2025

A Strategic Framework for Population Based Planning within Health Regions in Ireland

POPULATION BASED PLANNING PROGRAMME

Document Information

Acknowledgments:	The Population Based Planning Programme extends its gratitude to the many people who shared their insights to inform this framework including patients, community members, advocacy groups, HSE public health staff, clinicians and managers in the centre and regions.
Developed by:	The development of this draft document was led by the Population Based Planning Guidance Development Subgroup. Approval of this document and future versions rests with the Population Based Planning Steering Group.
Title:	A Strategic Framework for Population Based Planning within Health Regions in Ireland.
Version Number:	1.0.
Published Date:	6 January 2025
Cite this document as:	Health Service Executive - Population Based Planning Programme (2024). A Strategic Framework for Population Based Planning within Health Regions in Ireland, V 1.0. Dublin: Health Service Executive
For further information contact:	NationalHealthServiceImprovement@hse.ie
Associated documents:	N/A
Revision date:	2028

Version and Approval Control

Date	Version	Created by	Reviewed by:	Final document approved by
1/09/2024	1	Dr Aparna Keegan and Population Based Planning Guidance Development Subgroup, HSE	PBP Working Group PBP Steering Group PBP Expert Advisory Group	PBP Steering Group

We are dedicated to continuous improvement and learning, and we highly value your feedback on this document. Your insights provide an opportunity to refine our work and further enhance its impact.

Contents

List of Abbreviations

Abbreviation	Definition
CHAs	Community Health Assessments
CHNAs	Community Health Needs Assessments
COPD	Chronic Obstructive Pulmonary Disease
DHBs	District Health Boards
EAG	Expert Advisory Group
EHDS	European Health Data Space
ESRI	Economic and Social Research Institute
GDPR	General Data Protection Regulation
HiAP	Health in All Policies
HNA	Health Needs Assessment
HSE	Health Service Executive
HSPA	Health System Performance Assessment
HWBs	Health and Wellbeing Boards
ICB	Integrated Care Board
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
NSP	National Service Plan
PBP	Population Based Planning
PESTLE	Political, Economic, Societal, Technological, Legal, Environmental
PHM	Population Health Management
PHNs	Primary Health Networks
REO	Regional Executive Officer
SEAI	Sustainable Energy Authority of Ireland
SNA	Strategic Needs Assessment
SNAA	Strategic Needs and Assets Assessment
SWOT	Strengths, Weaknesses, Opportunities, Threats

Executive Summary

A Strategic Framework for Population Based Planning (PBP) in Ireland

Context and Rationale

The Health Regions Implementation Plan [1] emphasises PBP as critical to aligning health and social care services with regional population needs. This document is designed to achieve consensus and alignment across the Health Service Executive (HSE) on what we mean by PBP and what is involved in its delivery. This framework is intended for use by anyone working in PBP in the HSE centre and regions. It emphasises the need and how we bring data driven decision making that is responsive to the diverse needs of local populations into planning.

Core Features of the Framework

1. **Definition and Ways of Working**:
   - PBP involves a comprehensive, multi-sectoral approach to assessing health needs and assets to inform equitable service planning.
   - Principle ways of working include a focus on communities, equity, prevention, integration and evidence.

2. **The PBP Cycle**:
   - A dynamic, cyclical process with four key phases:
     - **Define**: Understanding needs and assets through both quantitative and qualitative data
     - **Design**: Make decisions through partnership working informed by data
     - **Deliver**: Implementing priority areas
     - **Demonstrate**: Monitoring and evaluation
3. **Strategic Needs and Assets Assessments (SNAAs)**:
   - A cornerstone of the PBP cycle, SNAA integrates demographic, health, and service data with qualitative insights to inform long term planning. The Define and Design phases form the foundation for conducting an SNAA. In this initial version (V1.0.) of the strategic framework, emphasis is placed on these Define and Design steps, laying the groundwork for further development in subsequent iterations. While the scope of this framework does not extend to implementation, key learnings from other countries' experiences with implementing PBP are highlighted as critical considerations for health regions during the Deliver and Demonstrate phases.
   - They promote a balance between addressing needs and leveraging community strengths.

The framework outlines actionable steps, including establishing robust governance structures, engaging communities and stakeholders throughout the process, aligning PBP efforts with planning processes and leveraging data analytics.

Anticipated Outcomes

Key outcomes include:

1. Equitable Resource Distribution
2. Improved Health and Wellbeing
3. Promoting Integrated Care
4. Reducing Reactive Demand
5. Better Value Healthcare Delivery

The document serves as a high level framework guide for regional health and care teams, policymakers, and stakeholders to collaboratively achieve better outcomes for all populations.

Forewords

A message from PBP Programme Lead and PBP Steering Group Chair.

We are proud to present A Strategic Framework for Population Based Planning within Health Regions in Ireland V1.0, a foundational step in aligning health and social care services to meet the needs and preferences of our regional populations.

Population Based Planning improves health equity, optimises resource allocation, and integrates services more effectively. This framework is a key move towards achieving the Sláintecare Health Regions Implementation Plan objective of a population based approach to service planning and delivery, which reduces health inequity. PBP is one of the workstreams to support the Health Regions Programme. Other key and parallel workstreams we are working closely with include integrated service design, networks of care, and population based resource allocation, to ensure alignment with Sláintecare strategic objectives.

This framework is an integral piece of our journey to plan and deliver healthcare based on the needs, strengths, and preferences of the people of Ireland. It reflects our commitment to co-design and work in partnership to deliver a responsive, community-focused health system.

We especially thank Dr. Aparna Keegan for her leadership, as well as the Population Based Planning Guidance Development Subgroup, Working Group, Steering Group, Expert Advisory Group, patients, community members, advocacy groups, HSE public health teams, clinicians, and managers for their contributions.

This framework supports stakeholders in undertaking Strategic Needs and Assets Assessments (SNAAs) and signposts how to incorporate SNAAs into the delivery of integrated, high-value care, which will in turn improve outcomes for all.

Dr Jennifer Martin
Director National Health Service Improvement
PBP Programme Lead

Dr John Cuddihy
National Director Public Health
PBP Steering Group Chair

A message from PBP patient and community member representatives.

From before the cradle to the grave, each and every person in Ireland will rely on our health service in some shape or form. This Strategic Framework for Population Based Planning is essential to enable the Health Regions to assess and meet our needs within a diverse population with diverse needs, delivering person-centred services to enhance outcomes for everyone across the region.

As service users and representatives, we see it as necessary that each and every person is regarded an active partner and an essential part of the healthcare team. This entails the health service, government departments and all agencies taking co-ordinated responsibility to equip each person with the basic knowledge, skills, agency, and confidence to be an active partner and advocate for their care and the care of their loved ones.

With each individual an active partner, true person-centred services are delivered with us, rather than to us. This difference should be the core experience of every patient, in every interaction with the health service. Empowering every person is a key enabler for prevention and shared decision-making through self-awareness, self-efficacy, and confidence.

The Health Regions and Integrated Health Areas have a unique opportunity to utilise this Strategic Framework to embed patient empowerment and health literacy across every demographic in the population, with a strong focus on those in poverty and marginalised communities.

We welcome the clear definitions of the key functions of Population Based Planning and the core themes across the PBP Cycle. We welcome in particular the Community Voice at the centre of PBP, together with Communications and the Whole System Approach - all of which must be deployed to provide each person with essential information to support the desired outcomes stated in this Strategic Framework.

We would also like to acknowledge the excellent work of frontline staff, often in challenging, high-pressure circumstances. At the same time, we recognise a lack of service in certain remits. Population Based Planning is vital in identifying and filling the gaps, and future-proofing health service delivery.

We look forward to seeing every patient and service user being an active partner in their own health care - including through health education provided wherever people are - as an integral part of schools, local communities, and beyond. We welcome this Framework as a crucial step in this journey.

Finally, we would like to thank Dr Aparna Keegan, Dr Jennifer Martin, and all of the Population Based Planning team for their openness and for listening to our voices.

Rosa Tomrop-Hofmann
Patient Member of PBP Programme
National Patient and Service User Forum Representative

Tiberius Pereira
Patient Member of PBP Programme
Secretary, Patients for Patient Safety Ireland
Lead - People Empowerment with Health Literacy Initiative

1.0 Introduction to Population Based Planning

The Health Regions Implementation Plan [1] highlights Population Based Planning (PBP) as a pivotal strategy for aligning health and social care services with the needs of regional populations. As part of the Health Regions Programme, PBP programme has the following key actions:

- Action 10: Develop a framework for health needs assessments.
- Action 12: Facilitate regional PBP by supporting regions with tools and frameworks for effective planning.

This document has been developed to support the delivery of these actions by fostering consensus and alignment across the Health Service Executive (HSE) on the definition and approach to PBP.

1.1 Definition of PBP

Before defining what PBP entails, it is crucial to articulate the concept of population health. The King's Fund defines population health as [2]:

"An approach aimed at improving the health of an entire population. It focuses on enhancing the physical and mental health outcomes and wellbeing of people within and across a defined local, regional, or national population, while simultaneously reducing health inequalities. Population health involves efforts to reduce the occurrence of ill health, ensure the delivery of appropriate health and care services, and address the wider determinants of health. This approach requires collaboration with communities and partner agencies."

Furthermore, a literature review conducted by the HSE National Health Service Improvement team identified initial population health principles, which form the foundation for ongoing efforts to refine and define our approach to population health.

In October 2023, a multi-stakeholder workshop was held to foster a shared understanding of PBP. The participants, representing various sectors within healthcare and public services, collectively defined PBP [3]:

"Population Based Planning is a cohesive, integrated, and comprehensive approach to assessing health needs and assets at national, regional or local levels to inform health and social care service prioritisation and planning, with the goal of improving the health and wellbeing of the entire population. It takes account of health outcomes, wider determinants of health and how the delivery of health and social care services (primary, secondary and tertiary services) are focused on meeting the needs of the population. It enables decision makers at different levels and across different sectors to make decisions that are equitable and orientated to the needs of the population."

Key Functions of PBP

PBP enables decision-makers at various levels, across different sectors, to make data-driven decisions that are aligned with the needs of the population and address health inequalities [2]. This includes [3]:

- **Strategic Service Planning**: Informing long term service delivery plans based on population needs.
- **Infrastructure Planning**: Ensuring physical resources like hospitals and clinics are aligned with community health needs.
- **Workforce Planning**: Guiding the recruitment and distribution of healthcare workers to meet anticipated demand.
- **Resource Allocation**: Supporting equitable distribution of financial and material resources across regions and health services.

1.2 Ways of Working PBP

The PBP Expert Advisory Group (EAG) through a focused mini workshop collaboratively identified the core ways of working that should guide the PBP process. Community, equity, prevention, integration, and evidence led approaches are foundational elements that, alongside other key methods of working, are essential for implementing a PBP approach that is both responsive to the population's needs and adaptable to the ever-changing healthcare landscape. These were converted into "We" statements to reflect a commitment to action and personal responsibility for enacting the ways of working by everyone participating in the PBP process.

Ways of Working	What We Mean
We are Community Centred	We aim to keep healthcare services responsive to individual needs and preferences. We focus on supporting and empowering individuals throughout their health journey, including areas like prevention and acute care.
We foster Equity and Inclusion**	We strive to address the needs of underserved populations and acknowledge unmet needs to improve health outcomes. We aim to reduce geographical and social inequalities to support more equitable access to healthcare services (e.g., Sláintecare Healthy Communities).
We emphasise Prevention and Early Intervention	We prioritise early intervention, aiming to shift health and care planning towards preventive measures rather than focusing solely on reactive care.
We encourage Integration and Coordination	We strive for consistent and integrated planning processes across all health and care levels. We seek to promote better connected services to improve continuity of care across different regions.
We are led by data, measurement and research	We focus on standardising data collection to facilitate timely access to information and to inform decision making. We value collecting qualitative data to address nuances missed by quantitative data. We aim to measure outcomes to assess the impact and acceptability of health interventions, encouraging continuous learning and improvement.
We promote Partnership and Collaboration	We aim to work with local communities and groups as active partners in service prioritisation and planning. We seek to collaborate with service providers including General Practitioners, primary care and those within

	and beyond the HSE (e.g., local county councils) to address social, economic, and environmental factors that influence health outcomes.
We encourage Sustainability	We take into account the 'triple bottom line' (social, environmental, and economic) to promote long term sustainability in health and care systems.
We support High-Value Healthcare	We aim for health and care interventions to contribute positively to health and care outcomes, with attention to safety and quality of life. We seek to enhance value for both service users and health and care providers.
We promote Accountability	We aim to establish governance structures that encourage transparency and accountability across the health and care system.
We aim to Build Capacity and Strengthen Systems	We aim to strengthen our system's ability to support population health by taking a holistic, system wide approach.

** It is essential to distinguish between health equity and health inequalities, as this distinction underpins the effective delivery of PBP. **Health inequalities** refer to measurable differences in health outcomes between different population groups, which may arise from biological, environmental, or social factors. However, not all health inequalities are inherently unjust. **Health equity**, as defined by the World Health Organization (WHO) [4] goes further, aiming to eliminate "unfair, avoidable and remediable differences in health status among groups of people… Health equity is achieved when everyone can achieve their full potential for health and wellbeing. "

1.3 Case for Change to PBP

The Health Regions Implementation Plan (July 2023) emphasises the need for a population based approach to health and care to ensure that services are better aligned with the health and care needs of regional populations [1]. This approach addresses both clinical care and the broader social determinants of health. Key role of PBP includes:

(a) Service Planning
A population based approach to service planning aims to improves the health and wellbeing of populations by considering all determinants of health and the distribution of these across society. It supports a holistic assessment, equitable funding, and the prioritisation of services to address health inequities and foster integrated care. Key benefits include:

- Informed resource allocation tailored to regional demographics.
- Equitable and transparent funding distribution.
- Efficient use of funds through evidence based, local decision making.

(b) Integrated Service Delivery
A population based approach to service delivery ensures services are inclusive and responsive to the needs of diverse communities, accounting for varied population cohorts. It emphasises prevention and early intervention, complementing programmes such as Healthy Ireland and the Sláintecare Healthy Communities Programme. By focusing on the broader determinants of health, it promotes integrated care across all levels of service.

Health Needs Assessment- a key tool to enable PBP

Additionally, the plan outlines the role of Health Needs Assessments (HNA) as a central tool for enabling PBP. Health Regions will be responsible for assessing local needs using a standardised national framework. The HSE Centre will collaborate with regions to develop consistent frameworks and provide support for regional planning aligned with both national priorities and local needs.

HNAs offer significant benefits for PBP. It shifts us away from simply reacting to disease trends, demands we know of, or respond to ad hoc needs as they arise (see Figure 1). Instead, we're taking a more systematic approach—assessing both the health needs and assets within the community to enable better [5]:

- Resource Allocation: HNAs help identify unmet needs, assess service effectiveness, and guide resource prioritisation to ensure the most impactful, equitable care.
- Community Partnership: HNAs enable better understanding of community needs and preferences and supports communities to actively partner in the planning and decision making process in a meaningful way.
- Cross-Sector Collaboration: HNAs promote collaboration across sectors like education, housing, and social services, addressing broader health determinants and aligning with the WHO's Health in All Policies (HiAP) approach.
- Healthcare Staff Participation: They gather health and care professionals' insights, involve them in service planning, and foster a common language for addressing health needs.

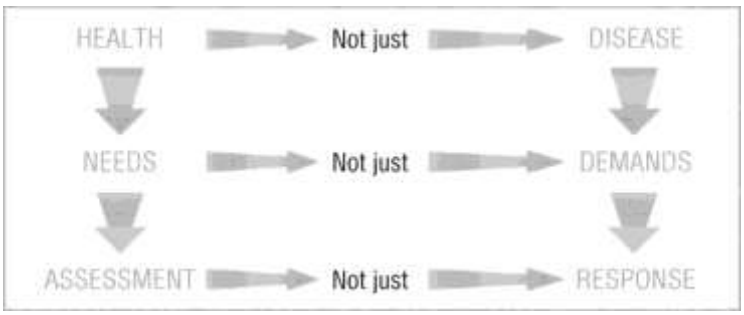

Figure 1: How HNAs support better decision making [6]

A Strategic Needs Assessment (SNA) is a specific type of Health Needs Assessment (HNA) that focuses on long term goals and strategic priorities to guide effective planning. Unlike traditional HNAs, which specifically focus on the health needs of a specific population, an SNA takes a broader approach, encompassing various sectors and factors beyond healthcare alone. The primary outcome of an SNA is the development of a strategic plan that outlines goals, priorities, and actions to address the identified population needs over an extended period. Furthermore, a SNA should be aligned with available resources and priorities to ensure its practical relevance and impact. Lastly a key action identified as a result of a SNA maybe the need for more detailed HNAs to address specific areas or populations requiring focused attention.

Recently, there has been a shift away from solely focusing on a deficit model towards recognising the strengths and assets within the community. This has led to the evolution of a **Strategic Needs and Assets Assessment (SNAA) which is recommended for PBP**. An SNAA is a SNA that acknowledges both needs and community strengths, creating more holistic and balanced strategic plans.

Although SNAAs are critical to delivering PBP outcomes, they represent only one element of the broader PBP planning cycle. Examples of how SNAs are used in other countries are highlighted in Appendix 2.

1.4 Desired Outcomes from PBP

Based on reflections from key stakeholders [3] and the Health Regions Implementation Plan [1] the key outcomes from PBP can be summarised as:

1. **Equitable Resource Distribution**: Aligning healthcare funding with regional population needs to reduce health inequities.
2. **Improved Health and Wellbeing**: Aiming to enhance the health and wellbeing of populations by addressing both clinical and social, environmental and commercial determinants of health.
3. **Promoting Integrated Care**: Promoting integrated care across all levels (acute, primary, community, and social care).
4. **Reducing Reactive Demand:** Shifting towards prevention and early intervention to reduce the demand for reactive healthcare services.
5. **Better Value Healthcare Delivery**: Enhancing service delivery and resource management for better patient outcomes and cost-effective care.

2.0 Population Based Planning Framework

2.1 What is Our PBP Cycle?

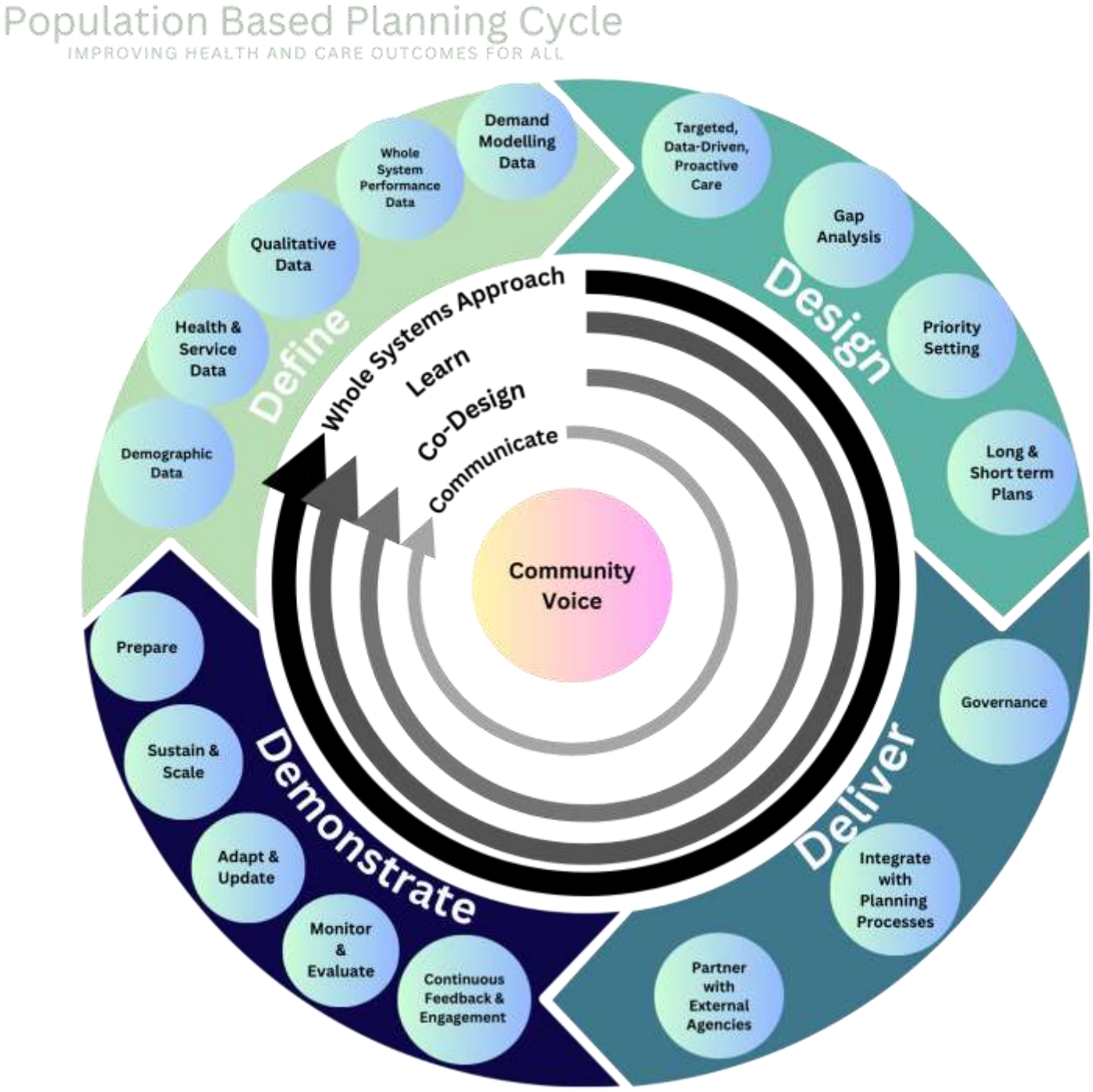

Figure 2: PBP cycle developed for health regions

The **PBP Cycle** model represents an evolving, cyclical process designed to continuously assess and respond to health and care needs, incorporating feedback and redesign based on insights gained over time. The high level model for PBP draws from international best practices (UK, WHO, Australia, USA) but tailored to local needs based on feedback from the PBP expert advisory group (EAG). The model has the following key features:

1. **Cyclical Process**:
    - The PBP cycle is not linear but cyclical, emphasising continuous monitoring, evaluation, and redesign. This means the system is constantly evolving and adapting to new information and capabilities to support planning.
2. **Four Key Phases**:
    - The model incorporates four main phases:
        - **Define**: Understanding needs and assets through both quantitative and qualitative data
        - **Design**: Make decisions through partnership working informed by data
        - **Deliver**: Implementing priority areas
        - **Demonstrate**: Monitoring and evaluation

    The **Define** and **Design** phases are the basis for a **SNAA**.

    Also note that there are potential overlaps between stages, particularly between the "Define" and "Design" stages (e.g., in gap analysis) and the "Delivery" and "Demonstrate" stages.

3. **Continuous Focus on Community, Communication, Co-Design, Learning and Whole-System Approach**:
    - The inner circles of the model reflect key priorities such as whole-system approach, co-design with the community and service providers, and effective communication and learning that are key across all phases of the PBP cycle.
    - By addressing health through a broader, interconnected framework, a whole systems approach seeks to create sustainable, equitable improvements in population health.
    - The emphasis on the learning underscores the importance of being a learning organisation that prioritises continuous improvement.
    - At the heart of the model is community voice, ensuring that populations are central to the planning and decision making process.

The model reflects a dynamic, learning based approach to health service planning, designed to respond flexibly to evolving population health needs and assets, and emphasising stakeholder collaboration and active community partnership at every stage.

2.2 Exploration of the elements of PBP cycle

The PBP cycle is structured around four key phases: **Define, Design, Deliver, and Demonstrate.** This structure provides a systematic approach to assessing, planning, delivering, and continuously improving healthcare services.

- **Define**: In the PBP context, this involves gathering insights through data, including existing demographic, health and service data, qualitative data, and demand modelling to define population needs, assets and preferences.

- **Design**: In the PBP context, this involves making decisions, in partnership with all relevant stakeholders, including communities, informed by data. This requires use of tools such as population health management (PHM) to provide targeted proactive care, undertaking gap analyses, priority setting, and establishing short- and long-term plans.
- **Deliver**: In the PBP context, this includes implementing actions to address priority areas with a focus on collaboration, governance, and integration into broader planning processes.
- **Demonstrate**: In the PBP context, this phase focuses on monitoring and evaluation. This includes continuous feedback and engagement, updating health and care services based on evaluations and scaling interventions as appropriate. This phase also feeds into the preparations for the next phase of planning.

Central to this are core themes that should be reflected across every phase:

Core themes across the PBP Cycle	Why is this important?	Key Steps
Community Voice	Active community partnership to ensure that health and care planning reflects their needs, preferences, and concerns.	A collaborative partnership approach should be taken, ensuring community stakeholders are equal partners. Partnership should be genuine, purposeful, planned, clear, inclusive, collaborative, accountable, and accessible.
Communicate	Clear, transparent communication ensures alignment, cohesion and understanding among all stakeholders throughout the PBP cycle.	Develop communication strategies that are clear, accessible, and tailored to the audience. Ensure regular updates to all stakeholders, including the community, healthcare providers, and relevant government departments, on progress and challenges.
Co-design	Co-design with the community and service providers ensures that health and care planning and interventions are tailored and effective.	Engage both community members and service providers in the co-design process, ensuring that input is sought at all phases of the PBP cycle. Maintain open communication and involve partners in decision making and priority setting processes.
Learn	Emphasis on the learn phase underscores the importance of being a learning organisation that prioritises	Regularly evaluate outcomes and processes. Implement feedback loops to capture insights from practice and research. Adapt plans and strategies based on data and lessons learned to ensure continuous improvement. Consider adequate training to meet the identified needs from evaluation of the outcomes and

	continuous improvement.	processes. Furthermore, adopting a spiral of learning—revisiting challenges with deeper understanding over time—and a beginner's mind, maintaining openness to new perspectives, ensures continuous improvement and adaptability in addressing complex health and care issues.
Whole-System Approach	By addressing health and care through a broader, interconnected framework, a whole systems approach seeks to create sustainable, equitable improvements in population health	Ensure collaboration across sectors (e.g., health, local authorities, education) to address the wider determinants of health. Build governance structures that support integration and partnerships. Promote shared accountability across all stakeholders.

2.1.1 Define and Design

The following are critical elements within the SNAA process and stretch across the define and design phases.

Elements in the PBP Cycle	Why is this important?	Key Steps
Demographic Data	Creating a comprehensive understanding of population demographics is crucial to tailoring health services and interventions based on age, sex, ethnicity, and other factors that influence health.	• Select key census indicators: population size, age, sex, ethnicity, country of birth, language, deprivation, carer populations, and population density. • Collect data on social determinants of health, including education levels and internet access. • Analyse geographic variation to identify regional differences in health outcomes. *Note: Regional Population Profiles have been developed for each health region.*

Health & Service Data	Collecting and analysing health outcomes and service level data helps identify areas needing improvement and available assets which ensures that resources are aligned with needs.	• Identify relevant health outcome indicators (e.g., mortality rates, disease prevalence, hospital admissions). • Analyse service provision and capacity, including asset profiles and workforce data. *Note: A framework of core indicators to support the development of this profile is being developed.*
Qualitative Data	Gathering insights from service providers, patient and community on experiences helps capture nuances that quantitative data may miss, ensuring more patient centred and community relevant planning.	• Develop methods to integrate community and service provider input. • Use qualitative data to enhance understanding of health needs and service gaps. • Qualitative data can also be used to assess the acceptability of health(care) interventions. • Ensure that underserved populations (e.g. Travellers and Roma communities) who may escape being captured by traditional data sources are also kept in focus, helping to identify unmet needs and address hidden disparities. Work is currently underway to identify ways to bring in the community voice into all aspects of PBP including gathering insights into need.
Whole System Performance Data	Analysing Ireland's health system and other system level datasets identifies strengths, weaknesses, and areas for systemic improvement.	• Use frameworks like the Health System Performance Assessment (HSPA) to gather and analyse data on health system performance. Currently work is in progress (lead by Department of Health) to regionalise this data. • Access place based data using tools like the Healthy Ireland Local Government Data Hub that are currently in development.
Demand Modelling Data	Predicting future health and care needs ensures that the system can proactively allocate resources to meet anticipated demands, avoiding future shortfalls.	Use demand and capacity modelling outputs to forecast future health and care needs. *Note:* *Work is currently underway within the HSE Demand and Capacity Modelling Group to support:* • *Predicting demand for the health service in 2025 as part of the service planning process.* • *Modelling demand for the 2024/ 2025 winter season.* *In addition, there are reports from work commissioned by the Department of Health from the*

		ESRI to project demand and capacity requirements for the health services.
Targeted, Data-Driven, Proactive Care	By identifying the factors that drive ill health and inequalities, we can better predict future risks and implement preventive measures, improving health outcomes overall.	• Build necessary infrastructure for Population Health Management (PHM), including data sharing systems. • Implement PHM tools such as population segmentation and risk stratification with a view to providing proactive care to groups of individuals. *Note: A HSE position paper on PHM was developed in 2022*
Gap Analysis	Conducting gap analyses ensures that health and care services address the most critical needs, helping to reduce disparities and optimise resource allocation.	• Identify discrepancies in healthcare provision and outcomes across regions against standards of care. • Identify the root causes of the gaps and evidence based solutions to address gaps.
Priority Setting	Focusing on the most pressing health and care needs ensures that limited resources are used efficiently to maximise their impact on population health.	• Use validated frameworks to guide priority setting based on health and care data. • The aim is to align resource allocation with the most critical population health issues.
Long and Short Term Plans	Translating data into actionable insights helps ensure that both immediate needs are addressed and long term health system improvements are realised.	• Develop long term strategies and short-term actions to meet evolving population health needs, to reduce gaps and to ensure equitable care. • Ensure flexibility to adapt plans as new data emerges.

2.1.2 Deliver and Demonstrate

Although implementation is beyond the scope of this framework several key learnings have been identified in the implementation of PBP in other countries (Appendix 2) that health regions should consider when implementing this framework.

One significant issue is the limited budget available for change, as often only a small portion of funding is allocated to implementing the changes recommended by the SNAA. Additionally, conflicts with existing plans can arise, as pre-existing priorities may not align with new findings from the assessment, creating tension in the planning process.

Another challenge is if there is a disconnection between decision makers and SNAA conductors, where poor communication between those conducting the assessment and those responsible for planning can hinder the effectiveness of the SNAA process. Moreover, where there is a lack of familiarity with the process among staff it can further complicate matters, as they may not have the necessary experience or expertise in health planning and prioritisation.

Time constraints also pose a challenge, as the short timeframe often given for completing the SNAA can limit the depth and thoroughness of the assessment. Finally, if there are organisational gaps between decision-makers and those implementing the SNAA, this may create barriers and complicate the effective translation of assessment findings into actionable plans.

Lessons from other countries (Appendix 2) on successful implementation of the findings of SNAAs are listed below as key aspects to consider in Deliver and Demonstrate phases.

Elements in the PBP Cycle	Why is this important?	Key Aspect to Consider for Health Regions
Governance	A clear governance structure and leadership for PBP will ensure effective coordination and ownership of the PBP process.	Consider who leads on PBP in health regions overall and who leads on each phase of the PBP cycle. Consider which members of the Health Regions' Senior Management will be part of the PBP process. Will a regional steering group for PBP be established? Consider the role of each of these stakeholders in the PBP process. Consider the role of the centre in supporting regions in PBP.
Integrate with HSE Planning Processes	Aligning the SNAA timing with the wider planning cycles ensures a smooth integration of SNAA priorities into broader service plans.	Consider how SNAA findings will impact local decision making at Integrated Health Areas and Community Health Networks. Consider how SNAA findings feed into the development of different planning processes: Long term government policy and strategies, HSE corporate plan, HSE National Service Plan and Regional Operational Plans.

		Consider when SNAA needs to be undertaken to ensure they fit into the above process.
Partner with External Agencies	Fostering collaboration among local authorities, other government agencies, non-governmental organisations, communities, health services, and stakeholders will maximise the impact on population health.	Consider the various fora available to support collaboration on identified priorities such as: • Regional Health Forums • Local Healthy Ireland coordinators and Healthy Ireland Plans • Sláintecare Healthy Communities partner organisations • Children and Young People's Services Committees • Local Economic and Community Plan • Local Area Challenges Programme areas
Continuous Feedback and Engagement	Engaging health stakeholders, communities, and advocates throughout all stages of the PBP process ensures relevance and alignment with community needs.	Consider how PBP outputs like SNAA are disseminated, such as through local planning forums on a regular basis or at annual events, such as planning days where wider stakeholders are invited.
Monitor and Evaluate	Ensuring the effective implementation of plans and tracking progress over time is critical for demonstrating impact long and short term.	Consider establishing a system of continuous monitoring and feedback to ensure the action plans can be adapted and scaled up over time as required. Ensure that the monitoring is along with other KPIs e.g. NSP. In addition, monitoring and evaluation will contribute to the statutory requirement on the HSE under the Public Sector Equality and Human Rights Duty [7].
Adapt and Update	Keeping SNAAs relevant and reflective of current health trends ensures that health planning remains responsive to changing population needs and data.	Consider how often SNAAs need to be undertaken and updated to support various planning processes (e.g., every 5 years). Consider how and when ad hoc data analysis and Health Needs Assessments fit into the PBP process to provide timely updates.

Sustain and Scale	Creating scalable and sustainable action plans is vital for ensuring long-term population health improvements and successful PBP implementation.	Use learnings to develop action plans that are sustainable over time. Use evaluation findings to inform future assessments and to scale successful initiatives across regions.
Prepare	Identify the key factors needed to ensure the PBP cycle is executed successfully.	Identify and engage with the key partners at the outset. Undertake an external and internal analysis to identify factors that will impact on the PBP in the specific health region. Ensure sponsorship of senior leaders.

References

1. Government of Ireland. Sláintecare Regional Health Areas (RHAs): HSE Health Regions Implementation Plan [Internet]. Dublin: Government of Ireland; [cited 2024 Sept 12]. Available from: https://www.gov.ie/en/publication/4eda4-slaintecare-regional-health-areas-rhas/#hse-health-regions-implementation-plan
2. The King's Fund. A population health approach [Internet]. London: The King's Fund; [cited 2024 Sept 12]. Available from: https://www.kingsfund.org.uk/insight-and-analysis/long-reads/population-health-approach
3. HSE PBP Workstream. PBP Workshop Report. October 2023. Developed by the HSE Population-Based Planning Workstream.
4. World Health Organization. Health equity [Internet]. Geneva: World Health Organization; [cited 2024 Oct 21]. Available from: https://www.who.int/health-topics/health-equity#tab=tab_1
5. Health Service Executive. Health Needs Assessment Framework v1.0 [Internet]. Dublin: HSE; [cited 2024 Sept 12]. Available from: https://www.hse.ie/eng/services/list/5/publichealth/publichealthdepts/population-planning/hna-framework-v1-0.pdf
6. Smith R. BMJ 316:1310 [Internet]. London: BMJ; 1998 [cited 2024 Sept 12]. Available from: https://www.bmj.com/content/316/7140/1310
7. Irish Human Rights and Equality Commission. Public Sector Duty [Internet]. Dublin: IHREC; [cited 2024 Sept 12]. Available from: https://www.ihrec.ie/our-work/public-sector-duty/

Appendix 1: PBP Programme Membership

1.1 PBP Steering Group Membership

Name	Title
John Cuddihy (JC)	National Director of Public Health (Chair)
Andy Phillips (AP)	Regional Executive Officer, HSE South West
Aparna Keegan (AK)	Consultant in Public Health Medicine, Health Service Improvement
Brigid Quilligan (BQ)	Patient/Community representative from Kerry Traveller Health Community Development Project
Carol Ivory (CI)	General Manager Access & Integration (Alternate for GR)
Deirdre Mulholland (DM)	Area Director of Public Health, Dublin and North East
Diarmuid O' Donovan (DO'D)	Director of National Health Improvement, Public Health
Elaine Birkett (EB)	Innovation, e-Development and Learning Lead Organisation Development & Design
Ellen O'Dea (EO'D)	Chief Officer - Head of Service, Health and Wellbeing, CHO DNCC
Emer Ahern (EA)	NCAGL for Older Persons
Geraldine Crowley (GC)	Assistant National Director Enhanced Community Care Programme & Primary Care Contracts
Grace Rothwell (GR)	National Director of Access & Integration
Jennifer Martin (JM)	Director of National Health Service Improvement, Public Health
Jo Shortt (JS)	Assistant National Director Health Regions Programme Team
John Fitzmaurice (JF)	IHA Manager Sligo Leitrim W Cavan S Donegal
JT Treanor (JT)	Patient/Community representative from Irish Heart Foundation High Risk Prevention Programme
Miin Alikhan (MA)	Assistant National Director, National Planning and Performance
Niamh Bambury (NB)	Consultant in Public Health Medicine, South West Region
Nuala Scannell (NS)	General Manager - Health Regions Programme Team
Paul Kavanagh (PK)	Director National Health Intelligence Unit, Public Health
Phillip Crowley (PC)	National Director Strategy and Research - PBP Expert Advisory Group (Chair)
Sarah Treleaven (ST)	Principal Officer, Department of Health, Sláintecare Regions Unit
Siobhan Ni Bhriain (SNiB)	Lead Integrated Care Clinical Design and Innovation
Tiberius Pereira (TP)	Patient/ Public Representative, Patients for Patient Safety Ireland

1.2 PBP Expert Advisory Group Membership

Name	Title
Phillip Crowley (PC)	National Director Strategy and Research (Chair)
Aine McNamara (AMcN)	Area Director of Public Health, HSE West Northwest Nominee
Andrew Hannigan (AH)	Assistant Principal Slaintecare Regions Unit
Aparna Keegan (AK)	Consultant in Public Health Medicine, Health Service Improvement
Beirne Flynn (BF)	ICT Deputy Delivery Director for Public Health
Carmel Mullaney (CM)	Area Director of Public Health, HSE Dublin and Southeast Nominee
David Hanlon (DH)	National Clinical Advisor & Clinical Programme Group Lead Primary Care
Deirdre Mulholland (DMu)	Area Director of Public Health, HSE Dublin and Northeast Nominee
Deirdre Mulligan (DM)	Area Director Nursing and Midwifery Planning and Development
Denise Cahill (DC)	Healthy Cities Co-ordinator, Cork City
Diarmuid O' Donovan (DO'D)	Director of National Health Improvement, Public Health
Eileen Whelan (EW)	Director of Nursing, Dublin Midlands Hospital Group
Elaine Dobell (ED)	General Manager, Clinical Design and Innovation
Helen Deely (HD)	Assistant National Director, Health and Wellbeing
Iolo Eilian (IE)	Assistant National Director, Patient and Service User Experience
Jennifer Martin (JM)	Director of National Health Service Improvement, Public Health
Jo Shortt (JS)	Assistant National Director, Health Regions Programme Team
Margaret McQuillan (MMcQ)	Head of Service Health and Wellbeing, CHO7, HSE Dublin and Midlands
Miin Alikhan (MA)	Assistant National Director Planning, National Planning and Performance.
Nat O Connor (NC)	Senior Public Affairs and Policy Specialist, Age Action Ireland CLG.
Priscilla Lynch (PL)	Head of Primary Care Services, HSE South West Nominee.
Rosa Tomrop-Hofmann (RTH)	Patient/Community representative, Family Forum Representative /CHO2
Ruth Glassborow (RG)	Director of Population Health and Wellbeing, Public Health Scotland
Ruth Kilcawley (RK)	Head of Social Care Professionals, HSE
Sarah Barry (SB)	Director of Academic Programmes, School of Population Health, Royal College of Surgeons Ireland
Sarah Burke (SBU)	Director of the Centre for Health Policy and Management, Trinity College Dublin
Sarah McBride (SMB)	General Manager, National Planning and Performance
Sarah O Brien (SOB)	NCAGL Chronic Diseases
Siobhan Ni Bhriain (SNiB)	Lead Integrated Care Clinical Design and Innovation
Suzanne Dunne (SD)	Chief of Strategy and Transformation, HSE Mid West Nominee

1.3 PBP Working Group Membership

Name	Role	
Jennifer Martin	Director of National Health Service Improvement (Chair)	National Health Service Improvement Public Health
Aileen Kitching	Consultant in Public Health Medicine (Health Inequalities – Social Inclusion)	National Health Service Improvement Public Health and HSE National Social Inclusion Office
Aparna Keegan	Strategic Guidance Development Group Co- Lead Consultant in Public Health Medicine	National Health Service Improvement Public Health
Breeda Neville	Specialist in Public Health Medicine	National Cancer Control Programme
Carmel Mullaney	Area Director of Public Health nominee	DPH Dublin and Southeast
Christopher Carroll	National Health Improvement, Public Health	National Health Improvement, Public Health
Declan McKeown	Strategic Guidance Development Group Co- Lead Consultant in Public Health Medicine	National Health Intelligence Unit, Public Health
Deirdre Mulholland	Area Director of Public Health nominee	DPH Dublin and Northeast
Estelle McLaughlin	Public Health Strategy and Development Manager	National Screening Service
Geraldine Sayers	Consultant in Public Health Medicine	National Health Intelligence Unit, Public Health
Grainne Begley	Project Manager	National Social Inclusion Office
Heike Vornhagen	Researcher	Data Science Institute University of Galway
Hugh Duane	Section Officer	DPH South West
Jacinta Mulroe	Population Based Planning Lead Consultant in Public Health Medicine	DPH Dublin and Southeast
Katharine Harkin	Consultant in Public Health Medicine	Child Health Public Health
Marie Casey	Consultant in Public Health Medicine	DPH Mid-West
Mark O Loughlin	Population Based Planning Lead Consultant in Public Health Medicine	DPH West & North West
Mary Browne	Consultant in Public Health Medicine	National Health Service Improvement, Public Health
Naomi Petty Saphon	Population Based Planning Lead Consultant in Public Health Medicine	DPH Dublin and Northeast
Niamh Bambury	Population Based Planning Lead Consultant in Public Health Medicine	DPH South West
Niamh Dever	Consultant in Public Health Medicine	DPH Dublin and Southeast
Niamh O'Callaghan	Population Based Planning Lead Consultant in Public Health Medicine	DPH Dublin and Midlands
Patricia Carney	Staff Officer	DPH Dublin and Midlands
Siobhan Reynolds	Programme Manager	National Health Service Improvement, Public Health
Stephen Barrett	Programme Coordinator	National Health Service Improvement, Public Health
Triona McNicholas	Consultant in Public Health Medicine	HSE Dublin and Midlands, Health Service Improvement, Public Health

1.4 PBP Guidance Development Subgroup Membership

Name	Role	Area /Function
Aparna Keegan Co-Chair	Consultant in Public Health Medicine	HSE National Health Service Improvement, Public Health
Declan McKeown Co-Chair	Consultant in Public Health Medicine	HSE National Health Intelligence Unit, Public Health
Geraldine Sayers	Consultant in Public Health Medicine	HSE National Health Intelligence Unit, Public Health
Greg Martin	Consultant in Public Health Medicine	HSE National Health Improvement, Public Health
Heike Vornhagen	Researcher	Data Science Institute, University of Galway
Mary Browne	Consultant in Public Health Medicine	HSE National Health Service Improvement, Public Health
Mary C. Morrissey	Psychology Lead	HSE National Health Intelligence Unit, Public Health and Research & Evidence
Naomi Petty-Saphon	Consultant in Public Health Medicine	Department of Public Health, HSE Dublin & North East
Niamh Bambury	Consultant in Public Health Medicine	Department of Public Health, HSE South West
Niamh O'Callaghan	Consultant in Public Health Medicine	Department of Public Health, HSE Dublin Midlands
Siobhan Reynolds	Programme Manager	HSE National Health Service Improvement, Public Health
Stephen Barrett	Programme Coordinator	HSE National Health Service Improvement, Public Health
Thomas Roux	Public Health Specialist Registrar	HSE National Health Service Improvement, Public Health

Appendix 2: Report on International Approaches to PBP

On behalf of PBP Guidance Development Subgroup

Dr Fionn Donnelly and Dr Aparna Keegan

August 2024

Contents

Background

The Sláintecare Health Regions Implementation Plan is a significant component of Ireland's healthcare reform strategy, which aims to embed PBP in all aspects of healthcare. This approach will invlove a "holistic assessment of needs, equitable funding, and prioritisation of health and social care services". [1]

This plan stipulates that Population based Needs Assessments should be used to inform service planning and resource allocation within each health region. This is envisaged to give more autonomy to the new regional executive officers (REOs), who will then be responsible for ensuring that services are tailored to the specific needs of their population.

In order to facilitate REOs and their teams to conduct regional Strategic Needs Assessments (SNAs), a toolkit will be developed which will detail the key domains to consider within the scope of the HNA, and the quantitative and qualitative indicators within each domain.

As a first step towards developing this toolkit, we decided to first look at some evidence from other countries who have experience with these assessments, in order to gather information on:

- An overview of the use of SNAs in each country
- What factors are within the scope of their SNAs
- What are the key learnings from each process which most strongly predict success or failure

Country 1: United Kingdom

Overview

The Joint Strategic Needs Assessment (JSNA) process in the UK was established as part of the Health and Social Care Act 2007.[2]

This comprehensive framework for local authorities, NHS England and Integrated Care Boards (ICBs) is designed so that they can collaboratively assess the health needs of different communities and regions. The process aims to ensure that local health strategies and commissioning decisions are evidence based and aligned with the needs of the population in question.[3] JSNAs are an iterative process, and should be responsive to changes in epidemiology and demographics over time.

Recommendations from the JSNA are used in the development of Joint Health and Wellbeing Strategies by Health and Wellbeing boards (HWBs), which can then be commissioned by Integrated Care Boards/ Integrated Care Partnerships. [4,5]

The goal is that the ICBs resources are allocated based on the identified needs from the JSNA. [6]

Scope of SNA

Demographics: Age, Gender, Ethnicity, Migration

Wider determinants of health: Housing, Employment, Education

Behavioural determinants of health: Diet, Physical activity, Smoking, Alcohol consumption.

Epidemiology: Life expectancy, Morbidity, Mortality, Incidence and Prevalence

Service Access and Utilisation: Social care, Screening, Immunisations

Evidence of Effectiveness: Literature review, Expert opinion, Best practice

Community, Patient, Service User Perspectives: Stakeholder engagement, Public consultations, Focus groups, Qualitative research

Asset Profile : Networks and groups, Human resources, Transport infrastructure, Physical resources e.g. libraries, leisure centres, local businesses

PHM : Using predictive analytics to understand how to plan future services

Health Profile : Detailed health intelligence reports on the region of interest[4]

Key Learnings

Collaboration between local authorities, the local community, the NHS, HWBs, ICBs and other stakeholders aims to get most bang for buck when it comes to addressing the specific health needs of the community. Modern data sources helps to identify health trends and priorities accurately.[4]

The importance of continuous data collection , stakeholder engagement throughout and updating the SNA when needed to reflect changing demographic and health trends in the population is also key.[7]

Other factors which are key to success include ;

Use of predictive modelling

Agile project management

Ensuring data used is relevant and up-to-date

Using consistent branding for SNA reports

Considering community strengths and assets

Using evidence-based approaches to identify key health issues

Establish clear governance structures and collaboration with local stakeholders

Regularly reviewing and adapting SNA processes based on feedback and effectiveness [4]

Country 2 : United States of America

Background

Community Health Assessment (CHA) is the term used for an SNA conducted by Public Health Practictioners in the USA. Since the passage of the Affordable Care Act in 2010, there has also been a mandatory requirement for non-profit hospitals to conduct Community Health Needs Assessments (CHNAs) every three years. The goal of this legislation was that hospitals and public health departments could use a structured and evidence-based approach to identify the most pressing health needs of their communities and then act to address them.[8]

Both CHAs and CHNAs use data from a range of sources, with CHNAs particularly focused on hospital and patient data, and CHAs having a broader scope, using census, survey and other routine sources of data. Hospitals may also coordinate their CHNA process with a public health department under certain circumstances. Stakeholder engagement from public health, hospitals, community groups, and residents is used to identify and prioritise health needs.[9]

Scope of SNA

CHAs include similar demographic data as would be used in a JSNA, and focus on health factors which produce the greatest morbidity and mortality such as;

Mental Health and Substance Abuse

Cancers

Chronic Diseases

Communicable Disease and immunisations

Trauma and disability

CHAs also place a significant focus on social determinants of health, and include a wide range of sources, including ;

Economic factors : Poverty, Employment, Food security, and Housing stability.

Education: Graduation rates, Literacy rates, Childhood education

Social and community factors : Civic participation, Incarceration rates, Immigration rates

Healthcare access factors : Health insurance coverage, Health literacy, Languages spoken

Neighborhood and built environment factors : Housing quality, Transportation availability, Water and air quality, Crime statistics

They also typically develop a community and asset profile, and combine data from all of these sources to best prioritise needs.[10,11]

Key Learnings

As the CHNAs are developed by the hospitals themselves, the strategies can be timed to be integrated into a hospital or hospital group's planning cycle. CHAs are also fed into the hospital planning system so that tertiary services can be informed by community health priorities.[8]

Active engagement with local communities and other stakeholders is also heavily emphasised, to ensure that the CHA meets the needs of the population of interest.[9]

A successful CHA should also lead to an action plan which is realistic and can be sustained over time. This plan can then be evaluated and monitored and the results incorporated into future CHAs.[8]

Country 3 : Australia

Background

Primary Health Networks (PHNs) were established in Australia in 2015, and one of their key functions is to carry out SNAs. To conduct an SNA, PHNs use data from both local and national sources, including census data, Australian Institute of Health and Welfare data (social determinants of health) and health system data. PHNs then engage with stakeholders through a consultation process as well as workshops and surveys to gain qualitative information.[12]

PHN's then assess and synthesise the data to see what assets and needs have been identified and prioritise the areas to recommend for action in the SNA report. The report is sent to the Australian Department of Health and made available for the public to read once approved.[12]

SNAs in Australia have a basic structure which should be followed but also allow for flexibility so that SNAs are tailored to the specific needs of each region and their local population, which can vary significantly, particularly urban vs rural. PHNs develop "Activity Work Plans" based on the results of the HNA.[13]

Commissioning can be done at a local level (sometimes by PHNs) or at a state or national level. PHNs are also responsible for ongoing monitoring and evaluation of the implementation of the HNA and to update the HNA when needed. [12]

Scope of SNA

Demographics : Births, deaths, migration

Epidemiology : Incidence and prevalence of health conditions, morbidity and mortality

Lifestyle risk factors : Smoking, obesity

Substance abuse/dependency : Prevalence, service demands

Aboriginal and Torres Strait Islander health : Unique health needs, disparities12

Digital Health: Telehealth, Access to digital records for continuity of care, E-referrals

Transport, Access : Referral pathways, access to primary care and allied health

Chronic disease management and prevention: Diabetes, COPD etc.

Early intervention and prevention: First 2,000 days of life, Developmental assessments

End of life care: Advanced care plans, access for rural and remote communities

Healthcare workforce[12]

Key Learnings

Continuous feedback is emphasised, as is involving stakeholders, patients and advocates throughout all stages of the process. SNAs should be a continuous process and created in a way that is easy to update whenever new data becomes available to ensure that they maintain their relevance.

Australian SNAs are also reccomended to use validated methods (e.g. Modified Hanlon Method) in order to prioritise the most important needs and direct resources to where they can bring the most benefit. [12,14]

Country 4 : New Zealand

Background

District health boards (DHBs) were established in New Zealand in 2001 with one of their requirements being to conduct SNA's to identify the health needs of the populations they serve. DHB's were formally replaced by a national entity "Health NZ" in 2022, although the process of change is still currently underway.[15]

The five steps for an SNA in New Zealand are as follows ;

Data collection

Community engagement

Analysis and Reporting

Integration with planning

Monitoring and updating [15]

Scope of SNA

Detailed data is available directly from the New Zealand Ministry of Health which manages several databases including;

National Minimum Dataset

Mortality Data Collection

National Non-Admitted Patient Data Collection

Cancer Registration data collection

Other sources include;

Demographic data : Births, deaths, migration

Modifiable and non-modifiable risk factors : Smoking, diet, physical activity, alcohol and drug use, exposure to violence/crime

Health service utilisation data [16]

Key Learnings

Key success factors identified as leading to a successful SNA include ;

District Health Boards being better connected with their HNA process as well as having the same priorities for purchasing

Prior experience with health planning and using a planning model

Using service planning groups

Synchronising the timing of the various processes

Having clear objectives and decisive leadership

Good communication

Ownership by and involvement of stakeholders

Sufficient time and funding [15,16]

Conversely some of the key challenges identified were;

Only a small fraction of the budget being available for change

Conflict with pre-existing plans

Poor connections between the DHB undertaking the SNA and the planning process

Staff lacking familiarity or experience with planning process/prioritisation

Short timeframe to complete HNA

Organisational distance between those making decisions versus those conducting the HNA [15]

Summary

A number of other countries which undertake PBP. These approaches were examined and summarised in Table 1 (see Appendix 2 for the full report).

Table 1: Approaches to PBP in different countries

Country	Assessment of Needs	Implementation	Evaluation & Monitoring	Additional Features
United Kingdom	Joint Strategic Needs Assessment process involving local authorities, The NHS, HWBs and ICBs	Development of Health and Wellbeing Strategies by Health and Wellbeing Boards, guiding service commissioning	Continuous assessment and monitoring by Health and Wellbeing Boards, with regular updates to strategies	Statutory requirement.
United States	Community Health Needs Assessments (CHNAs) conducted every three years for non-profit hospitals, CHAs conducted by Public Health Departments every 5 years	Development of implementation strategies called "Community Health Improvement Plan's" (CHIP) based on CHNA/CHA findings,	As part of the CHNA/CHA should include a process for monitoring of health outcomes and service delivery	Regulatory mandate for CHNAs under affordable care act.

Australia	Health Needs Assessments are led by Primary Health Networks (PHNs). PHNs conduct data analysis and consult with stakeholders	Development of Regional Health Plans based on HNA findings, guiding service commissioning by PHN's	Responsibility of the PHN	Focus on continually updating the HNA to reflect new data or changing health needs. Also focus on unique needs of vulnerable groups and continuous feedback throughout HNA process.
New Zealand	Health needs assessments conducted by District Health Boards (DHB) (required to be done every 3 years)	The New Zealand Health Strategy guides needs assessments although it is the DHB's role to develop their individual framework	Responsibility of the DHB	HNA's are undertaken with the planning cycle in mind and inform funding decisions and strategic planning.

This report provides an overview of how Strategic Health Needs Assessments (SNAs) are used in the United Kingdom, United States of America, Australia and New Zealand. There are many common domains such as demographics, epidemiology, lifestyle factors, service utilisation, and social determinants of health which are common to all countries.

Key success factors vary country to country, but all emphasise the importance of stakeholder engagement, data-driven approaches, and continuous monitoring and evaluation. These conclusions are supported by a 2023 review of 169 studies, which also found that the best SNA's included mixed quantitative and qualitative methods, an asset based approach, and in depth community participation.[17]

References

1. Organisational Reform HSE Health Regions [Internet]. 2023 Jul. Available from: https://assets.gov.ie/266115/7b86800b-934d-4849-88ae-e8fc4b809465.pdf
2. Department of Health. Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies [Internet]. 2013. Available from: https://assets.publishing.service.gov.uk/media/6304e6fdd3bf7f3664b65b35/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf
3. Department of Health. Joint Strategic Needs Assessment and joint health and wellbeing strategies explained [Internet]. 2011 May. Available from: https://assets.publishing.service.gov.uk/media/5a7c62dced915d696ccfc6e3/dh_131733.pdf
4. Public Health England. Best practice and opportunities for innovation in local Joint Strategic Needs Assessments [Internet]. 2020. Available from: https://intel-hub.eastriding.gov.uk/wp-content/uploads/2020/02/JSNA-best-practice-and-opportunities-PHE-2020.pdf
5. Health and wellbeing boards – guidance [Internet]. Gov.uk. [cited 2024 Jul 19]. Available from: https://www.gov.uk/government/publications/health-and-wellbeing-boards-guidance/health-and-wellbeing-boards-guidance
6. Guidance on the preparation of integrated care strategies [Internet]. Gov.uk. [cited 2024 Jul 19]. Available from: https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/guidance-on-the-preparation-of-integrated-care-strategies
7. Department of Health. Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies [Internet]. 2013. Available from: https://assets.publishing.service.gov.uk/media/5a7b88cced915d131105fdff/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf
8. CDC. Community planning for health assessment: CHA & CHIP [Internet]. Public Health Professionals Gateway. 2024 [cited 2024 Jul 19]. Available from: https://www.cdc.gov/public-health-gateway/php/public-health-strategy/public-health-strategies-for-community-health-assessment-health-improvement-planning.html?CDC_AAref_Val=https://www.cdc.gov/publichealthgateway/cha/plan.html
9. Community Health Assessment Toolkit [Internet]. Healthycommunities.org. [cited 2024 Jul 19]. Available from: https://www.healthycommunities.org/resources/toolkit/files/step8-implement-strategies
10. Stabler H. How to conduct a community health assessment: Guidance for AmeriCorps members [Internet]. Umn.edu. [cited 2024 Jul 19]. Available from: https://www.sph.umn.edu/sph/wp-content/uploads/2024/01/how-to-conduct-a-community-health-assessement.pdf

11. National Association of County and City Health Officials. Community Health Assessment and Improvement Planning [Internet]. Naccho.org. [cited 2024 Jul 19]. Available from: https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment
12. Needs assessment [Internet]. Western NSW Primary Health Network. [cited 2024 Jul 19]. Available from: https://www.wnswphn.org.au/about-us/our-region/needs-assessment
13. Australian Government Department of Health. Primary Health Network Program Needs Assessment Reporting Template [Internet]. 2022. Available from: https://swsphn.com.au/wp-content/uploads/2022/04/Needs-Assessment-2022-2025.pdf
14. Australian Government Department of Health. Primary Health Networks (PHNs) needs assessment policy guide [Internet]. 2021 [cited 2024 Jul 19]. Available from: https://www.health.gov.au/resources/publications/primary-health-networks-phns-needs-assessment-policy-guide?language=en
15. Coster G, Mays N, Scott C, Cumming J. The impact of health needs assessment and prioritisation on District Health Board planning in New Zealand. Int J Health Plann Manage [Internet]. 2009 [cited 2024 Jul 19];24(4):276–89. Available from: https://pubmed.ncbi.nlm.nih.gov/19946944/
16. Planning and Health Intelligence and Health Gain, Waitemata District Health Board. Waitemata DHB Health Needs Assessment 2017 [Internet]. 2017. Available from: https://www.waitematadhb.govt.nz/assets/Documents/health-needs-assessments/WDHBHealthNeedsAssessment2017.pdf
17. Wellington Ministry of Health. A Guide to Developing Public Health Programmes [Internet]. 2006. Available from: https://www.health.govt.nz/system/files/documents/publications/public-health
18. Ravaghi H, Guisset A-L, Elfeky S, Nasir N, Khani S, Ahmadnezhad E, et al. A scoping review of community health needs and assets assessment: concepts, rationale, tools and uses. BMC Health Serv Res [Internet]. 2023;23(1). Available from: http://dx.doi.org/10.1186/s12913-022-08983-3

Appendix 3: Workshop Outputs on Principles of PBP

Dr Aparna Keegan

August 2024

On 30th July 2024, the PBP EAG held a workshop to collaboratively define the core principles for the PBP process in Health Regions. Through structured group discussions, participants brainstormed potential principles, prioritised the most critical ones, and refined these into "ways of working" statements. Following the workshop, the outputs were consolidated, thematically grouped, and validated with the PBP EAG and the wider programme to ensure alignment our vision for PBP. The original principles identified during the workshop are outlined below.

Team 1

- Partnership - to tackle wider determinants (including local councils) and deliver impact (service providers beyond HSE)
- Sustainability - ESG? Triple bottom line? Economic sustainability?
- Prevention and early intervention
- Equity - underserved populations, met vs unmet needs
- Transparency & Accountability
- Good & Positive Communication - simple, accessible, different levels
- Improving outcomes
- Community Strengths and Assets - including policy context
- Focus on quality-of-life indicators (beyond DTOC etc), HSPA alignment
- Data standardised - timely access for reporting & measurement
- Building the ecosystem for delivering joined up approach to improving health outcomes (to tackle wider determinants)
- Policy alignment & take advantage of policies - to enable implementation of population based plans
- Evidence-based (effectiveness and quality)
- Measurement to evaluate impact - learning and improvement focus
- Build system capacity to deliver change and deliver on population health
- Consider other planning processes
- Whole system approach - includes frontlines
- Utilise new structures for partnership in regions

Team 2

- Health equity
- Addressing most vulnerable - overcome social exclusion e.g., unmet need - people who don't attend communities most disadvantaged
- Client centred - who is the client person focused
- Practical - put in shoes of implementers
- Collaboration - particularly community - other community groups
- Prevention and early detection - recalibrate planning
- Improved outcomes - include safety
- Data aggregated at appropriate level e.g., disaggregate age cohorts
- Spatial/geographical inequality

- Balance rights with data - not just
- Data driven
- Status - what is the entitlement to healthcare - ensure access to healthcare regardless of migration status
- Wider social determinants and co
- Monitoring
- Integrated planning in every way

Team 3

- Person centred Service User
- Focus on Equity
- Sustainability
- Meet needs local population
- Support and Empowerment - Life's Journey
- Outcomes focused - demonstrate improvements in health
- Evidence Based
- Partnership - Community Engagement
- Coordinated and connected services
- Wider social determinants of health
- Value - for people and for providers

Appendix 4: Glossary of Terms

Health Needs Assessment (HNA)	A systematic method of identifying the health needs of a specified population, including the identification of unmet health needs, and prioritising, using evidence-based methodology and a partnership approach, the actions to address this unmet need equitably, including specifying how these actions will be monitored and evaluated.
Population Based Planning	"Population Based Planning is a cohesive, integrated, and comprehensive approach to assessing health needs and assets at national, regional or local levels to inform health and social care service prioritisation and planning, with the goal of improving the health and wellbeing of the entire population. It takes account of health outcomes, wider determinants of health and how the delivery of health and social care services (primary, secondary and tertiary services) are focused on meeting the needs of the population. It enables decision makers at different levels and across different sectors to make decisions that are equitable and orientated to the needs of the population."
Population Profile	A profile of the key demographic features of a population to inform and support the planning of health services.
Strategic Needs and Assets Assessment (SNAA)	A specific type of HNA focusing on long-term goals and strategic priorities for effective planning. It encompasses various sectors beyond healthcare and leads to a strategic plan outlining goals and actions to address identified needs and assets over time.

Appendix 5: Stakeholder Needs

Dr Aparna Keegan

September 2024

Methodology

During Q3 2024, seven one-on-one empathy interviews were conducted with key stakeholders to develop user personas and identify the needs, goals, and challenges associated with PBP. The participants included:

1. Two Clinical Directors (one at the centre and one regional level).
2. Area Director of Public Health (ADPH).
3. Principal Officer, Department of Health.
4. Head of Health & Wellbeing.
5. Member of the National Planning and Performance Office.
6. Regional Executive Officer (REO).

Purpose

These interviews aimed to explore critical themes related to PBP, including its understanding, delivery, desired outcomes, governance, stakeholder involvement, integration of services, and system readiness. The insights gathered were used to create user personas, highlighting shared goals, pain points, and opportunities to enhance the planning and implementation of PBP.

Process

A standardised interview framework was used to ensure consistency. Participants were asked the same set of questions, designed to elicit detailed responses about their roles, experiences, and perspectives on PBP**.** Key contributors to the development of these questions:

- Heather Hegarty, Senior Public Health Research Officer, Department of Public Health, HSE South West.
- Dr Nimah Bambury Consultant in Public Health Medicine, Health Service Improvement, Department of Public Health, HSE South West.
- Mary C. Morrissey, Psychology Lead, National Health Intelligence Unit and Research & Evidence, HSE.

Analysis

The HSE National Health Service team supported the transcribing and the thematic analysis of the interview responses. Key findings were categorised and visualised using empathy maps, which provided a structured representation of stakeholder perspectives. These maps informed the creation of user personas. These user personas, representing key stakeholders, were instrumental in highlighting shared goals, challenges, and needs.

This approach ensured that the empathy maps and user personas provided valuable local stakeholder insights to the development of a framework for PBP.

A summary of the overall user persona is shown below.

Summary User Persona

Goals:

Across stakeholder groups, key goals include improving the efficiency of healthcare delivery, particularly within acute care, and ensuring equitable access to services, especially in disadvantaged areas. Stakeholders are strongly motivated to influence health service plans based on local needs, with a focus on aligning resource allocation with factors like deprivation and community health data. Additionally, they aim to integrate preventive measures and screening into health plans to mitigate future healthcare pressures.

Stakeholders expressed a desire to foster collaboration with local authorities and community organisations to deliver targeted health interventions. Other goals include achieving wellness outcomes that reflect Sláintecare principles, ensuring population health planning influences government policy, and empowering regional teams to operationalise population health objectives. Finally, they aim to base long-term healthcare priorities on population trends and data.

Needs:

Stakeholders consistently emphasised the need for better integration of real-time data systems that include demographic, health, and service data to support decision-making and planning. Improved IT infrastructure is crucial for streamlining data collection, sharing, and analysis to provide more accurate, actionable insights. Predictive data modelling is seen as essential for proactive healthcare planning and resource allocation.

Additionally, strong governance structures are required to ensure transparency, accountability, and cross-sector collaboration. Stakeholders also highlighted the need for funding, particularly in preventive care for underserved populations, and interagency cooperation to address broader social determinants of health. A unified, standardised approach to data-driven planning and improved communication between national and regional areas are critical to the success of PBP.

Pain Points:

Key pain points identified include the absence of an individual health identifier, which leads to data duplication and complicates service planning. Outdated and fragmented data systems also hinder effective resource allocation and integration between hospital and community services. Many stakeholders expressed frustration with reactive funding models that prevent proactive healthcare improvements, as well as the lack of flexibility in resource allocation, especially in disadvantaged areas with complex health needs.

Additional challenges include the limited involvement of clinicians and frontline staff in the planning process, as well as difficulties in aligning regional health outcomes with national

policies due to political and budgetary constraints. Prevention efforts are often sidelined by immediate service delivery pressures, and there is a struggle to balance long-term health planning with short-term budget limitations.

The fragmented nature of planning across services, compounded by inadequate IT infrastructure, complicates efforts to implement a unified, data-driven approach. Lastly, the absence of robust evaluation systems and the labour-intensive nature of qualitative data collection make it difficult to assess the long-term impact of population health interventions.

Interview Questions:

Setting the Scene: What is your current role in planning?

- **Section 1: Understanding of PBP**
  1. Can you share your understanding of what PBP entails?
  2. In your view, what are the key components or principles of PBP?
- **Section 2: Delivery of PBP**
  3. At what level do you think PBP should be delivered, and why? (e.g., Region, IHA, CHN)
  4. How do you envision the implementation of PBP at these levels?
- **Section 3: Desired Outcomes of PBP**
  5. What outcomes would you like to see from the implementation of PBP?
  6. In what ways do you think PBP can benefit the community?
- **Section 4: Scope of PBP**
  7. What do you believe is the appropriate scope of PBP?
  8. Are there specific areas or issues you think PBP should focus on?
- **Section 5: Stakeholder Involvement**
  9. Who do you think should be involved in the PBP process?
  10. What kind of input or contribution can you, as a key stakeholder, provide to the PBP process?
- **Section 6: Governance Structures**
  11. What governance structures do you think would best oversee the PBP process?
  12. How do you see these structures ensuring effective implementation and accountability?
- **Section 7: Integration of Services**
  13. How can PBP promote the integration of services across different sectors or organisations?
  14. Can you provide examples of how integrated services could work within the PBP framework?
- **Section 8: Creating Meaningful Change**
  15. In your opinion, how can PBP create meaningful and lasting change?
  16. What challenges do you foresee in achieving these changes, and how might they be overcome?
- **Section 9: Measuring Success**
  17. How do you think we should measure or evaluate the success of PBP?
  18. What indicators or metrics would be most important in assessing its impact?
- **Section 10: System Readiness for Change**
  19. How ready do you think the current system is for the changes required to implement PBP?
  20. What steps do you think are necessary to prepare the system for these changes?

Appendix 6: External Analysis

Dr Fionn Donnelly and Dr Aparna Keegan

September 2024

To conduct the PESTLE analysis, an initial discussion to identify potential political, economic, social, technological, legal, and environmental factors was undertaken to examine the external factors and the broader environment that could influence the HSE in adopting a PBP approach. These factors were categorised and further explored through a desk review of credible sources. The findings were analysed to assess their potential impact on PBP, with risks categorised by significance. Feedback on the draft analysis, was used to refine the findings. The relevant risks identified through the analysis are recommended to be considered for the PBP programme's risk register where appropriate.

PESTLE ANALYSIS		Risk
Political	**Government Policy**: Any changes in government could alter the level of support and funding allocated to the Sláintecare implementation effort. However, as Sláintecare has cross party support, and a change of Government after the next election looks very unlikely, this risk is low, for the time being. However, Sláintecare is 8 years into its 10 year remit, so it is possible that a review in 2026 could advise a change of strategy[1]	Low
	Regional Autonomy: There may be regional differences in priorities which might mean that some regions allocate less time and resources to conducting SNAA's, or place more or less value on a PBP approach. Additionally, political focus on specific issues (waiting lists, trolley crisis, lack of GP's etc.) may shift resource allocation and mean that planners and budget holders deviate from the priorities determined by the SNAA.	High
Economic	**Health Budget:** Any changes to the national budget could have downstream effects on the ability or willingness of the regions to conduct or implement SNAA findings. If Ireland has a recession or loses tax revenue for some reason (e.g. Multinational companies relocating due to changes to U.S tax policy for example) it could significantly affect our national and regional health spend.[2]	Medium

PESTLE ANALYSIS		Risk
	Cost of services: Inflation will increase the cost of staff, medicines, devices and infrastructure. This could impact the priorities of the REO, who might be more concerned with short term objectives, such as cutting costs/efficiency.[3] For a recent example of this, a hiring freeze was implemented by the HSE CEO in October 2023.[4]	Medium
Societal	**Demographic Changes:** Aging population, increasing life expectancy, increasing migration and overall population growth will all impact the types of services needed.[3]	Low- if existing predictions are taken into account, and stay relevant
	Public Pressure: Demand for specific services is likely to vary significantly in different areas. There are several reasons why populations may want certain services located in their region, and certain types may be perceived as more desirable. Additionally, it will be very challenging to scale back existing services or move staff to other areas of even if the SNAA advises this. For example; Sláintecare advises moving care from hospital to community where possible. However, in the past, whenever hospital services have been curtailed or cut back in Ireland there is generally substantial resistance from the local population due to the large downstream impacts this has, which in turn creates political pressure which can often lead politicians to delay or reverse these decisions.[5]	High
Technological	**Data Availability:** Differences in availability of data sources in different regions may make certain regions more capable of conducting an SNAA using the PBP approach. REO's may face challenges related to data collection and analysis, particularly with varying technological capabilities across regions. Additionally, the roll out of electronic health records and other new types of software may change completely the sources of data which would be relevant to an SNAA.[6]	High

PESTLE ANALYSIS		Risk
Legal	**Data Regulations:** Compliance with national and EU regulation (e.g. GDPR) will be needed, and may hamper the gathering or utilisation of data sources by REO's.[7] However, the evolving regulatory landscape provides opportunities for enhanced data sharing and transparency. The European Health Data Space (EHDS) legislation, which mandates cross-border interoperability and secondary use of health data, aims to streamline data sharing across EU member states, potentially reducing barriers to accessing valuable data. [8] Additionally, the forthcoming Health Information Bill, once enacted, is expected to further facilitate data sharing and promote greater transparency within the health system. [9]	Medium
	Public Procurement Law/Workforce law: Public sector regulations regarding procurement of services may limit the speed and flexibility of REO's to respond to identified needs. Additionally, policies about recruitment, working conditions, staffing levels etc. will influence how REOs can implement any recommended workforce changes. In addition any changes to these will need to consider trade union consultation and approval.	Medium
Environmental	**Sustainability in Healthcare:** There is increasing evidence for the health system to be more environmentally sustainable as part of the One Health efforts, particularly around energy usage. This will need to be factored into future plans.[10]	Low
	Public Health Emergencies: Pandemics or other acute health needs (including extreme weather events as well as novel threats such as Cyberattacks could derail strategic plans.	Medium

References

1. Burke S, Barry S, Siersbaek R, Johnston B, Ní Fhallúin M, Thomas S. Sláintecare – A ten-year plan to achieve universal healthcare in Ireland. Health Policy [Internet]. 2018;122(12):1278–82. Available from: http://dx.doi.org/10.1016/j.healthpol.2018.05.006
2. Irish Fiscal Advisory Council. How narrow is Ireland's tax base [Internet]. 2024. Available from: https://www.fiscalcouncil.ie/wp-content/uploads/2024/06/Box-B-How-narrow-is-Irelands-tax-base.pdf
3. Irish Government Economic and Evaluation Service Research Services & Policy Unit, Department of Health. Hospital Performance: An Examination of Trends in Activity, Expenditure and Workforce in Publicly Funded Acute Hospitals in Ireland [Internet]. 2024. Available from: https://www.gov.ie/pdf/?file=https://assets.gov.ie/297059/47604906-c790-4511-8339-d3d376608c9f.pdf
4. HSE freezes recruitment of junior doctors and other support staff due to shortfall in budget funding [Internet]. 2023. Available from: https://www.irishtimes.com/health/2023/10/13/hse-freezes-recruitment-of-junior-doctors-and-other-support-staff-due-to-shortfall-in-budget-funding/
5. RTE. Navan hospital rally calls for "investment, not closure" [Internet]. 2023. Available from: https://www.rte.ie/news/regional/2023/0121/1350038-navan-rally/
6. Walsh B. Developments in Healthcare Information Systems in Ireland and Internationally [Internet]. 2021. Available from: https://www.esri.ie/system/files/publications/SUSTAT105_0.pdf
7. General Data Protection Regulation (GDPR) [Internet]. 2024. Available from: https://www.hse.ie/eng/gdpr/
8. European Commission. European Health Data Space [Internet]. 2024. Available from: https://health.ec.europa.eu/ehealth-digital-health-and-care/european-health-data-space_en
9. Government of Ireland. Minister for Health publishes Bill to provide a legal basis for digital health records in Ireland [Internet]. 2024. Available from: https://www.gov.ie/en/press-release/21d04-minister-for-health-publishes-bill-to-provide-a-legal-basis-for-digital-health-records-in-ireland/
10. Health Sector [Internet]. Sustainable Energy Authority of Ireland. 2022. Available from: https://www.seai.ie/plan-your-energy-journey/public-sector/monitoring-and-reporting/public-sector-results/health-sector/

Appendix 7: Internal Analysis

Dr Aparna Keegan, September 2024

A SWOT analysis shows the factors influencing the implementation of PBP in health regions, emphasising both the external opportunities and threats for transformation and the internals strengths and weaknesses (based on stakeholder interviews see Appendix 5 for further detail).

Strengths

1. Strategic Vision: Clear advocacy and planning vision from key stakeholders for aligning services with population needs through the planning process.
2. Support for Population Health Approach: Stakeholders have a strong focus on health equity, addressing the social determinants of health, and early intervention. Broad support for integrating health services across sectors to reduce fragmentation and ensure cohesive, patient-centred care.
3. Expertise and Data: Availability of expertise in health data analysis that can inform planning.

Weaknesses

1. Data Quality and Availability: Concerns regarding the quality and accessibility of local-level data, which is crucial for effective PBP.
2. Labour-Intensive Analysis: The need for qualitative data analysis is resource-heavy and can hinder the progress of PBP, particularly in gathering and interpreting evidence.
3. Lack of Consensus: There is some confusion regarding terminology and the broader conceptual framework for PBP, especially across departments and stakeholders.
4. Resistance to Change: The large-scale transformation required to implement PBP might face resistance from stakeholders who are used to the current system of planning.

Opportunities

1. Cross-Sector Collaboration: There is opportunities for increased collaboration (e.g. local areas challenges scheme) between health services, public health, and other sectors like transport, education, and housing, which can enhance the impact of PBP.
2. Technological Integration: The development of digital health tools, such as shared care records, offers an opportunity to enhance integrated care delivery and support techniques such as PHM.
3. Policy Influence: PBP can support long-term health policy development, including influencing decisions at the European level and guiding national priorities over the next 10 years.
4. Pilot Regions for PBP: There are opportunities to pilot PBP in specific health regions, which are open to implementing this approach.

Threats

1. Funding Constraints: While PBP can guide more equitable allocation, there is no guarantee of additional funding, which limits the scope for scaling the approach.
2. Political Pressures: Short-term political pressures and the potential for shifting policy priorities may derail long-term PBP goals, especially if there is a lack of sustained political support.
3. Systemic Resistance: Potential reluctance from stakeholders within the health system who are sceptical of the broader changes that PBP will entail.
4. Evaluation Difficulties: The long-term nature of policy impacts and the difficulty in measuring immediate outcomes could result in a lack of buy-in if stakeholders do not see short-term benefits.

Published by Population Based Planning Programme.
Contact Details: HSE National Health Service Improvement
HSE Jervis House, Jervis St, Dublin D01 E3W9
Nationalhealthserviceimprovement@hse.ie
January 2025