**Head of Change Management**	Brian Kirwan

Portfolio Management Comments
Test Comment version 2

Programme Summary

Programme Name	Status	Programme Manager	Programme Sponsor	% Complete
Strategic Reform Programme - Ambulance Service	A	Joe Ryan	Laverne McGuinness	20.97 %
This is where a comment on Joe Ryans programme will go				
Strategic Reform Programme - Finance Operating Model	G	Joe Sheeky	Tom Byrne	22.83 %
Strategic Reform Programme - Health Business Services Strategic Reform				0.00 %
Strategic Reform Programme - Portfolio planning				11.13 %
Strategic Reform Programme - Acute Services				0.00 %
This is a sample comment for Acute Services				

Figure 16 – Sample Portfolio report from Project Vision