

***Self-Assessment Tool to***

***Explore Alignment with a***

***Population Health Approach***

**Version 1: Draft For Testing**

Document Information

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| **Acknowledgements:** | We would like to acknowledge and thank all those involved in the development of this self-assessment tool.  |
| **Document Title:** | Self-Assessment Tool to Explore Alignment with a Population Health Approach Version 1: Draft for Testing.  |
| **Document Developed By:** | This tool was developed by the Project Team on behalf of the National Health Service Improvement Team, Public Health HSE. Appendix A outlines the key steps taken in developing the first version of the tool for testing.  |
| **Document Version:** | **Please note**: This is a first version of this tool for testing. We are dedicated to continuous improvement and learning, and we highly value your feedback on this document. Your insights provide an opportunity to refine our work and further enhance its impact. This is a dynamic document, and we look forward to improving it with your feedback. **Please use the Appendix B questions to guide your feedback following use of the tool, and email your response to the Project Team at:** NationalHealthServiceImprovement@hse.ieIf you plan to adapt or use any component of the tool, please let us know at NationalHealthServiceImprovement@hse.ie and attribute this to National Health Service Improvement, Public Health HSE. |
| **Document Revision History:** | **This document is V1 for testing, 12/06/2025.** **Please note**: Appendix A details the key steps taken in developing the first version of the tool for testing. Previous versions created in the development of V1 include:* v0.3, 07/03/2025
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| **Approved By:** | Final approval of this document and future versions rests with the Director of National Health Service Improvement (Dr. Jennifer Martin).  |
| **Revision Date:** | Revision to develop Version 2 will be undertaken following outputs of the All Together for Population Health Project (**please note**: these are expected in Q4 2025) - this is a project led by Public Health HSE in collaboration with the Royal College of Surgeons in Ireland School of Population Heath, which aims to co-design a national consensus definition and principles for a population health approach. |

National Health Service Improvement, Public Health

*The National Health Service Improvement Team aims to improve population health and health equity by designing, testing, implementing and learning from health service improvements. We do this through system leadership, taking an evidence-led approach and building improvement capabilities across the health services.  At regional level, we work collaboratively with Departments of Public Health and other stakeholders, including patients, communities, and professionals in health and allied services, to address the health needs of the entire regional population.  At national level, we focus on specific priority cohorts, including underserved populations, working closely with people with lived experience and other stakeholders, to deliver targeted interventions that address the unique needs of these groups.  The National Health Service Improvement team can be contacted at:* NationalHealthServiceImprovement@hse.ie

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# Introduction

## Context - Population Health

Population health is an increasingly prominent concept. In Ireland, the need to re-orient heath service delivery and planning towards a population health approach, population needs, and prevention, is articulated in the Sláintecare policy vision for healthcare (1). The 2023 HSE Health Regions Implementation Plan (2) describes a population-based approach to planning as aiming to ‘improve the health and wellbeing of the entire population by considering all determinants of health.’

There is, however, no universally agreed definition for a population health approach, nationally or internationally. As part of a collaborative project undertaken over 2024 between the National Health Service Improvement (NHSI) Team, Public Health HSE, the HSE Clinical Director for Integrated Care, and HSE Clinical Design and Innovation, an interim definition and eight guiding principles of a population health approach were developed (3). A population health approach was defined for this project as ‘a cross-sectoral and interdisciplinary approach to prevention and optimising the physical, mental and social health status of, and equity within, a given population’, that ‘considers socioeconomic, environmental, cultural, behavioural and healthcare factors in improving population health and wellbeing and is underpinned by evidence-based action.’

The eight interim principles of a population health approach included:

1. A Population Perspective
2. Prevention
3. Equity
4. Determinants of Health
5. Partnership and Community Engagement
6. Climate Action and Sustainability[[1]](#footnote-2)
7. Integration of Care / Systems Lens on Health
8. Evidence and Measurement

While these are considered interim population health principles,over 2025 Public Health HSE are collaborating with the Royal College of Surgeons in Ireland School of Population Health, on a project which aims to establish a national consensus definition and principles for a population health approach. This tool will be revised accordingly with the outputs of this project.

**Figure 1** presents a high-level view of how the eight interim principles form a population health approach that is grounded in ongoing learning and improvement over time.

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**Figure 1.** Eight Interim Principles of a Population Health Approach, developed by the National Health Service Improvement Team (Public Health, HSE) in collaboration with the HSE National Clinical Director for Integrated Care, HSE Clinical Design and Innovation, and the National Clinical Advisor and Group Lead for Chronic Disease, in 2024 (3) – subject to iteration in 2025. **Note**: Climate Action and Sustainability was originally termed ‘Environmental Sustainability’ in the 2024 Project – this was updated for this self-assessment tool to be consistent with the terminology used by the HSE Climate Action and Sustainability Programme.

# About the Self-Assessment Tool

## What is the Self-Assessment Tool?

The self-assessment tool is intended to support those seeking to explore and enhance their current alignment with the principles of a population health approach. It provides an opportunity to take a systematic look at how current work aligns with these principles, providing insights to help identify gaps and opportunities to build on. The tool is a dynamic document that will be improved over time through an iterative approach as learning is identified from its use, so that it remains as relevant to users as possible. Ultimately, the tool represents a means to begin a journey towards greater alignment with a population health approach.

## Who can use the Self-Assessment Tool?

The self-assessment tool has been developed as a flexible tool to be used by people working in the design and delivery of, for example, clinical programmes, services and other similar areas in the HSE. It is expected that more potential users will be identified as the tool is tested and improved over time, and learning is generated from this process.

## Where does the Self-Assessment Tool fit with improving health services?

This self-assessment tool can support people who are working to improve health services. The National Health Service Improvement Team, Public Health, HSE has developed a working draft *Health Service Improvement Cycle[[2]](#footnote-3)*. This cycle includes five iterative steps outlined below, which when followed will support continuous learning and improvement:

1. **Discover** (what is the problem / opportunity for improvement?)
2. **Define** (what needs to change, and why?)
3. **Design** (the solution(s) needed)
4. **Deliver** (the solution(s) agreed)
5. **Demonstrate** (the learning)

This self-assessment tool particularly supports the first three steps in this cycle (Discover, Define and Design). The tool is, therefore, likely to be most informative in the planning phases of work - Discovery, Defining and Designing services to improve population health. It can also be used at the Demonstrate phase to review progress against achieving population health improvements.

## What is the benefit of using the Self-Assessment Tool?

The intended benefits of using the self-assessment tool include:

* Providing a consistent and clear understanding of the principles underpinning a population health approach
* Supporting the identification of current alignment and gaps with regards to a population health approach, together with opportunities and barriers to creating that alignment
* Supporting the development of an action plan to address gaps and opportunities to build on and enhance existing alignment

# How to Use the Self-Assessment Tool

## Structure of the Self-Assessment Tool

The self-assessment tool starts with a short explanation of each of the interim eight population health principles (**Section 1**). The tool then asks the user(s) to consider at high-level where their current work and resources (e.g. people, time, funding) are focused across the eight principles, noting any particular examples under each principle (**Section 2**).

Next, user(s) work through each of the eight principles using a set of questions (**Section 3**). Each question is presented with a table to facilitate exploration of current alignment, identification of gaps, and recording of intended steps to address gaps as part of an action plan.

At the end of the self-assessment, there is a template action plan to capture an overall summary and intended actions for each principle (**Section 4**).

## Completing the Self-Assessment

Where possible, the self-assessment should be completed through group discussion(s).

While the principles are ordered from 1 to 8 in the tool, there is no prescribed order in which they need to be considered. It may, however, be most logical to start with Principle 1: A Population Perspective.

For each principle, it is suggested to first read the explanation provided for the principle, and then consider each of the questions in turn, capturing key notes from discussion in relation to current alignment with the principle, and any gaps and opportunities identified.

After completing the questions for all of the principles, use of the template action plan is encouraged to record an overall summary of the self-assessment, and any actions identified.

# Self-Assessment Tool

## Section 1: Overview of the Principles of a Population Health Approach

**Action:** Review **Table 1** which presents a short explanation for each of the eight interim principles of a population health approach.

**Table 1.** Overview: Interim Principles of a Population Health Approach (3).

|  |
| --- |
| **Principle 1: A Population Perspective** |
| A population health approach seeks to improve the health of all members of a population, not just individuals or groups of individuals who seek healthcare. |
| **Principle 2: Prevention** |
| A population health approach focuses on preventing illness and promoting overall health and wellbeing (physical, mental, and social) throughout a person's life. It includes all types (also known as levels) of prevention: stopping illness before it starts (primary prevention), detecting illness early to intervene as early as possible (secondary prevention), and managing long-term illness to reduce complications and improve quality of life (tertiary prevention). |
| **Principle 3: Equity** |
| A population health approach contributes to improving health equity through efforts to reduce or eliminate unnecessary, unfair and avoidable differences in health status across the population. Health equity is achieved when everyone can attain their full potential for health and well-being. This principle includes supporting groups in the population that are underserved for any reason such as their social, geographical or other circumstances. |
| **Principle 4: Determinants of Health** |
| A population health approach understands and tackles the various factors that affect people's health. It recognises that these factors are many, complex, and interconnected, and they can influence health both on an individual level and within the broader community. |
| **Principle 5: Partnership and Community Engagement** |
| A population health approach is based on cross-sectoral collaborative partnerships with key stakeholders. The approach recognises that population health is a shared responsibility across many sectors, and as such, a foundation of partnership is key to enable coordinated, integrated and multi-faceted efforts to improve population health. This crucially includes partnership and engagement with patients and communities so that the voice, needs, preferences and strengths of individuals and communities are represented and central to work undertaken. |
| **Principle 6: Environmental Sustainability** |
| A population health approach prioritises sustainability through integration of climate action and sustainability considerations, so that current population needs are met without compromising the capacity to meet future needs. |
| **Principle 7: Integration of Care / Systems Lens on Health** |
| A population health approach focuses on care that is well-organised and managed so that patients and communities experience one health system, with coordinated integration of care across all relevant service providers, resulting in the right care being provided in the right place, at the right time. Integration includes a number of different dimensions - for example, between the different settings where care is provided, and between different services and disciplines providing care. Integration of care should also consider the requirements of patients and communities that may have multiple health conditions. |
| **Principle 8: Evidence and Measurement for Population Health Improvement** |
| A population health approach is underpinned by measuring what matters. Evidence on what has worked before in Ireland and abroad provides insights to inform work undertaken. Data, including key population health activity and outcome indicators as well as qualitative information, informs evidence-based decision-making. This allows for more effective prioritisation, planning, implementation and evaluation of actions, policies, practices and interventions to improve population health and reduce health inequities. Measurement also supports intersectoral accountability for population health outcomes. |

## Section 2: High-Level Mapping of Current Work

**Action:** Having reviewed the explanations for each of the eight principles, consider and document in **Table 2** below where your current work and resources (e.g. people, time, funding) are focused across the eight principles. Please also note any particular examples under each principle. This is intended to be a high-level starting point before **Section 3**, where you will work through the set of questions for each of the eight principles.

**Table 2.** Template Table to Identify What Principles You Currently Focus On.

|  |  |
| --- | --- |
| **Population Health Principle** | **Where are your current work and resources directed?****Are there any examples to capture?** |
| **A Population Perspective** |  |
| **Prevention** |  |
| **Equity** |  |
| **Determinants of Health** |  |
| **Partnership and****Community Engagement** |  |
| **Climate Action and Sustainability**  |  |
| **Integration of Care /** **Systems Lens on Health** |  |
| **Evidence and Measurement**  |  |

## Section 3: Self-Assessment Questions by Principle

**Action**: Consider each of the principles in detail by working through the set of questions and prompts. The short explanation of the principle is repeated below for ease of reference as you answer the questions.

### Principle 1: A Population Perspective

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| --- |
| **What does this mean?** |
| A population health approach seeks to improve the health of all members of a population, not just individuals or groups of individuals who seek healthcare. |

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| **Question 1.1** | **How do you define your population?** |
| **Prompts** | * What is your current definition of your population?
* What are the criteria you use to define your population?
	+ For example - clinical, demographic, and/or other criteria.
* Does your population include everyone at risk of a particular health condition, or only those who have a diagnosis of the condition? (if applicable)
* Does your population only include people who attend healthcare services?
* Are you missing any people who should be included in your population?
	+ If so, how might you address this?
 |
| **How are we currently aligned to this principle?** |  |
| **What are our gaps and opportunities?** |  |
| **What steps can we take to address our gaps and opportunities?** |  |

|  |  |
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| **Question 1.2** | **Is the design and delivery of your work informed by an understanding of your population’s health status, strengths and needs?** |
| **Prompts** | * What information do you use to understand your population’s health status?
* What information do you use to understand your population’s strengths?
* What information do you use to understand your population’s needs?
* Are you missing any information?
	+ If so, how might you address this?
 |
| **How are we currently aligned to this principle?** |  |
| **What are our gaps and opportunities?** |  |
| **What steps can we take to address our gaps and opportunities?** |  |

### Principle 2: Prevention

|  |
| --- |
| **What does this mean?** |
| A population health approach focuses on preventing illness and promoting overall health and wellbeing (physical, mental, and social) throughout a person's life. It includes all types (also known as levels) of prevention: stopping illness before it starts (primary prevention), detecting illness early to intervene as early as possible (secondary prevention), and managing long-term illness to reduce complications and improve quality of life (tertiary prevention). |

|  |  |
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| **Question 2.1** | **How are you supporting primary prevention activities for your population?** |
| **Relevant Definitions** | As noted in the [Glossary of Terms](#_Appendix_B:_Glossary), primary prevention activities focus on preventing the manifestation of illness. For example, addressing factors such as tobacco and alcohol legislation, immunisation, health behaviour education.  |
| **Prompts** | * Consider physical, mental and social health and wellbeing.
* Are there additional activities that could be considered?
 |
| **How are we currently aligned to this principle?** |  |
| **What are our gaps and opportunities?** |  |
| **What steps can we take to address our gaps and opportunities?** |  |

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| **Question 2.2** | **How are you supporting secondary prevention activities for your population?** |
| **Relevant Definitions** | As noted in the [Glossary of Terms](#_Appendix_B:_Glossary), secondary prevention activities focus on early detection of a problem, to support early intervention and treatment, and reduce the level of harm. For example, screening services. |
| **Prompts** | * Consider physical, mental and social health and wellbeing.
* Are there additional activities that could be considered?
 |
| **How are we currently aligned to this principle?** |  |
| **What are our gaps and opportunities?** |  |
| **What steps can we take to address our gaps and opportunities?** |  |

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| **Question 2.3** | **How are you supporting tertiary prevention activities for your population?** |
| **Relevant Definitions** | As noted in the [Glossary of Terms](#_Appendix_B:_Glossary), tertiary prevention activities focus on supporting better quality of life for those living with established illness. For example, rehabilitation programmes, disease management programmes including self-management. |
| **Prompts** | * Consider physical, mental and social health and wellbeing.
* Are there additional activities that could be considered?
 |
| **How are we currently aligned to this principle?** |  |
| **What are our gaps and opportunities?** |  |
| **What steps can we take to address our gaps and opportunities?** |  |

### Principle 3: Equity

|  |
| --- |
| **What does this mean?** |
| A population health approach contributes to improving health equity through efforts to reduce or eliminate unnecessary, unfair and avoidable differences in health status across the population. Health equity is achieved when everyone can attain their full potential for health and well-being. This principle includes supporting groups in the population that are underserved for any reason such as their social, geographical or other circumstances.  |

|  |  |
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| **Question 3.1** | **Are you able to identify underserved groups in your population?** |
| **Prompts** | * Examples of underserved groups include (**note**: examples listed represent a non-exhaustive list):
	+ Irish Travellers, Roma, people experiencing homelessness, people who use drugs (including alcohol), refugees and applicants seeking protection (Beneficiaries Of Temporary Protection (BOTP) and International Protection Applicants (IPA)), people in the justice system, sex workers, survivors of domestic, sexual and gender-based violence, LGBTI+ (lesbian, gay, bisexual, transgender, intersex, queer, +), other vulnerable migrants (e.g. undocumented migrants).
* How do you identify these groups at the point of care?
	+ For example, are you aware of things that might indicate a person if from an underserved group, such as their address?
* What measures do you collect that tell you about underserved groups?
	+ For example, do you collect data on ethnicity, country of birth, and language?
	+ How do you identify these groups in the data you collect?
* Are you missing data on underserved groups?
	+ If so, how might you address this?
 |
| **How are we currently aligned to this principle?** |  |
| **What are our gaps and opportunities?** |  |
| **What steps can we take to address our gaps and opportunities?** |  |

|  |  |
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| **Question 3.2** | **How is the clinical care that you design and/or deliver supporting the needs of the underserved groups in your population?** |
| **Prompts** | * How is the care designed and/or delivered (e.g. healthcare visits) adapted to language, literacy and cultural needs?
	+ For example,
		- Are translation/interpretation services readily available for use?
		- What else is in place to make the clinical care encounter easier?
		- How are people supported to attend appointments?
* Do you have links to Inclusion Health services?
* Do you have links to outreach services?
* Do you have links to HSE Social Inclusion?
* Are there others that you link in with on this, such as key workers or case managers?
	+ If so,
		- How do these links support the underserved groups in your population?
		- Do they support all underserved groups?
		- Which groups do these links support, if not all groups?
* How are resources provided as part of the clinical encounter adapted?
	+ For example, are information leaflets for patients adapted to different languages?
 |
| **How are we currently aligned to this principle?** |  |
| **What are our gaps and opportunities?** |  |
| **What steps can we take to address our gaps and opportunities?** |  |

### Principle 4: The Determinants of Health

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| --- |
| **What does this mean?** |
| A population health approach understands and tackles the various factors that affect people's health. It recognises that these factors are many, complex, and interconnected, and they can influence health both on an individual level and within the broader community. |

|  |  |
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| **Question 4.1** | **Which determinants do you consider to most impact your population?** |
| **Relevant Definitions** | As noted in the [Glossary of Terms](#_Appendix_B:_Glossary), the determinants of health include the social and economic environment, the physical environment, and an individual’s characteristics and behaviours. For the purposes of completing this self-assessment tool, the focus should be on the social determinants of health (SDOH) – these are the non-medical determinants that influence health outcomes. Examples of the SDOH include income, education, employment and the workplace, housing and the built environment, social status and social support.  |
| **Prompts** | * How do these determinants impact your population?
* Are there any determinants that you consider as particular priorities for your population?
 |
| **How are we currently aligned to this principle?** |  |
| **What are our gaps and opportunities?** |  |
| **What steps can we take to address our gaps and opportunities?** |  |

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| **Question 4.2** | **Are you involved in any activities or initiatives to address any of the social determinant(s) of health?** |
| **Prompts** | * What is the nature of the activities or initiatives?
* Which determinants do these activities or initiatives address?
* Who do you undertake these activities or initiatives with?
 |
| **How are we currently aligned to this principle?** |  |
| **What are our gaps and opportunities?** |  |
| **What steps can we take to address our gaps and opportunities?** |  |

### Principle 5: Partnership and Community Engagement

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| **What does this mean?** |
| A population health approach is based on cross-sectoral collaborative partnerships with key stakeholders. The approach recognises that population health is a shared responsibility across many sectors, and as such, a foundation of partnership is key to enable coordinated, integrated and multi-faceted efforts to improve population health. This crucially includes partnership and engagement with patients and communities so that the voice, needs, preferences and strengths of individuals and communities are represented and central to work undertaken. |

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| **Question 5.1** | **Who do you consider to be the key stakeholders for your work?** |
| **Relevant Definitions** | As noted in the [Glossary of Terms](#_Appendix_B:_Glossary), when we use the term ‘patient’, we are referring to people who use, or are supported by healthcare services, their personal support network, communities and anyone who may use healthcare services in the future. |
| **Prompts** | * Have you undertaken a stakeholder analysis?
	+ For example, stakeholders might include representatives of your population such as patients, community groups, different disciplines, programmes and services in the HSE, voluntary organisations, and other public sector bodies.
* Do you work with patients and communities?
* Who are the other stakeholders that you work with?
 |
| **How are we currently aligned to this principle?** |  |
| **What are our gaps and opportunities?** |  |
| **What steps can we take to address our gaps and opportunities?** |  |

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| **Question 5.2** | **How do you engage with your stakeholders?**  |
| **Relevant Definitions** | As noted in the [Glossary of Terms](#_Appendix_B:_Glossary), the HSE Change Guide outlines the different levels of stakeholder communication and engagement, including (from the lowest to the highest level of engagement) - No involvement, Information Sharing, Feedback Mechanisms Created, Consultation, Participation, Collaboration, and Partnership.  |
| **Prompts** | * With these levels in mind, consider the activities or processes you undertake to engage with your stakeholders as part of your work.
	+ Which of the above levels do they match to, and for which stakeholders?
* Are there other activities or processes that would strengthen the level of your engagements?
* If you are not already at the partnership level with key stakeholders, but want to get there, what is needed to reach this level?
 |
| **How are we currently aligned to this principle?** |  |
| **What are our gaps and opportunities?** |  |
| **What steps can we take to address our gaps and opportunities?** |  |

### Principle 6: Climate Action and Sustainability

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| **What does this mean?** |
| A population health approach prioritises sustainability through integration of climate action and sustainability considerations, so that current population needs are met without compromising the capacity to meet future needs. |

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| **Question 6.1** | **How do you bring climate action and sustainability considerations into your work?** |
| **Prompts** | * The HSE Climate Action and Sustainability Programme highlights seven key considerations for climate action and sustainability, which are aligned to the HSE Climate Action Strategy 2023 – 2050 (7):
	+ **Disease prevention** (**note**: **please refer to Principle 2: Prevention** in this self-assessment tool for your answers to this consideration).
	+ **A patient-empowered approach** e.g. patient education and self-management programmes, social prescribing, use of digital solutions to support patients (**note**: **please refer to Principle 2: Prevention** in this self-assessment tool for your answers to this consideration).
	+ **Lean pathways** – this refers to providing integrated care close to home and taking a systems lens on care e.g. access to care in community settings, e-Health-enabled options for care such as remote consultations (**note: please refer to Principle 7: Integration of Care / Systems Lens on Health** in this self-assessment tool for your answers to this consideration).
	+ **Clinical leadership** – this refers to promoting sustainability behaviours of a climate-informed workforce, with an understanding of the environmental impact of the care provided and actions that can be taken to reduce this impact.
	+ **Low-carbon alternatives** e.g. reduce, reuse, repurpose and recycle clinical instruments, move to dry powder inhalers, alternatives to single use plastics.
	+ **Operational resource use** e.g. considering the resources used when providing care, such as water, energy, modes of transport, and generation of waste.
	+ **Adaptation and resilience** e.g. how we adjust to the actual or expected effects of climate change to protect people and our healthcare systems from the changes that are brought about by a changing climate.
 |
| **How are we currently aligned to this principle?** |  |
| **What are our gaps and opportunities?** |  |
| **What steps can we take to address our gaps and opportunities?** |  |

### Principle 7: Integration of Care / Systems Lens on Health

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| --- |
| **What does this mean?** |
| A population health approach focuses on care that is well-organised and managed so that patients and communities experience one health system, with coordinated integration of care across all relevant service providers, resulting in the right care being provided in the right place, at the right time. Integration includes a number of different dimensions - for example, between the different settings where care is provided, and between different services and disciplines providing care. Integration of care should also consider the requirements of patients and communities that may have multiple health conditions.  |

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| **Question 7.1** | **Do you have a full understanding of the patient journey for your population, including all of the services they interact with?** |
| **Prompts** | * Have you considered the full patient journey, including all of the potential touchpoints for the patient within and outside of healthcare?
* Are there parts of the patient journey that you have not considered?
* Have you identified common transitions of care for patients?
	+ If so,
		- Have you considered how these transitions are currently supported by healthcare services?
		- What are the strengths and weaknesses of current transition of care processes?
 |
| **How are we currently aligned to this principle?** |  |
| **What are our gaps and opportunities?** |  |
| **What steps can we take to address our gaps and opportunities?** |  |

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| **Question 7.2** | **How do you support delivery of care in the right place at the right time?** |
| **Prompts** | * How do you support delivery of care at the lowest appropriate level of complexity when designing, implementing, and/or evaluating services?
	+ For example, delivering services in the community setting instead of the hospital setting, if clinically appropriate, and/or placing an emphasis on prevention.
* How are you enabling patients to self-manage their chronic condition(s)? (if applicable)
* How do you support healthcare professionals to deliver integrated care for your population?
	+ For example, through designing and implementing integrated care pathways, through supporting a multidisciplinary approach, through enabling and supporting information sharing activities between healthcare professionals.
* What are the clinical governance structures for your work, and do they support integration of care for your population?
 |
| **How are we currently aligned to this principle?** |  |
| **What are our gaps and opportunities?** |  |
| **What steps can we take to address our gaps and opportunities?** |  |

### Principle 8: Evidence and Measurement

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| --- |
| **What does this mean?** |
| A population health approach is underpinned by measuring what matters. Evidence on what has worked before in Ireland and abroad provides insights to inform work undertaken. Data, including key population health activity and outcome indicators as well as qualitative information, informs evidence-based decision-making. This allows for more effective prioritisation, planning, implementation and evaluation of actions, policies, practices and interventions to improve population health and reduce health inequities. Measurement also supports intersectoral accountability for population health outcomes. |

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| **Question 8.1** | **What measures are included in the core dataset for your work?** |
| **Prompts** | * Consider all structure, activity/process, output and outcome measures.
	+ Include quantitative and qualitative measures and information.
	+ Examples of qualitative measures may include surveys, focus groups, interviews.
 |
| **How are we currently aligned to this principle?** |  |
| **What are our gaps and opportunities?** |  |
| **What steps can we take to address our gaps and opportunities?** |  |

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| **Question 8.2** | **Does your measurement inform planning, monitoring, identification of priorities and decision-making regarding your population?** |
| **Prompts** | * Do you have data on population health need and disease burden, and the spread of same, paying particular attention to any underserved populations?
	+ If so, record any measures here.
* Do you have qualitative information, including direct input from your population on what matters to them?
	+ If so, record any measures here.
* How do you act on findings from your measures?
	+ For example, do you have any examples of where you have changed activities as a result of your measures?
* What monitoring processes do you have in place?
	+ For example, who reviews your measures and how often are they reviewed?
* Do you have a subset of measures that you feed into HSE processes such as operational planning and National Service Planning?
* Do you have a process for feedback and sharing of information to patients and healthcare professionals on the front line?
 |
| **How are we currently aligned to this principle?** |  |
| **What are our gaps and opportunities?** |  |
| **What steps can we take to address our gaps and opportunities?** |  |

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| **Question 8.3** | **Does your measurement tell you if you are achieving the improvements that you have set out to achieve for your population?** |
| **Prompts** | * Do you have a clear aim statement for your work?
* Do you have output and outcome measures aligned to this aim?
* Do you have activity measures across all aspects of your work?
	+ If so,
		- Do your measures tell you if planned activities are occurring as intended and with full population coverage?
		- Do you augment these measures with audit to check that the actions are occurring as intended?
		- Do you have data that tells you that activity is happening for all of your population?
* Do you pay particular attention to population groups that may not be receiving the care they should – for example, underserved populations?
* Do you have any measures pertaining to costs or cost-effectiveness of your work?
 |
| **How are we currently aligned to this principle?** |  |
| **What are our gaps and opportunities?** |  |
| **What steps can we take to address our gaps and opportunities?** |  |

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| **Question 8.4** | **Have you undertaken any self-evaluations or commissioned any evaluations of your work?** |
| **Prompts** | * Do you have information from any evaluations undertaken or commissioned pertaining to your work?
	+ If so, how has this information been used to make changes in your work?
 |
| **How are we currently aligned to this principle?** |  |
| **What are our gaps and opportunities?** |  |
| **What steps can we take to address our gaps and opportunities?** |  |

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| **Question 8.5** | **How does published evidence or international experience inform your work?**  |
| **Prompts** | * Are you aware of the national or world leaders and experts in your area of work?
* How is published evidence and/or international experience used to inform your work?
	+ Do you have any past examples of this?
* Are you up to date with most recent evidence regarding your population as it refers to the principles of population health approach in this tool?
 |
| **How are we currently aligned to this principle?** |  |
| **What are our gaps and opportunities?** |  |
| **What steps can we take to address our gaps and opportunities?** |  |

## Section 4: Template Action Plan to Address Gaps and Opportunities Identified

**Table 3** below provides a template action plan to capture a summary of the responses provided to the self-assessment tool, focusing on current alignment, gaps and opportunities, and next steps. In terms of progressing the next steps identified, continuing with the steps of the working draft health service improvement cycle developed by the NHSI Team, Public Health HSE referenced in **Figure 2** may be helpful in conceptualising actions and supporting continuous learning and improvement.

**Table 3.** Template Action Plan.

|  |  |  |  |
| --- | --- | --- | --- |
| **Population Health Principle** | **How are we currently aligned to this principle?**  | **What are our gaps and opportunities?** | **What steps can we take to address our gaps and opportunities?** |
| **A Population Perspective** |  |  |  |
| **Prevention** |  |  |  |
| **Equity** |  |  |  |
| **Determinants of Health** |  |  |  |
| **Partnership and****Community Engagement** |  |  |  |
| **Climate Action and Sustainability**  |  |  |  |
| **Integration of Care / Systems Lens on Health** |  |  |  |
| **Evidence and** **Measurement**  |  |  |  |

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7. Health Service Executive. HSE Climate Action Strategy 2023 – 2050. 2023. Available from: <https://www.hse.ie/eng/about/who/healthbusinessservices/national-health-sustainability-office/climate-change-and-health/hse-climate-action-strategy-2023-50.pdf>

# Appendices

## Appendix A: Key Steps in the Iterative Development of the Self-Assessment Tool

**This tool was developed using the Plan-Do-Study-Act (PDSA) model[[3]](#footnote-4). The key steps to develop this first version (V1) for testing were as follows:**

1. A rapid review of self-assessment tools by national and international organisations, as listed in **Table A** on the next page, to review examples of structure and content to inform design of this tool. As new tools were identified over the course of the development of this tool, they were reviewed and added to **Table A**.
2. The first draft (v0.1) was developed, informed by Step 1 and the content of a population health principles checklist developed for the 2024 project described in the Introduction part of this document.
3. The draft v0.1 was shared with the NHSI Team, 2024 Project Working Group, and the three NCPs that were involved in the 2024 Project as participants for a focused exploration of programmes. Their feedback on the content, usefulness and usability of the tool was sought.
4. The second draft (v0.2) was developed, informed by feedback from Step 3. This completed PDSA Cycle 1.
5. The draft v0.2 was tested with a NCP through an in-person facilitated workshop with the NCP Team to gather feedback on content, usefulness and usability. (**Note**: This was a different NCP to those referenced in Step 3).
6. A series of virtual meetings with predominantly internal HSE stakeholders (plus one external academic stakeholder) were arranged to inform development of specific principles that were identified as particularly needing further expertise to inform question and prompt development (these principles were Principle 3: Equity, Principle 6: Environmental Sustainability and Principle 7: Integration of Care / Systems Lens on Health).
7. Draft v0.3 was developed, informed by feedback from Step 6. This completed PDSA Cycle 2.
8. Draft v0.3 was shared again with the 2024 Project Working Group[[4]](#footnote-5) for review and feedback, with the intention of using this feedback to produce a V1 for testing.
9. The final V1 for testing was developed, informed by feedback from Step 8. This completed PDSA Cycle 3. The V1 tool has been developed for testing with target audiences to inform the development and improvement of the next version of the tool.
10. PDSA Cycle 4 will commence with planning for and testing use of V1.

**Table A\***. Self-Assessment Tools and Other Relevant Resources Included in the Rapid Review to Inform in Tool Development.

**\*Please note**: Feel free to share with us, as part of your feedback, any other self-assessment tools or similar resources you are aware of which you think we should consider for future improvements to this self-assessment tool.

|  |  |
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| **Document Title and Organisation** | **Link to Document** |
| Self-Assessment Tool for National Health and Social Care Data Collections (**Health Information and Quality Authority**) | <https://www.hiqa.ie/sites/default/files/2017-05/Self-Assessment-Tool-for-national-health-and-social-care-data-collections-May2017.pdf>   |
| Sample Self-Assessment Tool to assess compliance with the National Standards for Safer Better Healthcare (**Health Information and Quality Authority**) | <https://www.hiqa.ie/sites/default/files/2024-09/Self-assessment-Tool-against-National-Standards-for-Safer-Better-Healthcare.pdf>   |
| Self-Assessment Questionnaire and Quality Improvement Tool for International Protection Accommodation Services (**Health Information and Quality Authority**) | <https://www.hiqa.ie/sites/default/files/2017-01/IG-Self-Assessment-Form.pdf>   |
| Self-assessment tool for the evaluation of essential public health operations in the WHO European Region (**World Health Organization**) | <https://iris.who.int/handle/10665/344398>  |
| Improvement Capability Self‐Assessment Tool (**Institute for Healthcare Improvement**) | <https://s20056.pcdn.co/wp->content/uploads/2017/01/IHIImprovementCapabilitySelfAssessmentTool-2.pdf  |
| A Self-Assessment Tool: A National Action Plan to Advance Patient Safety (**Institute for Healthcare Improvement**) | <https://forms.ihi.org/national-action-plan-downloads?submissionGuid=e3b22d72-f3f7-4742-8145-b568aa623c0c>  |
| Culture of Improvement Self-Assessment (**Virginia Mason Institute**) | [info.virginiamasoninstitute.org/l/447922/2020-07- 20/995kby/447922/257320/Culture\_of\_ Improvement\_Self\_Assessment.pdf](https://info.virginiamasoninstitute.org/l/447922/2020-07-20/995kby/447922/257320/Culture_of_Improvement_Self_Assessment.pdf)  |
| Population Health: A Self-Assessment Tool for Rural Health Providers and Organizations (**Rural Policy Research Institute – University of Iowa**) | [https://ruralhealthvalue.public-health.uiowa.edu/files/ RHV%20Pop%20Health%20Assessment.pdf](https://ruralhealthvalue.public-health.uiowa.edu/files/%20RHV%20Pop%20Health%20Assessment.pdf)   |
| Population Health Management Capabilities Self-Assessment Tool (**Kaiser Foundation Hospitals**) | <https://phminitiative.com/wp-content/uploads/2023/06/PHM-Capabilities-Assessment-Tool.pdf>   |
| Critical Appraisal Skills Checklists (**Critical Appraisal Skills Programme**) | <https://casp-uk.net/casp-tools-checklists/cohort-study-checklist/>   |
| Designing our Public Services - Design principles for Government in Ireland(**Department of Public Expenditure and Reform – Government of Ireland**) | <https://assets.gov.ie/269839/eea535fe-311f-4204-8d34-866ce0e3bda6.pdf>  |
| NHS IMPACT Self-Assessment(**National Health Service**) | https://www.england.nhs.uk/nhsimpact/assessment-and-improvement/self-assessment/ |
| Quality and Patient Safety Competency Navigator(**Health Service Executive**) | https://www2.healthservice.hse.ie/organisation/nqpsd/featured-articles/quality-and-patient-safety-competency-navigator/ |
| Health Equity Assessment Tool(**UK Office for Health Improvement and Disparities**) | https://www.gov.uk/government/publications/health-equity-assessment-tool-heat/health-equity-assessment-tool-heat-executive-summary |
| Health Emergency Preparedness Self-Assessment Tool: User Guide(**European Centre for Disease Prevention and Control**) | https://www.ecdc.europa.eu/sites/default/files/documents/Technical-Doc-HEPSA-tool-update-dec-18.pdf |
| Standards for Equity in Health Care for Migrants and Other Vulnerable Groups: Self-Assessment Tool for Pilot Implementation. (**Health Promoting Hospitals and Health Services Taskforce: Migrant Friendly Hospitals and Health Services**) | https://cespyd.es/a/wp-content/uploads/2018/01/Equity-Standards-SAT-2014\_Light.pdf |

## Appendix B: Feedback on the Self-Assessment Tool

Please use the following questions to guide your feedback after using the tool, and email your response to our team at: NationalHealthServiceImprovement@hse.ie

**Question 1: What Worked Well**

To start, what worked well from your experience of using the self-assessment tool?

**Question 2: Usability and Navigation**

How easy or difficult was the tool to use and navigate?

**Question 3: Reflective Value**

To what extent did the tool help you reflect on the alignment of your work with the principles of a population health approach?

**Question 4: Clarity and Detail of Principles**

Were the population health principles clearly explained with enough detail? If not, what else would have been helpful?

**Question 5: Quality of Questions**

Were the questions helpful in guiding your reflections and discussions? Did any questions feel repetitive, unclear or too detailed? If so, which ones and why?

**Question 6: Quality of Prompts**

Were the prompts helpful in guiding your reflections and discussions? Did any prompts feel repetitive, unclear or too detailed? If so, which ones and why?

**Question 7: Overall Usefulness**

How would you describe the overall usefulness of the tool for your work?

**Question 8: Suggestions for Improvement**

What suggestions do you have for improving the tool (content, format, usability, etc.)?

**Question 9: Impact on Action**

Did the tool prompt any new ideas or actions you might take in your work in relation to a population health approach? If so, please share any examples. If not, please share why and/or any barriers to action.

**Question 10: Open Feedback**

To finish, please share any other comments or reflections you'd like to add.

**Thank you for your feedback.**

## Appendix C: Glossary of Terms

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| **Term** | **Explanation** |
| Levels of Prevention[[5]](#footnote-6) [[6]](#footnote-7) | Primary* Activities focused on prevention manifestation of illness (e.g. addressing determinants of health such as tobacco and alcohol legislation, immunisation)

Secondary* Activities focused on early detection of a problem, to support early intervention and treatment and reduce the level of harm (e.g. screening services)

Tertiary* Activities to support better quality of life for those living with established illness (e.g. rehabilitation programmes, disease management programmes)
 |
| Equity[[7]](#footnote-8),8 | The absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). This aligns with the Public Sector Equality and Human Rights Duty which applies to the HSE.  |
| Determinants of Health9,10 | Includes the social and economic environment, the physical environment, and an individual’s characteristics and behaviours. Examples of these determinants include income, social status, education, healthy workplaces, social support, health services, genetics, personal behaviours. The term ‘social determinants of health’ refers the non-medical factors which influence health outcomes.  |
| Partnership11,12 | Partnership is the highest level of stakeholder communication and engagement identified in the HSE Change Guide and is characterised by joint planning and decision-making. |
| Patient13 | When we use the term ‘patient’ we are referring to people who use, or are supported by healthcare services, their personal support network, communities and anyone who may use healthcare services in the future. |
| Clinical Governance14 | The HSE defines clinical governance as ‘a framework through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they deliver. It is built on the model of the chief executive officer/general manager or equivalent working in partnership with the clinical director, director of nursing/midwifery and service/professional leads. A key characteristic of clinical governance is a culture and commitment to agreed service levels and quality of care to be provided.’ |

1. Climate Action and Sustainability was originally termed ‘Environmental Sustainability’ in the 2024 Project – this was updated for this self-assessment tool to be consistent with the terminology used by the HSE Climate Action and Sustainability Programme. [↑](#footnote-ref-2)
2. This is aligned to the HSE Change Guide (4), the ‘Designing our Public Services’ Design Principles developed by Government (5) and design thinking approaches (6). [↑](#footnote-ref-3)
3. <https://assets.hse.ie/media/documents/HSE_Quality_Improvement_Guide_and_Toolkit_2024.pdf> [↑](#footnote-ref-4)
4. Includes members of the National Health Service Improvement Team, the HSE National Clinical Director for Integrated Care, the HSE Clinical Design and Innovation, and the National Clinical Advisor and Group Lead for Chronic Disease. [↑](#footnote-ref-5)
5. <https://knowledge4policy.ec.europa.eu/health-promotion-knowledge-gateway/promotion-prevention_en> [↑](#footnote-ref-6)
6. <https://publichealthscotland.scot/our-areas-of-work/public-health-approach-to-prevention/the-three-levels-of-prevention/> [↑](#footnote-ref-7)
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14<https://about.hse.ie/api/v2/download-file/file_based_publications/clinical-governance.pdf/> [↑](#footnote-ref-8)