

**SERVICE PLANNING IN
THE HEALTH SECTOR**

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EXECUTIVE SUMMARY

This discussion paper focuses on service planning within the health sector. Through an exploration of the experiences of service planners and the processes and issues involved, a framework for service planning is developed. Reference is also made to service planning in other health systems and a comparative review of service plans produced by the eight health boards in Ireland in 1999 is used to identify elements of good practice.

The paper begins by highlighting the growing importance of the service plan in the light of reforms aimed at devolving responsibility for planning and improving equity and quality in the health sector, and the considerable and increasing proportion of public expenditure consumed by health services. In general, views were positive about the requirement to produce a service plan.

A number of key issues which require attention are identified in the study. These include:

- The role of the service plan needs to be clarified within the overall planning framework, including how it should be used and what it should contain.
- The Department of Health and Children has a key role in providing strategic direction and ensuring coherence in service planning. This needs to include ensuring consistency across divisional structures and the range of care groups being developed by health boards.
- Needs assessment should be further developed to ensure that service planning is focused on achieving health and social gain.
- The service plan is a high-level document and should provide a high-level overview, but draw on operational detail contained in operational plans. It should refer to achievements and challenges in the previous year.
- The focus of the service plan needs to go beyond new developments to include the full range of services provided by the health board.
- Clarity is required in the service plan in terms of explicit links to the board's strategic plan and the allocation of resources, and in terms of clear and measurable objectives.
- Monitoring and evaluation need to be strengthened.
- Effective communication is required between:
 - the Department of Health and Children and health boards, to ensure that department priorities and board priorities are aligned and to provide feedback on how service plans can be improved,
 - health boards and providers, and
 - stakeholders.
- Work on the service plan needs to begin early in the year to allow time for consultation and to reduce the difficulties presented by the tight time-frame required in legislation.
- A number of suggestions are made as to how guidance can be improved.

A framework is put forward for service planning within the strategic planning framework. In it the service plan provides the vital link between the strategic and the operational and ensures that services are moving progressively towards what needs to be achieved, while allowing changes occurring on the ground to be incorporated. It also enables the Department of Health and Children to fulfil its role in monitoring and evaluation.

It is proposed that the key elements of a service plan are:

- the board's *mission/vision*: articulating the board's identity and direction in the context of the people it serves;
- *achievements over the previous year*: in terms of a succinct review of the board's current position against the objectives outlined in the previous service plan;
- *strategic direction*: in the context of the board's mission/vision, the current strategic issues that need to be addressed;
- *key priorities for the coming year*: providing the link between long-term goals and what is achievable in the year in the light of the likely challenges and allocated resources;
- *objectives and targets*: clear and measurable objectives stating what is to be achieved in the year, by how much and by when;
- *arrangements for monitoring and evaluation*: explicit arrangements for
 - monitoring achievements against the service plan by managers and by the board, and reporting to the Department of Health and Children, and
 - assessing the effectiveness, appropriateness and efficiency of new and existing programmes and customer satisfaction with services.

A review of service planning in England and New Zealand identifies some notable features that could be considered for service planning in Ireland:

- central strategic direction on national priorities and how they might be addressed
- explicit arrangements to match services with assessed needs
- the explicit use of formulae in the allocation of resources
- moves towards the introduction of longer-term agreements between regions and providers
- clear accountability structures between levels of the system and explicit reporting requirements
- the development of performance indicators.

The second part of the review of the international literature focuses on the development of performance indicators across a number of countries. Issues discussed include issues in defining performance indicators and using them effectively and the need to prioritise the data collected.

The final section of the paper concludes that there are clear benefits to the requirement on boards to produce a service plan but that the service plan needs to be developed further to reach its full potential as a key management tool. A number of recommendations are made to help to take this forward, drawing on the research findings.

INTRODUCTION

1.1 Focus of report

This report on service planning in the Irish health sector was commissioned by the Committee for Public Management Research. The study focuses on the production of an annual service plan by health boards within the overall context of service planning in its broadest sense. A framework for service planning and the service plan is developed through an examination of the processes and issues involved from the perspectives of service planners from health boards and the Department of Health and Children. In addition, examples of good practice in the development of service planning and the content of service plans are identified. A number of points raised on service planning in the international literature are highlighted with reference to the study's findings. The report concludes with recommendations regarding the further development of service planning.

1.2 Background and context

Public expenditure on health in 1998 accounted for almost 17 per cent of total gross expenditure, at almost £3 billion, and was second only to spending on social welfare (Department of Finance 1999). Expenditure on health services is growing at about 9 to 10 per cent each year and more quickly than in any other part of the public sector. In the year 2000 the newly established Eastern Regional Health Authority will have an annual budget of close to £1.5 billion, one of the largest budgets in either the public or private sector.

Over the last decade several developments have influenced the way in which the Department of Health and Children (the department) carries out its functions and conducts its relationship with health boards and agencies in the context of this significant utilisation of public resources:

- The 1994 health strategy *Shaping a Healthier Future* outlines the changing roles of the department, health boards and agencies, and emphasises the need to focus on improving health and social gain. The three principles underpinning the strategy are equity, accountability and quality of service.
- The Strategic Management Initiative, as outlined in *Delivering Better Government* (1996), gives a Government commitment to 'the reform of our institutions at national and local level to provide service, accountability, transparency and freedom of information'.
- The Health (Amendment) Act (No. 3), (1996) significantly enhances the role and responsibilities of health boards and health board chief executive officers (CEOs), and strengthens accountability for service planning.
- The Comptroller and Auditor General (Amendment) Act, (1993) provides a legal requirement for the Comptroller and Auditor General to provide independent assurance to Dáil Éireann that health resources are used economically, effectively and efficiently. Over recent years, several value for money (VFM) studies have been carried out in the health sector, and each year health boards and agencies agree specific VFM targets with the department.
- Health board CEOs are now required to go before the Committee of Public Accounts.

- The Freedom of Information Act, (1997) establishes the rights of individuals to access publicly-held information that relates to them, to have such information amended if it is inaccurate or incomplete, and to obtain reasons for decisions made that affect them.

Year on year, there has been a gradual and progressive shift towards increased accountability and transparency, and improving equity and quality in health services. These developments have serious implications for health service planners, both at health board or agency level and within the department.

The service plan is a critical component of the accountability framework in terms of ensuring the provision of appropriate, effective and equitable services, and for the effective control of resources. The Health (Amendment) Act (No.3), (1996) sets out the requirement for health boards to submit a service plan to the Department of Health and Children each year. In the service plan, health boards are required to outline the services to be provided for the year, along with estimates of income and expenditure. The legislation also sets out a specific time-frame within which the service plan is to be produced and approved, and specifies that health board chief executive officers are responsible for the implementation of the annual service plan. Dixon and Baker (1996) suggest that service plans could become a central component of enhancing accountability. They also suggest that service plans could become a key feature of organisational performance review, providing an opportunity to integrate programme objectives and to cascade resulting performance requirements down to units or departments.

The service plan needs to contend with the considerable difficulty of predicting health needs in any given year. A number of situations can arise over which the department or health boards have little or no control, but which have serious implications for how allocated resources have to be used. For example, the release of a new drug or a flu epidemic can upset the best-made plans.

In addition political decisions may be made which influence resource allocation. For example, the introduction of tax incentives to encourage more people to establish nursing homes has increased the resources required for nursing home subvention. A court may make a ruling that a particular type of specialised care is required for an individual with special needs, or the media may raise a particular issue that the health boards are forced to respond to. Nevertheless health boards are required under the 1996 Act to remain within budget. Any over-spends will be the first charge on funds allocated in the following year.

The preparation of annual service plans is seen as a means of establishing the principles of the Strategic Management Initiative (SMI) in health boards, and as a strategic management tool. The first service plans were produced in 1997 and health boards have been developing their approach to service planning significantly over the last few years. Thus a considerable amount of learning has already occurred within health boards and the department.

STUDY DESIGN

2.1 Terms of reference

Over the course of the study it was agreed that the research would:

1. review existing Department of Health and Children guidelines and arrangements for service planning, including a comparative review of service plans;
2. review existing health board experience with service plans, focusing on the perceived benefits and problems arising to date;
3. undertake a review of the international literature/case study material on health service planning and health service evaluation; and
4. develop a good practice framework for service planning, giving particular emphasis to enhancing evaluative capacity as a result of the service planning framework.

2.2 Methodology

Much of the research centred around group and individual interviews with representatives from the Department of Health and Children, the eight health boards and the ERHA taskforce. The range of individuals interviewed is outlined in Appendix 1. The research also involved a comparative review of the 1999 service plans, and a number of other department and health board documents relating to service planning. A literature review sought to address some of the issues raised in the findings by drawing on international experience in service planning.

2.3 Structure of the report

This report contains five further sections. Section 3 provides a summary of the main interview findings, starting with the benefits of service plans and following on with the key issues identified. Section 4 provides an overview of the emerging framework for a strategic approach to service planning, based on interview findings, and addresses the key issues identified. It also draws on examples of good practice and of novel approaches by health boards to address the issues faced. It further provides a framework for the service plan as a strategic management tool. In Section 5, good practice in service plan development is explored through a comparative review of the service plans submitted by the eight health boards to the Department of Health and Children in 1999, using a number of key elements of a service plan that emerged during the research. International developments in service planning are outlined in Section 6 in the light of some of the issues raised during the review of service planning in the Irish system. This section also includes a review of the development of performance indicators and some of the issues identified. Section 7 contains a number of recommendations drawing on the study findings, and identifies six key areas to be developed further in order to advance service planning.

SUMMARY OF MAIN INTERVIEW FINDINGS

3.1 The benefits of service plans

One very positive finding from this study is the degree of buy-in from respondents to the need for service planning and a general acceptance of the principles of producing an annual service plan. Based on their experiences of service planning to date, interviewees report that there are clear benefits arising from the requirement to produce an annual service plan. The benefits perceived by departmental and health board representatives include:

3.1.1 Vision and unity of purpose

From the conceptual aspect, health board representatives suggest that the requirement to produce a service plan had resulted in boards clarifying their thinking on a range of issues and on the board's vision, encouraging a unity of purpose.

3.1.2 Improved planning

The requirement to produce a service plan has improved planning. As the only essential document in planning it has forced a discipline on it. Imposing a formal planning and allocation process has moved service planning away from the worst aspects of the previous approach, which some respondents characterise as drip feeding and supplementary bail-outs. On the ground, respondents report an increased awareness of the need to plan, with professionals becoming more involved, thus increasing ownership. They also report that the service plan shapes planning by forcing boards to look at issues such as equity.

3.1.3 Improved monitoring of services

Respondents indicate that the accountability legislation has increased transparency and responsibility for service planning. They report that for the first time serious questions are being asked about the utilisation of services, and service planning has also shaped reporting relationships between managers and the board.

3.1.4 Better control over spending

Department representatives report that service plans have a major impact on the way the department does business and that as a result it has become more planned and rational. The department now has better control over spending, with few health boards coming in over budget. In addition, interviewees report that health boards are increasingly trying to solve their own problems rather than look to the department to provide additional resources. During the fieldwork, it was evident that a lot of work is ongoing within health boards in developing service planning. Interviewees suggest that better collaboration could help to bring the process forward by sharing good practice. In addition, some suggest that health boards could make better use of the newly established Office for Health Management to assist in the development of service planning.

3.1.5 Improved management of services

Interviewees suggest that the service plan has several functions which help to improve the management of services. The primary function of the service plan, and that set down in the 1996 legislation, is to provide 'a statement of services ... and estimates of income and expenditure' for the coming year. The legislation also requires the statement of services to be 'consistent with the financial limits determined by the Minister'. Reflecting this requirement, interviewees suggest that the function of the service plan from the Department of Health and Children's (the department) perspective is firstly to check that planned expenditure is, and remains, within that outlined in the Letter of Determination (LoD), and that staffing numbers are within those agreed with the department. Secondly, it is hoped that the requirement to produce annual service plans will encourage the development of planning in health boards. Within health boards, interviewees identify four key functions of the service plan:

1. It is a legal document, providing evidence that the board is meeting its objectives and demonstrating that services are the result of sound planning, reflecting national policy.
2. It forces a discipline on strategic planning, providing the opportunity to review the board's progress against longer-term strategies.
3. It is a management tool that sits somewhere between the board's strategy and operational plans. As such the service plan articulates to managers the objectives to be achieved during the year.
4. It is the vehicle through which board approval is sought for the range of services proposed for the coming year.

3.2 Key issues identified

A common theme among interviewees is that the full potential of the service plan as a strategic management tool has yet to be realised. The service plan is the central mechanism through which the department can devolve responsibility and accountability for operational issues to health boards (in line with the proposals in *Shaping a Healthier Future*, 1994). Therefore it is important that the development of service planning continues. Despite the positive views of the benefits of service planning, interviewees raise a number of issues that need to be tackled if service planning is to continue to have a positive impact. These issues are highlighted here:

3.2.1 Defining the role of the service plan

The findings suggest that in order for service planning to be further advanced, the role of the service plan itself needs to be more clearly defined. Such a definition should include the position of the service plan in the overall planning framework, how the service plan should be used, and what it should contain.

Several respondents suggest that service planning should be given higher priority both within the department and by health boards; that dealing with service plans and service planning needs to be seen as an integral part of the work done within divisions; and that the planning process and the service plan have been developed in some boards more than in others.

3.2.2 Coherence in service planning

For effective planning, a coherent approach is required, both within and between health boards and the department. The evolving role of the department, as outlined in *Shaping a Healthier Future* (1994), gives it responsibility for the provision of a strategic framework for health services and a role in overseeing strategic development throughout the health service. Respondents suggest that although the overall policy of the department is explicit, boards need more detailed direction from the department in terms of national policy for specific services. In this context the recent initiative for a national strategic approach to cancer services was identified as a particularly useful one that could be extended to other services.

Some respondents from both the department and the health boards have concerns about the impact of organisational structures on service planning. The majority of health boards are moving away from the traditional programme-based classification of services towards the development of care groups. One service plan suggests that this move is intended to improve the integration of services. Two particular issues were raised during the research. Firstly, the approach taken varies considerably among health boards, such that no two health boards have developed the same framework for services. This has serious implications in terms of the generation of comparable data. Secondly, the organisation of services in health boards along different lines to the division structure within the department can raise communication difficulties for service planners. More recently, the department has developed a team structure in its dealings with Tallaght hospital, with the establishment of the Eastern Regional Health Authority and in dealing with the blood issue. One respondent suggests that such team-based structures could address the issue of coherence, if they were applied to the department's dealings with health boards.

3.2.3 The link to the assessment of needs

Several interviewees highlight the necessity to develop needs assessment further in order to shift the emphasis in service planning towards achieving health and social gain. They suggest that this would provide more of a balance between health outcomes and accountability for expenditure. Within boards, needs assessment is very much in its infancy but the department is working on the development of the Public Health Information System to provide good information on health status. It is anticipated that this will add to thinking at local level, with a greater emphasis in health planning on outcomes, mortality and morbidity. The role of health boards' Departments of Public Health also needs to become more explicit in targeting health needs, with Directors of Public Health having a significant involvement in drafting the service plan.

3.2.4 The content of the service plan

- a. *The service plan as a high-level document:* In considering what level the service plan is to be pitched at, it is important to balance the needs of both the department and the health boards. Interviewees from health boards stress the difficulty that they can have in getting board approval for the service plan if there is too much operational detail in it. Therefore they feel the service plan should provide a high-level overview of the quantum of services to be delivered by the board for the coming year. The point is also made that the accountability legislation, (the Health (Amendment) Act (3) 1996), gives health boards and CEOs responsibility for the provision of services at a regional level. The emerging

separation of policy and operational issues suggests that operational detail is not appropriate in service plans.

- b. *Level of detail of the service plan:* In terms of the service plan content, there are issues about the level of detail that should be required in a service plan. The previous suggestion that the service plan is a high-level document outlining the quantum of services to be provided for the coming year suggests that operational detail should only be reported in operational plans. The service plan would then draw on or refer to that contained in operational plans. There is no statutory requirement for health boards to submit operational plans to the department, but department respondents who have seen some suggest that operational plans could provide more of the type of routine data they require. Operational plans are not yet produced by all health boards, but with the exception of one board, those who do produce them suggest that they would have no objection to the department receiving information from these in addition to service plans.

The guidelines require the service plan to review the previous year's provision in considerable detail. Interviewees accept that it is important to demonstrate how plans for the coming year build on what has been achieved to date (i.e. where the board is now), what has not been achieved, and the particular challenges faced during the year and to be accommodated in the coming year. However, they suggest that going into too much detail and looking backwards rather than forwards detracts from the report's primary function, which is to outline planned provision for the coming year.

- c. *The focus of the service plan:* As stated in the previous section, the primary function of the service plan is to outline the range of services to be provided during the coming year. Several respondents note that the general focus in the service plan tends to be on new service developments, which only account for about 10 per cent of total expenditure. They suggest the emphasis should move more towards how the full range of services to be provided for the year meets the needs of the local population. For a strategic approach to service planning, planning decisions need to refer to the entire range of services provided, with consideration given to the effectiveness of current arrangements for service provision and the possibility that it might be appropriate to rationalise services. Thus the service plan needs to refer to the total quantum of services to be provided for the year, drawing on long-term objectives in the strategic plan.
- d. *The service plan as a management tool:* A number of issues exist about the way in which services are outlined in service plans. The key messages coming through in the findings are: the need for clarity in the quantum of services outlined and what is to be achieved during the year; clarity regarding how resources are to be allocated; and how what is outlined fits into the strategic plan for each care group/service area. For the service plan to serve its purpose as the key link between the strategic and the operational, and to ensure accountability, it must set out clearly for managers what needs to be achieved, and inform the department of the board's key result areas. Objectives must be expressed in tangible and measurable terms.

3.2.5 Monitoring achievement against service plans

There is general agreement that monitoring of service plans other than on a financial basis is weak and needs to be developed in order to ensure that allocated funding is used to provide appropriate and effective services. Interviewees identify the following concerns: the lack of good management data being produced, the role of the department in monitoring service plans, and how monitoring needs to be developed to move from inputs and outputs to measuring the impact and effectiveness of services.

In terms of the lack of good data, the IT infrastructure and data definitions are the biggest issues. Interviewees suggest that many health boards are collecting data manually, or that existing systems are not able to provide the type of data required for service planning. A number of health boards are looking at this issue and are developing reporting systems.

Monitoring by the department is currently based on Integrated Management Returns (IMRs), which it is suggested do not provide the type of data required to measure performance comprehensively. Interviewees are concerned about the accuracy of data provided in IMRs, missing data, and delays in returning data. They suggest that there is a need for more regular monitoring of progress on service plans by the department. In terms of the department's role in monitoring, the biggest issue is the perception that the department's emphasis is on finance; some interviewees suggest that once a health board comes in within budget the department is happy. Interviewees suggest that there needs to be a bigger emphasis on the effectiveness and appropriateness of services and quality. Currently a few services are externally evaluated by the department each year. However, interviewees suggest that health boards need to take the initiative in evaluating services, with results feeding back into service planning.

One section in the letter of determination asks health boards to produce performance indicators (PIs). Several interviewees feel that this is inappropriate at this stage as good performance indicators have not yet been developed, nor do health boards have the information systems to provide the data. There are health boards who have included some performance indicators, but more who have not. Several respondents are concerned that targets may be included that they could not achieve, which would reflect badly on the health board, or that misleading comparisons could be made. However, others feel that there is no reason for not working towards the development of PIs and the inclusion of at least basic measures in service plans. This is on the basis that once introduced, they can be developed year on year. One interviewee suggests that the inclusion of performance indicators in service plans has started people thinking and raised discussion. Another interviewee suggests that it is better to overstretch the health board than to underchallenge, and that more is likely to be achieved in this way.

There is no consensus in terms of how the annual report fits into the strategic framework. *Shaping a Healthier Future* (1994) proposes that the requirement to produce an annual report will enhance accountability for services provided and reinforce 'budgetary observance'. While boards are required under legislation to produce an annual report, no guidance has been issued on the shape that it should take. The 1999 service plan guidelines require health boards to produce an annual report, which it states should be aligned with the service plan to allow monitoring. While some interviewees feel the annual report would be a useful document to demonstrate that the service plan has been implemented and that key objectives have been achieved, others feel that it has developed into a 'glossy magazine' and has little value beyond an introduction to the services provided by the board.

3.2.6 Communication

The findings suggest that communication needs to be developed on several fronts to support service planning effectively.

- a. *Aligning priorities in allocations with priorities identified by boards:* Interviewees suggest that the link in the service planning process between the identification of strategic priorities at board level and the identification of priorities by the department in the allocation of funding needs to be developed. A number of health boards are considering ways to address this issue. For example, one health board, in its developing framework for strategic planning, has proposed that it will formally notify the department of the priorities for the year before the letter of determination is issued. This is dependent on the service planning cycle beginning very early in the year and within a strategic

framework. The department has already indicated to boards that a multi-annual approach will be required in the future towards the planning and financing of services in the context of the move to multi-annual budgeting. It will be necessary for boards to consider how they should be preparing themselves for this new environment.

- b. *Providing feedback on service plans*: Several interviewees suggest that the annual service planning meeting between health boards and the department, whilst necessary, is of limited value in providing the type of feedback required on service plans. They feel that there is an over-reliance on the meeting for feedback, and that it is not possible to cover everything in the service plan in one meeting or to have meaningful discussion. There is a perceived need for more detailed discussions, which are best conducted between the boards and the line divisions of the department during the year. Health boards are generally in agreement that through regular, formal contact, divisions can build profiles of regional needs and provide feedback on service plans.
- c. *Better collaboration between boards and providers*: Interviewees believe that health boards and voluntary hospitals could learn a lot from what each is doing, and that better collaboration would help to spread ideas about good practice in service planning. Two respondents suggest that health boards and voluntary hospitals could improve the way that they work by considering the benefits of forming strategic alliances with neighbouring health boards or voluntary hospitals, thus reducing duplication of services. They also suggest that, in service planning, little consideration is given to the users of services from outside of the region served by the health board.
- d. *Involving stakeholders in service planning*: Interviewees highlight the importance of involving other stakeholders such as clinicians and user groups in the service planning process to encourage ownership and for successful implementation of the service plan. In order to allow stakeholders to be involved in the planning process, service planning needs to begin early in the year. However, experiences by one or two health boards suggest that the consultation process needs to be managed carefully so that the service planning process does not get bogged down at this stage.

3.2.7 *The time-frame in which service planning takes place*

The tight time-frame in which the production of the service plan takes place is a key issue from both the health board and department perspectives. In addition, the pressure time occurs over Christmas and New Year, a time when staff levels are low. The timing comes from the legislation, which requires the letter of determination to be issued within twenty-one days of the publication of the Government's Estimates for Supply Services. The health board must then, within forty-two days, adopt and submit a service plan to the Minister. During this time, the service plan must be finalised and put to the board, allowing time to get papers out to members before the board meeting, and allowing time should the board have to be recalled. While some boards already have the service plan in an advanced state before receiving the letter of determination (LoD), others prefer to wait for the letter of determination before undertaking too much work on the service plan. Difficulties relate to predicting what will be in the letter of determination.

Once the service plan is submitted, the department has twenty-one days to either accept a service plan, or recommend amendments. Once again, department staff find the time-frame difficult. For example, the departmental pre-meeting of all those involved may not take place until the morning of the meeting with the health board contingent. The time of year is also an issue within the department.

3.2.8 Guidance on service plans

Interviewees suggest that perceived inconsistencies between the guidelines issued on the service plan in 1997 and those issued in 1998 caused problems for service planners. However, the intention was that one set of guidelines would build on the other. In addition, instructions on the content of the service plan outlined in the letter of determination are not necessarily seen as consistent with those in the guidelines. Interviewees raise several issues about the guidance issued on service plans:

1. The need for guidance to encourage a more coherent approach in the light of variations among boards. Considerable variation is evident in the comparative review of service plans for the purposes of this study. The framework outlined in the 1998 guidelines was not used in its entirety by any health board although some service plans are a lot closer to it than others.
2. The unresolved debate about 'what is a service plan' and how it relates to other planning documents (see 3.2.1). Interviewees suggest that the department needs to provide feedback to boards on the gaps and weaknesses in service plans and to identify good practice to be shared.
3. The requirement for guidance on the service plan within the context of the overall planning process. There is a view that the guidelines should refer more to developing planning and evaluation than to the production of the document, and that the guidelines should clarify the links required between the service plan and other planning documents such as strategic and operational plans.
4. The need for guidelines to focus more on performance, monitoring and evaluation of services. There is also the difficulty of achieving compromise between guidelines that are either so generic that they are useless or so prescriptive that they stifle innovation.
5. The role of the joint department/health board service planning group in providing a framework for service planning. Interviewees suggest that communication within the group and between group members and health board service planners could be improved.

ADDRESSING THE ISSUES: THE EMERGING FRAMEWORK FOR GOOD PRACTICE IN SERVICE PLANNING AND THE SERVICE PLAN

This study focuses on the service plan within the overall context of service planning. As such a range of issues is raised in this report relating to both the process of service planning and the process of producing an annual service plan. In the following sections a framework for service planning is put forward, based on interview findings, in order to address the issues raised. This is followed with a more detailed focus on the service plan within the overall strategic planning context and an outline of the key elements of service plan suggested in the findings. This emerging framework forms the basis of the comparative analysis of the 1999 service plans to highlight examples of good practice.

4.1 The emerging framework for a strategic approach to service planning

Based on interview findings, a comparative review of the 1999 service plans, and the literature on strategic planning, a framework for a strategic approach to service planning is emerging. The emerging framework is illustrated in Figure 1. It is proposed that the development of the annual service plan should take place within an overall strategic approach to service planning, and that the service plan provides the opportunity for health boards to review progress against the overall strategy, to demonstrate that objectives are being moved forward and for the department to fulfil its role in monitoring and evaluation.

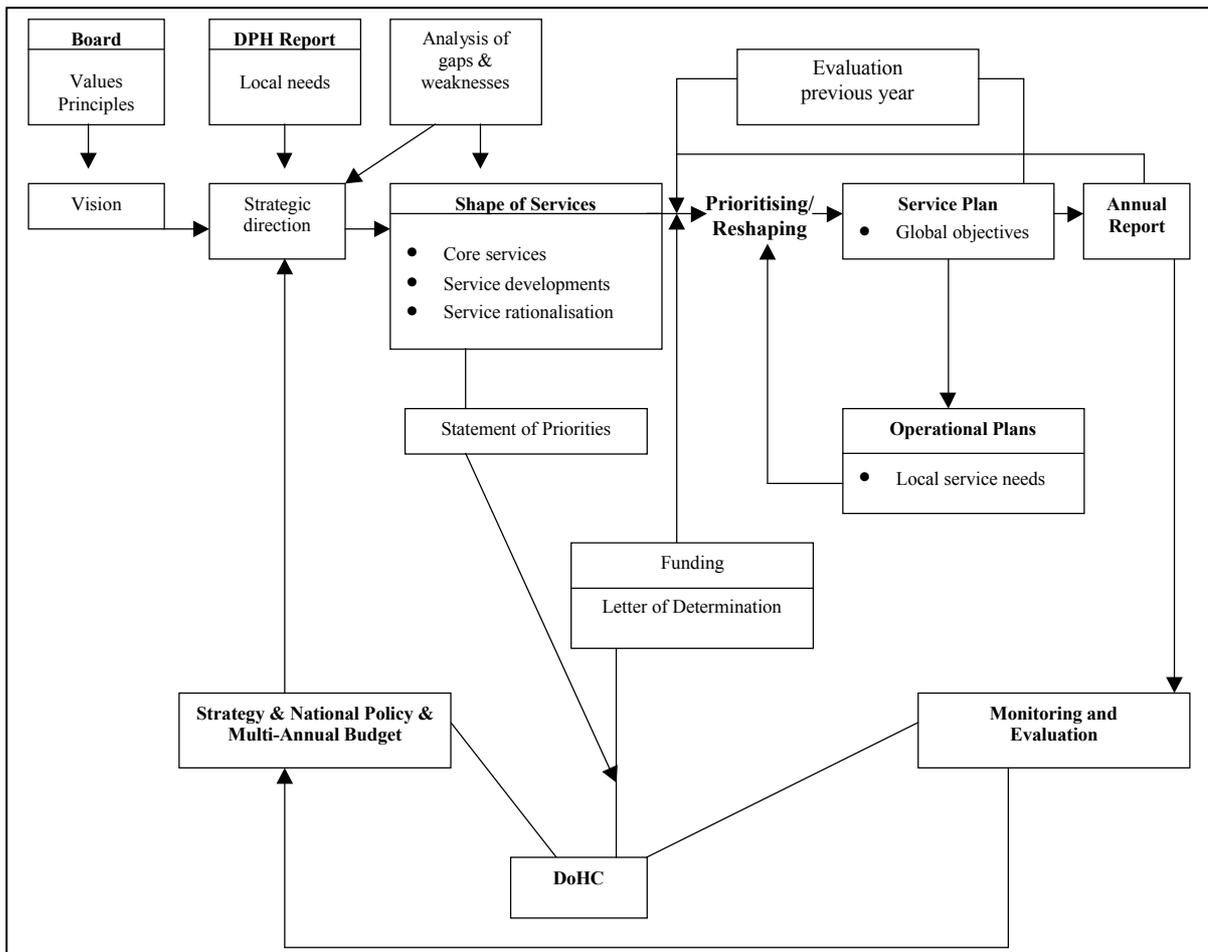
Humphreys and Worth-Butler (1999) have previously made reference to the strategic approach to planning in the public sector. Drawing on the work of Smith (1994) the strategic approach can be defined as a total business approach to planning and implementation which encapsulates all of the complexities within which an organisation functions.

It is a continuous, reflective and comprehensive approach to management with an emphasis on effective change, visible leadership and staff involvement. The approach is led by clarifying aims, identifying means to achieve them and pursuing viable opportunities wherever they can be identified.

The key features of strategic management, according to Smith (1994), are:

- A link between the longer-term objectives and the present. Decisions are made on the basis of regular monitoring of success in meeting longer-term objectives. There is a clear link between strategy and operations - action plans, projects and budgets flow from the strategy. People need to know what is expected of them.
- Top management have a major role in ensuring the direction for the organisation through coherent strategies and objective analysis.
- There is a shared vision which is communicated throughout the organisation and involvement in the planning process is through consultation and 'a proper mixture of top-down and bottom-up'.
- The strategy creates the future and is proactive with consideration of the scope for future activities and the underlying requirements of users.

Figure 1



- Monitoring is continuous and the focus is on the strategic. In-year objectives are related to the longer-term, embracing user perceptions, underlying quality, efficiency and capability. Monitoring includes not only business results but external developments which might have implications for the strategy.
- Decision-making is continuous and changes are made as required within the overall direction of the strategy or the understanding developed during strategy formulation. Decision-making is not erratic nor does it involve regular changes of mind.

In the proposed framework for service planning, the strategic direction of the board is based on its vision for the board along with the strategic direction and national policies outlined by the Department of Health and Children; an assessment of local needs, and an analysis of the gaps and weaknesses in the current service provision. Clearly the service plan itself is not the appropriate vehicle for elaboration of longer-term strategy. This suggests that a specific strategic plan is needed in health boards which pulls together national and local strategic developments. In the strategic plan, the longer-term direction of the board is outlined along with key objectives to be achieved. The strategic plan provides a map of the shape of service provision required for the board to meet the needs of the population it serves. Against this, an analysis of the gaps and weaknesses of services helps to provide a shape for how services need to be developed and/or realigned for the board's strategy to be achieved.

The annual service planning process then requires an identification of the key priorities for the year, balancing what needs to be achieved with what can realistically be achieved within the resources available. The priorities identified need to be reflected in how allocated resources are apportioned among the various services.

As stated by Smith, monitoring and evaluation are key elements of strategic planning and a review of the previous year's achievements informs the priorities for the coming year. Operational plans provide the clear link to implementation, making explicit to managers and staff what is required of them. They also provide the bridge between local and regional needs in service planning.

Interviewees suggest that a shift towards taking the longer-term view is required as many service developments are not achievable in a year. The introduction of multi-annual budgeting (MAB) framework for the public service has been proposed to shift the focus from the short-term to the longer-term perspective in budgeting and decision-making. The SMI Working Group's report on *Financial Management in a Reformed Public Service* (1999) states that the introduction of the MAB framework is aimed at positioning the budgetary and decision-making process within a three year time-frame. It suggests that this move will enable departments to consider priorities over a period longer than the traditional year, thus fully capturing the longer-term cost implications of Government decisions.

Specifically in the health sector, the Department of Health and Children has indicated to health boards that a multi-annual approach to planning will be required in the future. Interviewees outline the difficulties that health boards can have in linking objectives outlined in the service plan with the strategic/longer-term view, within the current annual funding framework. The current approach is also viewed as limited by several interviewees because there is not an explicit link between allocations and assessment of needs, and it is perceived that uncertainty year-to-year about funding encourages a degree of short-termism in service planning.

The need for a multi-annual approach to planning is put forward with multi-annual budgeting linking all of the parts - the Board's medium-term strategies with national priorities with the multi-annual approach to funding between the Department of Finance and the Department of Health and Children. Multi-annual budgeting is also put forward as a framework to enable capital, revenue and human resource allocations to be integrated into a three- to five-year planning cycle, picking off what is achievable each year, which is then outlined in the service plan. Thus, within a strategic approach to planning, supported by a MAB framework, the service plan ensures that services are moving progressively towards what needs to be achieved, and allows changes occurring on the ground to be incorporated.

4.2 Approaches to developing service planning

All health boards report that the service planning process has undergone considerable development in the past few years. However, there are differences among health boards in terms of the degree to which the service planning process has been advanced, and where the emphasis on development is placed. Two health boards have undertaken a full review of planning processes. In one the emphasis is on planning processes and building a framework for planning, while in the other the emphasis is on creating new structures to improve communication in service planning. In other health boards, development is more gradual and seen as evolving or incremental.

Strategies and policies to inform the service planning process are at various stages of development in health boards. In one or two health boards, board strategies and policies have yet to be agreed but the intention is that once agreed, they will inform service planning. In other health boards, services are being reviewed one by one resulting in a series of strategies to guide service planning. In one board an executive group has been established with the explicit role of linking the strategic to the operational.

The other major difference among health boards is in terms of the attention given to developing supporting documents such as operational plans and the annual report. In most health boards operational plans are well developed and have an important place in the planning process, in providing the link between local and global issues and in informing managers and staff of what is required of them. In two boards, service and business plans have been identified as areas that the board would now like to develop. As previously stated, there are considerable differences of opinion on the role of the annual report. Nevertheless, a number of boards had put a lot of effort into developing the annual report to reflect the service plan.

Several boards have developed internal reporting procedures to allow monitoring of the service plan. They include monthly reporting between area or programme managers and senior managers to review progress, and regular reporting of progress to the board during the year, including reasons for not achieving targets. Three health boards are specifically involved in developing performance indicators across the range of services, while one board is concentrating on developing performance indicators for new developments. Another board is considering how performance measures can be built into the data collected on the financial system. In all, good practice here indicates that with regard to reporting procedures, boards should aim to ensure that there are regular review meetings between area/programme managers and senior managers and periodic review reports on progress to the board. They should also try to ensure the development of appropriate performance measures of service provision.

These findings suggest that the service plan cannot be developed further without full consideration and review of the whole strategic planning framework. It is also suggested that boards could learn a lot from each other by sharing their experiences of developing the different aspects of service planning.

4.3 The service plan

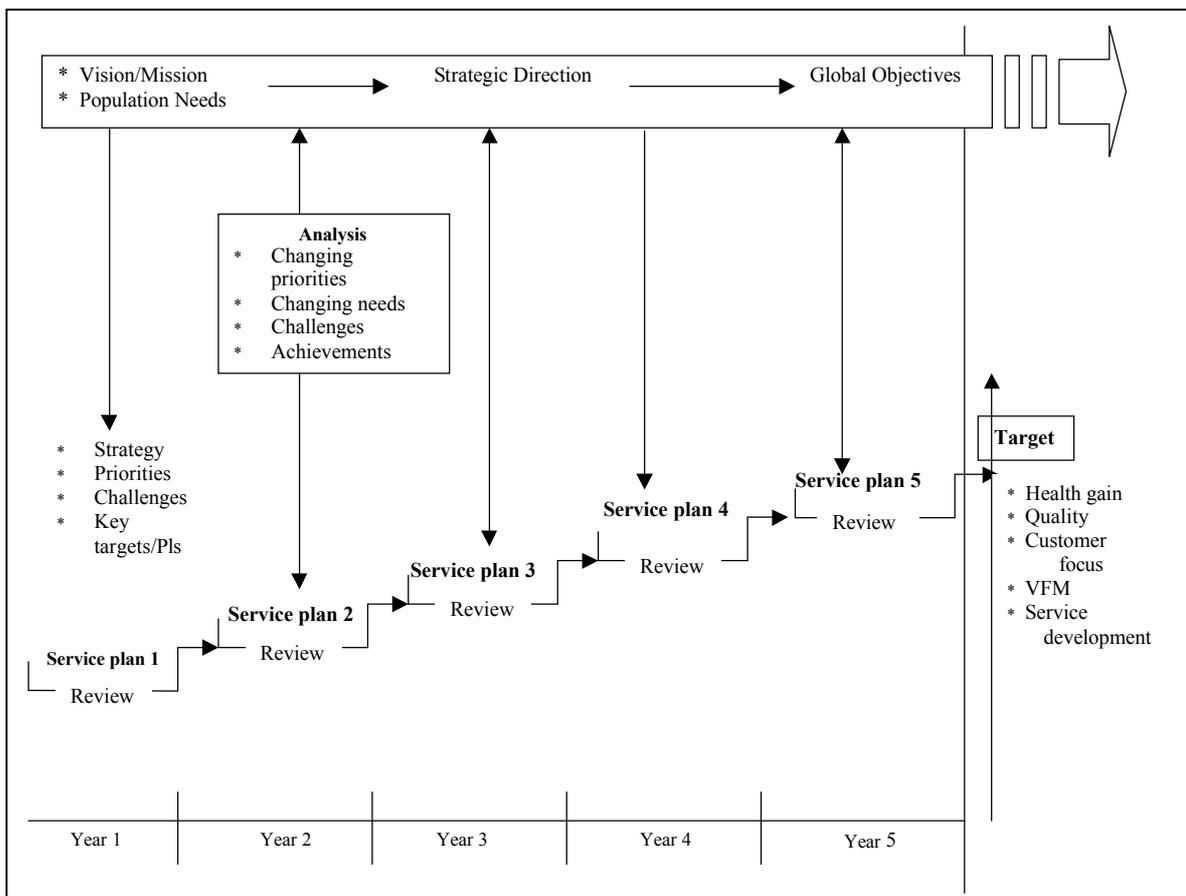
The service plan needs to be seen as a key management tool in the context of strategic planning. The service plan has strategic value in pushing forward the long-term strategies. It provides the opportunity each year to review service progression thoroughly against global objectives and changing needs, and to realign priorities accordingly.

A study commissioned by the Department of Health (Dixon and Baker 1996) reported that there was an absence of clear accountability in health service organisations and that the potential for performance management at various levels had not been fully exploited. Particular issues for them were that managers produced plans without any clear guidelines

on the overall strategic objectives to which they were supposed to be working and that few received feedback. They suggested that service plans could become a central component of enhancing accountability. They also suggested that service plans could become a key feature of organisational performance review, providing an opportunity to integrate programme objectives and to cascade resulting performance requirements down to units or departments.

As previously stated, the findings suggest that there is an urgent need for the role of the service plan to be more clearly defined and for its position and purpose to be clarified within the overall planning framework. The findings suggest that the service plan needs to become the key management tool linking the strategic to the operational (see Figure 2). As such it provides the mechanism to drive change forward and for health boards to achieve their objectives. This involves a process of reviewing achievements against the longer-term strategic objectives, in the light of the challenges faced over the previous years and the changing needs of the local population. Against this analysis the health board outlines the quantum of services that it will provide for the coming year within the resources allocated to it. Priorities are identified which include both core services and areas for development.

Figure 2



One key issue identified is that the service plan needs to outline how the health board is going to spend the money allocated to it - the service plan is not a vehicle for bidding for additional funding. For the service plan to be an accountability mechanism and for progress to be assessed against the service plan and the longer-term strategy, objectives must be set out in meaningful and measurable terms.

GOOD PRACTICE IN SERVICE PLAN DEVELOPMENT

A comparative analysis of the 1999 service plans was carried out using the proposed key elements of a service plan that emerged during the interviews with service planners. Reference was also made to supporting and associated documents such as operational plans and annual reports, and the previous year's service plan. The purpose of the review is to identify examples of good practice in the content of service plans. It should be noted that this analysis focuses specifically on what is written in service plans and it is likely that there are other examples of good practice in service planning in health boards that are not reflected in the service plan. Based on this analysis of good practice, the key elements of a service plan are summarised in Figure 3. In the following sections, each element is explored in more detail. Whilst the elements are listed in a particular sequence in the figure, it is accepted that, with the exception of the mission/vision element, elements could appear in a service plan in a different order, depending on the preferences of individual health boards. Good practice suggests that these elements should be present, in one form or another, in a service plan.

Figure 3: The key elements of a service plan

Mission/vision:

The organisation's identity and direction in the context of the people it serves

Achievements over the previous year:

A succinct review of the board's current position against the objectives outlined in the previous year's service plan

Strategic direction:

In the context of the board's mission/vision, the current strategic issues that need to be addressed to achieve long-term goals

Key priorities for the coming year:

Providing the link between long-term goals and that achievable in the year in the light of likely challenges and allocated resources

Objectives and Targets:

Clear and measurable objectives stating what is to be achieved, by how much and by when

Arrangements for monitoring and evaluation:

Explicit arrangements for:

- 1) monitoring achievements against the service plan by managers, by the board and reporting to the Department of Health and Children, and
- 2) assessing the effectiveness, appropriateness and efficiency of new and existing programmes and customer satisfaction.

In the comparative review of service plans examples of good practice were seen in all service plans and relating to all of the elements in the emerging framework. In the sections following, each element is discussed in turn, drawing on the examples of good practice seen.

5.1 Mission/vision

The mission/vision articulates the organisation's identity and direction, in the context of the people whose interest it serves. The mission/vision provides a sense of purpose and it must be relevant to all stakeholders in order to gain their commitment to and support for achieving the organisation's objectives. Thus it is important that the board's mission/vision is articulated in the service plan. The central importance of the board's mission/vision in service planning suggests that it needs to be outlined at the outset in the service plan.

One example of good practice is where the board's mission is outlined on the first page of the service plan. This is where the board sets out its *raison d'être* - 'to seek to improve the health (health gain) and quality of life (social gain) of the people of the region' - and the key means by which it strives to achieve it. In addition, there is consistency between the overall mission and that outlined for each care group. Mission/vision statements are included in several service plans, but often they are introduced quite late in the plan, or explicit linkages are not made to service areas.

5.2 Achievements over the previous year

Achievements over the previous year are reported in almost all service plans. Suggested good practice is that in the overview/introduction a succinct review is provided of the board's current position against the previous year's service plan. It should include:

- the board's financial position
- trends in activity overall
- a summary of the key achievements for each service area
- reference to the particular challenges faced during the year, the reasons for them and particular measures to deal with them
- relating these challenges to the plans for the coming year.

This analysis should include a review of reported achievements against the objectives outlined in the previous service plan. Because of differences in style or format between versions, it is not always easy to compare achievements reported in one year with objectives outlined in the previous year. In addition, the emphasis in some service plans is on reporting only what has been achieved. These findings suggest that for good practice:

- reported achievements should very closely reflect the objectives outlined in the previous service plan;
- both objectives and reported achievements need to refer to measurable benchmarks, such as percentage increases or decreases; and
- reports should include objectives not met and how they will be addressed in the coming year.

5.3 Strategic direction

In the context of the board's mission/vision, the strategic direction identifies the current strategic issues which need attention, and which are reflected in the plans for the coming year.

In one service plan examined, this issue of strategic direction is dealt with well through each service area having a section on the strategic direction/context in which service planning for the area takes place. This section refers to the key issues/principles underpinning service delivery for the year such as ensuring equity or developing team work; references to national or local strategies; and changes in legislation or recent incidents that are likely to have a direct impact on services. In other examples, strategic priorities based on board strategies are listed as the board's top priorities or as programmes of change. Although the strategic direction is outlined in a number of service plans, in general better links could be made to the board's mission/vision.

5.4 Key priorities for the year

This element refers to how the overall priorities for the board, and for each service area, are outlined. This aspect of the service plan is covered very well in a number of service plans and the particular good practice points noted are that:

- There are clear links between the global and service specific priorities. Global priorities for the year are highlighted in the overview/introduction to the service plan. These are then followed up in each programme and care group referring to the specific priorities for each area but also reflecting the board's overall position.
- Priorities reflect a clear link between the long-term/strategic goals of the board/service area and achievements and changes that occurred in the previous year.
- Priorities are reflected in objectives and targets.
- Priorities are relevant to the total range of services provided and are not limited to the development of new services. For example, on a global level priorities might aim at ensuring the equity and quality of services. At the local level priorities might include addressing waiting list issues and introducing quality reviews or service evaluations.

5.5 Objectives and targets

Two health boards include objectives linked to targets and performance indicators. They also stress the importance of the development of performance indicators in the overview section. In one service plan this is done in terms of shifting the emphasis from 'how much is done to what are the benefits of what is done'. In both, the link between measurable objectives and achieving long-term/strategic goals is explicit. In two other service plans there are examples of good targets but only in one section of the service plan each. One health board adopted a novel approach in outlining the objectives for the year for each section. Using the heading 'Implementing a national health strategy' the focus of objectives is on achieving health and social gain.

Examples of good practice include:

- objectives expressed in tangible, measurable terms, referring to deadlines for achievement; and
- achievements related to services as a whole, that is, both core services and new developments. For example, including improving the responsiveness of or reducing waiting times for existing services.

Targets should be related to SMART (specific, measurable, achievable, realistic and timebound) objectives or objectives that clearly state what will be achieved, by when and by how much. Generally, notwithstanding the good practice examples, the objectives seen in service plans tend to be broad statements that are not easily measurable, or where there is no mention of time-scale. Statements typically refer to the establishment or implementation of a new service, to continuing something commenced in the previous year, or to extending a particular service. Statements that are more specific, for example that refer to appointing someone, rarely include a date by which the task should be achieved. There are some more measurable targets such as a 95 per cent immunisation uptake. References to time-scale and key stages of achievement are the biggest gaps.

5.6 Arrangements for monitoring and evaluation

This refers to arrangements for monitoring the service plan and for evaluating services.

1. *Monitoring the service plan:* Four service plans spell out explicit arrangements for monitoring service plans. In addition, we are aware that another board has recently introduced measures to monitor progress against the service plan on a monthly basis. In the four service plans mentioned there are references to monitoring via board sub-committees and reporting to the board on pay and non-pay expenditure against budget, and activity or out-turn. In addition, one service plan refers to reporting on corrective action taken, and another to reporting on performance. In one service plan explicit reference is made to using the CEO's commentary facility in the IMRs to provide monthly feedback to the Department of Health and Children. The emphasis on monitoring tends to be on arrangements between senior managers and the board. However, in one case there are references to arrangements to provide clinicians with feedback on activity and budget on a monthly basis. As outlined in section 4.2 of this report, good practice would involve regular reporting among the board, senior managers and area/programme managers.

2. *Evaluation:* There are numerous references to service evaluations in almost all service plans. It seems that evaluation is almost always service-led, and only in one service plan are there suggestions of central co-ordination or that specific criteria are set out centrally for the evaluation of services.

5.7 Conclusion

To summarise, we have identified the key elements which a service plan would be expected to contain, based on good practice in service plan developments. The key message is that clarity is required in terms of where the board wants to go and where it is to date; what are the likely challenges to be addressed; what are the key objectives to be achieved over the coming year; and how will progress be demonstrated.

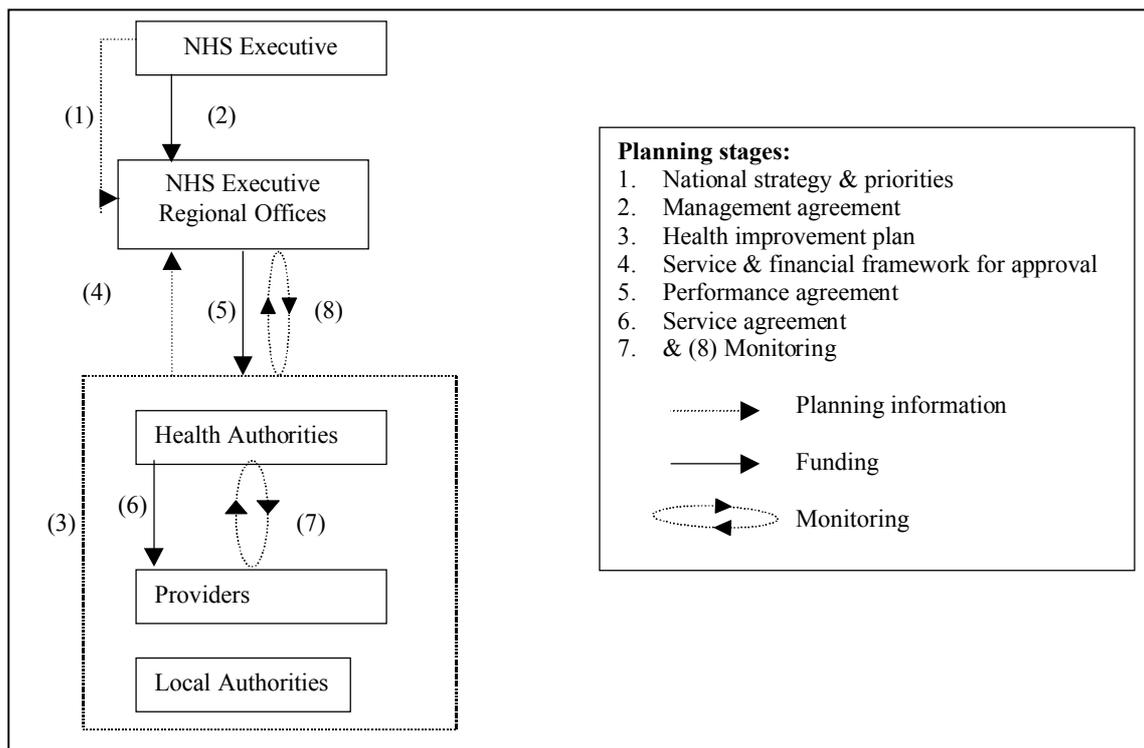
INTERNATIONAL DEVELOPMENTS IN SERVICE PLANNING

In this section of the report the key findings from a review of the literature on service planning are outlined. Two broad themes are presented aimed at key issues identified during the course of the study. The first looks at the overall framework for service planning by comparing the Irish framework (outlined previously in Figure 1) with that in England and New Zealand. (In the English case, the documentation reviewed specifically related to service planning in England. Similar arrangements are in place in Scotland, Wales and Northern Ireland). This gives a useful international perspective on the context for service planning. Second, given the current emphasis on the development of performance indicators both in Ireland and internationally, the development of performance indicators across a range of countries including England and New Zealand is investigated.

6.1 Service planning in England and New Zealand

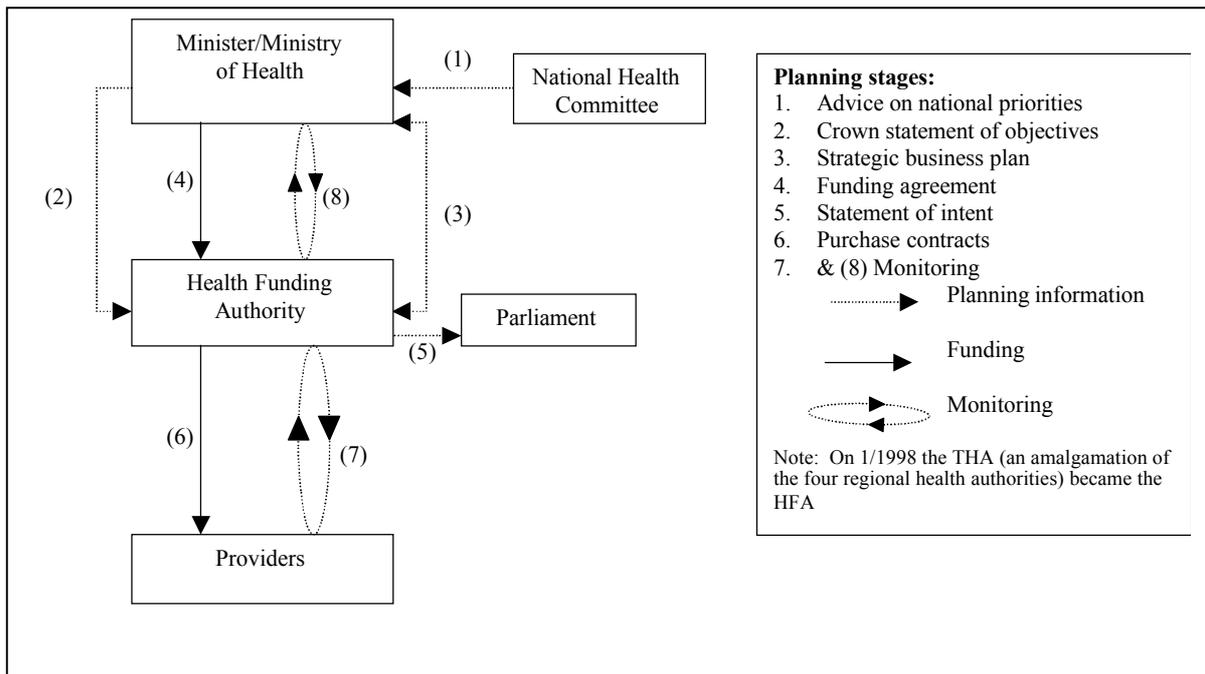
The framework for service planning in England and New Zealand is not unlike that in Ireland, the main differences between them and Ireland being the relationship between purchasers and providers, and payments at the point of delivery. An outline of the framework for service planning for both countries is provided in Figures 4 and 5. The two countries are used here firstly because of their comparability with Ireland in terms of their planning frameworks, and secondly because of the availability of up-to-date information on service planning.

Figure 4: Service planning in England



Source: Health Service Circulars 1998-1999

Figure 5: Service planning in England



In England and New Zealand a purchaser/provider split has been pursued over recent years, aimed at enhancing accountability. More recently in England, the emphasis on competition among providers has been replaced with an emphasis on co-operation. Both systems are now built around devolution of responsibility for planning within a set regulatory framework. This approach is aimed at shifting the focus from inputs to outputs, thus providing an emphasis on results while leaving room for innovation.

In England recent developments are also aimed at matching national priorities for health improvement with local needs for health and personal social services. The key elements in service planning in both systems are identified in the section.

6.1.1 Central strategic direction

One of the issues raised in the findings in the Irish system was the role of the Department of Health and Children in providing strategic direction and ensuring overall coherence in service planning. In New Zealand the Ministry of Health provides the strategic direction for the development of health services. It receives advice on national priorities from the independent National Health Committee. The Ministry of Health (1998) outlines its strategy to develop the health and disability sector, focusing on five strategic result areas (SRAs). A number of projects are aimed at improving the Ministry's role in providing strategic direction for the sector including:

- the provision of quarterly advice on developments in the health sector, particularly focusing on five policy areas
- national policy development
- organising a national health goals conference
- work on regulatory reform.

The Crown Statement of objectives issued each year to the Health Funding Authority (HFA- since 1997 an amalgamation of the four regional health authorities) outline the Government's overall objectives for the sector and the performance expected of the HFA.

In England the role of the National Health Service Executive (NHSE) is to provide clear strategic leadership to health authorities and NHS trusts to enable them to secure the greatest possible improvement in physical and mental health through the resources available. Its leadership role includes providing the strategic framework for health service development, disseminating knowledge and information, and managing the NHS to ensure that national policy is implemented. Each year the NHSE plan provides an overview of the external factors affecting demand and the likely impact on services, and in-year priorities for the NHS contributing year-on-year to longer-term strategy and key objectives. *NHS priorities and planning guidance* are issued to health authorities (HAs) and the NHSE's business plans draw on the annual NHSE plan.

6.1.2 Linking service provision to needs assessment

The findings outlined in section 3.2.3 suggest that the place of needs assessment in service planning needs to be developed towards achieving health and social gain. Two aspects of matching services to local needs are to be found in developments in England and New Zealand over recent years.

1. Strategic service planning at the local level

The recent requirement of Health Authorities in England to produce health improvement programmes (HIImPs) (1999/2000) is aimed at providing a bottom-up approach to strategic planning to complement the central strategic direction provided by the NHSE. HIImPs are to provide a shared statement of local response to national priorities and targets. HIImPs will be based on the health authority's assessment of local needs working with primary care groups, NHS trusts, local authorities and other local interest groups and will include action plans to address issues raised.

2. An emphasis on equity in the distribution of resources

In New Zealand resource allocation between the four HFA divisions is based on the *population-based funding formula* (PBFF), which is based not only on the size of the population but also on some of the key health-related characteristics of each population. It is reported that there is now equity among the four divisions after many years of concern to address known inequities between the Southern region and the other three regions. Health policy specifically identifies the need to tackle known disparities between Maori and non-Maori health outcomes.

In England funding is allocated to districts on the basis of weighted capitation to try to ensure equity in the distribution of services. The formulae used are based on the Resource Allocation Working Party (RAWP) formula developed in 1979, which was modified considerably in 1990 and again in 1995. Allocations made to each health authority are published each year, including a breakdown by area of service. More recently the introduction of Health Actions Zones is aimed at a cross-cutting approach to reducing known inequalities in health by targeting particular geographical hot spots.

6.1.3 Matching planned provision with allocated resources

One issue raised in our findings in the Irish system was that in order to be able to produce the service plan within the tight time-frame required once the letter of determination was received, development of the service plan needed to begin much earlier in the year. However, planners found this difficult, as allocations were not certain until the health board was formally informed in the letter of allocation. Some respondents also raised the issue of how resources allocated reflected regional/local priorities. One major difference between the two countries and Ireland in the annual planning cycle is that in England and New Zealand an outline of the year's planned provision is approved before funding is agreed.

The emerging English system requires health authorities (HAs) to submit *service and financial frameworks* (SFFs) to the NHSE regional offices before performance agreements are drawn up between the NHSE and the HA. The SFFs provide the link between local and national priorities and between immediate and longer-term priorities. They take into account anticipated allocations and require wide consultation with professionals and the public. According to the NHSE (1997) the SFF has a role in securing early decisions on the broad framework for the year, and should settle any strategic issues in good time in order to ensure time to resolve constructively the detailed issues on service agreements with providers. The SFF, once received, will be evaluated by the NHSE regional office to ensure that it is consistent with national priorities and targets and is acceptable as the basis of corporate contracts between the HA and the NHSE regional office:

[The SFF] should provide all parties with a clear overview of the services planned for the health authority population in [the year], the resources available for them and the priorities that will be followed if it proves necessary to modify plans to reflect changing circumstances (NHSE 1997, p5).

The 1999/2000 accountability framework required the HFA to be issued with the Crown Statement of Objectives (CSO) by 30 September 1998, and in response to produce by 31 March 1999 its strategic business plan. The Ministry contributes to the development of the strategic business plan and was required by 30 June 1999 to agree the funding agreement based on the strategic business plan and the CSO. The HFA then publishes its Statement of Intent.

6.1.4 Moves towards multi-annual budgeting

As previously stated (3.2.6) the department has indicated to boards that a multi-annual approach to service planning will be required in the future in the context of the move to multi-annual budgeting. Service planning in England and New Zealand, like that in Ireland, involves an annual planning/purchasing cycle between the centre and regions, within a wider strategic framework. While there are no explicit plans highlighted in the literature to move away from this annual cycle, there are suggestions of a more flexible approach to planning arrangements between health authorities/the HFA and providers.

In England, longer-term agreements are currently being introduced between HAs and providers on a phased basis. Their introduction is aimed at reducing bureaucracy and refocusing clinical and management effort on quality and cost-effectiveness. They are directed at reflecting longer-term arrangements among HAs, primary care groups and NHS trusts and on developing a shared view of the outcomes of care needed.

In New Zealand, the range of contracts between the HFA and providers includes annual contracts, multi-annual contracts and contracts set up as and when needs or opportunities arise during the year.

6.1.5 Clear monitoring and accountability arrangements

One issue raised in the findings on service planning in Ireland was that monitoring of service plans needs to be strengthened to ensure that allocated funding is used to provide appropriate and effective services. One key finding from the review of service planning in England and New Zealand is that lines of accountability and systems to monitor performance have been clearly defined through recent reforms. As previously stated health planning in England and New Zealand is based around devolution of responsibility for planning to health authorities at regional level within an explicit regulatory/accountability framework.

Key features evident in the two systems included:

- a. *There are specific lines of accountability following funding pathways.* That is, the HFA/health authorities are responsible for monitoring the performance of providers and the HFA/health authorities in turn are monitored by the Ministry/NHSE, with whom they have funding contracts/management agreements.
- b. *There are regular formal arrangements for reporting and the return of management information to demonstrate performance.* In New Zealand the HFA is required to report monthly on financial management and quarterly on other areas of performance. The key accountability document is the funding agreement which contains a number of performance measures and a service coverage schedule.

In England health authorities are required to provide central data returns on a monthly, quarterly or annual basis. Required data are generally organised into datasets and standardised as *central returns*. Data collected centrally is reviewed every three years to assess its current value in the light of the cost of collection.

c. *Among the range of published reports required each year is an annual report.* In England health authorities are required to publish each year an annual report describing performance over the previous year, an annual report of the Director of Public Health, and an annual report on performance against Patient's Charter rights and standards. Health authorities are also required to publish a five-year strategy document and are required to make available on request annual purchasing plans and contracts with providers.

- d. *There is a particular emphasis on the development of performance indicators.* England and New Zealand are among a number of countries moving towards the development of national performance indicator systems. The development of performance indicators is discussed in more detail in the following section.

6.1.6 Conclusion

Four key points are highlighted by comparing service planning in Ireland with that in England and New Zealand. The first point relates to the requirement in Ireland to produce annual service plans within a strategic approach to service planning. This is not unlike the approaches in England and New Zealand where an annual purchasing/funding round of negotiations and agreement takes place within a strategic framework. A top-down approach is taken in New Zealand where national priorities are identified by the independent National Health Committee and disseminated by the Minister of Health to purchasers. In England recent reforms are aimed at providing both a top-down and bottom-up approach to identifying strategic priorities.

The second key point relates to the allocation of funding between health authorities/purchasers. As shown in the systems in England and New Zealand formulae are used in an attempt to match allocations with differences in assessed need.

The third key point relates to matching key priorities with resource allocation. As shown in this review, arrangements for service planning in England and New Zealand allow the priorities for service provision to be agreed before funding is allocated.

The fourth key point raised is in relation to monitoring in the service planning process. As shown there are clear arrangements in both systems for monitoring between the centre and purchasers and between purchasers and providers. The approach includes clear lines of accountability, the requirement to produce annual reports and to make other planning documents available on request, and to return data on performance. However, what is not clear from the literature is how such returns and reports are required to reflect the key objectives outlined in planning documents are opposed to centrally set targets and indicators.

6.2 The development of performance indicators

As previously reported monitoring of service plans needs to be strengthened. The development of performance indicators is very much in its infancy. The Committee for Public Management Research has approved another study focusing on performance measurement in the local government and health sectors which is currently under way. Nonetheless, the terms of reference for this study agreed that a particular emphasis would be given to enhancing the evaluative capacity of service plans. We have raised a number of issues on the availability of good management data, monitoring and evaluation and reporting systems both within health boards and between boards and the department. We have identified the essential characteristics of good practice in performance indicators. In the following section the development of performance indicators is set in the context of performance indicator development internationally and some of the issues are identified. Recommendations made on the basis of experiences to date are presented.

6.2.1 International moves in the development of performance indicators

The World Health Organisation (1998) clearly places performance measurement centre stage in the development of decentralised strategic planning systems for health services in a number of countries:

Traditional centrally-driven masterplans are increasingly being replaced by strategic planning frameworks that feature greater flexibility to allow local priority setting while at the same time imposing more realism with regard to available resources. Ministers need better information, new skills and new tools with which to map and work with divergent pressure groups and partners ... performance monitoring and audit are central features of these new approaches (WHO 1998, p1).

Jee and Or (1998) report that countries are now as concerned about maximising health as they are about cost containment and that the concept of effectiveness is high on the health care agenda. Sheldon (1998) suggests that the emergence of performance indicators is the result of 'new public management' requiring organisations and people to be accountable and to set down 'benchmarks for the legitimacy of organisational action'. Buchan (1998) states that those providing resources want measurable proof of the quality of services and the push towards performance indicators has resulted from the need to demonstrate value for money and measurable ways to assess the quality needed. In addition she refers to recent 'quality failures' which have resulted in media and public pressure for accountability and openness about performance.

In the UK work began in 1982 on developing a package of performance indicators for regions, districts and units. More recently a national set of high-level performance indicators were road-tested in 1998 and are currently being implemented. As high-level indicators they are aimed at providing a more rounded assessment of performance. It is planned that later more detailed and comprehensive indicators will build on them. The high-level indicators are aimed at assessing performance in terms of quality and efficiency, and encouraging benchmarking among health authorities, trusts and primary care groups. The initial set of indicators is based on six specific aspects of health care provision - health improvement, fair access, effective delivery of appropriate health care, efficiency, patient/carer experience, and health outcomes of NHS care. A seventh area on human resources was proposed during the consultation process and will be followed up later. The high-level performance indicators will allow comparisons to be made on three dimensions: by population group, by condition/client group and by service organisation. In addition in the UK, the Department of Health's Clinical Accountability and System Performance Evaluation research group (CASPE) is developing health outcome indicator sets for ten conditions. Leatherman and Sutherland (1998) suggest that performance indicators can provide an important link between the strategic and the operational.

In New Zealand a nation-wide performance indicator system is currently being developed. Borman and Wilson (1998) report that the Health Funding Authority had recently selected ten national integrated care demonstration projects for the development of collaborative provider performance frameworks. They also outline for discussion a range of potential performance indicators across a range of healthcare settings. These 'draft' indicators draw on key Ministry of Health reports to identify health issues of particular relevance to New Zealand. In addition, in the current service planning framework in New Zealand, a number of performance indicators are included in funding agreements as the key accountability document between the HFA and the Minister of Health. Areas covered include outcomes for better health, a people-centred approach, improved safety, equity, effectiveness, efficiency and financial and risk management.

The Australian Council on Health Care Standards' (ACHS) Care Evaluation Program (CEP) is aimed at developing objective measures for the management and outcomes of patient care in acute health care organisations. Currently there are about sixteen indicator sets in use for the ACHS's accreditation programmes. The indicators are being developed in collaboration with medical colleges and associations. The national Hospital Outcomes Program is aimed at the development of a set of nationally consistent indicators for acute hospital services. A study by Boyce et al (1997) recommends the development of a core set of indicators supplemented with modules for specific services. They identify eight dimensions of quality of care for performance indicators: access, efficiency, safety, effectiveness, acceptability, continuity, technical proficiency, and appropriateness. They also identify a set of essential attributes of indicators by which to assess the potential utility of performance indicators for a nationally consistent quality and outcome indicator set.

In the USA several organisations are involved in the development of performance indicators such as the Joint Commission on Accreditation of Healthcare Organisations (JCAHO) Indicator Management system; the National Committee for Quality Assurance (NCQA) Health Employer Data and Information Set; the Maryland Hospital Association Quality Indicator Project; Consortium Research on Indicators of System Performance (CRISP); and a number of others (Boyce et al 1997).

6.2.2 Defining performance indicators

Wilson (1992) using JCAHO material outlines a number of distinct features of indicators. Firstly he suggests that indicators are always a number - a quantity that tells us something about quality:

Indicators without a structured numerical context are mute; without one or more comparators, they say nothing (Wilson 1992, p50).

The second point made by Wilson is that indicators are signals that provide a quick look at the bottom line and their meaning is not clear until the underlying factors are unearthed through further investigation. The documentation around the National Performance Assessment Framework in the UK states clearly that the high-level performance indicators currently being developed are meant not as direct indicators of quality but to flag up areas of concern for further investigation.

Thirdly, Wilson (1992) suggests that indicators are of two kinds - sentinel events and rate-based indicators. *Sentinel events* are single, highly significant events such as a death, a fire or a lawsuit, requiring immediate investigation. *Rate-based indicators* are monitored more regularly for variation from their mean or norm.

Fourthly, Wilson suggests that indicators can be positive or negative. Thus they can focus on desirable events as well as adverse events.

6.2.3 Using indicators effectively

A number of issues are raised in the literature about the use of performance indicators (Buchan 1998, Sheldon 1998, Leatherman and Sutherland 1998). They include:

- A focus exclusively on the measures and the associated methodological problems fails to consider the critical issue of how people and the organisation in which they work react to data.
- Tensions may exist between approaches promoting blame-free recognition of error and those requiring public accountability.
- The use of performance indicators may upstage existing quality promoting activities, which are effective despite their informal status. There is also the perceived danger that performance indicators will replace current values with abstract managerial ones.
- There may be unintended consequences to the introduction of performance indicators, such as a focus on improving quality in measured areas at the expense of quality in areas not measured, or focusing on this year's indicators at the expense of longer-term issues.
- The inability of macro indicators to reflect micro issues. For example, the focus of performance measurement might be on the number of procedures performed. However, this measure does not reflect appropriateness, equity or the quality of procedures.
- Indicators may result in a focus on the negative or outlying performers rather than on the positive.
- Publicly available performance indicators may encourage providers to focus on producing information that looks good rather than reflecting good patient care. Also information that matters to patients may be different to that that matters to clinicians or budget holders.
- Considerable resources are needed for the collection, analysis and reporting of good comparative data if performance indicators are to be used effectively.
- There may be a jaundiced view of performance indicators because previous ones tended to focus on cost and resources as opposed to quality of care.
- There may be dysfunctional side-effects to performance indicators such as fear of or feelings of loss of control on the part of professionals, inappropriate use of performance indicators and an overemphasis on measurement at the expense of curiosity and learning.

- As most data is defined, recorded and coded locally it is open to manipulation. There is also the danger of deliberate underachievement intended to imply steady and continued improvement.
- Interpreting findings is difficult due to the number of variables involved and due to case-mix variations among comparators. In addition, adverse results may reflect past rather than current performance.

The issues raised do not suggest that performance indicators should be abandoned but alert us to considerations to be taken in their use. Boyce et al (1997) conclude that the benefits of having a national quality indicator set would include enhanced accountability, the availability of information to guide consumer choice, and clear incentives for quality improvement. However, for the benefits to be realised, a careful approach is required in developing and implementing performance indicators. Most of all they recommend that in order for indicators and indicator systems to be credible and to have real value in decision-making, they should be comprehensive, collaborative, consumer-focused, current and cost-efficient.

Based on his interpretation of international experience with performance indicators, Sheldon (1998) also recommends caution and that performance indicators should be integrated and co-ordinated with other approaches to quality improvement such as evidence-based practice. For example, performance indicators must be consistent with clinical guidelines. In Australia, the National Health and Medical Research Council is currently developing guidelines for care in particular clinical conditions. Boyce et al (1997) suggest that these could be converted into quality indicators.

Leatherman and Sutherland (1998) claim that there is evidence that the use of performance indicators can change behaviour but it is important to 'get it right'. They advocate a 'blended approach' - a mixture of top-down and bottom-up, which although it is more difficult to organise and manage is necessary for 'political viability and content stability'. They claim that for the construction of robust performance indicators, the expertise of clinicians and managers must be balanced with the unique insights of the patient.

Wilson (1992) proposes three key principles for performance indicators:

1. The use of performance indicators must contribute to quality improvement.
2. Performance indicators must focus on results or outcomes of care.
3. Performance indicators must be validated and piloted.

On this last point, in the UK data collected centrally in the NHS is subject to a review and approval process that requires every set of data to be reviewed every three years to ensure that the information gained justifies the cost of collection.

6.2.4 A national indicator programme?

Boyce et al (1997) set out their rationale for the development of a national quality and outcome indicator programme. They suggest that such a programme should not impose an unacceptable burden of collection on providers, that it should be at reasonable cost to the community and that it should not create incentives for undesirable behaviour by providers. It should allow quality and outcomes data to be compared with the confidence that the data is collected consistently across the system. Boyce et al suggest that this should encourage benchmarking. They anticipate that there would be economies of scale in the development of indicators at a national rather than an individual level, that national indicators would enable prioritisation of quality improvement efforts, and that they could encourage providers to direct their attention to national health goals and targets.

In terms of the nature of indicators used, Boyce et al suggest that:

- National indicators should incorporate quality issues relevant to patients and purchasers of care.
- They should be compatible with internal quality review, external accountability and informing consumer choice.
- The development of performance indicators should be accompanied by parallel projects to test and review performance indicators themselves.

6.2.5 *Prioritising indicators*

Jee and Or (1998) report that a group of national experts on health statistics agreed that the highest priority should be given to the development of indicators directly linked to health policies and interventions. They proposed that indicators selected at national level should reflect health problems of major concern and areas involving substantial resources and burden of disease; and that indicators should be sensitive to quality of care differences. From this they suggest that countries should move towards the development of a core set of performance indicators for areas representing the greatest burden in terms of disease, disability and quality of life. They also recommend international comparisons based on a family of performance indicators for selected conditions causing high premature mortality across countries.

At operational level, Wilson (1992) suggests important indicators need to be differentiated and prioritised from those that do not add any value to the process. He identifies four categories of indicators to help managers to choose among the hundreds available to them.

1. *Risk indicators.* These are described as priority one. They are always important and must be recorded and reviewed as early as possible. Patient deaths, fires, crimes and wound infections are given as examples.
2. *Leading or key indicators.* These are described as priority two, are always important and are highly sensitive and indicative of a department's performance. Wilson suggests that such indicators should be recorded and plotted on a monthly basis. Number of grievances, length of stay, surgical cancellations, and sickness/absence rates are given as examples.
3. *Descriptive indicators.* As priority three Wilson describes these as useful but he points out that they become important when their values change significantly. He suggests that they are not important enough and are too expensive to report regularly but may be generated when specifically relevant.
4. *Dispensable data.* This is data that is of questionable or no value and should not be collected. While it may be useful to management or relevant in the context of an audit, as stand-alone data it tells the department nothing.

6.2.6 *Conclusion*

A review of the international literature on the development of performance indicators (PIs) suggests that there are clear benefits to developing and using PIs but a cautious and well-planned approach must be taken. The interest shown in the development of PIs across a range of countries is central in moves towards devolution of responsibility for health service planning to provide more flexibility at local level, within a clear accountability framework. It is consistent with a growing emphasis on results across a range of concepts of effective health care provision within the resources available.

The key messages emerging on the development of a PI system are:

- PIs should be developed through a mixture of top-down and bottom-up approaches;
- clarity is essential in terms of what is meant by performance indicators, how they should be used and their limitations;
- a number of potential issues should be considered before a PI system is implemented, including the likely impacts of the system on existing and effective mechanisms to manage performance and the likely impacts on those working in the system;
- the measures selected should provide a valid and balanced indicator of performance in terms that have real meaning for those using and working in the system;
- PIs are not stand-alone and they need to be integrated with other approaches to improving performance and to reflect current understandings of good practice;
- the benefits of PIs should outweigh the cost of data collection and it is important to be selective in what is monitored and regularly to review data collected.

CONCLUSIONS AND RECOMMENDATIONS: TOWARDS A FRAMEWORK FOR SERVICE PLANNING AND THE SERVICE PLAN

This study has examined the service plan within the overall context of service planning in the Irish health sector with a view to recent international developments in service planning. The service plan has a central role in: ensuring health services are well planned in terms of the provision of appropriate, effective and equitable services; enhancing accountability and transparency in the health sector; and establishing the principles of strategic management in health boards and agencies.

Our main findings are that there are clear benefits to the requirement of health boards to produce service plans but that further development is required for the service plan to reach its full potential as a strategic management tool. Our research found examples of good practice and also identified issues to be resolved in order to further advance service planning. A number of recommendations are made in the following section based on our research findings. Firstly recommendations are listed based on service planning in its broadest sense. Secondly the recommendations focus specifically on the service plan.

7.1 The development of a strategic approach to service planning

The service plan must be seen within a strategic approach to service planning overall. Within a strategic framework the service plan draws on the organisation's longer-term objectives, ensuring that services are moving progressively towards what needs to be achieved, but also captures significant changes occurring during the year. The service plan is also the key link between the strategic and the operational. Thus the service plan within the strategic context provides a structured approach to service development. The plan is aimed at meeting regional/ local needs and increasing health and social gain.

7.1.1 Strategic aspects of service planning

In order to ensure that there is coherence in service planning between and within health boards and the department, clarity of roles is required and both the department and boards need to ensure that they have the skills and competencies to fulfil their roles in a strategic approach to planning. The department has a key role in providing strategic direction, co-ordinating service planning, and overseeing the development of service planning in boards, agencies and the department. There is a consequent need to further develop skills and competencies in strategic leadership and performance management. Boards need to ensure that they have the appropriate structures, processes and clarity of roles to support a strategic approach to service planning and for effective communication. Particular skills and competencies to be emphasised here include strategic planning, environmental analysis and needs assessment, prioritising and target-setting, information system development, leadership and performance management. The Office for Health Management and the Institute of Public Administration have a role to play here in supporting management development, including service planning.

Service planning should begin with a comprehensive assessment of needs and an analysis of the weaknesses and gaps in the current range of services provided to meet the needs identified. This will require a stronger focus on analysis in service planning and the development of current information systems. Equity and equality need to be key considerations.

Boards need to prepare for the proposed introduction of multi-annual budgeting in the health sector. This will allow them to align their medium-term strategies with national priorities. It will enable capital, revenue and human resource allocations to be integrated into a three- to five-year planning cycle, with boards picking off each year what is achievable for inclusion in the service plan.

It has previously been suggested that the annual service planning cycle tends to focus on new service developments. However, consistent with a strategic approach to planning, the service plan should incorporate the service as a whole, that is, both core and new services. The emphasis must be on how the total range of services meets local needs and on opportunities to realign services.

7.1.2 Operational aspects of service planning

The department, boards and agencies need to ensure that structures and processes support effective communication. Ongoing and effective communication is required between the department and health boards so that the allocation of funding matches board priorities. As identified in the developing framework for service planning, boards and line divisions should be working together to identify the key priorities to be addressed in the service plan well before the letter of determination is issued. Ongoing communication is required for the department to fulfil its role in providing strategic and policy direction for health boards and to ensure coherence throughout the health system. In particular, feedback to health boards on service plans needs to take place through regular meetings between line divisions and health boards, rather than through the annual service planning meeting currently relied on. Within the department, effective and ongoing communication is required among divisions to ensure a corporate and holistic approach to developing the range of services funded.

In service planning, effective communication is required among stakeholders to encourage ownership, to increase the success of implementation and to provide information on the issues at ground level to inform planning. The findings suggest that boards need to consider carefully how they are going to manage the consultation process and allow sufficient time for consultation in the various stages of the planning cycle.

The findings from the study also suggest that health boards and agencies could work together better to share ideas on good practice, to pool their efforts on the development of service planning and performance measures, and to ensure coherence in service planning. It is also suggested that better collaboration could help to reduce duplication in service provision.

The joint department/health board service planning group has a central role in the development of service planning and in issuing guidelines to ensure that everyone is working to the same model of service plan. The emphasis in guidance needs to be on the process of service planning and evaluation, and on the provision of a common framework for the service plan. Guidance needs to clarify the place of the service plan in the overall planning process and how it relates to other documents such as operational plans and the annual report. Guidance also needs to include feedback to health boards on gaps and weaknesses and examples of good practice in service plans. A balance is required in the guidance between being too broad and generic, and being too prescriptive.

The legislation-enforced time-frame for completing the service plan once the letter of determination has been received, and for reviewing and accepting the service plan, is troublesome for both health boards and the department. To minimise the effects it is important that the service plan is well advanced before the letter of determination is received.

7.1.3 Accountability aspects of service planning

The findings suggest that the monitoring and evaluation aspect of service planning needs to be strengthened, both to inform the identification of priorities for the service plan and to enhance accountability. This requires the establishment of clear lines of accountability among the department, health boards and agencies, with specific arrangements for regular reporting of performance information. The service plan needs to become the benchmark against which progress is monitored on an on-going basis both within health boards and between health boards and the department. In this context the role of the annual report in monitoring and how it relates to the service plan needs to be clarified.

A clear framework is required for the evaluation of the effectiveness, efficiency and quality of services, which is co-ordinated within health boards and overseen at national level by the Department of Health and Children. A co-ordinated approach led by the department is required to define performance data which allow comparisons to be made over time and among health boards, and which focus on outcomes, quality and effectiveness. Specifically relating to the move from programmes to care groups, the department in its co-ordination role needs to ensure that boards are developing care groups along comparable lines to support and facilitate monitoring and evaluation.

7.2 The implications for the service plan

The service plan needs to be seen as an integral part of the work done by the department and health boards/agencies, and needs to be developed as a management tool central to the whole approach to planning. A number of particular findings from the study with regard to the service plan are worth highlighting:

- a. In order to further advance the development of service planning, the role of the service plan needs to be clarified in terms of its purpose, how it should be used and what it should contain.
- b. The service plan should provide a high-level overview of the quantum of services to be provided for the coming year in the light of changes in needs, progress made and challenges met in the previous year. It should draw on high-level policy and be supported by operational documents. As such, the level of detail required should reflect its high-level status and its link between the strategic and the operational. Key objectives for the coming year should be included along with meaningful indicators to enable the board to monitor progress and to demonstrate what has been achieved.
- c. The service plan should refer to the progress made against the objectives set out in the service plan for the previous year, in tangible and meaningful terms. It should draw on the detail provided in operational plans.
- d. The key elements of a service plan include:
 - an outline of the board's mission/vision indicating its identity and direction in the context of the people it serves;
 - a succinct review of the board's current position against the objectives outlined in the previous year's service plan;
 - the current strategic issues to be addressed by the board;
 - key priorities for the coming year;
 - the key objectives for the year in clear and measurable terms; and

- explicit arrangements for ongoing monitoring of the board's progress over the year and for the evaluation of the effectiveness, efficiency and quality of new and existing programmes.

7.3 Concluding comments

In this discussion paper the central role of the service plan as a strategic management tool is outlined, along with a range of issues currently facing service planners. The findings strongly support the benefits of the service plan but also suggest that service planning needs to be further developed over the coming months and years. Looking to further developing the service plan within a strategic approach to service planning, six key areas can be identified on which activity can usefully be focused:

1. needs assessment and analysis;
2. monitoring and evaluation, including the development of performance indicators, standardised data definitions, compatible data collection infrastructure, and the annual report;
3. operational and business planning, and multi-annual planning;
4. communication;
5. collaboration between health boards and agencies to share good practice; and
6. the development of comparable care groups.

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Appendix 1

Participants in the study

1. Health Boards - chief executives and individuals involved in service planning
2. Members of the Joint Department of Health and Children/ Health Boards Service Planning Group
3. Individuals involved in service planning within the Department of Health and Children - including line divisions, finance, planning and information management units
4. Members of the ERHA taskforce