Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Clinical Strategy and Programmes Division

CSPD reform and the establishment of Integrated Care Programmes Charter

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1. DOCUMENT PURPOSE

This document sets out the programme of work involved in reforming the Clinical Strategy and Programmes Division, including the establishment of Integrated Care Programmes.

The development of Integrated Care Programmes (ICPs) is a major element of the reform agenda intended for the health and social care system in Ireland. The Clinical Strategy Programmes Division (CSPD) is establishing five ICPs to support a fundamental requirement of *Future Health – A strategic Framework for Reform of the Health Service 2012–2015*, published by the Department of Health. The objective of this framework is "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 ICPs will work with, and build on the success of, the existing National Clinical Programmes. The intention is that the ICPs will have a benefits focus, to ensure that the integrated models of care are patient centric, clinically sound and fit for implementation across the system. In order to best meet the recommendations set out in the *Future Health* framework, the CSPD must reform to position itself as the Clinical Design Authority for clinical reform. It is intended that this will be achieved through the work of the reform programme. In its new role, the CSPD will be responsible for directing that changes implemented by the five operating divisions are consistent with the integrated models of care. Each ICP will develop a 'programme initiation document' to articulate the scope, work streams and structure for delivering its vision and benefits.

The objectives of this document are to:

- provide a background and introduction to the reform programme
- clearly articulate the programme's vision and benefits
- describe the programme's governance, outlining clear responsibility for decision-making
- define the reform approach and the key work streams involved
- describe the high-level plan for the reform, with key milestones to be achieved
- describe the communication and engagement approach for the reform programme
- develop a mechanism to monitor programme risks and issues
- provide an outline of the programme's reporting methodology
- describe the resource requirements for the programme.

This charter will form the basis for managing the CSPD reform programme and the establishment of ICPs.

2. BACKGROUND/CONTEXT

The Quality Patient and Clinical Care Division was established by the HSE in 2009. It was subsequently divided into the Quality and Patient Safety Division and the Clinical Strategy and Programmes Division (CSPD). The CSPD's strategic role is to develop a national, strategic and co-ordinated approach for the design of clinical service improvements, in order to deliver improved patient care, improved access and better use of resources. Clinical services are currently provided through the work of the National Clinical Programmes (NCPs). These are agreed, scoped and resourced under the remit of the CSPD, and updates on their deliverables are reported via the respective National Clinical Leads. The CSPD is responsible to the Director General of the HSE, who is, in turn, accountable to the Secretary General of the Department of Health. The CSPD's role, through the work of the NCPs, is to help improve the patient experience and quality of care through the design of standardised models of care that are implemented throughout the healthcare system. These models of care are developed by bringing together healthcare professionals (clinical and management) across all relevant disciplines and enabling them to identify innovative solutions that can deliver increased benefits to every user of our health services. This is achieved by designing and specifying standardised models of care, guidelines, pathways and associated strategies for the delivery of evidence-based, integrated clinical and social care. While the implementation of these strategies is outside the scope of the NCPs, the programmes provide clinical leadership to support local implementation teams, where needed.

The first phase of NCPs involved developing excellence in individual specialties, specific diseases and stages of care, such as acute medicine, diabetes and surgery. The NCPs have been instrumental in driving improvements in clinical care in Ireland. It is intended that the programmes will continue to be the 'engine room' to enable the establishment of the ICPs as part of the reform programme.

In November 2012, the Department of Health published *Future Health – A Strategic Framework for Reform of the Health Service 2012–2015*. *Future Health* states: '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

In order to best meet the recommendations set out in *Future Health*, the CSPD must reform to position itself as the Clinical Design Authority. The CSPD is building on, and incorporating, the existing NCPs while also establishing ICPs to enable the delivery of integrated models of care in the healthcare system within Ireland. The CSPD has identified five ICPs that meet the defined international principles of an ICP. However, for the avoidance of doubt, all clinical services provided through the health service form part of the scope for consideration for delivering integrated models of care.

The five ICPs, which will be established on a phased basis, are as follows:

- Integrated Care Programme for Patient Flow
- Integrated Care Programme for Older People
- Integrated Care Programme for the Prevention and Management of Chronic Disease
- Integrated Care Programme for Children
- Integrated Care Programme for Maternity.

These ICPs will seek to work with the existing clinical programmes and with other key enablers such as Finance, HR and ICT to ensure that the appropriate business supports are available to deliver seamless, patient-centric services.

The agreed working definition of an ICP is one that outlines a framework for the management and delivery of health services which ensure that patients receive a continuum for preventive, diagnostic, care and support services, according to their needs over time and across different sectors of the health system. The supporting models of care will incorporate multidisciplinary 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 that puts the user's needs first. The ICPs will be underpinned by **proactive management of interfaces** between services in order to reduce barriers to integration and allow for cohesive care provision across a continuum of services.

A set of principles has been developed to help identify potential ICPs. It includes situations where:

- a disease or condition currently affects significant population cohorts
- there is significant potential to reduce the burden of illness
- there is significant potential to alleviate service pressure points/waiting lists/delays in the current system
- members of vulnerable groups (socially deprived/young/old/those with disabilities) are greatly affected by their condition

- outputs will result in appropriate care, delivered in the appropriate setting and at an appropriate level of acuity
- implementation of the model will result in improved quality of care
- it is considered appropriate by patient advocacy representatives
- potential to obtain value for money within the health budget is high
- the services delivered by at least three operating divisions would feature in the associated model/framework
- the programme would require multidisciplinary care planning
- 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
- services are well co-ordinated around these assessed needs
- it is preventive, enabling, anticipatory, planned, well co-ordinated and evaluated
- 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 spectrum 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. While the integrated care team often functions differently according to the setting, mutual respect and communication are critical at all settings.

The World Health Organization 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 the CSPD and the establishment of the ICPs is set out in Figure 1.

4.2.CSPD REFORM THROUGH THE ESTABLISHMENT OF INTEGRATED CARE PROGRAMMES – VISION AND BENEFITS

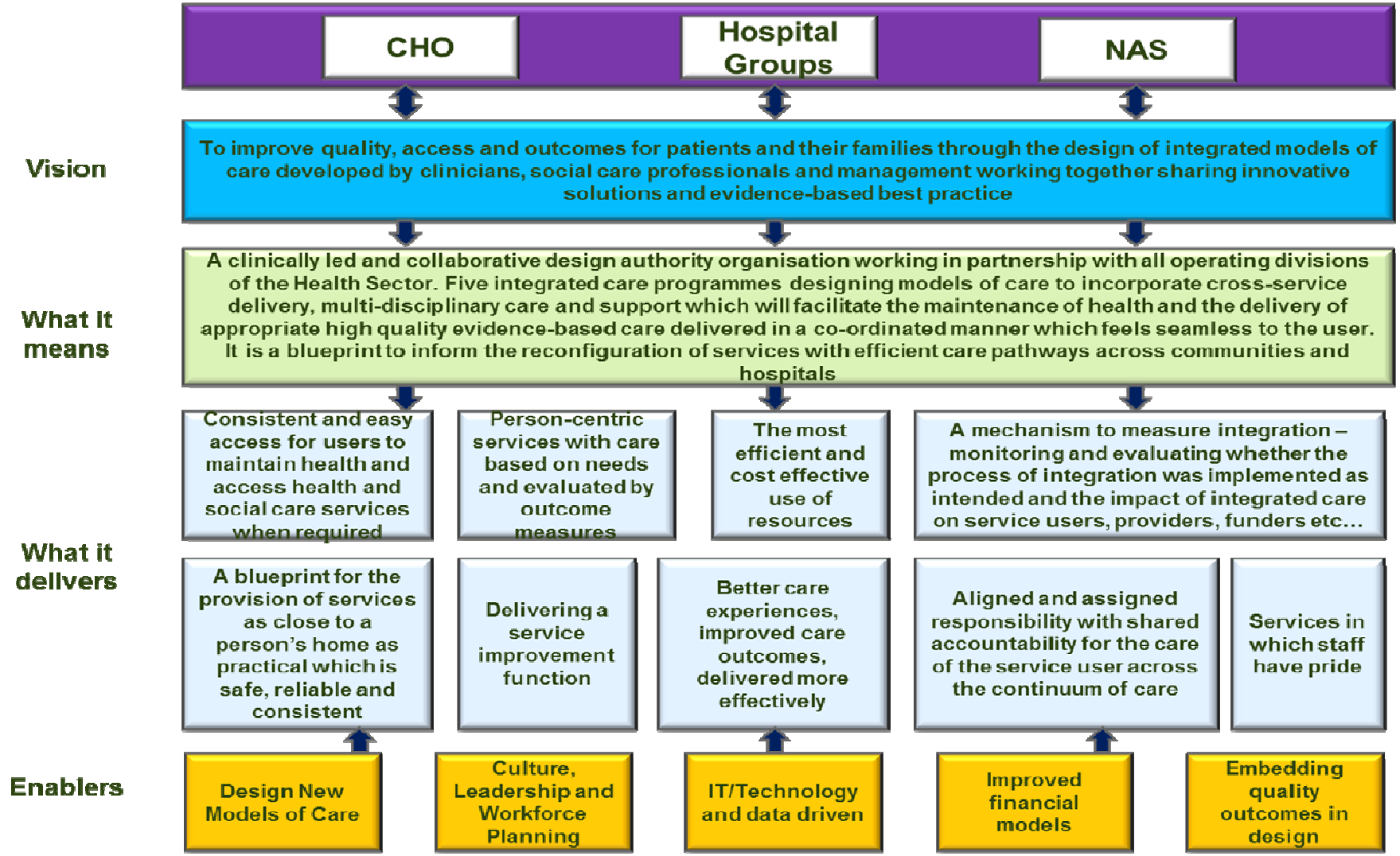

Figure 1 – CSPD reform through the establishment of Integrated Care Programmes

4.3. Integrated Care Programmes

An 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 sectors of the health system.

An ICP is underpinned by the principles of illness prevention, patient empowerment, multidisciplinary, 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 that is responsive to the changing needs of patients and their families.

4.4. Key features of establishing the Integrated Care Programmes

The ICPs will adopt the following key features in order to promote the vision of developing the health service:

- They will be designed by clinicians, with formal structures agreed with the medical colleges for input and sign-off; similar structures will be developed with nursing and midwifery and with health and social care professionals.
- A cross-organisational view will be taken, basing the models and pathways around the needs of the patient rather than organisational structures.
- Each ICP will be chaired by an executive with deep knowledge and experience of the challenges of implementing integrated services.
- Each programme will utilise the best available evidence for the design of the models of care; within each programme, specific work streams will be prioritised for immediate work.

The vision for each ICP is set out in the pages that follow.

4.5. PATIENT FLOW INTEGRATED CARE PROGRAMME – VISION AND BENEFITS

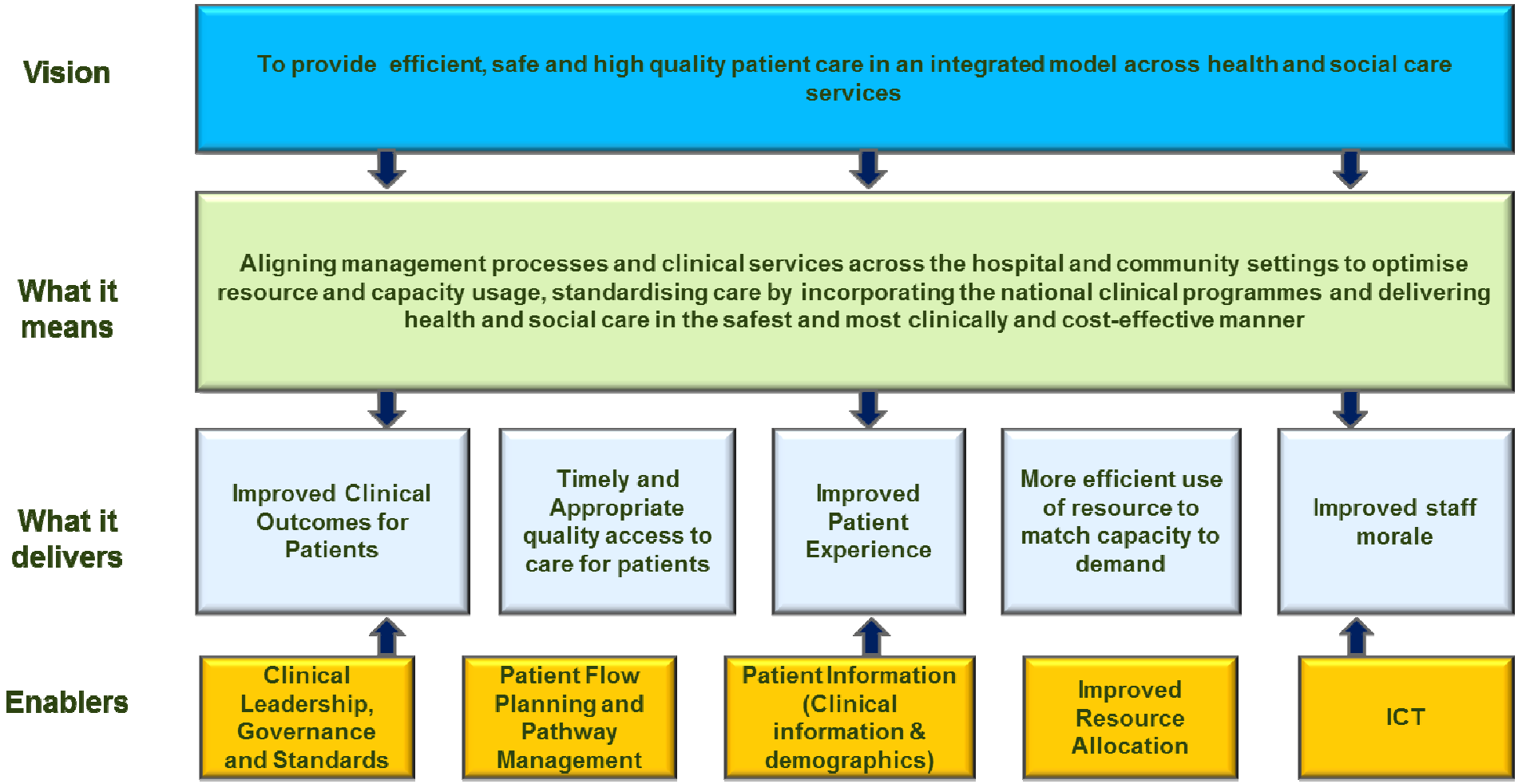

Figure 2 – Patient flow Integrated Care Programme – vision and benefits

4.6. Older Persons' Integrated Care Programme – vision and benefits

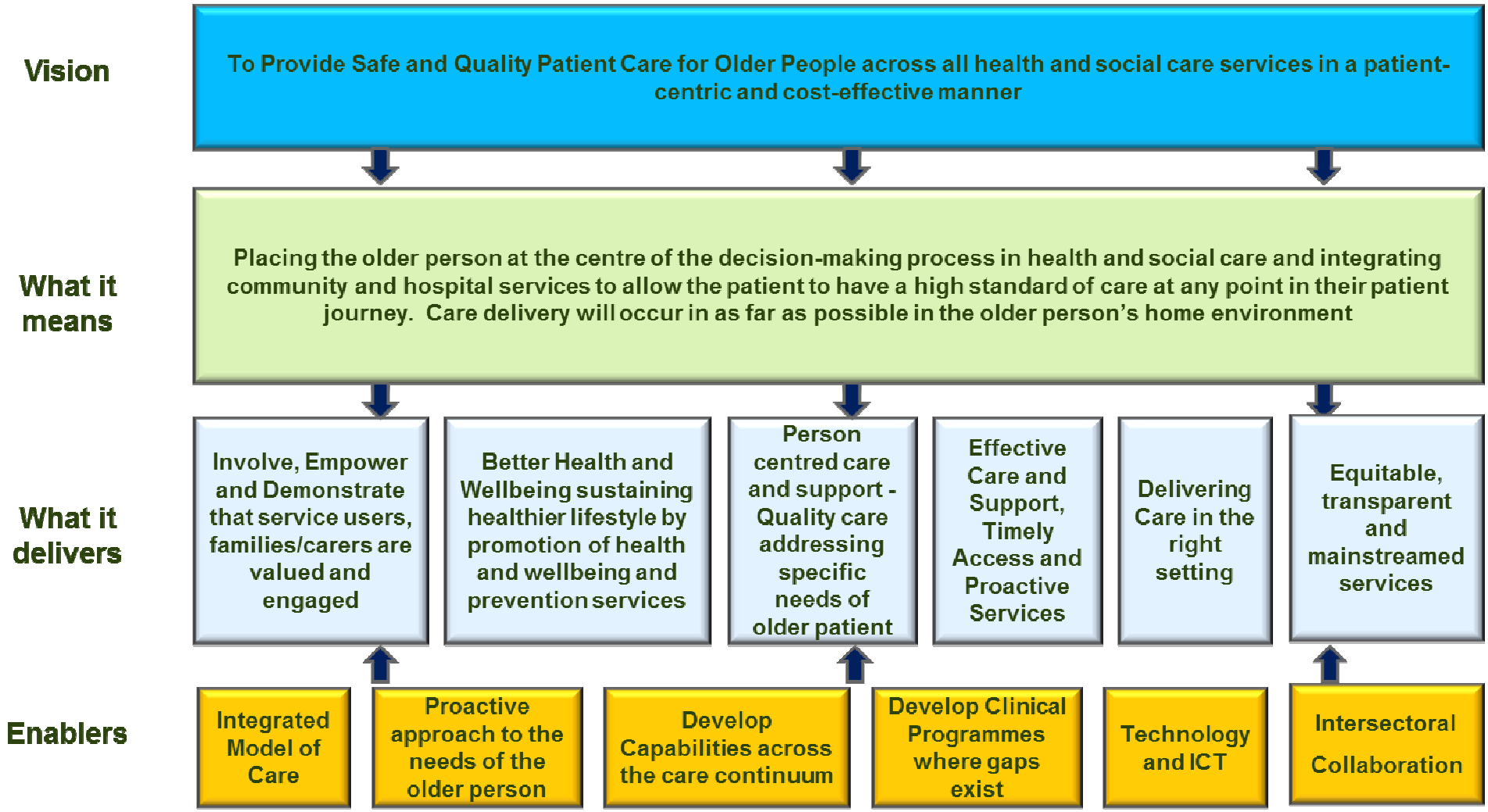

Figure 3 –Older Persons' Integrated Care Programme – vision and benefits

4.7. Chronic Disease Prevention and Management Integrated Care Programme – vision and benefits

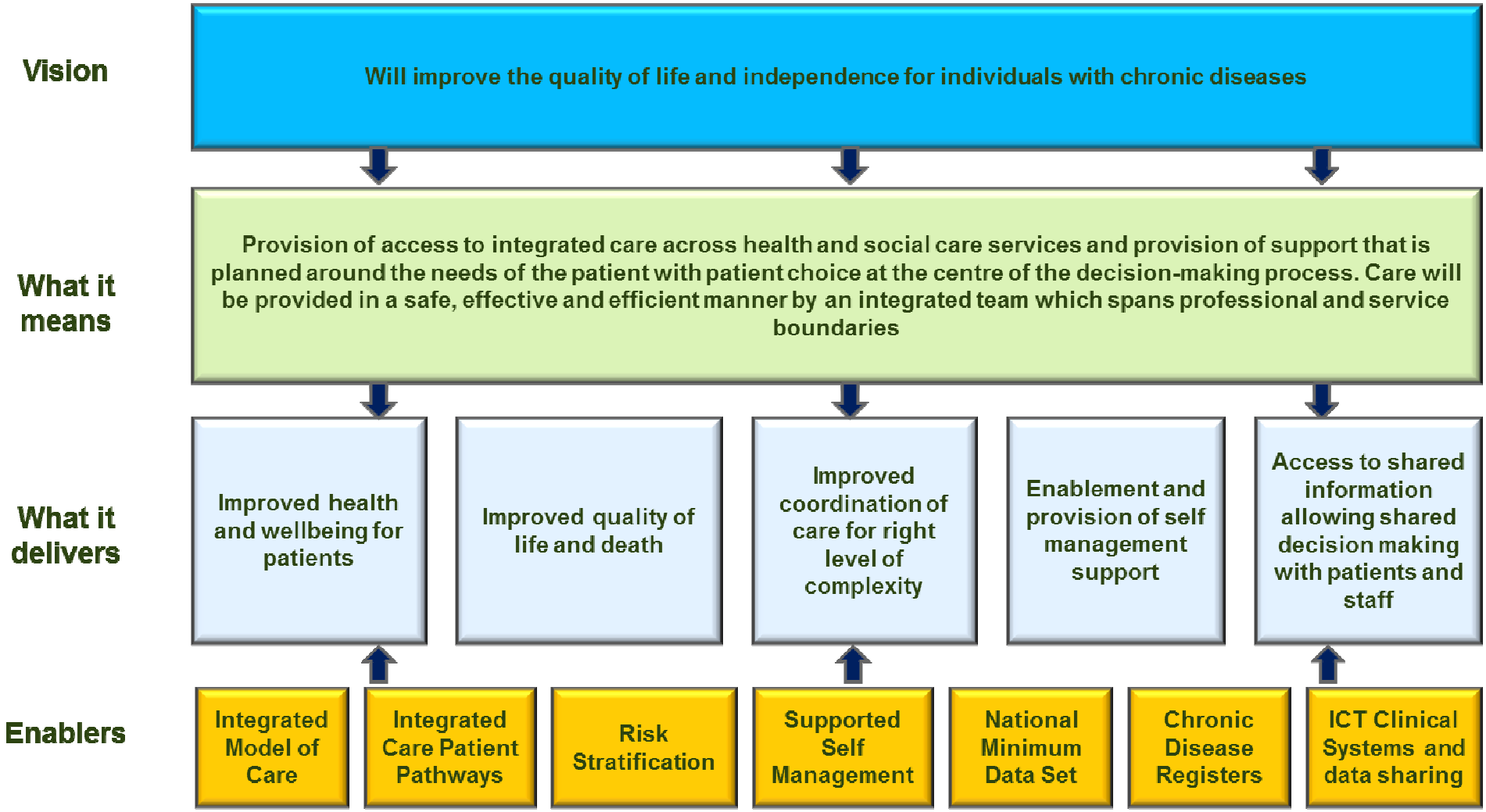

Figure 4 – Chronic Disease Prevention and Management Integrated Care Programme – vision and benefits

4.8. Children's Integrated Care Programme – vision and benefits

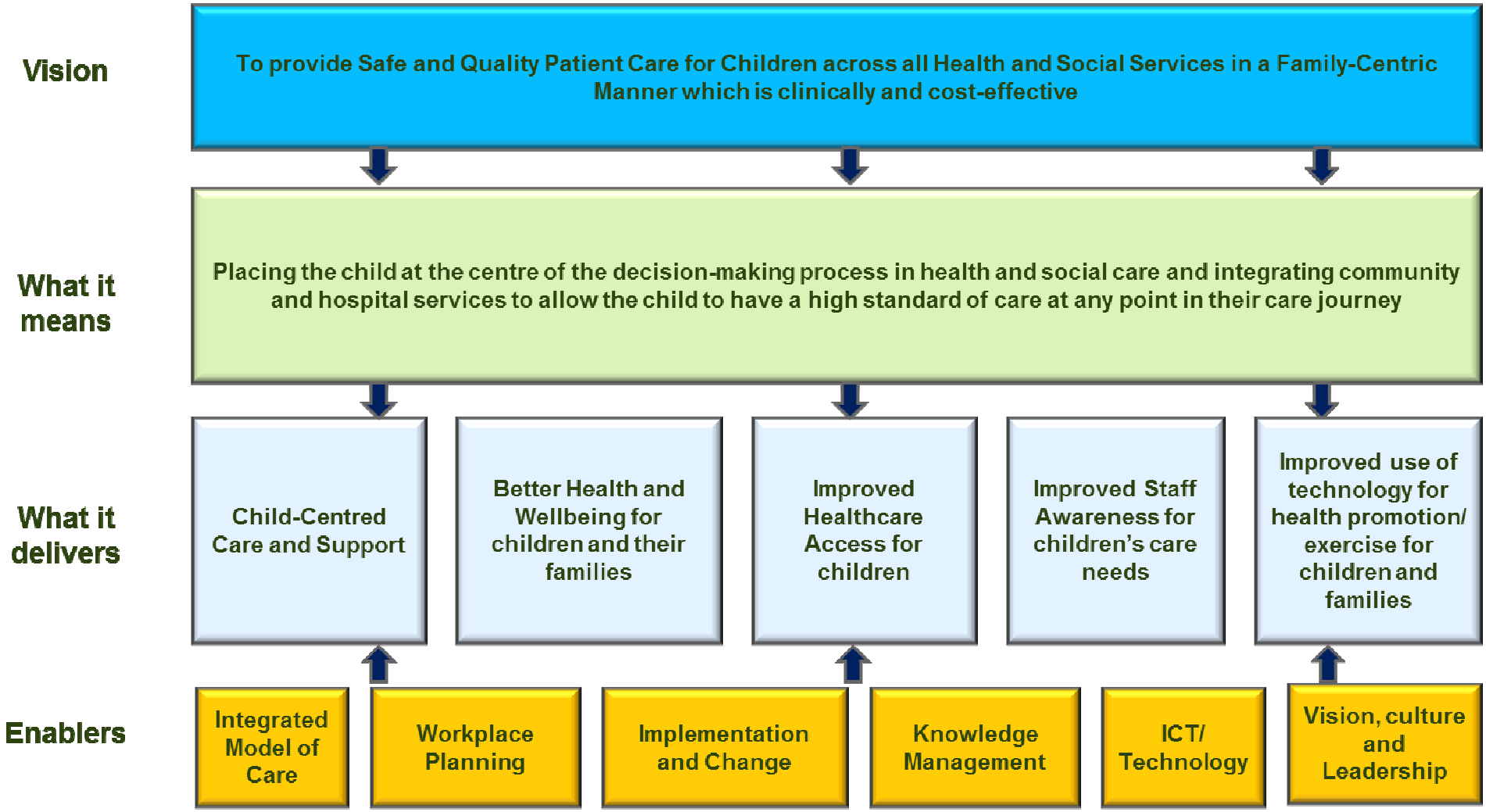

Figure 5 – Children's Integrated Care Programme – vision and benefits

4.9. Maternity Integrated Care Programme – vision and benefits

A benefits workshop is yet to be conducted in order to draft the appropriate vision and benefits for this ICP.

5. GOVERNANCE

Given the complex nature of integrated clinical reform, it is vital to ensure that the appropriate governance is in place at all levels of the portfolio of programmes and projects. This section sets out the proposed governance model for ensuring successful delivery of the entire portfolio. This model sets out clearly the roles and responsibilities of all key stakeholders and also provides a clear decision-making framework. The governance model is outlined in Figure 6.

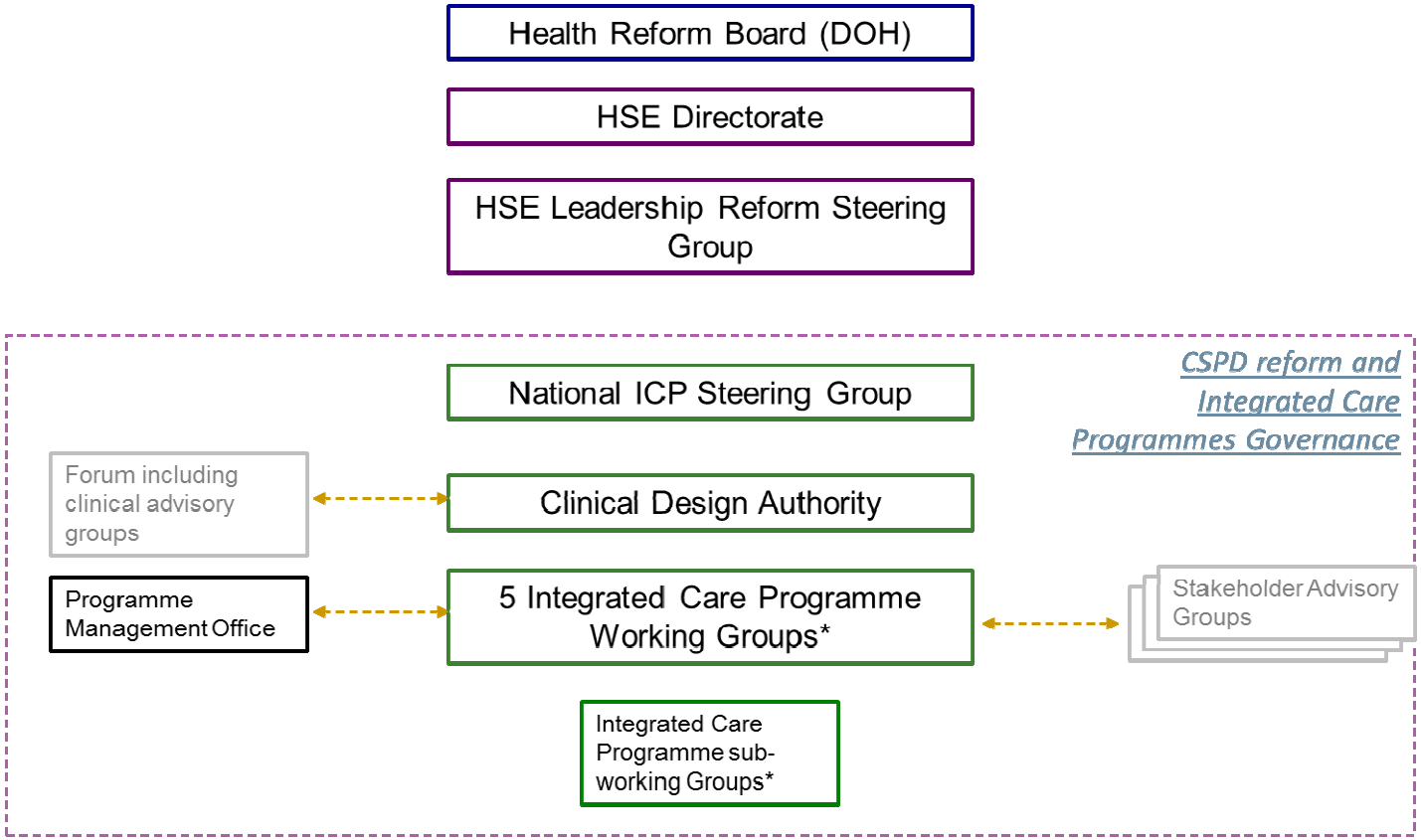

Figure 6 –Proposed governance model

CSPD reform and the establishment of Integrated Care Programmes Charter

Building on the principles of the HSE system reform governance, the governance model will include the following key levels:

- CSPD Reform Steering Group, accountable for the successful reform of the CSPD
- Clinical Design Authority, providing assurance of the clinical design for implementation of the ICPs;
- core CSPD reform team, responsible for the day-to-day management and delivery of reform within the CSPD;
- Programme Management Office (PMO) to provide guidance and control for the ICPs and National Clinical Programmes (NCPs);
- ICP teams to deliver implementable integrated models of care supported by:
    - ICP 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 with groups such as nursing and midwifery, and with health and social care professionals.

Proposed CSPD Reform Steering Group (meets every six to eight weeks)	
The membership of the Steering Group has been selected to promote alignment between the CHO and Hospital Groups programmes. It is envisaged that the steering group membership will evolve over time. The proposed membership is as follows: – Dr Aine Carroll, National Director, Clinical Strategy and Programmes (Programme Sponsor and Chair) – Mr Pat Healy, National Director, Social Care – Dr Stephanie O'Keeffe, National Director, Health and Wellbeing – Mr John Hennessy, National Director, Primary Care – Ms Anne O'Connor, National Director, Mental Health – Mr Liam Woods, National Director for Acute Hospitals – Mr Patrick Lynch, National Director, Quality Assurance – Dr Philip Crowley, National Director, Quality Improvement – Mr Richard Corbridge, CIO (Clinical Information) – Mr Ian Tegerdine, Interim National Director, Human Resources – Mr Stephen Mulvany, CFO – Senior Department of Health representative, to be nominated – Mr Damian McCallion, National Director, National Ambulance Service	The role of the Steering Group will be to: – approve the models of care – account for the successful reform of the CSPD, 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 the 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 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 interdependent 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.

CSPD reform and the establishment of Integrated Care Programmes Charter

Clinical Design Authority (meets every four weeks)	
The membership of the Clinical Design Authority is as follows: – Dr Aine Carroll, ND Clinical Strategy and Programmes (Programme Sponsor and 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 and 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 ICPs) – Health and social care professionals	The role of the Clinical Design Authority will be to: – ensure that the work of the ICPs 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 ICPs; – agree and approve the vision, scope and benefits for the ICPs; – understand and, where necessary, resolve issues related to the complex set of interdependencies between the ICPs and the NCPs; – ensure alignment of the models of care with the CSPD strategy and delivery within their respective organisational division/department; – help to identify and make resources available for the planning and delivery of the ICP models of care – provide progress reports to the National ICP Steering Group and ensure that critical issues and risks are escalated appropriately through the overall reform governance structure.

5 *Integrated Care Working Groups (meet every two to four weeks)	
The membership of the Integrated Care Working Group(s) is as follows: – ICP Chair (Integrated Care Programme Sponsor and Chair) – Integrated Care Programme Manager – primary care representative – acute hospitals representative – mental health representative – health and wellbeing representative – social care representative – nursing representative – national ambulance service required for patient flow working group) – advisors for the key enablers, ICT, HR, Finance and Quality (Note – It may be prudent to have a work stream in the respective reform programmes dedicated to the ICPs 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 ICPs.	The 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 ICP – 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 ICP 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 to identify resources required to deliver the workstreams and demonstrator projects – provide progress reports to the Clinical Design Authority through the Programme Management Office (PMO) 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 to 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 ICP's working group.

Key roles

Programme Director and CSPD reform team	Integrated Care Programme Chair
– day-to-day management of the overall reform programme – drive the overarching reform programme plan and direction – monitor overall progress of the 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 PMO updates and provide to the Clinical Design Authority and Steering Group as required – embed agreed System Reform Group (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 Managers to ensure successful delivery of their ICPs – provide and co-ordinate 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 also ensure that resources are in place to deliver on the required capabilities – meet at least on a four-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
The key responsibilities of the Senior Programme Managers for the Integrated Care Programmes are as follows: – 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 – co-ordinate and commission the delivery of workstreams or work packages with the identified resources (including the current NCPs) to deliver on the ICP plan – establish the core ICP team to deliver specific elements of the plan – provide leadership and direction to all staff in relation to the ICP – motivate, drive and challenge to achieve the change objectives as quickly as possible. Embed agreed SRG tools/standards across the overall programme.

Programme Management Office (PMO)

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

The challenge to meet this need is compounded by a number of factors, which include:

- the complexity of the programmes and the consequent need to co-ordinate and integrate activities across the programmes to deliver a fully integrated approach
- the inevitability of conflicts and the imperative of having the means to support and direct these programmes through the provision of a PMO
- the need for a coordinated view, so that priorities may be set and conflicts identified and resolved as quickly as possible
- the need to provide flexible information flows to facilitate rapid, well-informed decision-making and ensure effective communication.
- the need to identify and manage issues and risks to ensure that 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 NCPs, 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 three-phased approach to provide a controlled environment to establish the ICPs; transition to the new CSPD operating model with ICPs can be constantly reviewed and enhanced if necessary. The three phases are:

Phase I: **Initialisation (three months)**: Short-term actions to be taken to establish and resource the ICPs:

- agree and sign off the CSPD vision and the vision for each ICP
- establish the governance structure
- establish the PMO
- design and sign off on an integrated programme framework
- fill identified resource gaps for the CSPD and ICPs
- assess the work plans of the National Clinical Programmes and their alignment with the ICPs
- develop the programme initiation documents for each ICP
- develop the communication strategy for the CSPD and the ICPs
- develop the target organisational and performance model for the CSPD and plan for transition to this model
- develop 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 and clear benefit plans
- appropriate governance structures and stakeholder engagement at overarching and ICP level
- further delivery of clinical reform aligned to the ICPs through demonstrated projects against agreed outcomes and KPIs
- development of the key principles for change, implementation and mainstreaming of integrated clinical reform

- 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 KPIs
- identification of further innovation to deliver improvements in healthcare in line with strategic goals for improved outcomes.

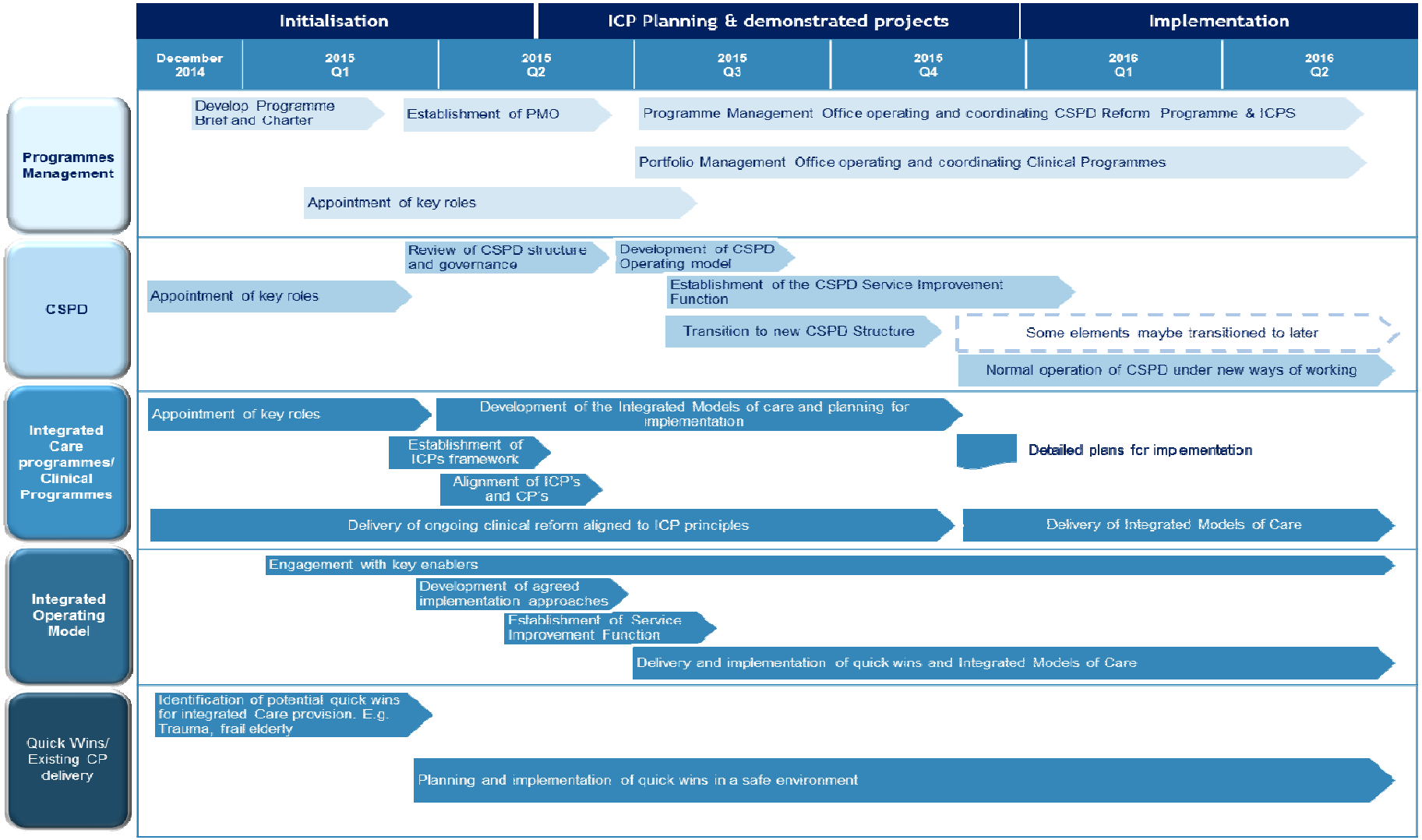

Figure 7 –CSPD reform and the establishment of Integrated Care Programmes – high-level plan

7. OUTLINE SCOPE FOR EACH WORKSTREAM

Five programme workstreams have been identified to support the overarching programme vision, (as set out in Section 3). The workstreams are set out individually on the following pages. (Responsibility for each project or workstream will need to be defined.)

The following workstreams are set out in this section:

- Project management process
- Clinical Strategy Programme – organisation, structure and performance
- Establishment of the ICPs
- Establishment of the integrated operating model
- Delivery of existing NCPs and integrated care 'quick wins'

Figure 8 outlines how the core workstreams will support the move towards the development of integrated services for healthcare:

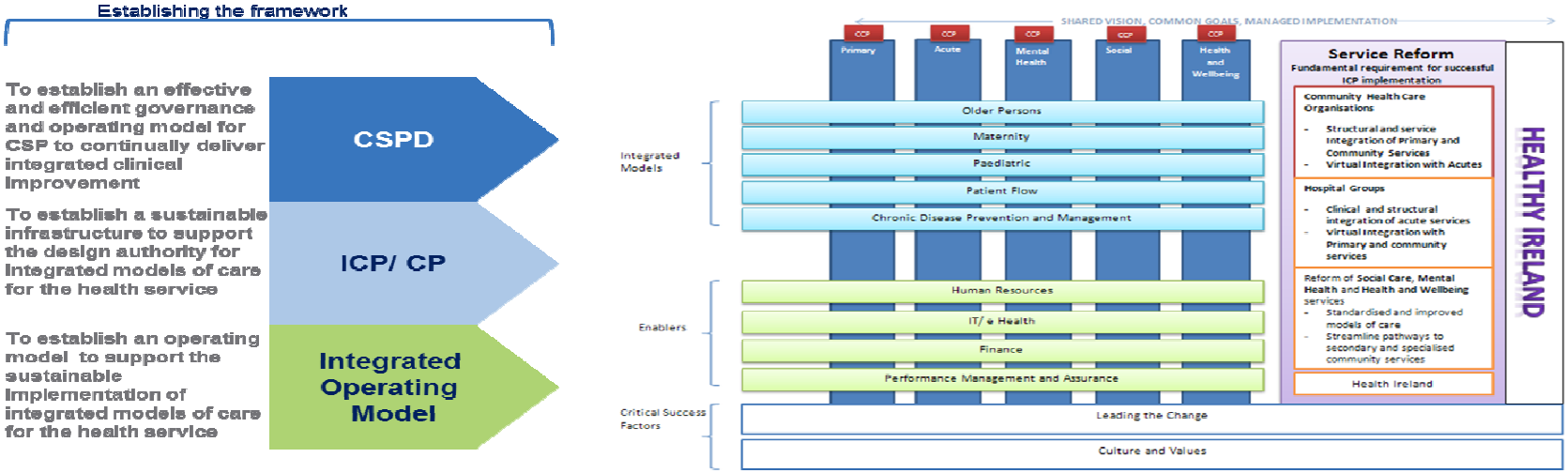

Figure 8 – Programme's major workstreams and the move towards integrated services

7.1. PROGRAMME MANAGEMENT PROCESS

Objective

The objective of this workstream is to establish a clear governance structure and accountability to support the reform programme and the establishment and transition to delivering ICPs.

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 of 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 CSPD is committed to supporting the development of a strong system of integrated corporate and clinical governance within the NCPs. As the new integrated care models for health and social care are developed, the CSPD needs to have the appropriate governance and management structures, processes, people, outcomes and ways of working, in order to ensure that it can carry out its functions effectively in guiding the full integrated clinical reform. This operating model will seek to build on the current model, aligning with the divisions of care within the HSE Directorate, while 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 KPIs 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 Senior Management Team
- agreement on appropriate KPIs for the effective operation of the 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 the 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
  - performance management.
- develop a plan for the senior leadership team to promote continual improvement at a team and individual level
- recruit people to fill the new key roles that have been identified within the CSPD core team 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 CSPD
  - 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
- 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 memorandums of understanding and support for PBAI.)
  - patients and patient organisations
  - Department of Health
  - 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
  - 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 of 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, multidisciplinary, cross-organisational design authority for patient-centred, integrated models of care will ensure that all clinical programmes that meet the criteria for ICPs deliver the best outcomes in an integrated manner for patients and the health service.

Critical success factors

- development of an effective ICP framework
- a "commissioning" model for integrating the ICPs with the NCPs
- delivery of early demonstrator projects as proof of concept of the integrated model
- KPIs 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 Integrated Care Programmes

- define and implement governance and management and reporting structure for ICPs
- develop the compelling case to clearly articulate the real value of each of the ICPs
- definition and establishment of the ways of working for the ICPs and the PMO
- development of the overarching ICP programme framework
- ensuring the correct alignment with existing system reform programmes, including the work being undertaken in relation to the process redesign support for Acute Hospitals (particularly important for patient flow)
- ensuring the ICPs are appropriately aligned with the following:
    - Programme for Government
    - *Future Health*
    - Healthy Ireland
    - Vision for Change
    - National standards for safer and better healthcare
    - Department of Health priorities
    - 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 ICP, so as to ensure that the principles underpinning integrated care are adopted. It is essential to ensure that the NCPs are adopting the appropriate integrated approach for delivering healthcare.

- develop a stakeholder and communication engagement plan to include consideration of public, clinical, academic, and economic stakeholders
- develop the workstreams and related project plans for each ICP, including resourcing plans
- prioritise workstreams with a particular focus on 'quick wins'
- develop the appropriate roles and responsibilities to ensure that clarity is provided between the ICP and its related NCPs; this will include clarification between the roles using a responsibility matrix
- develop 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
- 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 enable the commissioning of the current NCPs, as appropriate, into the planned ICP 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 ICPs 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 KPIs and metrics

Key decision points

- agreement and sign-off on the full integrated operating model with Service Divisions and key enablers
- agreement on appropriate KPIs and metrics for measuring 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 Hospital Group/CHO. This 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 and development)
    - ICT (supporting systems influence strategy)
    - finance
    - performance indicators
    - quality indicators/measures.
- Embed key enablers into implementation of integrated models of care including:
    - human resources (recruitment; contractual)
    - ICT
    - finance

  - performance indicators
  - quality indicators/measures.
- describe the implementation strategy – how, who and outcomes (also evaluation tool for audit)
- create link to innovation (Enterprise Ireland) and research (Health Research Board).

Key risks

- lack of engagement with the key enablers who are also embarking on significant reform programmes
- insufficient key resources
- ongoing reform within both the HSE and the health system means that the environment is constantly 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 NCPs 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 and social care through 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 National 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 National 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
- co-ordination with other groups driving improvements such as the Special Delivery Unit (SDU)

Key dependencies

- the current status of the NCPs
- resourcing the ICP initiatives and aligning, if required, with current NCPs

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

It is envisaged that the resources outlined in Figure 9 will be required during the initialisation phase of the reform programme and in the establishment of the ICPs:

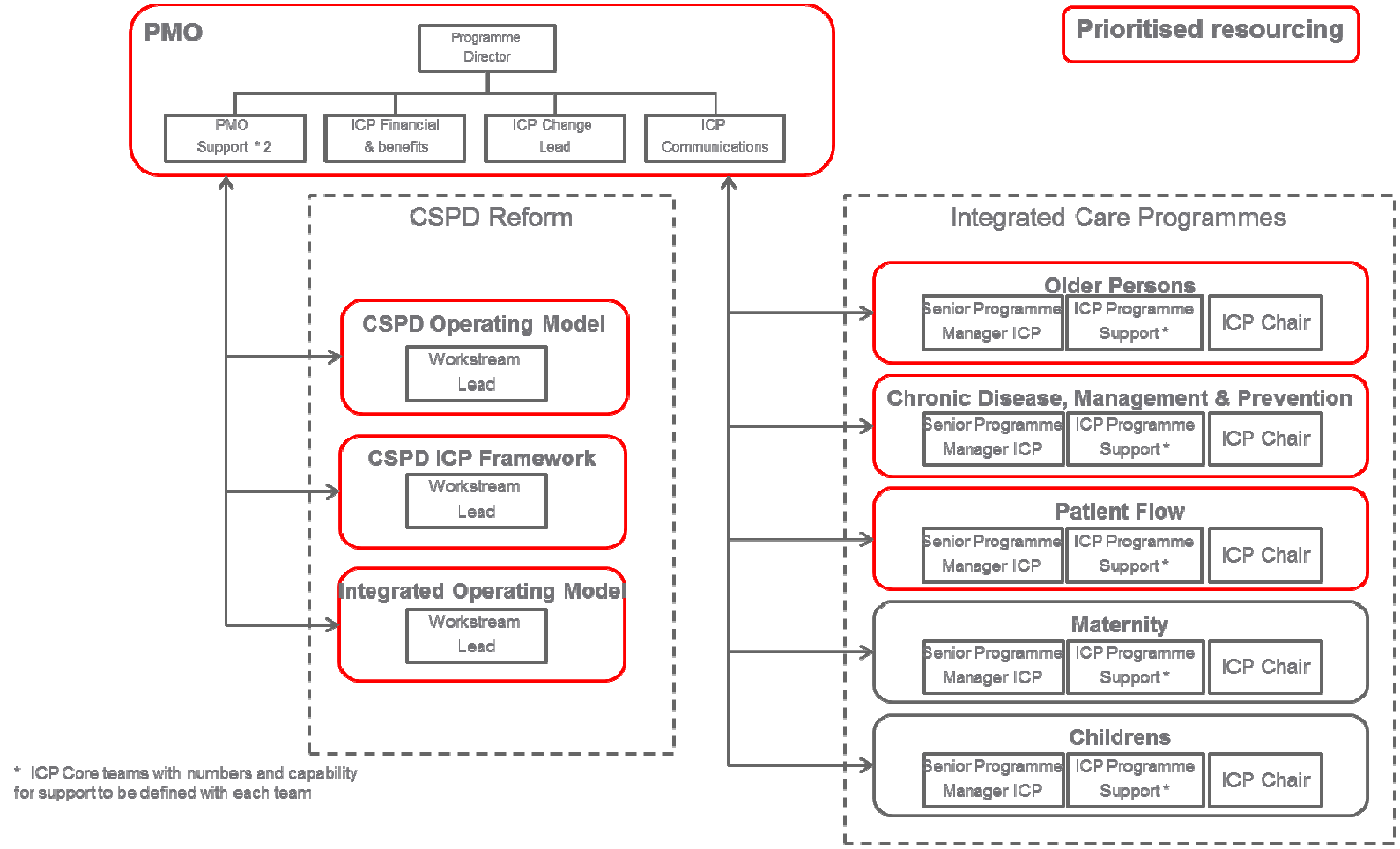

Figure 9 –Initial resources required

7.6.1. PROGRAMME MANAGEMENT OFFICE

The PMO should be established in a single location, operating with the core ICP teams to provide the ICPs with a hub that promotes integration at all levels. In order to provide the right mix of support and control for the ICPs and the reform programme, the PMO needs to focus more often on driving the appropriate capabilities and behaviours, as well as programme processes and controls, as highlighted in Figure 10:

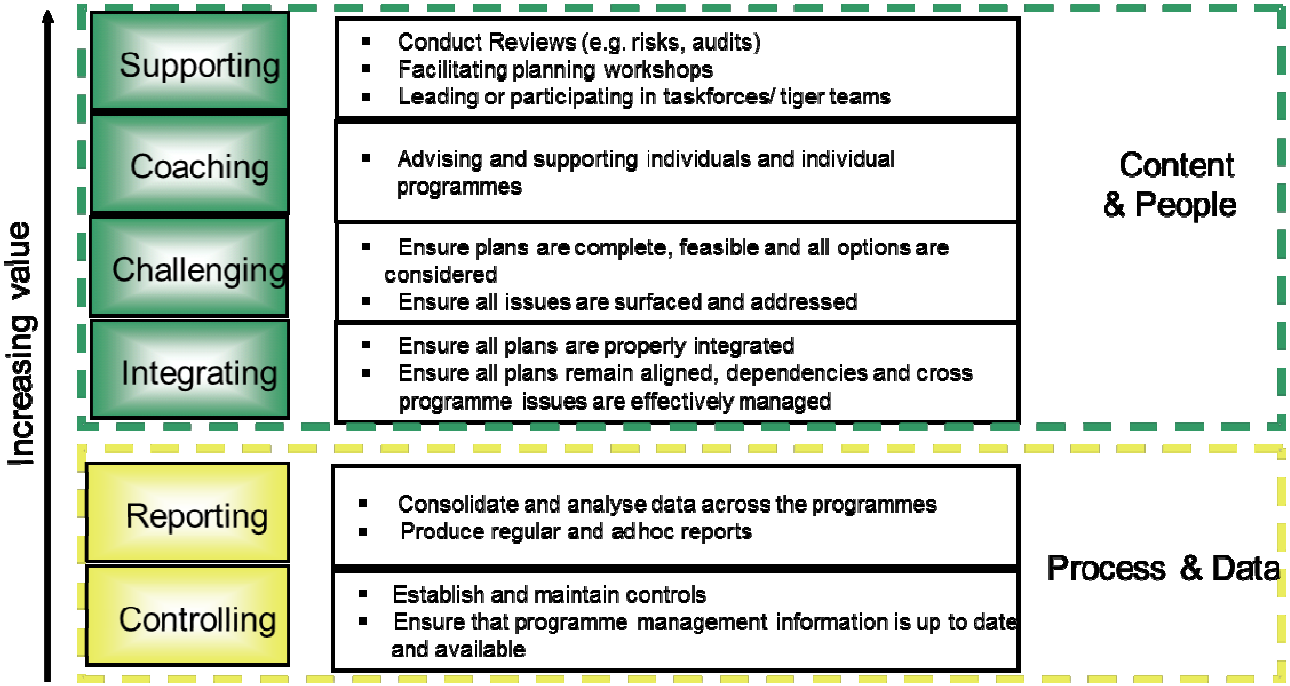

Figure 10 – Proposed PMO capabilities

8. STAKEHOLDER ENGAGEMENT AND COMMUNICATION

Major transformation programmes that succeed have a number of characteristics in common. They usually set clear targets, develop a clear structure and pathway, maintain interest and involvement throughout and finally, but critically, have strong and visible leadership.

Interest and involvement can only be maintained if the vision, goals, aspirations, themes/initiatives and milestones on the journey are effectively communicated to all stakeholders. This will ensure that they remain aligned with, and continue to support, the goals of the reform programme. Strong and visible leadership is critical to achieving this, and to facilitating change at all levels.

Therefore, if change is to happen, it is vital 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 that 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.

Figure 11 sets out a communications and engagement approach; an initial programme communication strategy will be drafted in due course for this reform programme.

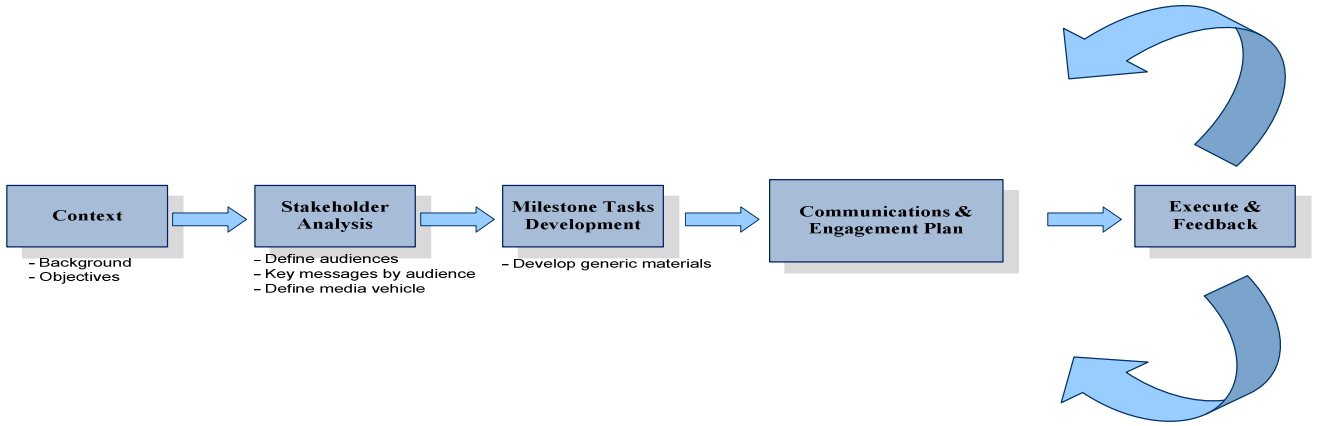

Figure 11 – Strategic communications and engagement approach

9. RISK AND ISSUE MANAGEMENT

9.1. RISK MANAGEMENT

The ability to identify and quantify risk is crucial to the delivery and success of the ICPs. Initial programme risks will be identified with the CSPD and ICP managers on their appointment, and will then be monitored on a regular basis by the Programme Manager(s), Programme Director and PMO. Figure 12 outlines the risk management approach.

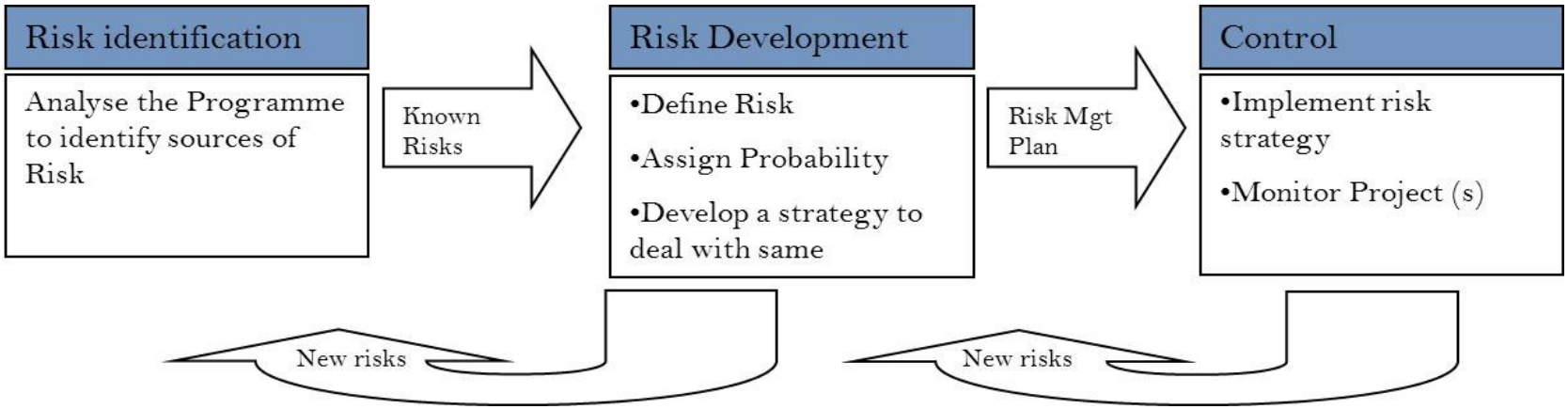

Figure 12 Risk management approach

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 shows a screen shot of the Project Vision risk template.

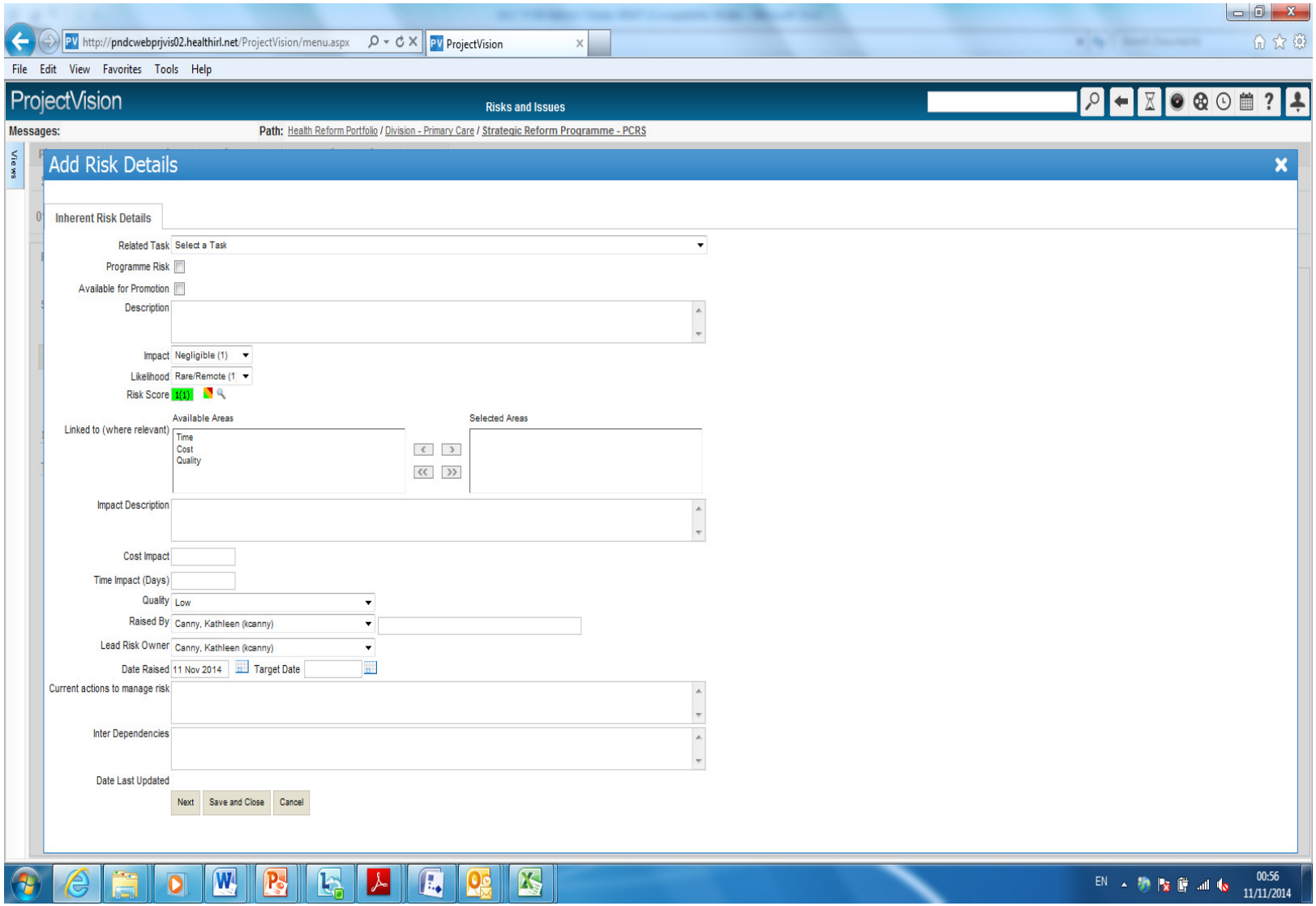

Figure 13 – Project Vision screen for recording risks

9.2. ISSUE MANAGEMENT

The Project Vision tool will also be used for issue management. Within this programme an issue is defined as being 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 Steering Group.

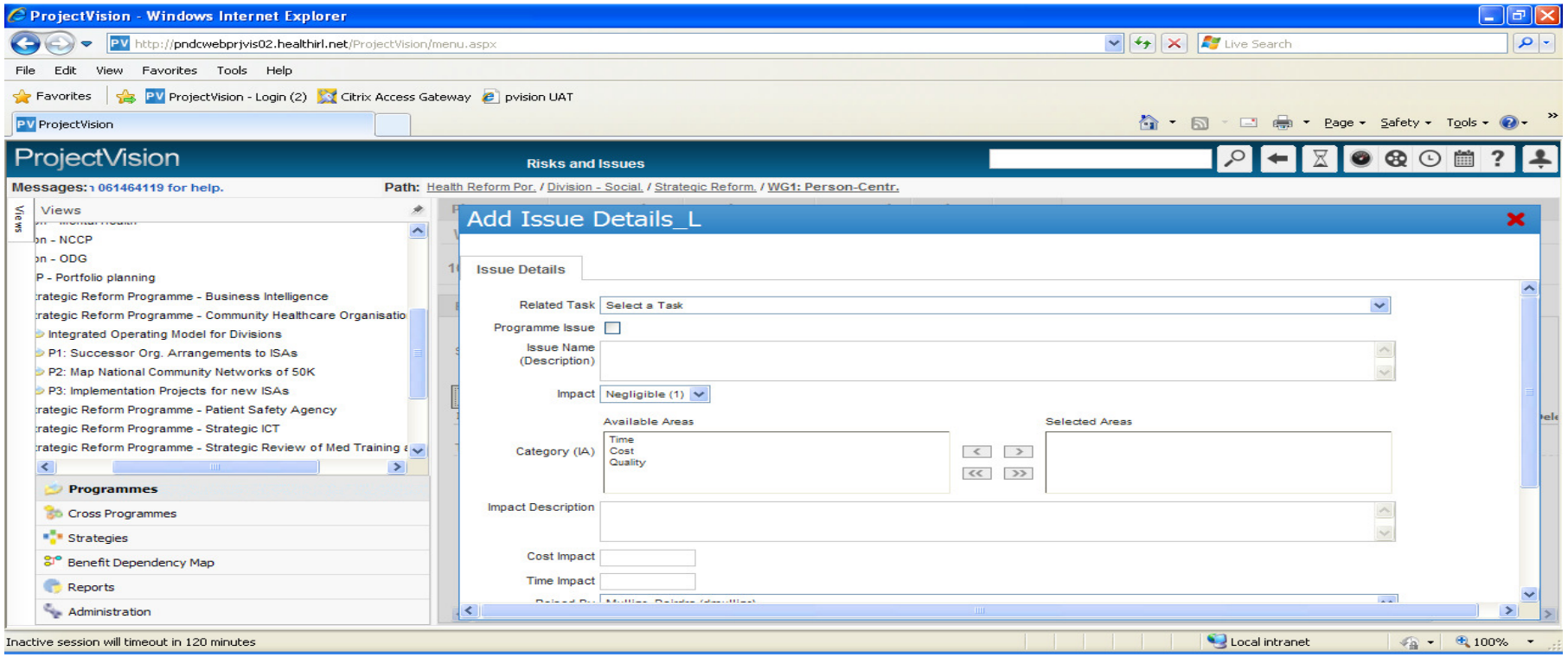

Figure 14 – Project Vision screen for recording issues

10. REPORTING

A key element of managing the CSPD reform programme and the establishment of ICPs will be to ensure that progress is regularly monitored against the baseline plan. ICP Programme Managers will produce a monthly report, using the Project Vision system. Figure 15 shows a sample report. Setting up a project on Project Vision requires the inputting of information relevant to the programme, such as scope, deliverables with associated timelines, risks, issues and dependencies. The system can then be set to provide regular, up-to-date reports for each project and programme. The Programme Director will collate these monthly reports into a monthly programme dashboard to formally ensure delivery and report progress on programme/project success, risks and issues to the Clinical Design Authority and the ICP Steering Group. A dashboard format will enable and facilitate effective decision-making by providing absolute clarity on programme performance and milestone achievement or milestone slippage. The Programme Director, in the first instance, will decide which, if any, ICPs he/she 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