Towards Better Health Care: Planning in Health Boards

Volume III

THE DEPARTMENT OF HEALTH

July 1971

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July 1, 1971

Erskine Childers, Esq., T. D.
Tánaiste and Minister for Health
Custom House
Dublin 1

Dear Tánaiste:

The accompanying report Towards Better Health Care: Planning in Health Boards is intended to guide management teams in Health Boards in the development of plans to meet priority health care needs over the next few years.

Better planning is the major administrative need in the Irish Health Service. The increasing pressure on resources as needs increase, for example, with the rising proportion of aged in the population, as demands increase, for example, with the population raising its minimum acceptable standard of health care, and as costs inflate, ensures that money and staff required will always outstrip what is available.

Therefore, those in the health service must ensure that (1) health care gets the maximum proportion possible of the national budget and, (2) resources that are made available are spent where and how they can do most good. Competent planning serves both these ends. By evaluating the current satisfied and unsatisfied needs in health care and by demonstrating how resources can be used with high impact, planning enables the Minister and his Department to make a strong case (in political and economic terms) when competing for available funds. By identifying and allocating the funds only to the highest priority projects and by checking that existing expenditure continues to serve a high priority need, planning ensures that resources consumed by health care have the greatest possible impact.

The technique of planning that we recommend is programme planning. The report outlines how a management team should assess the situation it faces and develop a comprehensive plan for the Health Board's area. After formal review

and approval by the Health Board and the Department of Health, the plan becomes the management team's main tool for monitoring its own progress and for providing the framework for future plans. The report is in four sections:

1. Subprogrammes for planning. The three programmes - community care, special hospital care and general hospital care - are too broad in scope for detailed planning. Therefore, in Chapter 1, we describe the subprogrammes that should be used for planning. Dividing each programme into subprogrammes enables management to focus attention in planning on the needs of manageable target groups.

2. Setting objectives. It may sound trite to say that the first step in planning should be to set objectives - i.e., to state what is to be achieved for identifiable patient or population groups. Nevertheless, in our experience, time spent on this first step in planning is time well spent because objectives, once set, tend to influence strongly the commitment of resources in the future. For example, a decision to provide for in-hospital delivery for all mothers-to-be who want it (as opposed to providing for a significant proportion of domiciliary confinements) would be a major determinant of future maternity costs.

Therefore, the first section of the report describes how to identify the target groups of people needing health care and how to set objectives for meeting their needs.

3. Determining priorities. The scarcity of resources ensures that all objectives cannot be pursued with equal dispatch. Therefore, the report describes how to quantify and analyse care needs to give management the perspective required to judge its priorities for action and for the allocation of resources - i.e., to decide which needs should be satisfied and which needs should remain unsatisfied.

Unless priorities are consciously determined, resources and time tend to be allocated on the basis of 'more of the same'. In other words, existing services continue largely unchanged and additional resources are allocated in proportion to previous years' spending. As a result, it becomes very difficult to allocate or reallocate resources to where they can do most good.

4. Producing plans. The final section of the report describes how to decide on and map out a plan of action within a Health Board to satisfy priority health care needs within pre-determined total spending limits for capital and revenue over the next 5 years.

Developing plans in the degree of detail we envisage will take a number of years as the systems and experience are built up. Nevertheless, even going through the planning process the first time, it should be possible to pick out and attack the major opportunities facing each Health Board.

You will see that we have made use of examples in the report. They are purely illustrative and are not intended to be taken as recommendations. For example, in Chapter 3 we have used specific standards of provision in describing the use of programme definition statements. In fact, the development of standards of provision is a major task needing extensive further work by your Department, the Health Boards and Regional Hospital Boards.

Finally, any planning system needs to be reviewed and updated in light of experience. The magnitude of the changes currently taking place in the Irish Health Service makes it particularly important to monitor the progress of the new systems and to incorporate the results of experience into them. (Appendix C in the report summarizes a suggested timetable for phasing in planning and control).

* * *

We are grateful for, and have enjoyed, the opportunity of this further work for the Irish Health Service. We look forward to seeing the results of the hard work of the many who have worked with us culminating in better health care.

Respectfully submitted,

McKinsey & Company, Inc.

1 - PM — To identify the major priorities of the programme
    DCC — To assess and agree priorities for health care needs and services in the community with the P.M. CC.

2 - PM — To develop and cost plans for the services within his programme
    DCC — To develop targets and plans for services in the community

3 - PM — To ensure that plans, when agreed, are put into operation appropriately
    DCC — AS ABOVE

4 - PM — To initiate action for the reallocation of resources in response to changes inside and outside the programme
    DCC — To follow up and report on performance of services

5 - PM — To establish a high level of efficiency in the services provided in the programme, consistent with his objectives for developing professional and administrative staff.
    DCC — To establish a high level of efficiency in the services in his community

6 - PM — To enhance the effectiveness of his officers & their staff
    DCC — To enhance the effectiveness of the [illegible] members of his

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1. Determine needs. priorities. resources.
2. Set objectives
3. Make plans.
4 Implement plans.
5. Evaluate progress
6. Reassess situation

CURRAGH CLINICAL CLUB

Dear Doctor,

Annual Dinner Dance: 16th December 1975.

I have been asked to inform you that your Annual Dinner Dance will take place on Tuesday, 16th December 1975 in the Officers' Mess, McGee Barracks, Kildare at 8.00 p.m. for 8.30 p.m.

Subscription for guests is £2.50 each

[redacted]

TOWARDS BETTER HEALTH CARE:

PLANNING IN HEALTH BOARDS

THE DEPARTMENT OF HEALTH

VOLUME III

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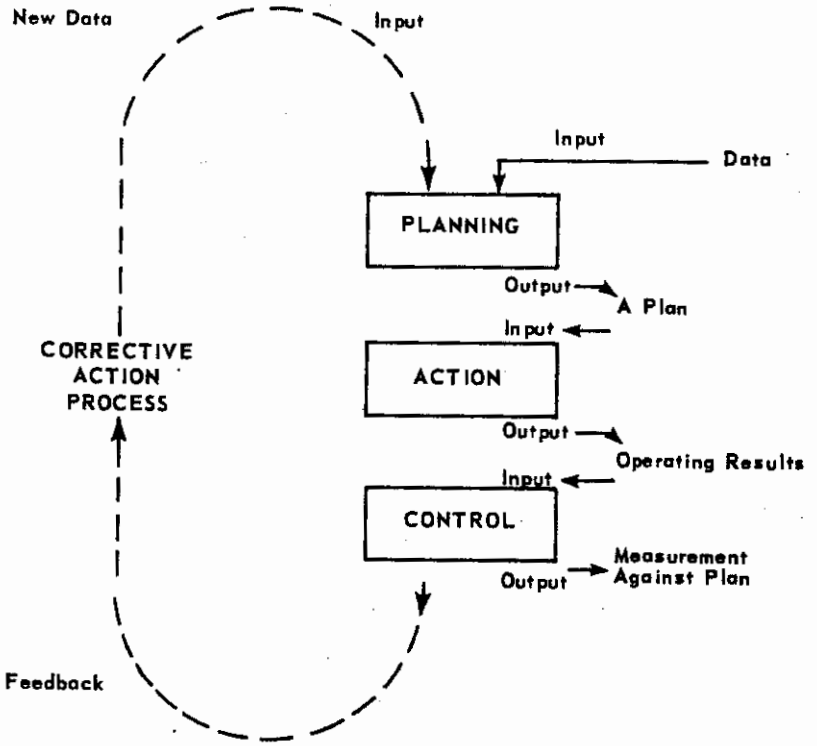
TOWARDS BETTER HEALTH CARE:

PLANNING IN HEALTH BOARDS

THE DEPARTMENT OF HEALTH

INTRODUCTION

Management is a continuous process consisting of three basic elements: deciding what to do (planning), doing it (action), and seeing whether the action taken has produced the desired results (control). The output from each element is the input to the next. Moreover, the process is repetitive in that the control information provides new data from which to base further planning, as illustrated below.



This report is directed to describing the planning aspect of management.

The purpose of planning health services is to maximize the improvement of health care. Improving health care implies change, so new planning procedures must emphasize change and the actions necessary to achieve it.

As health services grow more complex and the demands on limited resources become heavier, deciding on the right changes becomes both more difficult and more important. New planning procedures must therefore also provide a systematic and disciplined approach to change, to ensure that scarce resources are deployed in the best possible manner.

This report describes a systematic planning process, programme planning, that

- Focuses on target patient groups and their needs
- Determines what changes will best meet those needs
- Allocates resources to make those changes
- Spells out the responsibility and deadlines for taking action.

The report indicates initial steps that must be taken to get a new planning procedure under way. It then describes the comprehensive planning cycle by which the Health Board managers should plan the full range of a Health Board's activities for the following year and, in broader terms, for a further 4 years. In particular, it emphasizes the steps that programme managers must take to prepare plans for their individual programmes, since these plans form the basis for the final Health Board plan.

The planning process described in this report will be still more effective in improving health care if it generates, and then builds on, additional fringe benefits; for example:

- An improved decision-making process at all levels through more effective delegation
- Improved communications throughout the health service
- The coordinated effort, activity and development of all Health Board programmes.

The report presents illustrations of the planning process drawn from 'real life' situations based on field work in the Health Boards. Appendix A shows the entire process schematically. The report discusses it in detail in four chapters:

- ¶ Subprogrammes for planning in Health Boards
- ¶ Setting programme objectives
- ¶ Determining priorities
- ¶ Producing Health Board plans.

Effective management - "A system of decision making which works within a framework of clear objectives, which has a hierarchy of consistent and coherent priorities, and which allocates resources in a rational manner"

Essence of management = "Deciding what should be done + getting other people to do it."

Deciding what should be done (a) Planning and setting objectives.
(b) Organising available resources – human, material, financial.

Getting other people to do it. (a) Motivating and training staff.
(b) Controlling the fulfillment of the plan.

The 3 skills of management. Technical.
Human.

1 - SUBPROGRAMMES FOR PLANNING

1 - SUBPROGRAMMES FOR PLANNING IN HEALTH BOARDS

Planning in Health Boards requires management to be able to focus attention on manageable groups of needs for the population as a whole or for target groups of people. The three programmes - community care, special hospital care and general hospital care - are useful as a basis for the organization and for overall planning, but are too broad in scope for detailed planning. Thus, we have recommended that each programme be divided into a number of subprogrammes specifically for planning purposes. To avoid possible confusion later, it is worth emphasizing that subprogrammes are primarily for planning and are not intended to provide a basis for the organization of Health Boards below the management team, partcularly in community care (although in the hospital programmes there would in fact be a large degree of correspondence between the organization and subprogrammes if all our recommendations are implemented). Moreover, as explained later in this chapter, it is vital to recognize homogeneous services like GPs, dentists, X-ray, pathology, etc., and make additional plans for each of these groups to support the programme plans.

Thus, in this chapter we describe the subprogrammes that we now recommend, after several discussions with CEOs and the Department.

RECOMMENDED SUBPROGRAMMES FOR HEALTH BOARDS

Community Care	Special Hospital Care	General Hospital Care
Preventive health and community protection Mother and infant Children The Aged *The handicapped* General community care (not included in other subprogrammes) Overheads and administrative support services	Mental health Mental handicap Geriatrics Overheads and administrative support services	General medicine General surgery Obstetrics and gynaecology Paediatrics Orthopaedics Ophthalmology and ENT Infectious diseases Other regional specialties* Overheads and administrative support services

** - Other regional specialties may involve more than one subprogramme*

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Seol aon fhreagra chun:
(Address any reply to:—)

AN RÚNAÍ
(The Secretary),

ag lua na huimhir seo:
(quoting:—)

AN ROINN SLÁINTE
(Department of Health)

TEACH AN CHUSTAIM
(Custom House),

BAILE ÁTHA CLIATH 1.
(Dublin 1.)

Copies to Dr Brown, Mr O'Donovan, Dr Bergin, Mr Ell..., Mr Doyle, Dr O'Donnell & ...

12 November, 1971.

EASTERN HEALTH BOARD CHIEF MEDICAL 22 JUN 1972

Dear C.E.O.,

I notice that in Volume 4 of the McKinsey reports it is visualised that the Director, Mental Handicap Service, should work with voluntary organisations for the development of plans and will agree revenue and capital grants in regard to services for the mentally handicapped.

Health boards are, of course, concerned with mental handicap as many of the mentally handicapped are maintained in mental hospitals and the vast majority of those in voluntary homes are paid for by Health Boards. It is not, however, visualised that for the present Health Boards should deal with the general question of the development of services, or with the financial aspects of the voluntary bodies. In June of last year representations were made on behalf of a number of the voluntary bodies that there would not be sufficient representation for mental handicap interests on the Health Boards. The Minister intimated that it was not intended to make any change, for some years at any rate, in the administration of these services arising out of the establishment of the Health Boards. He agreed that the Department, and not the Health or Regional Hospital Boards, would continue to decide all such matters as extensions of the services, capital for new buildings and capitation rates and that, in practice, the new Health Boards and the Regional Hospital Boards would have no functions in any of these matters other than such functions as were previously exercised by Health Authorities.

As indicated in Dr. Hensey's circular letter of 30 September it is intended that there will be a discussion on the McKinsey report but I thought it well to let you know, in advance of that discussion, of the Minister's decision in regard to mental handicap.

Yours sincerely,

[signature]

Chief Executive Officer,
EASTERN Health Board.

SUBPROGRAMMES IN GENERAL HOSPITAL CARE

The subprogrammes in general hospital care should mainly reflect the different and definable needs to be found in each specialty in general hospitals. Thus, the subprogrammes should include

- General medicine
- General surgery
- Obstetrics and gynaecology
- Paediatrics
- Orthopaedics
- Ophthalmology and ENT
- Infectious diseases
- Other regional specialties, for example, neurology*
- Overheads and administrative support services not attributable to specific subprogrammes.

Specialty Subprogrammes

The specialty subprogrammes largely follow the 'firms' that already exist in general hospitals. However, a subprogramme should apply to the need for services Board wide and should not be thought of in the context of individual hospitals. Thus, for each subprogramme, the total need in the Board for beds, staff and support services (for example, X-ray, pathology) should be identified and compared with the existing resources for each subprogramme. Plans should then be drawn up, in light of needs and priorities, to provide services for the subprogramme in the best way. In particular, the contribution by each hospital should be decided in light of its ability to provide the required level and quality of services and recognizing demands by other subprogrammes on it. Similarly, the demands of the subprogramme for support services, like pathology, should be accumulated with the agreed levels of service for other subprogrammes to determine the provision of these support services.

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* - There may be a need to have separate subprogrammes for some of the 'other regional specialties' rather than including them all in a single subprogramme.

Overheads and Administrative Support Services Subprogramme

There will be a number of services and associated costs in the general hospital care programme that, unlike say X-ray and pathology, cannot be attributed to individual subprogrammes. In other words, decisions taken in light of specialty subprogramme needs do not have a quantifiable effect on this general overhead subprogramme. The exact boundary between attributable and non-atrributable services remains to be drawn in light of consultation on this report and experience in developing programme plans for Health.

The alternative to a general overheads subprogramme is to try to determine the need for these services and costs by allocating them on a fairly arbitrary basis (for example, total beds or total wages) to specialty subprogrammes. This has the disadvantages that the allocation in no way assists decision making for specialty subprogrammes and would tend to detract from the control of overheads in total.

SUBPROGRAMMES IN SPECIAL HOSPITAL CARE

The special hospital care programme was defined separately (and organized separately in larger Boards) because of the special attention that needs to be focused on these patients now. Moreover, they represent a serious problem in terms of economics as well as humanity because, once institutionalized, special hospital care patients have tended to remain as inpatients with low and undifferentiated treatment. But the treatment needs of the geriatric, mentally ill and mentally handicapped patients can be quite different. Therefore, we recommend a subprogramme for each.

Mental Health Subprogramme

The mental health subprogramme should encompass planning for all treatment of the mentally ill in mental hospitals, acute psychiatric wards of general hospitals and in the community including adults and children. The combination of community care and hospital care in this subprogramme is unique in our recommendations, but is justified by the need to move patients into hospital for short periods followed by treatment in the community or a day centre. Thus, with frequent discharge and readmission of individual patients, we do not recommend the provision of a separate community care mental health subprogramme at this stage, particularly since the skills required for community mental health care are currently only available in the special hospital care programme manager's organization.

Therefore, the activities in the mental health subprogramme would include, for example, assessment of existing patients in mental hospitals and of potential new admissions, acute treatment of patients in mental and general hospitals, provision of long-stay and sheltered accommodation, and rehabilitation and continuing treatment in the community as appropriate.

Mental Handicap Subprogramme

The provision of services for mentally handicapped children depends largely on the voluntary organizations. Moreover, many of the mildly handicapped can be supported in the community with no need for institutional care. Therefore, this subprogramme caters primarily for the institutionalized mentally handicapped adult (over 16 years old).

Activities would be, for example, assessment, vocational training and sheltered work, and provision of long-stay and sheltered accommodation. However, this subprogramme should also include the financial resources for payments to voluntary organizations providing inpatient care.

Geriatric Subprogramme

Geriatric* patients tend to be scattered throughout all hospitals in a Health Board. Thus, old people needing essentially welfare care can be found in acute hospital beds and others needing intensive nursing can be found in mental hospitals. Some of these patients are not receiving the care they need; others are blocking expensive acute beds, preventing others with greater need from occupying them.

Therefore, the purpose of the geriatric subprogramme is to plan comprehensively for all geriatric patients in institutions to ensure that they receive intensive care and rehabilitation when needed but do not block expensive acute beds when, for example, lower levels of nursing are appropriate. (There should also be a separate geriatric care subprogramme in the community care programme.)

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* - There is no accepted, precise definition for the geriatric patient. The 65 years of age criterion is being questioned on the grounds that the trends for 75-year olds and over are more relevant to the future needs for care of the aged. The 'old people without acute symptoms' definition is not completely satisfactory because many old people are likely to enter the hospital system as acute cases although, after initial treatment, they may stay in hospital but be classified as geriatric cases. Thus, in planning and managing the geriatric subprogramme there is a need for flexibility between the special and general hospital care programmes.

The activities in the special hospital care geriatric subprogramme should include assessment, rehabilitation, long-stay and welfare care. All the Board's hospitals are likely to be involved initially.

Overheads and
Administrative Support
Services Subprogramme

As in the general hospital care programme, we recommend a general overheads subprogramme for special hospital care to cover planning for costs that cannot be reasonably attributed to the patient care subprogrammes. Once patients in mental hospitals have been grouped and geriatric patients in general hospitals cared for in assessment units or appropriate accommodation, it should be possible to make reasonable allocations of most costs to the subprogrammes. However, there will still be general overheads that are more appropriately considered separately, for example, the programme manager and some of his support staff.

SUBPROGRAMMES IN COMMUNITY CARE

The subprogrammes for planning in community care are less obvious than for the hospital programmes for two reasons. First, the complexity and number of activities involved in community care mean it is sometimes difficult to group activities in order to keep the number of subprogrammes down to manageable proportions. Second, the subprogrammes in community care will not mirror the organization, as tends to be the case in the hospital programmes. Therefore, we have tried to keep in mind the need to use subprogrammes to plan services for specific patient groups (for example, the aged) or activities with a common objective (for example, preventive health) and we recognize that one group of people (for example, doctors and nurses) will in fact be providing services to a number of different subprogrammes every day. This dilemma is discussed further at the end of this chapter.

In light of the above, and after a number of discussions inside and outside the Department of Health, the following subprogrammes seem to be needed for community care.

- Preventive health and community protection
- Care of mother and infant (up to 6 weeks old)
- Care of children (from 6 weeks to 16 years old)
- Care of the aged
- Care of the handicapped

- General community care (not included in other subprogrammes)

- Overheads and administrative support services.

Preventive Health and
Community Protection

The purpose of this subprogramme is to prevent ill health through activities directed at the individual, for example, health education and controlling the spread of epidemics. In addition, there would be activities concerned more with the control of the environment like food hygiene and fluoridation of water supplies. Because of local government's involvement in public health control, part of this subprogramme is likely to be planned in concert with local government's needs.

Care of Mother and
Infant Subprogramme

The purpose of this subprogramme is to support the mother and her child from early pregnancy until the infant is 6 weeks old. Thus, activities included should be antenatal and postnatal care and education, domiciliary delivery where it exists, screening, general medical services and home help or nursing, dental care for the expectant mother, welfare services such as free milk and payment of the maternity cash grants.

Care of Children
Subprogramme

The purpose of this subprogramme is to care for children in the community roughly between the ages of 6 weeks and 16 years. It will include the school health service, immunization, general medical services, including identification of emotional disturbance, dental, ophthalmic and oral services, care of 'problem' children and care of handicapped children in the community.

Care of the Aged
Subprogramme

The purpose of this subprogramme is to support the aged in the community and to minimize any unnecessary burden on the hospital programmes. Thus, it would include medical and welfare services, day centres and transport, finance and assistance in kind such as provision of appliances and home conversion.

Care of the Handicapped
Subprogramme

This subprogramme provides support, training and employment mainly for the adult, mildly mentally handicapped, not in need of institutional care. It also provides support for the adult physically handicapped in the community. Such groups would include the deaf and blind and those with missing limbs. Support for the physically handicapped is likely to be mainly in the form of appliances and finance.

General Community
Care Subprogramme

The purpose of this somewhat general subprogramme is to provide the remaining community care services in addition to all the services planned for the specific target groups described above. In addition to the medical, dental, ophthalmic, oral and welfare services, activities might include, for example, mass radiography.

Overheads and
Administrative Support
Services Subprogramme

As in the hospital programmes, we recommend the general overheads subprogramme to eliminate the need for arbitrary allocation of planned expenditure to patient care subprogrammes.

PLANNING FOR DISCRETE SERVICES

Discrete services - like general practitioners, dentists, X-ray departments, pathology departments, etc. - need to be planned as a whole. They obviously cannot be expected to develop miraculously along the right lines merely as a result of programme plans. This is not to say that one has the choice of planning for subprogrammes or for these discrete services. Plans must be developed for both.

The need for these services is derived from the subprogramme plans in much the same way as patient needs are determined in subprogrammes. Thus, the total need in a Health Board for, say, dentists should be determined by accumulating the various requirements for dentists in each of the subprogrammes. The services should then be planned as an entity to meet this total need.

In practice, of course, the development of a service's plan would probably involve a certain amount of to-ing and fro-ing between subprogramme plans and the service plan to ensure that the services incorporated in each of the subprogramme plans match the total planned availability.

ILLUSTRATIONS OF PLANNING FOR SUBPROGRAMMES AND FOR SERVICES

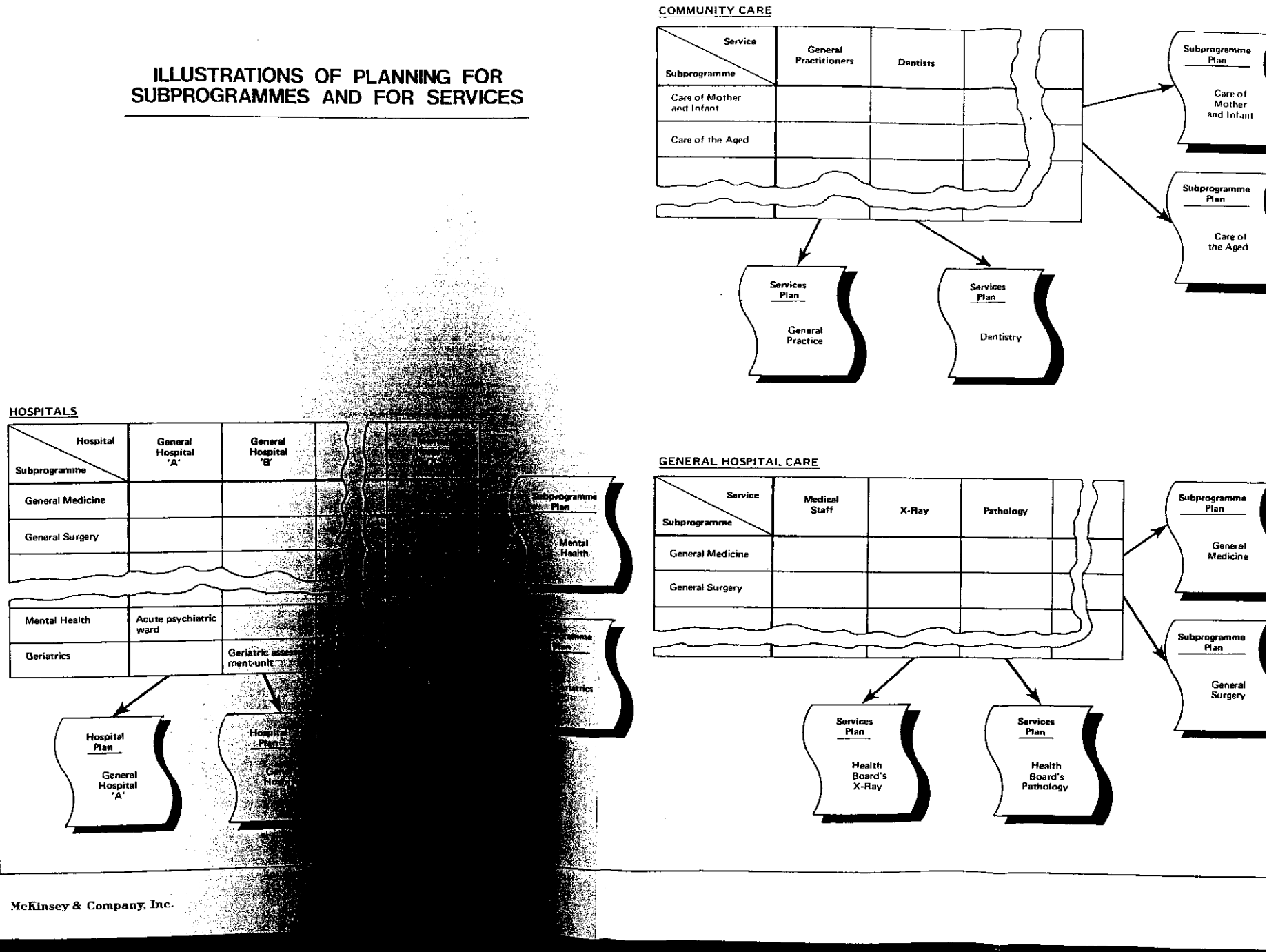
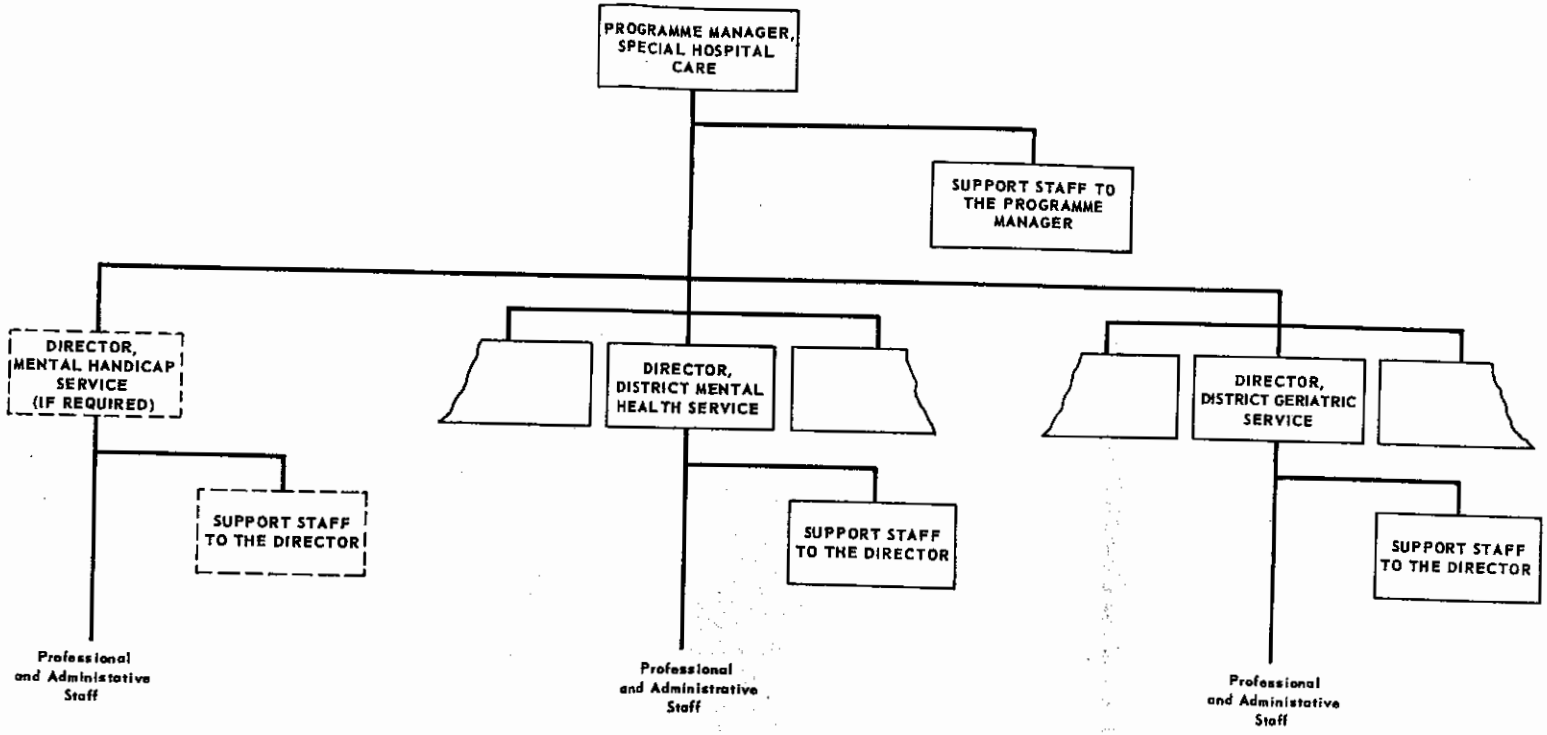


EXHIBIT II

PROPOSED ORGANIZATION FOR SPECIAL HOSPITAL CARE IN HEALTH BOARDS



Note: A Health Board should have a number of directors of district mental health service, and directors of district geriatric service; but, at most, one director of mental handicap service

Positions on this chart do not necessarily indicate relative status

Thus, services need to be planned initially by subprogramme to ensure that the Board's resources are allocated first of all on the basis of their contribution to achieving objectives for target patient groups. However, in practical terms, the required level of each service can only be planned in detail and services developed efficiently, if each of these services, and similarly each hospital, is also viewed as a whole. The matrices on the facing page illustrate the two-cut approach to planning that is needed.

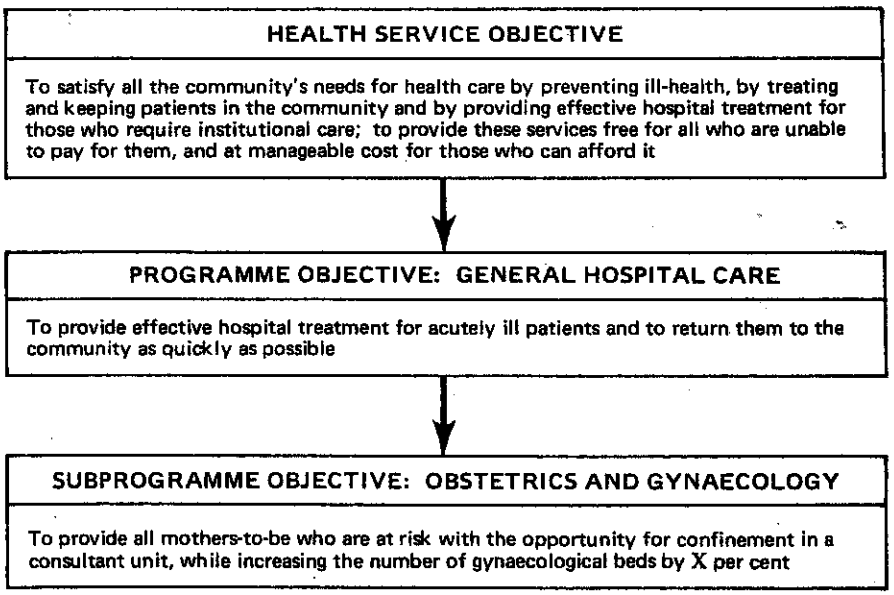
2 - SETTING PROGRAMME OBJECTIVES

2 - SETTING PROGRAMME OBJECTIVES

Before even considering what changes should be planned for the future, Health Board managers need to determine their objectives. An objective identifies the target groups to be served (for example, eligible adults, all children), specifies the appropriate level of service to be aimed for and thereby indicates the direction of change. It should be a statement of purpose covering a period of at least 5 years, since it is concerned with establishing direction and, therefore, requires a long-term perspective. It should be specific and so framed that progress towards it can be measured. If possible, it should be quantified so that the numbers involved will clearly spell out the measure of success in meeting it. Clearly, therefore, objectives should be agreed as the first step in planning.

In Chapter 1 we describe how programmes should be structured specifically to facilitate the attainment of objectives. That is, activities sharing common aims are grouped into related programmes and subprogrammes.

Resources will subsequently be allocated around these programmes and subprogrammes. Therefore, when setting objectives, programme managers need to follow this programme structure, setting objectives for each level of the programme. For example, the objectives at different levels, using the general hospital care programme as an illustration, might be:



Management - "Deciding what needs to be done & getting other people to do it."

Deciding what needs to be done:-

(a) Planning & Setting Objectives

(b) Organising available resources - human, material & financial.

Getting other people to do it.

(a) Motivating and training staff.

(b) Controlling the fulfillment of the plans.

For purposes of national planning and comparative information, it is important that programme structures be uniform throughout all Health Boards; although structures would be reviewed periodically to ensure continued relevance and usefulness, any revision by the Department should apply nationally.

To set realistic objectives, programme managers will need to compile information on the resources available and their present utilization. Using this information, they will then meet with other programme managers, and with senior medical officers, to discuss and agree objectives. The Department of Health and the Regional Hospital Boards will be active in helping Health Boards to set objectives at programme and subprogramme levels; but programme managers themselves must take the initiative in this matter. The rest of this chapter, then, describes what programme managers must do to

- ¶ Compile resource information
- ¶ Discuss and agree objectives.

COMPILING RESOURCE INFORMATION

Before setting objectives, programme managers will need to gain a comprehensive picture of the services being provided in their programmes. To do so, they must

- ¶ Ascertain resources available within the programme
- ¶ Measure the productivity of the resources being used
- ¶ Assess the effectiveness of the services being provided.

Operational Research.

Ascertain Resources Available

Programme managers should take stock of all physical resources available to their programmes - buildings, personnel, materials and equipment - both within the Health Board organization and also outside, such as the voluntary hospitals and the voluntary organizations in the community. They should list

resources by subprogramme, in order to put together a comprehensive picture. For example: the following diagram shows the available bed resources* for each of the general hospital care subprogrammes in the Southern Health Board.

Year: 1971	*Population:* 480,000					*Health Board:* Southern					
Beds / Hospital	Subprogrammes								Total	Ger. AU	Grand Total
	Medical	Surgical	Maternity	Paediatric	Orthopaedic	Ophth./ ENT	Other Spec.	Infect. Diseases			
St. Finbarr's	122	62	59	67	16		74	68	468	58	526
St. Mary's					188				188		188
St. Stephen's							40		40		40
Mallow	33	50	5	10					98		98
Tralee	68	75	21		26				190		190
Bantry	34	64	16	16					130		130
Bon Secour	59	73	60	24		24	21		261		261
Mercy	54	71	6	52		3	8		194		210†
North Infirmary	46	50	2	20		4	2		124		124
South Infirmary	35	57	6	26		10			134		134
Erinville			76						76		76
Eye, ENT						59			59		59
Victoria	34	24	8			4	4		74		74
District and private			114					44	158		158
AREA TOTAL	485	526	373	215	230	104	149	112	2,194	58	2,268†

† - Grand total for Mercy includes 16 beds not designated to subprogrammes

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* - The inclusion of voluntary hospitals in the available bed resources does not suggest any change in their relationship with the Health Board. Their inclusion is necessary because patients are treated in both Health Board and voluntary hospitals and all resources available to meet needs in the areas should be determined.

DEFINITION OF TERMS USED IN THE TABLE ON PAGE 2 - 4

TERM	DEFINITION
Average occupancy rate	Patient days as a percentage of available bed days
Non-urgent admissions rate	Admissions from a wait list as a percentage of all admissions
Urgent admissions rate	Urgent admissions as a percentage of all admissions
Peak occupancy rate	Peak number of patients in hospital during a period as a percentage of the hospital's normal bed complement
Average duration of stay	Total patient days divided by number of discharges
Short stay (investigation)	Patients who were in hospital for purposes of investigation only and left within 48 hours, as a percentage of all patients
Short stay (emergency)	Patients who were admitted as emergencies but left within 48 hours, as a percentage of all patients
Long stay	Patients who were in hospital for 28 days or more, as a percentage of all patients
Discharge to other institutions	Patients sent to other institutions for convalescence or more specialized treatment, as a percentage of all patients
New over-65 admissions	Percentage of all admissions who were aged 65 or over
Social stay	Percentage of total patient days represented by days between a patient being certified fit for discharge and actual discharge

In assembling this programme information, programme managers should measure the programme resources against the area population (e.g., beds, doctors, per 1,000), and should compare their area with accepted norms. These comparisons will start to indicate possible improvement opportunities. And, because of the focus on subprogrammes, they will permit much closer and more specific conclusions to be drawn than has previously been possible. Initially, programme managers may have difficulty in making these comparisons. For this reason it is important for the Department to ensure that all Health Boards move towards a common information system; it also points towards the need for developing national standards of provision.

Finally, programme managers should be alert for any significant trends in resource availability. If, say, radiologists are increasingly in short supply, programme managers should become aware of this as soon as possible, for example, by comparing notes on the time it takes to find suitably qualified candidates for vacancies.

Measure the Productivity Of Resources Used

Efficiency in health care can be measured by output achieved with the physical resources available - the services rendered, the number of patients treated, the cost per patient - in short, resource utilization. The sample format for general hospital care concentrates on three major items, and supports them with more specific, qualifying indicators.

GENERAL HOSPITAL CARE PERFORMANCE INDICATORS

Inpatients	General Medicine	General Surgery	Obstetrics and Gynaecology	Paed
OCCUPANCY Average occupancy rate Non-urgent admissions rate Urgent admissions rate Peak occupancy rate				
DURATION OF STAY Average duration of stay Short-stay (investigation) Short-stay (emergency) Long stay Discharge to other institutions New over-65 admissions Social stay				
COST				

Some measures of resource utilization already exist, but programme managers may need to develop these measures in terms of subprogrammes. For example, hospital costs per day have been established, but not down to departmental level. Initially, programme managers should keep these indicators simple, emphasizing only major measures. The Department should work out a comprehensive list of indicators for general use in Health Boards.

To derive most benefit from these indicators, programme managers should compare their resource utilization with that of similar units in other areas. The Department should develop a set of common productivity measures and costing systems. The Inpatient Survey now being conducted by the Medico Social Research Board will also in time provide valuable 'case' information.

In such areas as radiology and pathology, the programme manager may need to do further work to develop and introduce the pointage systems for work measurement. Programme managers will also need to conduct a continuing series of special surveys and spot checks to uncover problem areas of productivity.

At the same time, programme managers need to understand where and how their financial resources are being used, again in terms of particular subprogrammes. Some costs will have been divided among different subprogrammes; for example, general practioner service costs would have to be divided among a number of community care subprogrammes; similarly, radiology and pathology services contribute to all hospital subprogrammes. Formal accounting by subprogrammes will take at least another 2 years' preparation. In the meantime, programme managers must try to establish, even if only approximately, how the funds are being used. For example, in general hospital care:

SAMPLE REGIONAL HOSPITAL INPATIENT COSTS

£ per month

Subprogramme / Resource	General Medicine	General Surgery	Obstetrics and Gynaecology	Etc.
Doctors	4,136	4,264	1,273	
Nurses	5,564	6,098	4,408	
Professional support	3,459	4,045	1,141	
Medical supplies	3,504	4,789	1,427	
Subtotal medical	16,663	19,196	8,249	
Hotel support	6,436	5,056	2,307	
Administration	2,203	1,711	757	
Attributable Overheads	4,211	4,211	2,105	
Subtotal non-medical	12,850	10,978	5,169	
TOTAL	29,513	30,174	13,418	

Assess the Effectiveness Of Services Provided

Service effectiveness is more difficult to measure than the efficiency of resource utilization. The quality of care is not necessarily apparent in efficiency measures, nor do efficiency measures indicate the success of the services in meeting the real needs of the community. For considering the effectiveness of services, attention must be focused on such questions as: Are waiting lists too long? Are too many patients being readmitted to hospital? Are the services provided reaching all the community in need? To answer these questions, performance indicators for each subprogramme (by unit) will need to be developed to show total performance for the area. The Department should take the initiative in developing, defining and calibrating the indicators that would be used on doing this. For example:

Indicator \ Subprogramme	General Medicine	General Surgery	Obstetrics and Gynaecology	Paediatrics	Orthopaed
READMISSIONS					
Readmissions rate					
Scheduled readmissions rate					
Unscheduled readmissions rate					
WAITING LIST					
Waiting list rate					
Urgent waiting list rate					
Non-urgent waiting list rate					
Urgent waiting > 4 weeks					
Total waiting > 12 weeks					

These indicators will enable inter-area and inter-unit comparisons to be made on a subprogramme basis to show whether, for example, low costs in one area result from a low level of service or high standards of efficiency. Programme managers should also try to identify trends: Is the waiting list for places in mental health day institutions growing? Is the demand for gynaecological services increasing?

Performance indicators will require substantial development and refinement, as experience shows which are the key areas for monitoring, as a consensus is reached on a common information system, and as the Department involves itself in guiding and coordinating the information flow and providing national standards. Compiling this initial information base is a vital part of preparing the ground for planning, and should be the new programme manager's priority task.

DISCUSSING AND AGREEING OBJECTIVES

Having compiled this resource information, programme managers will be able to start formulating possible objectives for their programmes and subprogrammes. To help them in this task, they will hold further discussions with senior medical personnel in the area, to gather their suggestions and recommendations. They can then identify the range of alternative objectives for each subprogramme and subject them to critical analysis.

The sort of problems involved in setting objectives can be illustrated in the obstetrics and gynaecology subprogramme. Programme managers will have to consider a range of possibilities, both in identifying the appropriate target group to be served, and in specifying the appropriate level of service. Some possible targets and service levels for obstetrics might be:

Possible Target Group

- All maternities
- All demanding services
- High risk only
- First birth only
- Emergency only

Possible Level of Service

- Full consultant care (including ante- and postnatal)
- In-hospital delivery, hospital recuperation
- In-hospital delivery, home recuperation
- Domiciliary delivery

Choosing among possible objectives for this subprogramme would clearly have a major impact on costs. For example, moving to a service level of in-hospital delivery, home recuperation might reduce present in-hospital patient-days (maternity) by 40 per cent.

Programme managers should summarize their findings and recommend the best alternatives for discussion with the management team - the other programme managers, the functional officers and the Chief Executive Officer. The CEO, in his participation in this discussion, must ensure that the objectives are

- Consistent with any Departmental guidelines and directives
- Consistent with the objectives of other programmes and subprogrammes
- Able to meet questions from the Health Board.

When the management team is in agreement, or when the CEO has taken his decision, all programme and subprogramme objectives will then be referred to the Health Board for review and decision. This review is a vital part of the Health Board's contribution to the area's health services, since clearly its decisions at this point will determine subsequent emphasis and direction of all health care.

* * *

Objectives set for a 5-year period will not be substantially adjusted in the annual planning programme. However, programme managers should expect to review objectives in light of new developments, to make sure that they remain appropriate to the situation. In future years, as in the past, the Department of Health will develop guidelines and directives that should have a major influence on area objectives.

3 - DETERMINING AREA AND PROGRAMME PRIORITIES

Determining area priorities for the allocation of funds is the Health Board's most difficult, yet most critical responsibility. Expansion of medical techniques and social expectation has led to dramatic increases in health expenditure; moreover, international experience indicates that this trend will continue in the future. Therefore, demands for service will always exceed resources available.

Traditionally, health authorities have responded to new demands by examining proposed projects on a piecemeal basis, and then referring them to the Department for approval or rejection. Often they considered more projects than the new Health Boards could possibly afford. In the new organization, however, responsibility for pulling together the priorities in all three programme areas, reviewing and ranking these priorities against agreed criteria, and incorporating them into plans will be at the Health Board level. In this part of the planning cycle, programme managers

- Incorporate Departmental guidelines and directives
- Produce programme definition statements*
- Agree area priorities.

INCORPORATING DEPARTMENTAL GUIDELINES

While reorganization into eight Health Boards should decentralize the decision-making process, the Minister and/or the Regional Hospital Boards will continue to direct the provision of health services by laying down guidelines for the Health Boards and by issuing directives under the Health Acts. Departmental guidelines will outline new priority policies in health care, and will also advise Health Boards on the financial allocations - capital and revenue - that will subsequently support Health Board plans. The guidelines will thus help to coordinate the development of services among the eight Health Boards, and will be reflected in the development of programme plans.

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* - The programme definition statement (PDS) is described in detail in this chapter. It is essentially a device for systematically determining need and comparing it with resources available to identify the extent of unsatisfied need.

Policy Guidelines
And Directives

The Department will suggest new ways in which health services should be improved. Policy guidelines will cover the whole health care field, and will include changes in

1. Emphasis among programmes and subprogrammes. For example, guidelines or directives might relate to the establishment of geriatric assessment units in all major hospitals under the control of a geriatrician, to ensure that

- Aged patients are promptly and effectively assessed and treated
- Community services encourage the speedy return of patients to the community.

2. Treatment. For example, the introduction of day surgery for minor operations might be considered.

3. Standards. For example, waiting-list times in orthopaedics might be reduced to a maximum of 3 months.

4. Administrative practice. For example, medical social workers might be employed in all acute hospitals.

The management team will discuss priorities contained in these guidelines, in order to assess implications for the current provision of service. As a first response to the Department's guidelines, the team might agree on preliminary standards of service - for example, the target number of assessment beds that would adequately meet the priority for geriatric care. If the Department spells out specific standards in the guidelines, programme managers should incorporate them directly into their plans. In the hospital programmes they should, of course, take account of facilities available in voluntary hospitals.

Financial Guidelines

The Department will also tell each Health Board what figure for spending it should use in developing its plans. Until better information is available on the costs and performance of separate programme areas, this advice will probably be limited to one revenue sum and one capital sum per Health Board; later the Department will specify down to programme level. Provided Health Boards remain within these limits, they should be free to plan the allocation of funds to subprogrammes as individual needs and priorities dictate.

At the same time, the Department should indicate the level of capital and revenue spending likely for the subsequent 4 years. This will give Health Boards greater continuity in developing their long-range plans.

1 Analysis of Needs. (Resources) X
2. Setting of Objectives & Priorities
3. Consideration of alternatives X
4. Detailed Plan and Consultation. (Programme Expenditure Statement)
5 Logistics Planning
6 Strategy of Implementation
7. Implementation
8 Feedback.
9 Evaluation
10. Reassessment of Needs.

PRODUCING PROGRAMME DEFINITION STATEMENTS

Having considered Departmental guidelines, the programme managers should next produce their programme definition statements (PDS). These basic working documents help programme managers to identify needs and opportunities, and provide the basic information for action plans. They allow programme managers to gain the agreement of the management team and the Health Board on what needs to be done, even if resources are not immediately available.

Programme definition statements record the need for services based on agreed target standards of service, and compare the need with the current provision of service. The difference between need and current provision establishes the gap (underprovision or overprovision in services). To complete programme definition statements, programme managers must take six steps: (1) determine relevant service items, (2) identify target patient group for each item, (3) agree standards of provision, (4) deduce area needs, (5) review current provision, and (6) calculate gaps.

PROGRAMME DEFINITION STATEMENT

Subprogramme: **General Medicine**

Item of Service	Target Group	Standard of Provision	Need	Current Provision	Gap
Beds	480,000 area population	0.8 beds per 1,000	384	370	14

Determine Relevant Items of Service

Each subprogramme contains major items of service, and the programme manager will indicate these on the PDS, using his discretion in determining which to highlight. For example, items that need to be highlighted in a particular subprogramme might include:

General Hospital Care	Special Hospital Care	Community Care
Beds	Beds	General practitioners
Doctors	Psychiatrists	Public Health Medical Officers
Nurses	Geriatricians	Dentists
Paramedical	Physiotherapists	Public Health Inspectors
Equipment	Occupational therapists	Public Health Nurses
Drugs	Clinics	Meals-on-wheels
OPD	Day centres	Fluoridation

Identify Target Patient
Group for Each Item

For each item of service, programme managers must identify a target population - i.e., the particular section of the population for which the service is intended. In general hospital care, the target group for general surgery would be the total area population. For obstetrics the target group would be the women in the area expected to give birth in each year. For 'regional' specialties - e.g., neurosurgery, plastic surgery, neurology, renal dialysis - the target group would reach beyond the Health Board area.

Programme managers may have difficulty in establishing clientele statistics. In community care, special surveys have been used to identify the clientele for whom some of these services are intended.

Subprogramme: **Care of the Aged in the Community**

Item of Service	Target Group	Standard of Provision
Home help	290 aged	
Meals-on-wheels	300 aged	

Programme managers should also be concerned with the changes occurring in the clientele, and they should adjust their PDSs accordingly.

Agree Standards
Of Provision

Standards of provision are the levels of service that the Health Board considers appropriate to meet the needs of the target group. Some standards are imposed by statute - for example, for food hygiene. Departmental and RHB guidelines will indicate other standards - for example, one consultant per 35 beds in general medicine or surgery. And the Health Board's own analysis and review will develop still other standards.

In considering the standards appropriate to the item of service, the programme manager will need to focus on the item's main features, in order to avoid overloading the PDS and thereby obscuring the priority issues. For example, existing hospital beds may result in an unsatisfied need for a variety of reasons.

Subprogramme: **General Medicine**

Item of Service	Target Group	Standard of Provision (hypothetical)
BEDS		
Numbers available	480,000	0.8 per 1,000 clientele
Size of unit		35 minimum per unit
Age of building		Less than 80 years
Spacing between beds		3' 6" minimum
Support amenities		Bed light, locker-table, WCs per bed
Nursing convenience		Height, weight, mobility
Therapeutic requirements		Back-raise, 'ripple', traction
Privacy		Screen, curtain, partition
Comfort		Springs, mattress, pillows

The primary standard should be the number of beds available, whether too few or too many, and should be shown in the PDS; the secondary features, for which standards should be established, would be shown only on an exception basis.

Initially, developing appropriate standards of provision will be a difficult job. For some subprogrammes, such as care of the aged, no one is yet certain of the correct standard for items of service such as doctors, nurses or beds. Until standards are developed, programme managers should estimate them in these cases. For all items, programme managers must regularly review service standards, and their review should be both systematic and exhaustive.

Deduce Area
Service Needs

To deduce area needs, programme managers will multiply the numbers of the target clientele with the agreed standard of provision - a matter of simple arithmetic. For example, the need for beds is the number of population (480,000) multiplied by the standard of provision (0.8 per 1,000), which is 384 beds.

Item of Service	Target Group	Standard of Provision	Need for Services
Beds	480,000	0.8 beds per 1,000	384 beds
Consultants	384 beds	1 consultant per 35 beds	11 consultants

Review
Current Provision

The PDS now forces the programme manager to examine the existing level of service in his area in detail. As with the setting of service standards, the programme manager needs to conduct a systematic and exhaustive review of programme performance.

In the example below, the need for beds for the general medicine sub-programme (384) is contrasted with the number currently provided. The PDS then points out the ways in which those beds fail to meet the required standards.

Subprogramme: **General Medicine**

Item of Service	Target Group	Standard of Provision	Need for Services	Current Provision
Beds	480,000 total population	0.8 per 1,000 in hospitals constructed and operated in accordance with DoH circulars	384	370 - 60 beds in buildings surveyed and found unsatisfactory - 30 beds located in hospitals whose catchment area is too small

Calculate Gaps

In the final section of the PDS, the programme manager calculates gaps (underprovision or overprovision) in service level.

Subprogramme: **General Medicine**

Item of Service	Target Group	Standard of Provision	Need for Services	Current Provision	Gap
Beds	480,000 total population	0.8 beds per 1,000	384	370	14 plus 90 beds in hospitals needing development or closure

The PDS thus gives a complete gaps summary that can be reviewed by the management team, and, where desired, by the Health Board. The PDS gaps become the basis for all subsequent debate in determining Health Board priorities* and, on the national level, those of the Department.

AGREEING AREA PRIORITIES

The new or updated PDSs will enable the management team to conduct a comprehensive review of the gaps existing in the current provision of service. From this review, the team will then select the most important gaps of each programme and rank them in order of importance. The management team should also propose tentative financial allocations to meet these priorities, and then submit both the ranked priorities and the allocations to the Health Board for approval. By gaining agreement on priorities and allocations, the management team will ensure that subsequent plans concentrate on those priorities.

Rank Priorities

The PDS presents a complete picture of existing services, in order to permit informed judgement and to ensure that all gaps are considered when the management team selects priorities. But the PDS does not pre-empt the need for value judgement in this selection. No mechanical technique for evaluating gaps in one area against another exists, and even a method such as assessing cost benefit, which can help the management team to make decisions in reasonably specific situations, involves broad value judgements.

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* - Three illustrative PDSs are shown in Appendix B.

The management team must consider each gap in terms of its importance in meeting national or local objectives, the size of the gap to be filled (is it a 10 per cent or 90 per cent gap?), the approximate cost of closing it, or closing part of it, the feasibility of closing it (e.g., are there enough geriatricians, therapists, etc., available?) and the time it would take to get results.

By considering these factors, the management team will discover those gaps for which further analysis is required, and those gaps for which corrective action appears to be of secondary importance. The team can then rank the remaining priorities, and annotate them, for review with the Health Board.

PRIORITY NEEDS

Subprogramme	Item of Service	Current Provision of Service	Gap Against Standard of Provision	Revenue Cost Per Annum To Close Gap	Capital Cost To Close Gap	Comments
Mental Health	Inpatient acute treatment centre beds Nurses Psychiatrists	160	60	£7,500	£150,000	

The priority needs should be accompanied by a commentary in which the management team summarizes its assessment of the needs gaps by ranking and grouping needs in logical order. Using mental handicap as an example:

- Mental handicap resources are inadequate
  - 100 children are awaiting places in day treatment centres
  - 75 beds in children's residential homes are blocked by adolescent patients
  - Mental hospitals are short of staff. Specifically, ...
- Adult mentally handicapped patients are mixed with other patient categories in mental hospitals.

This commentary will provide a focus for the discussion with the Health Board, and enable the Health Board to contribute more effectively to the development of area priorities.

Propose Allocations

Before submitting a list of ranked priorities to the Health Board, the management team will also propose preliminary financial allocations for programmes and subprogrammes, reflecting proposed priorities. The Finance Officer will prepare both a summary of past annual expenditure by subprogramme, and a forecast of the expenditure needed to continue present service levels for the coming year. Using these summaries, the management team must make a preliminary allocation to each subprogramme in support of the stated planning priorities.

The scope for redeployment of resources will naturally be limited, certainly in the short term, and a subprogramme's share of health expenditure would be unlikely to expand by more than 5 per cent (in real terms) in any one year. However, only through the budgetary allocation will programme managers realize area planning priorities.

ALLOCATION PROPOSAL

Programme	Revenue						Capital			
	1972		1973 No Change		1973 Proposed		1973 Committed		1973 Proposed	
	£000	%	£000	%	£000	%	£000	%	£000	%
General hospital care	5,000	50.0	6,000	50.0	5,700	48.0	200	40.0	150	30.0
- General medicine	1,130	11.3	1,360	11.3	1,300	10.5	–	–	–	–
- General surgery	1,400	14.0	1,680	14.0	1,600	13.3	–	–	–	–

Submit for
Health Board Review

The management team now formally submits its list of priorities and proposed financial allocations to the Health Board for review and decision. Having also been involved in the setting of programme objectives, and being aware of national developments and Departmental guidelines, the Health Board's responsibility now is to focus on the proposals. It must ensure that

- Standards are updated and relevant
- Ranking of priorities is consistent with Health Board objectives

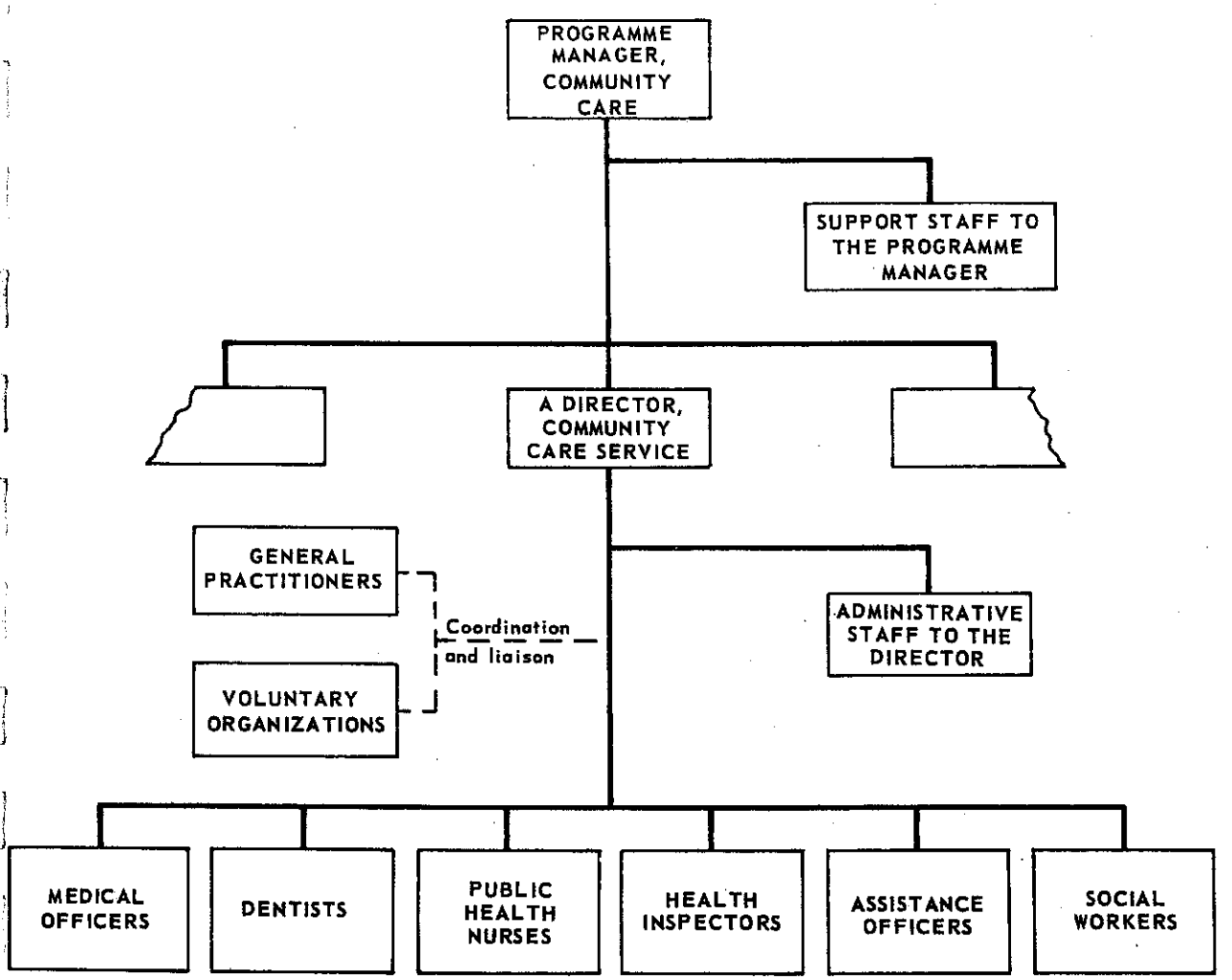
- Financial implications are adequately spelled out for each of the gaps listed

- Allocations to subprogrammes, for both revenue and capital expenditure, properly reflect the planning priorities.

The Health Board's decision on priorities and allocations is the crux of the planning process. The extent to which the Health Board revises priorities at this review will depend on the way in which the CEO and the management team liaise with the Health Board.

IIBIT I

PROPOSED ORGANIZATION FOR COMMUNITY CARE IN HEALTH BOARDS



Note: Positions on this chart do not necessarily indicate relative status

4 - PRODUCING HEALTH BOARD PLANS

The Health Board Plan describes the specific changes to be made in providing health care for the coming year, and indicates the resources - in both money and people - that will be allocated to make these changes. The plan is consolidated from draft programme plans, the Financial Plan and the Manpower Plan; once approved, it establishes budgetary limits within which programme managers are committed to carrying out the changes in the individual programmes.

The management team produces the Health Board plan in three steps:

1. Produce draft programme plans
2. Consolidate into draft Health Board plan and submit for review
3. Produce final action plans.

PRODUCING DRAFT PROGRAMME PLANS

The draft programme plan spells out proposed use of programme resources and describes changes in terms of specific projects. Programme managers produce their draft programme plans by examining each subprogramme in the light of priorities confirmed by the Health Board. In particular, they should

- Identify cost reduction opportunities
- Decide on projects that will best achieve priorities
- Document their proposals.

In appropriate circumstances, the special skills of individual Board members may be made available to programme managers, for example, through a special committee.

Identifying Cost Reduction Opportunities

In facing the perpetual dilemma of unlimited demands on limited resources, and in confronting the current escalation of prices and wages, the programme managers must clearly appreciate that a more effective service depends largely on greater efficiency. Reducing costs therefore becomes a major responsibility, and requires more systematic attention than it may have received in the past.

Cost reduction calls for detailed analysis and creative imagination; it demands a strong sense of the practical; it requires managerial skill in implementation and follow-up; but the results can be substantial. For example:

¶ In the general medicine and general surgery subprogrammes, improving radiology and pathology support in one hospital would cost £50,000 capital, £24,000 revenue; it would reduce patient-days by 15 per cent - equivalent to £80,000 per annum - thereby saving £56,000 a year, and paying back the capital cost in under a year. (Of course, the hospital would in fact be used more intensively rather than a saving actually achieved.)

To identify possible cost reductions, programme managers should concentrate on the facilities and resources at their disposal in each subprogramme. They should examine which of the facilities can be reduced or redeployed, while still maintaining current levels of service; they should explore ways in which the service could be delivered faster; they should compare costs with other units inside or outside the Health Board area, to discern possible anomalies and specific improvement opportunities; here the Department has a significant role to play. If an opportunity for significant cost reduction involves extraordinary capital allocation, they should put the case forward in the programme draft plan for the management team's consideration.

Incorporating Priorities

Even though they may have identified cost reduction opportunities, programme managers' improvements will be limited by the subprogramme planning allocations already approved by the Health Board. Therefore, programme managers will have to decide how far the priorities they have been given can be incorporated into their draft plans. The proposal on priorities, which will have been submitted earlier by the management team to the Health Board, will have included a range of potential projects and indicated the sort of specific action steps required to meet those priorities. Programme managers should review those projects in the light of the planning priorities and allocations received and decide which projects to include in their plans and which to exclude. In this review, they should assess projects in terms of three criteria: cost, feasibility and impact.

1. Cost. Both the capital and revenue implications of all potential projects must be weighed. Projects that offer cost reduction potential, even though requiring substantial capital outlay - for example, improving pathology to reduce average duration of stay - should always receive close consideration, since they will be relatively hard to find. On the other hand, projects that

involve small capital outlay but will impose a heavy revenue burden in future years - for example, establishing new staff-intensive services such as artificial kidney units - require considerable scrutiny and justification before being accepted.

2. Feasibility. Programme managers should analyse projects and prove that the proposed projects are feasible. They should be able to call upon the Department for information and guidance, either in securing external corroboration for the projects or in carrying out pilot tests locally. They must be able to satisfy themselves on items such as the availability and reliability of specific resources and ensure than any major obstacles can be satisfactorily overcome. Programme managers must, in short, be able to face subsequent challenge from the management team when the programme plans are brought together.

3. Impact. Although the Health Board will already have determined the priorities for improving health care, programme managers still face the difficulty of deciding which particular projects will have the greatest impact and can be met from the limited funds available. For example, a programme manager may have to choose among four projects serving high priorities in separate subprogrammes. His choice must be largely determined by his assessment of the impact of each project in relation to its cost.

PROGRAMME: GENERAL HOSPITAL CARE

Subprogramme	Priority	Project	Revenue (£000)	Capital (£000)	Impact
Obstetrics and Gynaecology	Reduce overcrowding by 50 beds	1. Build new wing	100	200	Adds 50 beds
		2. Improve outpatients department	18	50	Equivalent 20 beds
General Medicine	Improve intensive care	1. Build new unit	12	40	Intensive care for all at risk
		2. Buy four monitors	4	8	Faster reaction to crises

Documenting Proposals

After incorporating new priorities, programme managers must now assemble the draft programme plans, including the supporting budgets, for review with the management team. Programme managers should present their plans in two sections: programme projects and programme budgets.

1. Programme projects. The programme manager lists the proposed projects, provides the supporting facts and figures to justify each one of them and comments on feasibility and each project's impact on health care. The revenue and capital implications are stated for the 5-year period.

PROJECTS PLANNED TO START IN 1973

Project	New Revenue (£000)					Capital (£000)					Feasibility	Impact
	1973	1974	1975	1976	1977	1973	1974	1975	1976	1977		
1. Mental Health												
- Establish inpatient treatment centre in											Space available in hospital grounds	Reduces overcrowding in patient treatment centre
. Mental hospital											Nurses available; Bord Altranais is prepared to recognize unit	Provides more effective treatment for patients with a high rate of readmission
- Accommodation	–	12.0	4.5	–	–	75.0	75.0	–	–	–		
- Nurses	–	20.0	10.0	–	–	–	–	–	–	–		
- Psychiatrists	–	15.0	–	–	–	–	–	–	–	–		

New revenue, in the above illustration, refers to the change made by the project to the level of revenue expenditures in the year that the change occurs - i.e., the projection is not cumulative. The cumulative revenue impact of, say, accommodation would be £16,500 by 1975, and the total capital cost £150,000.

2. Programme budgets. These summarize the impact of the proposed projects on the revenue and capital expenditures of each subprogramme. In the example below, the increased revenue effect of proposed projects for the mental health subprogramme will be fully apparent by 1975. The total revenue planned - i.e., committed to specific projects - is compared with the amount provisionally allocated to the programme over the next 5 years. The resulting difference constitutes the reserve for financing additional projects starting in future years.

REVENUE BUDGET FOR 1973
SPECIAL HOSPITAL CARE PROGRAMME
(£000)

Subprogramme	Estimated 1972	Planned				
		1973	1974	1975	1976	1977
Mental Health	675	735	810	845	845	845
Geriatrics	1,700	1,720	1,770	1,846	1,937	1,988
Mental Handicap	680	715	735	755	755	755
TOTAL	3,055	3,170	3,315	3,446	3,537	3,588
Provisional allocation	3,000	3,170	3,455	3,677	3,896	4,139
Unallocated amount	–	–	140	231	359	551

The capital budget also spans the 5-year period and indicates for each subprogramme: (1) the capital allocation approved in previous plans, (2) the planned allocation for projects starting in the coming year, and (3) the total capital commitment in all plans proposed to date.

At the draft plan stage, preliminary budgets for the major organization units, for example, larger hospitals, should also be prepared. These budgets should reflect the financial implications resulting from the proposed projects, as well as the many other smaller changes that might be planned within an organization, but might not find their way into a specific project, for example, minor changes in staffing levels, small cost reduction projects. Final budgets for all organization units should be prepared after the Department's review of draft plans. These budgets will sometimes cut across the programme budgets used for planning because the larger hospitals, for example, might be serving a number of subprogrammes in both general and special hospital care. Thus, the programme budgets provide the planning tool focusing on patient needs and priorities; the organization unit budgets (for hospitals, communities, etc.) reflect the way in which resources are actually managed day to day.

SUBMITTING DRAFT HEALTH BOARD PLANS FOR REVIEW

Programme managers must now bring their draft programme plans together so that the management team can review and consolidate them into a draft Health Board plan. Both the Health Board and the Department of Health - and, where appropriate, the Regional Hospital Board - will then review the draft plan. For planning purposes, all reviews must be completed before stipulated deadlines - but they should nevertheless involve dynamic discussions of ideas and projects. Specifically, they should not be conducted as summary 1-day hearings. Thus, the first step is consolidation of programme plans into a Health Board plan by the management team, followed by review by Boards and the Department.

Management Team Consolidation

The programme managers submit their programme plans to the management team, who will review them in order to consolidate them into a comprehensive draft Health Board plan. In this review the management team appraises the validity of the proposed projects and budgets, and considers the projects held back because of inadequate funds. The management team will consider the draft programme plans in terms of the following questions:

- Do proposed projects reflect the priorities for better health care?
- Have the projects been realistically assessed in terms of cost, feasibility and impact?
- Are there excluded projects in one subprogramme that are more important than projects included in the same or other subprogrammes?

The Chief Executive Officer is responsible for consolidating the draft Health Board plan. The plan summarizes the individual programme projects and relates the projects to the original priorities that the Health Board earlier confirmed. For example:

- Improve care of the geriatric patient in the community, in hospitals and in welfare homes.
  1. Develop district geriatric services further - Project No. IX
     - Appoint two directors, district geriatric service
     - Develop 40-bed assessment and rehabilitation unit.

2. Provide grants to expand the community social services for the aged - Project No. X

   - Increase grants for meals-on-wheels, home help services to £x, etc.

The commentary of the draft Health Board plan pulls together the key elements from the programme plans and provides a coherent summary that the Health Board, and subsequently the Regional Hospital Board and the Department of Health, can readily assimilate and constructively criticize.

The project proposals should be accompanied by the consolidated revenue and capital budgets, in which the Finance Officer brings together the three programme budgets and shows the total financial picture over the 5-year period.

At the same time, the Personnel Officer draws up a Health Board manpower plan in which he compares current manpower resources with future needs and thereby identifies the recruitment or training required.

MANPOWER REQUIREMENTS 1973–1978
GENERAL HOSPITAL CARE PROGRAMME

Grade	Staff in Post 1.4.1972	Estimated Staff Wastage						Staff Needed for New Posts						Staff Needed To Fill New Posts and Account for Wastage					
		72/3	73/4	74/5	75/6	76/7	77/8	72/3	73/4	74/5	75/6	76/7	77/8	72/3	73/4	74/5	75/6	76/7	77/8
RMS	1	–	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Medical Staff																			
- Consultants	36	–	2	1	2	2	2	–	4	4	6	5	2	–	6	5	8	7	4
- Registrars	18	3	3	2	4	4	3	–	2	2	–	4	4	3	5	4	4	8	7
Paramedical Staff																			
- Occupational therapists	6	1	2	1	2	2	1	–	–	–	–	2	2	1	2	1	2	4	3

The management team then presents the complete draft plan to the Health Board, and thereafter to the Department of Health.

Producing the draft Health Board plan serves two major purposes - not only does it force the management team to document its proposals properly and thereby ensure that it has thought through the consequences of what it is proposing; but it also provides the specific material to which the Health Board, and later the Regional Hospital Board and the Department of Health, can react positively and constructively.

Health Board Review

Before finally endorsing the Health Board plan, the Health Board should fully challenge its proposals, to ensure that the management team has

- Built into the draft plan the priorities that the Health Board confirmed before
- Proposed and properly documented projects that are soundly based
- Included cost reduction plans in each programme
- Proposed budgets that are consistent with the Department's financial guidelines and directives and the Health Board's planning allocations
- Projected future impact of proposals on revenue and capital requirements realistically
- Planned interprogramme coordination fully
- Taken into account all facilities and services, both inside and outside the Health Board organization.

The review of plans by the Health Board is potentially a very valuable part of the planning process. Members with considerable experience in health care or management, coming to the problems comparatively fresh, could build on the management team's work. However, the value of the Board's contribution will be largely determined by the material quality of the draft plan itself. If the plan is poorly documented - proposals inadequately described or supported, statements restricted to generalizations instead of numbers, consequences of proposed actions poorly thought through and/or documented - the Board cannot react positively. The Board must therefore insist that the CEO produces the highest standards in the documentation and presentation of the draft plan.

Department Review

The Department of Health contributes in various ways as the plans are produced. In particular, programme managers incorporate Departmental guidelines when they are determining area priorities; and the Department should receive information and give advice as programme managers develop and discuss project proposals and allocations. Thus, when the management team actually completes the draft plan, and the Board submits it for review by the Department and Regional Hospital Board, the Department will have three major tasks to complete (as opposed to starting from scratch): (1) to check the detail of the plan, (2) to challenge proposed projects, and (3) to review implications of the proposals.

1. Check the detail of the plan. To do this, the Department should consider the following questions:

- Is the plan within the financial guidelines?
- Are priorities in line with national guidelines?
- Are the projects adequately documented?
- Are the numbers realistic and consistent?

2. Challenge the proposed projects. The Department should constructively challenge all projects and the basis on which they are made, using the following questions:

- Is the evidence justifying them - cost, feasibility, impact - explicit and selfsustaining?
- Is the ranking of projects logical and acceptable?
- Have alternatives been considered? Are the grounds for their rejection acceptable?
- Are the projects in line with national guidelines?

3. Review the implications of the proposals. The Department should ensure that the full implications of the proposals have been adequately thought through by the Health Board management teams.

- Are the plans consistent and coordinated? Have interprogramme implications been incorporated?
- Do plans allow for critical shortages of staff?
- Has the future financial burden of new services been fully considered?
- Do the plans allow for future uncertainties? What flexibility is there in the event of a breakthrough? (as for example, when the marked reduction of TB made some sanatoria redundant).

At the same time, the Department should review the implications of the proposals on national policy and future guidelines. Thus, the Department's review should be a 2-way process. The Department passes on its experience to the Health Boards and, at the same time, finds out what is going on in the Health Boards in time to modify national policy and priorities.

PRODUCING FINAL ACTION PLANS

The draft Health Board plan spells out the major developments for the health services. Once the draft proposals have been approved, the management team prepares the final plan, which translates the draft plan into detailed action plans.

Confirming Draft Plan Proposals and Budgets

The Department should communicate its suggestions for revisions to the CEO and should discuss them with him and the management team. The CEO, in turn, should communicate these revisions and final allocations to the programme managers, enabling them to finalize subprogramme plans and budgets.

Preparing Plans for Each Organization Unit

Programme managers should then draw up for each organization unit - for example, each hospital, clinic, community, district - budgets and specific action plans, with responsibilities and timing clearly spelled out. Programme managers should try to gain the agreement of these units' management to the plans and to the budgets that result from them. The plans, when decided, thus become the working documents by which programme managers will measure subsequent performance.

In the matter of costs particularly, programme managers should discuss the budgetary implications for each organization unit, indicating the ways in which the unit will have to respond to the inevitable financial pressures. Programme managers must be quite explicit about expected improvements, such as reduced average duration of stay in general hospitals, or increased community treatment for geriatrics. And programme managers should communicate to all relevant personnel any specific items with cost reduction potential that have been incorporated into final plans - for example, accelerating or expanding radiology services.

SAMPLE ACTION PLAN

Project No:	V	*Responsibility:*	Programme Manager
Programme:	Special Hospital Care	*Start:*	May, 1972
Subprogramme:	Mental Health	*Complete:*	October 1, 1974
Objective:	Complete assessment of all patients in the mental hospitals		

Action Step	Responsibility	Date	
		Start	Complete
1. Complete pilot assessments in four wards	Directors, District Mental Health Service	August 1, 1972	December 1, 1972
2. Revise assessment process	Directors, District Mental Health Service	December 1, 1972	January 1, 1973
3. Undertake assessment throughout all units	Consultant Psychiatrists	April 1, 1973	July 1, 1973

Incorporating
Performance Measures

To ensure that plans are properly implemented, the programme manager should build in specific measures of performance. These measures, or targets, should be monitored on an agreed basis, and substandard performance promptly identified. Without control, some projects would inevitably fall behind schedule.

In certain cases, the performance measures may simply be reports on the completion of particular stages in the action plan; for example, a plan to effect comprehensive assessment of all mentally ill inpatients might require reports to be submitted when 25 per cent, 50 per cent and 100 per cent of the target has been achieved, and might then require a continuing month-end report on the numbers awaiting assessment. Other cases may require more complex measures; for example, a plan to increase social services for the aged might require performance measures not only about the services provided but also about the effectiveness of those services in keeping the aged in the community.

The performance measure, then, is designed to ensure that the project's end result is indeed realized and, which may be just as important, that the result continues in the future. Thus the performance measure is the control function that closes the management loop - plan, act, control.

* * *

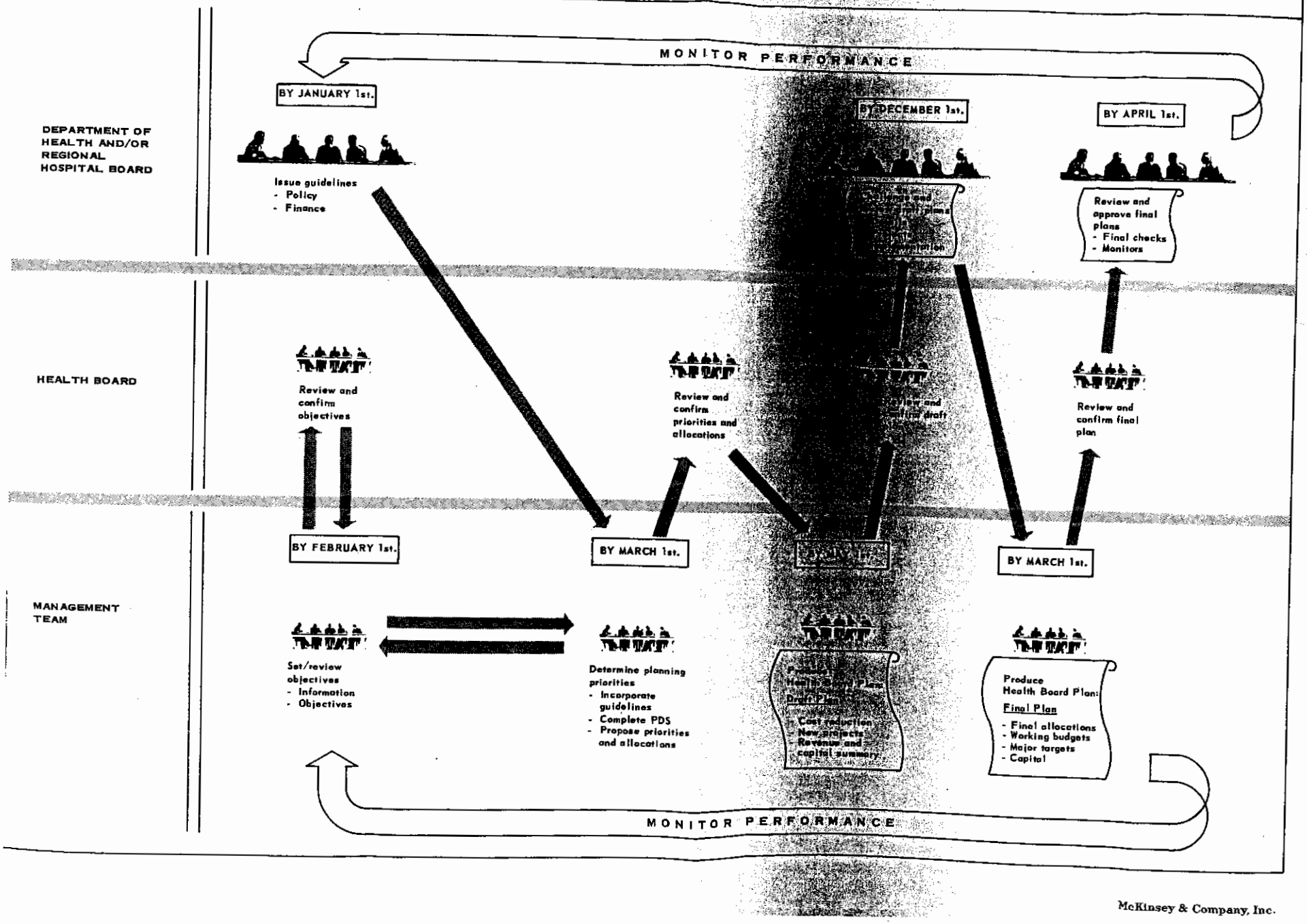
If Health Board plans are to succeed, the Health Board and the management team must monitor action plans and budgets regularly and thoroughly. The Health Board must therefore ask hospital executive committees, consultants and other senior medical personnel in hospitals and in the community to accept responsibility for achieving planned targets, and for making necessary adjustments when these targets are not met.

The Health Board itself must be prepared to take corrective action if the implementation of plans falls behind schedule. Health Board members can investigate such situations either by committee visits or in Board hearings. These follow-up responsibilities and procedures are essential, because without effective implementation, Health Board plans will be worthless.

Appendix C suggests a timetable for phasing in the planning and control processes over the next 3 years.

APPENDIX A - THE PLANNING CYCLE

PROGRAMME PLANNING - THE PLANNING CYCLE



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PREPARING THE DRAFT PLAN

	JANUARY	FEBRUARY	MARCH	APRIL
CEO		**PRIORITIES AND ALLOCATIONS** CEO gains Board approval for proposals on planning priorities and programme allocations, based on - Departmental guidelines - Updated PDSs - Analyses completed earlier		**PREPARING DRAFT HEALTH BOARD** CEO pulls together an overall draft plan ensuring that - Priorities of excluded projects in each programme are not higher than for projects included elsewhere - Plans can sustain challenge - Future commitments of projects in hand to be started are fully incorporated - Programme plans complement each other
PROGRAMME MANAGERS AND PLANNING AND EVALUATION OFFICER	**IDENTIFYING AND UPDATING STANDARDS OF PROVISION** Determine standards of provision from departmental guidelines and medical advice		**PREPARING DRAFT PROGRAMME PLANS** Develop draft programme plans incorporating Total finance required Reduction in services contributing to money available Priorities implicit in the recommended plan Broad action plans for major projects Overall estimates for main organization units Points of flexibility in the plan	
	COMPLETING PROGRAMME DEFINITION STATEMENTS Identify where changes are needed by reviewing and updating or completing - Programme structure and objectives - Standards of provision for identifiable clientele - Needs - Assessment of current provision of services - Gaps (over or under-provision)			
FINANCE OFFICER	**FINANCIAL ADVICE** Converts financial guidelines into usable form for programme planning, e.g. highlights cash available for development			**PREPARING HEALTH BOARD ESTIMATES** First Year - Total expenditure plans for all programmes - Details of impact of major developments or changes All 5 Years - Capital committed and proposed - Projection of revenue expenditure
PERSONNEL OFFICER		**PREPARING PERSONNEL PLANS** Identifies the impact on personnel of - Staff turnover - Developments or changes - Training needs Prepares draft plans for recruiting, moving or training staff		

PREPARING THE FINAL PLAN

	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
CEO	**ASSESSES PERFORMANCE** Evaluates past year's performance against plan - Identifies projects behind schedule - Assesses impact of programmes - Reports conclusion to Health Board			**ADJUSTMENTS TO DRAFT PLAN** Pulls together comments and suggestions made by Health Board and Department after study of draft plan			**GUIDANCE** [illegible]			**APPROVAL** CEO consolidates plans and presents to Health Board, Department and/or RHBs for final approval
PROGRAMME MANAGERS AND PLANNING AND EVALUATION OFFICER								**FINAL PROGRAMME PLANS** Finalize plan in detail for first year: - Final allocation to subprogrammes; - Action plans and budgets for each organizational unit - Major targets to be achieved		
FINANCE OFFICER								**PREPARING BUDGETS** First Year - Budgets for each organizational unit - Capital spending Future Years - Capital and operating projections - Expenditure available for development		**FINANCE FUNCTIONAL PLAN** Detailed functional plan for - Systems improvement - Cash flow - Cost reduction identification
PERSONNEL OFFICER								**DETAILED PERSONNEL PLANS** - Staffing forecasts - Plans for training - Major personnel projects to be accomplished		

ILLUSTRATIVE ONLY

MENTAL HEALTH: SPECIAL HOSPITA

EASTERN HEALTH BOARD

PROGRAMME DEFINITION STATEMENT

Mental Health Objective: To provide care and services in the community and in the ... life of the mentally ill and their families

Items of Service Required for Subprogramme	Target Group	Standard of Provision for Target Group	Need for Servi...	...ance Between ...es Provided ...dNeeded	Comments/— Important Questions
ACUTE CARE					
¶ Outpatient Treatment Centres	860,000 total population (needs to be updated and projected	1 attendance per 18 people per annum Clinic premises to be provided with facilities and services in accordance with Department of Health memorandum	Total attendance... 48,000 15 clinics, each ... offering 3,000 o... more attendance... year	...attendances ...ics too small ...r 1,000 atten...	
- Psychiatrist Care in Out-Patient Treatment Centres	24,000[2] attendances	1 senior psychiatrist[1] can effectively diagnose and treat 30 patients per week	16 senior psychiatrists	...enior psychiatrists	
- Psychiatrie Nursing and Drug Prescription in Out-Patient Treatment Centres	24,000[2] attendances	1 psychiatric nurse (or equivalent) can provide 60 prescriptions per week for patients requiring drugs	9 psychiatric nurses	...psychiatric nurses - All requiring training in prescription of psychiatric drugs	

1. This assumes each senior psychiatrist shares his time equally between inpatient and outpatient treatment centres.
2. Present estimates suggest that one half of attendances are for follow-up drug prescriptions according to treatment prescribed by the consultant and each psychiatric nurse provides inpatient care and work in the community.

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CHILDREN: COMMUNIT

MIDLAND HEALTH BO

PROGRAMME DEFINITION STATEMENT

Children Subprogramme Objective: To enable all children to develop their lives in [illegible] treatment or examination is required, to detec[illegible] possible

Items of Service Required for Subprogramme	Target Group	Standard of Provision for Target Group	Need for Services	[illegible] Provided	[illegible] Unmet	Comments/ Important Questions
Developmental Pediatric Clinics	1925 children (age 0 - 2 in towns with population over 5,000)	All newly-born children to be examined at clinic All children in group to be examined at 6 months, 12 months and 2 years (i.e., average of $1\frac{1}{2}$ visits per infant per year)	983 examinations		[illegible] examinations to be under-	The figures in column 5 are the result of extrapolations from monthly attendance figures at clinics. It should be noted that this service has only been provided since December 1970. The gap in examinations is equivalent to 42 per cent not being examined. Initial Departmental objectives were that 25 per cent of this group be examined and thus a gap of 75 per cent would be tolerable.
School Health Examinations	3,450 National school entrance	Each year all new entrants should be examined	3,450 infants to be examined	2,247 infants examined	1,203 infants not being examined	This is equivalent to a gap of 35 per cent infants not being examined.
Dentists	32,793 National school children	1,000 - 1,500 chairside hours per dentist per year Each school child to receive at least 1 hour of chairside treatment per year	20 dentists required full-time for child work	Equivalent of $10\frac{1}{2}$ dentists working full-time on children	A further equivalent of $9\frac{1}{2}$ dentists required for children's work	The standard of 1 hour's chairside treatment per child per year is likely to be cut at least in half once fluoridation takes effect.

ILLUSTRATIVE ONLY

OTHER REGIONAL SPECIALTIES : GENERAL HO

SOUTHERN HEALTH BOARD

PROGRAMME DEFINITION STATEMENT

Other Regional Specialties Objective: To develop new specialties and teams for [illegible] Cork Regional (CRH), while reviewing wh[illegible] might be provided outside the CRH

Items of Service Required for Subprogramme	Identifiable Clientele	Standard of Provision for Identifiable Clientele	Need for Services	[illegible]	Difference Between Services Provided and Needed	Comments/ Important Questions
BEDS	800,000 regional population	0.58 per '000	465	[illegible] - Includes [illegible] Cork - Dublin continues to take majority of cases	18 - New CRH to provide 225 beds - St. Finbarr plans to introduce . Neurosurgery . Cardiac surgery . Etc.	Review St. Finbarr development prior to CRH - Beds from existing departments? - Equipment costs?
CONSULTANTS	147 beds (current)	1 per 25	6	4	2	In pipeline
	318 (anticipated)	1 per 25	13	4 (allowing for retirement)	9	Develop plans for building specialty teams in preparation for CRH

PHASING IN THE PL

AND CONTROL PRO

Year Planned	1972-73	1973-74		1975-76
Programme Planning	- First cut at PDS. Crude standards of provision - Main areas of priority identified - Action plans for main steps in organizational units - Main issue identified	- Full PDS with some standards of provision thought through - Incorporate completed analysis of one issue - Rough ranking of all priorities - Detailed action plans for main organizational units		
Budgeting	- Costs allocated to sub-programmes by rough cuts - Major projects (revenue and capital) budgeted for over several years	- Costs allocated to sub-programmes by rough cuts - Rough budgets for main organizational units - First cut at projections over five years		
Control System	- Financial control unchanged - Action plans monitored to ensure completion of tasks on time	- Existing financial control system maintained but special analysis made to show actual spending against budget for main organizational units - Formal review of performance against action plan	- Comparison of actual costs against detailed budgets (in parallel with existing system) - Formal review of performance against action plan - First cut at Board comparisons of cost and impact of services	
Accounting System	- Unchanged	- Unchanged	- Existing system run in parallel with first cut at system for providing actual costs versus budget for main organizational units - Decide on feasibility of computerization and allocating actual cost to subprogrammes	