PROJECT INITIATION DOCUMENT (PID)

Framework to Enhance Clinical Care in Northern Ireland Care Homes

Version 5.0

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I INTRODUCTION

Introductory Note

1.1. The Rebuilding HSC Services Programme will bring together a number of individual projects/workstreams. This Project Initiation Document (PID) outlines a plan of work to take forward one of these projects whose aim is to develop a new framework for enhancing clinical care within Northern Ireland Care Homes. The project will provide the Rebuilding Health and Social Care (HSC) Services Management Board an assurance that the project has established:

- clear terms of reference;
- an appropriate management structure;
- that sufficient initial planning has taken place; and
- the required resources can be made available.

Purpose of Document

1.2. The purpose of this document is to:

- set out the aims and objectives of the project;
- define the scope of the project;
- set out the activities, resources, responsibilities and outputs required to facilitate the completion of the project;
- set out the management structure for the project; and
- act as a base document against which the Rebuilding Management Board can assess project progress on an ongoing basis.

Strategic Context

1.3. COVID-19 has presented unprecedented challenges for the HSC, which had already been facing huge strategic challenges in the form of an ageing population, increasing demand, long and growing waiting lists, workforce pressures and the emergence of new and more expensive treatments. The HSC has also experienced significant budget constraints and reliance on in year monitoring to meet inescapable recurrent costs.

1.4. While the Department took action to preserve the highest priority essential services to mitigate this impact, the downturn in normal business will lead to some diseases going undetected or untreated longer than is desirable with potential impact on long term health outcomes. The uncertainty and concern about the pandemic combined with the impact of the lockdown will also likely have had an adverse on mental health, especially for the most vulnerable in society.

1.5. Services will not be able to resume as normal for some time due to the continued need to adhere to social distancing and continued need for Personal Protective Equipment (PPE) at volumes not required prior to the pandemic. In addition, the resilience of the health and social care workforce is likely to have been eroded and will continue to be impacted.

1.6. In this context, the Department has published a new Strategic Framework to rebuild health and social care services. The Strategic Framework identifies actions to stabilise HSC service delivery and business operations and workforce; new service delivery models and business structures required to stabilise the system; oversight structures; areas for priority action. The Strategic Framework also considers the extent to which innovation and new delivery models developed during the emergency response can be incorporated as health and social care services are rebuilt.

1.7. The aims of the Rebuilding programme are:
   a. to incrementally increase HSC service capacity as quickly as possible across all programmes of care, within the prevailing COVID-19 conditions;
   b. to maximise service activity within the context of managing the ongoing COVID-19 situation;
   c. to embed innovation and transformation; incorporating the Encompass programme, in service delivery models; and
   d. to prioritise services; develop contingencies; and plan for the future.

1.8. One of the key priority areas of the Rebuilding programme is a focus on Nursing and Residential Care homes and the learning over the past few months has highlighted the high level of frailty and clinical acuity of residents in our care homes for older people, with a need for much greater resilience. It is also important that individuals with a disability, whatever age receive the clinical care that they need. On 17 June 2020, the Minister announced plans for a new framework for nursing, medical and multidisciplinary in-reach into care homes. This project will review how we build on the wide range of measures deployed to protect residents, during the Covid-19 pandemic and support them going forward.

Background

1.9. There are 483 registered independent nursing and residential homes in Northern Ireland, 235 residential facilities and 248 nursing home facilities. In total the sector has 16,000 beds; this compares with an estimated 6,000 hospital beds in the HSC acute sector. 99% of **nursing** care beds (10.5k) are provided in the independent sector and 80% of **residential** care homes beds (5.5k).[1] All are commissioned by HSC Trusts normally within the tariff agreed by the HSCB on an annual basis however this is uplifted to meet additional needs of residents if required.

1.10. There has been an important shift in the complexity of care provided in care homes over recent years. A greater proportion of care home residents have complex clinical healthcare needs, including a significant number of care home residents living with a dementia/cognitive impairment, than would not have been the case in the past. Residents who would have been in hospital five years ago and receiving palliative or end of life care are often now cared for in nursing and residential homes. Residential homes are often now providing a level of care

[1] Data provided by RQIA May 2020

that would have previously been found in nursing homes. Individuals in our care homes should receive the highest standards of care that holistically addresses these complexities. The project aims to achieve this through collaborative working with care home providers, HSC Trusts, voluntary and community sector, residents and their families and the staff who provide the care.

1.11. The impact of COVID-19 on society in general and for those living and working in care homes, has been considerable. Care homes are people's homes as well as places where healthcare is provided so that measures that have been taken to protect this vulnerable population (such as physical distancing, isolation and restricted visiting) have a significant impact, particularly on those in the last years of their lives.

1.12. The World Health Organisation (WHO) has identified people living in care homes as a vulnerable population, more susceptible to infection from COVID-19 and for subsequent adverse outcomes.[2] The level of risk most likely relates to age and associated underlying long-term conditions. This is compounded by the risks of communal living with unavoidable levels of physical contact from carers and consequent increased probability of contagion across residents and staff.

1.13. A review of international evidence and initial modelling was completed by the Public Health Agency (PHA) which predicted a potential outbreak of respiratory infections, all likely to be COVID-19 cases, in anything from 160 and 360 (i.e. 33-75%) of nursing and residential care homes. In April 2020 there was a growth of outbreaks of respiratory infections in Care Homes (Figure 1).

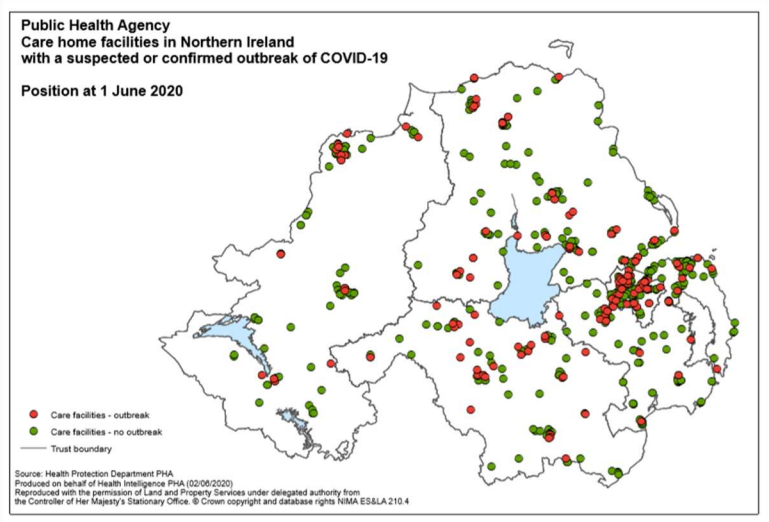

Figure 1: COVID-19 Outbreaks in Care Homes March – 1 June 2020

[2] WHO 2020, Infection Prevention and Control guidance for Long-term care facilities in the context of COVID-19 Interim Guidance (21 March 2020)

Table 1 below sets out the frequency of deaths of residents in care homes over the pandemic period, with a peak identified in mid- April 2020.

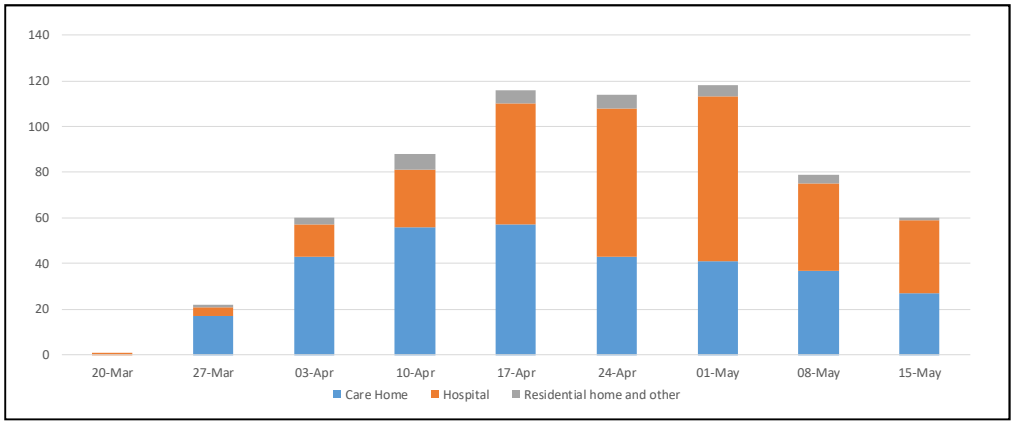

TABLE 1: Weekly COVID-19 deaths occurring by place of death (provisional) Source NISRA

1.14. The learning over the past few months has highlighted the need for much greater system and professional resilience. Therefore it is timely to review how we build on the wide range of measures deployed to protect residents, during the COVID-19 pandemic and support them going forward. This will inform the ongoing response to the virus and help rebuild care home provision for the long term. This will include examining how we would strengthen nursing, medical and multidisciplinary support, clinical leadership and specialist skills in collaboration with social work and care home staff. It will also include providing alternatives to hospital-based care for residents where appropriate.

Project Authority

1.15. The authority for the project to develop a Framework to enhance clinical care in Northern Ireland care homes was included in the Minister's announcement on 17 June 20 and within the Dept of Health is provided by the Perm Secretary. Charlotte McArdle, Chief Nursing Officer, is the SRO.

II PROJECT DEFINITION

Project Overview

2.1 The Senior Responsible Officer (SRO) is responsible for ensuring robust project plans are in place, that progress is monitored, and risks and issues managed to ensure that the project stays on track and contributes to achievement of the overall objectives of the Rebuilding HSC Services programme.

2.2 This document defines the management, organisation and timescales within which the project objectives will be met, including:

- what outputs are to be delivered, by whom and when;
- how changes to the project deliverables are to be controlled; and
- how the project delivery will be undertaken.

Project Aim

2.3 The aim of this project is to ensure that people who live in care homes are supported to lead the best life possible, their Human Rights and right to access equitable healthcare provision are fully observed. This includes ensuring that they have access to the right clinical care, ensuring that future surges can be dealt with effectively taking the learning from the first COVID-19 surge. The outcome is the development of a framework to be available for future COVID-19 surges and to enable continuing safe, high quality and person centred clinical care within care homes. This will include optimal clinical pathways integrated across community, primary, independent and hospital sectors with the benefit of a stronger clinical model, and a robust partnership approach post COVID-19.

Project Scope

2.4 In line with the Minister's priorities and lessons learned from the first surge of COVID-19, this project will consider all relevant aspects of the multidisciplinary clinical care (including nursing, allied health professions, pharmacy, medical care provision), provided within care homes and develop the most appropriate model for delivery of services in the context of clinical need, population size and projected growth in service demand. The work will be carried out in partnership with care home management and staff to understand and identify workforce skill requirements and training needs that will enable staff to feel empowered to fully undertake their clinical care role. The project will work closely and collaboratively with the Social Services team to inform the Framework and project aim.

Project Objectives

2.5 The project will have the following specific objectives:

1. Identify current and future demand for these services taking into account future demographic changes.

2. Review the existing policy framework, in Northern Ireland, Republic of Ireland, England, Scotland and Wales, the evidence base, developments across the UK and, taking into account service user and clinical staff views, consider how the future configuration of services can adopt advancements in technology, and new frameworks for clinical care.

3. Identify the workforce training needs, career pathways, role requirements and associated costs of future framework including the commissioning model of what is planned, purchased and monitored.

4. Identify actions required to ensure services are underpinned by effective governance and quality assurance mechanisms.

5. Produce a framework with accompanying costed implementation and investment plans setting out a resilient platform for provision of optimal clinical care in care homes.

Key Project Delivery and Deliverables

2.6 The SRO and Project Manager are responsible for successful delivery including:

- ensuring that the project meets its objectives and delivers the projected benefits;
- taking decisions and being proactive in providing leadership and direction throughout the life of the project;
- ensuring robust internal governance arrangements and delivery plans are in place through the identification of milestones, timelines, dependencies and risks and issues logs;
- identification of resource requirements including options for redeployment and reprioritisation of resources, including bids and the development of business cases;
- ensuring that the project has appropriate financial input and support from the outset;
- identifying dependencies between delivery work streams and projects;
- monitoring progress towards achievement of the measurable ambitions and taking action to keep on track;
- identification of risks and issues and ensuring that these are appropriately managed, escalating risks that cannot be managed within the project to the Management Board as appropriate;
- submitting any proposed changes to the delivery of objectives to the Management Board for approval; and
- provide appropriate progress reporting information and data to the Management Board to inform updates to the Minister.

2.7 The key project deliverables are as follows:

a. Streamlined processes and structures to provide safe, effective and person centred clinical care across boundaries between the independent sector and HSC organisations.

b. A refreshed model of personalised healthcare building on the 'frailty model' focusing on 'What matters most' to residents, families and staff.
c. Participation approach to decision making regarding and access to the right clinical care, delivered by the right person at the right time e.g. rehabilitation, anticipatory care, long-term condition management and palliative care.
d. A workforce development policy which will include a new healthcare acuity tool to inform future nurse staffing requirements for the care home sector and career pathways that will enhance MDT working.
e. Promotion and use of data and information technology in the care home setting.
f. Enhanced primary care medical support model for care homes.
g. Enhanced AHP support model for nursing homes.
h. Enhanced MDT care model that meets the needs of both acutely ill residents and those with chronic healthcare and/or rehabilitative needs.
i. Enhanced pharmacy model for care homes.

Assumptions

2.8 The project is predicated on, but not limited to, the following assumptions:

- That the health and social care system is there to serve residents who live in a care home setting.
- That residents whose home is a care home setting are entitled to specialist clinical care and support when care needs are identified.
- The framework will be developed in line with the regional co-production guide where the voice of care homes residents and their families will be central to the work of the project, as will the views of staff.
- The project will be managed through a collaborative effort including DoH, HSC Trusts, HSCB, PHA and Independent Care Home Providers, Primary Care, RQIA, Trade Unions, PCC and their representatives (as per collective leadership strategy).
- That the quality of health and social care is dependent upon the expertise and collaborative working of the multidisciplinary team and care home capability.
- The work of the project will be guided by the principles of: empowerment; protection; prevention; partnership and accountability.
- That progress should be subject to regular external review.
- That all key stakeholders must be involved in the development of the improvement plan to ensure the best outcomes for those who use the services as well as those who plan and deliver health and social care services.
- That decision making will be in line with the Regional Framework for Advice and Support on Ethical Decision making (DoH June 2020).

Exclusions

2.9 It is recognised that for long-term sustainability of the sector that financial consideration should be taken account of within the normal commissioning and delivery of services; whilst outside the remit of this project, any findings of this Framework to enhance clinical care in Northern Ireland Care Homes Project will advise the process. Secondly, while not dealing directly with issues of regulation and improvement, the findings of the project will advise such reforms.

Project Constraints

2.10 The constraints on this project are as follows:

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- Timescale – the framework should be developed by March 2022 and possibly require public consultation.
- Policy – Impact of COVID-19 second wave may affect HSC services.
- Financial – A budget of £222k mainstream funding has been secured and £342k has been bid for and is subject to approval.
- Staffing – the need for input from a wide range of stakeholders, including representatives of the workforce, also needs consideration.
- Equality – services are available to everyone equally, on the basis of need and choice. However differentials exist between HSC Trusts with regards to the availability and cost of the full range of services.
- Capacity pressures on Primary Care/GP services
- Workforce - Nursing and AHP workforce shortages

Key Stakeholders

2.11 The project is dependent on input from the following key stakeholders:

- DoH;
- Independent Care Home sector;
- Public Health Agency (PHA);
- Health and Social Care Board (HSCB);
- Health and Social Care Trusts;
- Voluntary and Community sector;
- Commissioner for Older People;
- GPs;
- Associated professional bodies;
- Patient Client Council (PCC);
- RQIA;
- NISCC;
- District/Local Councils;
- relevant Trade Union representation

2.12 In as far as has been possible those organisations, individuals, projects or programmes that link to the Framework to enhance clinical care in Northern

Ireland Care Homes Project will be identified and individuals representing the constituencies engaged in the relevant group. In addition the individual Sub-groups will identify key interfaces and linkages as they work through the plans for meeting the project objectives and consider how these might be addressed.

Interfaces and External Dependencies

2.13 There are other projects and pieces of work which interface with the project as follows:

- Urgent and Emergency care review;
- Commissioning review;
- Workforce planning;
- Encompass project;
- Reform of Adult Care and Support;
- Rebuilding Programme; and
- Resettlement Programme.

2.14 This project to develop a Framework to enhance clinical care in Northern Ireland Care Homes will rely heavily on the direct engagement and participation of independent care home sector and HSC organisations in the development of the recommendations and implementation of any changes/improvements. The Project structure as far as is practicable has taken account of such external dependencies.

III PROJECT ORGANISATION

Project Board

3.1 It is envisaged underneath the Programme structure and Rebuilding HSC Services Management Board, chaired by DoH Perm Sec, that there will be a Project Board structure chaired by the SRO for this individual project. A diagram of the overarching project structure is attached at **Annex A**. Members of the Project Board are as follows:

Name	Business Area	Position/Role	Function on Project Board
Charlotte McArdle	DoH	Chief Nursing Officer	Senior Responsible Owner (SRO)
Sean Holland	DoH	Chief Social Worker	Member
Cathy Harrison	DoH	Chief Pharmaceutical Officer	Member
Jenny Keane	DoH	Chief Allied Health Professions Officer	
Brendan Whittle	HSCB	Social care	
Dr Margaret O'Brien	HSCB	General medical services	
Rodney Morton	PHA	Director of Nursing	
Vivian McConvey	PCC		
Rita Devlin	Royal College of Nursing NI		
Dr David Johnston	Royal College GPs		
Elaine Connelly	RQIA		
Eddie Lynch	Older Peoples Commissioner		
Seamus McGoran	HSC Trust	Chief Executive	
Nicki Patterson	HSC Trusts	Director of Older People Services	
Suzanne Pullins	HSC Trusts	Director of Nursing	
Dr Conor Barton (Psychiatry of Old Age Faculty Chair)	Royal College of Psychiatrists NI		
Dr Mark Roberts	British Geriatrics Society NI		
Linda Robinson and nominee	Voluntary and Community sector	Age NI	

Lesley Anne Newton	Voluntary and Community sector	ARC	
Rosemary Kelly	CMO advisor for older people medicine		
Anne Speed	UNISON		
Patricia Higgins	NI Social Care Council (NISCC)		
Janet Montgomery	Hutchinson Care Homes		
Carol Cousins	Four Seasons Health care		
JP Watson	Domestic Care NI		
Mary Stevenson	Healthcare Ireland Group		
Pauline Sheppard	Independent Health and Care Providers (IHCP)		

Working Group and Sub Groups

It is envisaged that to support the decision making Project Board there will be a Project Working Group, co-chaired, by representatives from the Independent Care Home sector. This working group will research, investigate and formulate recommendations for decision by the Project Board. The working group will also co-ordinate information from a variety of other sub groups, work streams or task and finish groups which include representatives of the workforce.

3.2 Clinically led, managerially led or co-chair work streams will be established to take forward the work of the review as necessary. It is expected that membership may change over the course of the project and other individuals/organisations may be approached as specific areas are explored which may require more focus and work streams will be established to deliver the Project's objectives as required. Additional advice and information may be sought from critical friends or expert advisers.

3.3 The Framework to Enhance Clinical Care in Northern Ireland Care Homes project at this initial stage will comprise of three main sub groups, which will report/feed into the Project working group, as follows:

1. Multidisciplinary Working: to include Medical (primary care and acute), AHPs, Pharmacy, Nursing, to develop the following Clinical Pathways: rehabilitation, anticipatory care, long-term conditions, palliative care;
2. Workforce Development: Career Pathways and Acuity Staffing; and
3. Informatics, Technology and Quality Improvement.

3.4 Inevitably there will be cross over between individual sub groups and other work streams which may exist outside this project or the Rebuilding HSC services Programme. Where possible these linkages have been identified and arrangements put in place.

Stakeholder Engagement/Co-production

3.5 Delivering together commits health and social care to:

- adopt the co-production and co-design model for development of new and reconfiguration services;
- maximise the lived experience (service user and carer) voice across the system;
- engage staff particularly staff who are closest to those who use our services in co-design and in the co-delivery of services; and
- build and strengthen partnerships working with other providers of clinical care, including those in the community and voluntary sector and in other government sectors in support of Programme for Government (PfG) priorities.

Project Plan

3.6 A high level Project Plan outlining the main stages of the Project has been included at **Annex B.** A summary of the project deliverables, responsibilities and timeframes is included in the table below:

	Deliverable	Description	Responsibility	Completion Date
1	Draft Project Plan and PID	Define objectives, structures & recruit membership to Project Board and working group co-chairs	SRO/ Project Manager	
2	Involvement Strategy	Development of an Involvement strategy to reflect the needs of key stakeholders	PHA	
3	Project Working group and Sub groups	Agree membership of working group and engage with sub groups	Project Manager	
4	Business case development	Development of business case for resources to support project	Project Manager	
5	Communication Strategy	Development of a communication strategy for the project		
6	Implementation Plan	Identification of level of evidence required and risk		

	assessment for investment and implementation

Risk Management

3.7 The project will maintain its own risk register and will escalate those risks that cannot be managed within the project to the Management Board via regular reporting. The risks relevant to this project are contained in the risk log at **Annex C.**

Communications

3.8 The Project Manager is responsible for ensuring the development of the Involvement and Communication Strategies for the Project, whereby all key stakeholders are engaged in the implementation of the Framework to enhance clinical care in Northern Ireland Care Homes Project using the co-production approach. DoH Co-production Guide puts this vision into practice to create the

opportunity for people to work in genuine partnership and to take shared responsibility for improving health and social care outcomes[3]

3.9 With this overall aim in mind the Involvement and Communication Strategies set out to ensure appropriate plans are developed, utilising a wide range of communication channels available (including social media), to connect with the various stakeholder groups (including some target audiences).

3.10 The Involvement Strategy outlines the framework for the involvement of a wide range of stakeholders to work together to help, inform, shape and implement the improvement plans, for the benefit of current future users of Care Home services, families and staff.

Governance

3.11 The Health Minister is accountable to the Assembly and the public for the delivery of health and care services. He will set the priorities for rebuilding health and social care services. The Management Board for Rebuilding HSC services will oversee the delivery of the programme of work arising from the Minister's priorities for Rebuilding HSC Services and will govern a number of thematic projects, including this project, to deliver the strategic rebuilding outcome sustainably over the medium to long term. To ensure effective delivery, the HSCB, PHA, HSC Trusts, BSO and Primary Care will be represented on the Management Board. In addition, the Minister and the Management Board will obtain advice from experts working in health and social care fields to inform the rebuilding of HSC services as required.

3.12 The Management Board will be chaired by the Department of Health's Permanent Secretary and will report to the Minister. The Management Board will be run as a programme for an initial period of two years commencing on 10 June 2020. The continuing need for the Management Board will be reviewed at six month intervals.

Project Support

3.13 During the course of the project, the Project Manager may identify the requirement for ad hoc resourcing to complete a number of administrative tasks, e.g. documenting meetings, financial modelling, photocopying and data gathering. Where this is required, they will communicate this requirement to the Project Board in advance for approval and resourcing.

Project Assurance

3.14 Project Assurance is the responsibility of the Project Board who have nominated the following staff for this role.

[3] Department of Health (2018) Co-production Guide at https://www.health-ni.gov.uk/publications/co-production-guide-northern-ireland-connecting-and-realising-value-through-people

Name	Position	Role
TBC		

Project Benefits

3.15 The project aims to create a high quality, sustainable acute care services network that meets the needs of the entire population of Northern Ireland. This will deliver improved planning and increased resilience at local and regional levels and help to stabilise and sustain long term service provision for the NI population. These include but are not limited to:

- Improvement in the quality of healthcare provided by care homes and their ability to manage residents during the COVID-19 pandemic with a resultant enhancement in the confidence and experience of residents and their families.
- Voice of the resident/client ensuring more effective outcomes.
- Voice of the workforce ensuring more effective outcomes.
- Enhanced advocacy and support arrangements in place for residents and families.
- Improvements in the governance and oversight of services in respect of healthcare needs of care home residents.
- Collaborative partnership between the statutory and independent sectors to ensure sustained engagement in a constructive environment for the early identification of emerging issues and improvement of services.
- Building public confidence in care home healthcare services.

Costs

3.16 A business case will be developed for resources to support this Project in line with the DoH guidance. The Project Manager will lead a team drawn from the Independent Care Home sector, the DoH, HSC Trusts, Public Health Agency, RQIA, relevant Trade Union representation and other agencies as necessary. Initial resources include:

- Department of Health – CNO team and an administration team to support work across the Project;
- HSC staff will be drawn from Trusts with experience and responsibility for care home services;
- resources of the Project team will be supplemented by expert policy advice from other Departmental policy staff, such as workforce, finance, primary and secondary care;
- support and advice will also be provided from the Chief Social Services Officer, Chief Nursing Officers group, Chief Medical Officers group, and other Chief Professional disciplines; and

- in addition, where required, the working group and sub groups will be supported by staff with particular expertise, which may necessitate drafting in such capability from outside NI public services and at times outside the region.

IV PROJECT APPROACH

Project Stages

4.1 This section outlines the stages and phasing of the project along with any methodologies to be used. The project will be managed using the PRINCE2 (Projects in Controlled Environments) standards and associated project controls.

4.2 The project will consist of a number of stages as follows:

- **Stage 1 - Project Initiation Document**
  The PID will be prepared and then presented for approval to the Rebuilding HSC Services Management Board. The PID will then be tabled for agreement by the Project Board, chaired by SRO.
- **Stage 2 – Evidence Gathering**
  A needs assessment will be commissioned in order to forecast the local and regional impact and understand the key interdependencies with other medical specialities.
- **Stage 3 – Project Board**
  A Project Board will be established and members appointed including Chief Nursing Officer as SRO; and the Project Manager/Secretariat. Regular meetings will take place at least monthly and there will be agreement of the key work streams and timelines.
- **Stage 4 – Workshops**
  A series of workshops will be created to gather customer and key stakeholder views in order to effectively analyse the existing service models. As a follow on, the information and evidence will be collated and reviewed to develop possible options.
- **Stage 5 – Interim report**
  An interim report will be drafted for internal departmental and Project Board consideration, including a summary of the issues, challenges and the gathered evidence from the workshops and needs assessment.
- **Stage 6 – Final Proposals report**
  A final report will be produced setting out an analysis of the options and proposals for a new regional framework supported by a Strategic Outline Case (SOC); alongside consideration of equality, rural and other relevant impact assessments.
- **Stage 7 – Public Consultation**
  If required the public will be consulted on the proposed new framework.
- **Stage 8 – Analysis of responses and OBC**
  The Project Manager will review any responses to inform the fully costed Outline Business Case (OBC) and high level implementation plan and investment plan.
- **Stage 9 – Implementation**
  Upon receipt of the appropriate approvals a new framework will be implemented including if appropriate, identification of sites to trial the new framework of clinical care prior to full implementation.
- **Post Project Review/Evaluation**

Following completion of the project, a post project review and evaluation will be carried out to ensure that objectives have been met, benefits realised and lessons learned.

Principles to guide the project

4.3 A set of 12 principles have been developed to guide the analysis undertaken, the conclusions reached and the recommendations made. These are:

1. Our primary focus is safe, high quality clinical care for all people accessing our services.
2. We commit to the principles of personal and public involvement (PPI), co-design and co-production engagement and involvement.
3. All people accessing our services should be cared for in a setting most appropriate to their clinical care.
4. Fundamental change is required across the HSC, underpinned by a rights based approach in order to deliver optimum, sustainable and high quality future clinical care.
5. The project will define the best integrated clinical care arrangements for the entire population of Northern Ireland, irrespective of HSC Trust or local boundaries.
6. There shall be standardised delivery of services across the region to ensure that all people accessing our services, irrespective of location, can access the same standard of clinical care.
7. The new framework will be implemented on a regional basis and will be responsive to local needs.
8. The new framework should be designed, resourced and staffed optimally to meet the population's clinical care needs while noting a need to deliver value for public money.
9. The new framework will enable all people accessing our services to access reliable health information in order to make informed choices about how to access the right services which best meets their clinical care.
10. The new framework will be underpinned by a comprehensive workforce plan taking into account skills mix, training and new and emerging roles, and within which staff must feel supported including financially and respected.
11. The new framework will take account of, and contribute to, evidence of best practice and innovative models both locally and internationally.
12. The new framework should fully consider and make appropriate use of new and emerging technological advances.

Project Controls

4.4 The Project Board assumes overall responsibility for the control of the project. The Project Board receives information from the Project Manager (and any assurance roles appointed) and has control over whether the project continues, stops or changes direction or scope.

4.5 The major controls for the Project Board are:

- **Project Initiation -** to ensure that, before significant resource is spent on a project, everything involved in the project has been agreed on e.g. Project objectives, roles and responsibilities, project scope and boundary, project controls. The Project Initiation meeting will be held to agree this PID and give approval to move to the next stage.
- **End Stage Assessment -** the Project Board only commits to one stage of work at a time. This assessment approves the work to date and provides authority to proceed to the next stage.
- **Highlight Reports -** provided by the Project Manager to the Project Board on a regular basis to report progress during a stage. The Highlight Reports for this project will be produced monthly and will contain details of progress to date, achievements in the current period and achievements expected in the next period, details of actual or potential problems and suggestions for their resolution.
- **Exception Reports -** notification by the Project Manager to the Project Board that the stage (or project) plan will deviate outside tolerance limits. This details the problem, outlines the available options and identifies the recommended option.
- **Mid-Stage Assessment -** this assessment is held between the Project Board and Project Manager after an Exception Report or a significant milestone to determine how the project will proceed.
- **Project Closure -** the Project Board formally closes the project, confirming that the project has been completed.

4.6 Other project controls which will be used during the project are:

- **Checkpoints -** these meetings will be held every two weeks between the SRO, Project Manager and the Project Teams to discuss the progress of the Project against the plans and any problems that need to be resolved.
- **Tolerance -** permissible deviation from the stage or project plans without recourse to the Project Board.

Standards and Quality Control

4.7 The following Departmental standards will apply to the project:

- PRINCE2 is the defined project management standard;
- Project plans should be generated using Microsoft Project; and
- Microsoft Word is to be used for word processing documents.

4.8 The quality requirement for the project is the production of project products suitable for use. Specifically these must be produced:

- on time;
- to budget; and
- to an acceptable level of quality.

4.9 The Quality Management System to be used in the project is composed of the following components:

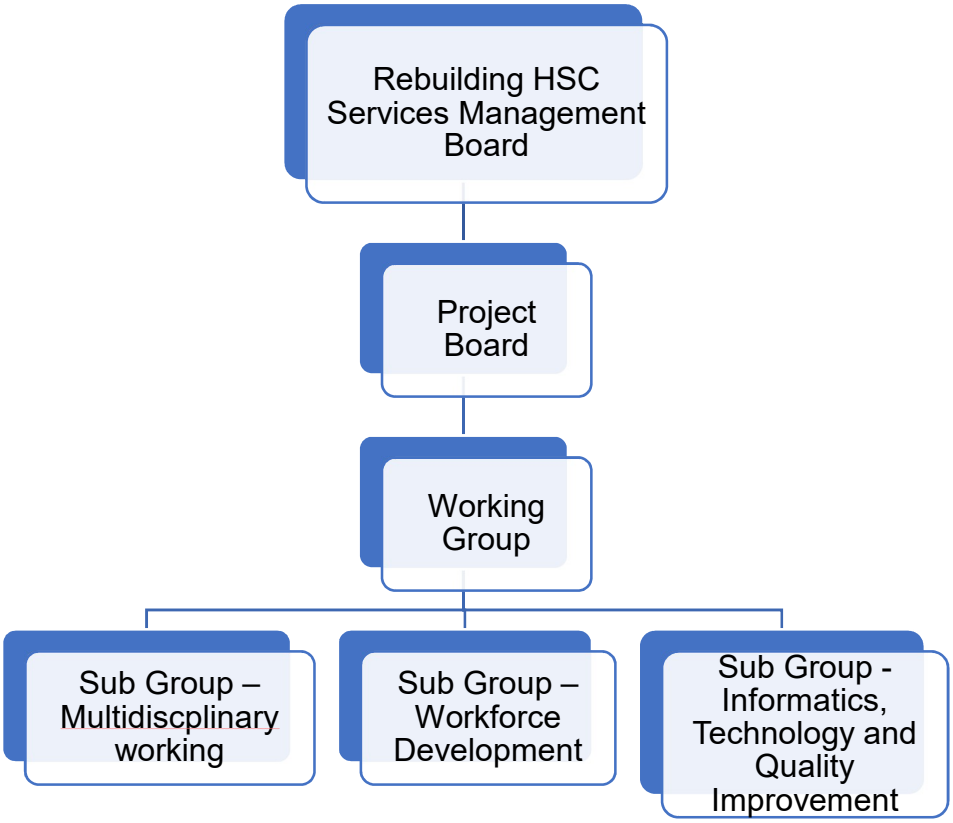
- a set of standards to be applied to the production of project products;

- a quality assurance procedure for all products;
- a set of project procedures to facilitate project issues;
- a set of project procedures to facilitate change control; and
- the implementation of a configuration management system for selected products produced by the project.

4.10 The Quality Review process will check to identify any:

- errors;
- omissions;
- misunderstandings;
- false assumptions;
- ambiguity; and
- non-compliance with Departmental ICT Strategy and NICS/Departmental policies and procedures.

Annex A – Project Structure



Annex B – High Level Project Plan

Task Name	Description	Start Date	End Date
Project Initiation Document (PID)	Production of the PID.	June 20	
Evidence based needs assessment	A needs assessment will be commissioned in order to forecast the local and regional impact and understand the key interdependencies with other medical specialities.		
Establish Project Board	Project Board will be established and members appointed including CNO as SRO; and the Project Manager/Secretariat. Regular meetings will take place monthly and there will be agreement of the key work streams and timelines.		
Workshops	A series of workshops will be created to gather customer and key stakeholder views in order to effectively analyse the existing frameworks. As a follow on, the information and evidence will be collated and reviewed to develop possible options.		
Production of Interim report	An interim report will be drafted for internal departmental and Project Board consideration, including a summary of the issues, challenges and the gathered evidence from the workshops and needs assessment.		
Production of Final proposals report and SOC	A final report will be produced, setting out an analysis of the options and proposals for a new regional framework supported by a Strategic Outline Case (SOC); alongside consideration of equality, rural and other relevant impact assessments.		
Analysis of responses and OBC	The Project manager will review any responses to inform the fully costed Outline Business Case (OBC) and high level implementation plan and investment plan.		
Implementation	Upon receipt of the appropriate approvals a final framework will be implemented including as appropriate identification of sites to trial the new framework of clinical care prior to full implementation.		
Post Project Review, Evaluation	Following completion of the project, a post project review and evaluation will be carried out to ensure that objectives have been met, benefits realised and lessons learned.		

Annex C – Risk Log

Risk Description	Impact	Likeli-hood	Owner	Manage ment Strategy	Resource Require-ments, Necessary Action	RAG Status (Red, Amber, Green)
Lack of commitment, availability from appropriate staff	High	Medium	DoH/ HSC	Ensure staff are fully briefed and allocated to priority activities.		Green
Covid 19 second wave	High	Medium				Green
						Green

Annex D – ISSUE LOG

Care Home Improvemement Programme (CHIP) - ISSUE LOG							
Action No	ISSUES	ISSUE OWNER	TARGET DATE	STATUS	CLOSURE DATE	Reminder Issued	COMMENTS
				Open			
				Pending			
				Closed			

Key:	
Open	Action has not yet taken to resolve the AP
Closed	The AP has been resolved
Pending	Resolution to the AP is in hand, but action has not yet been taken

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Annex E – Action Log

Care Home Improvemement Programme (CHIP) - ACTION LOG							
Action No	ACTIONS	ACTION OWNER	TARGET DATE	STATUS	CLOSURE DATE	Reminder Issued	COMMENTS
				Open			
				Pending			
				Closed			