Questions guiding our review

• What are the operational workforce planning models, tools and processes used at a national and regional level in other countries for health care workers?
• Who feeds into and uses the national operational health workforce planning models, tools and processes?
• How do they feed into them and how do they use the outputs?
• What documented benefits and disbenefits are derived from the use of health workforce planning models, tools and processes in other countries?
Summary

• All countries start where they have existing data, typically with doctors, and iterate from there.
• Models are not complex or complicated. Data gathering is.
• Successful WFPs are seen as a tool to inform a broader strategy for health service delivery.
• Successful WFPs use the data gathering for the model as part of a structured dialogue with representatives of various health care professionals.
Search Strategy & Interview Process

*search terms defined as ‘workforce planning’; ‘manpower planning’; ‘workforce forecasting’.
Theory & Data-Gathering

• Modeling Relationships between stocks and inflows and outflows over time.

• Looking for scenarios & policy responses to those scenarios.
Example country: Scotland (Please see Section 4.2.1)

- 6 step WFP methodology following establishment of a WFP forum.
- Suite of formal tools including workforce trees, skill mix analysers, Nursing and midwifery workforce tools and emergency department multi-professional tools.
- The model does not solve the real problems with regard to the attraction and retention of junior doctors.
- Began with payroll as the predominant information source for data collection needs, the rationale being that everybody gets paid, that is guaranteed.
- The next step was to ascertain where the money goes, the profile of investment.
- The next step was looking at education outputs.
  A profile of deployment was consolidated, on the ground, using qualitative and quantitative data in order to find out where people are actually working.
- HR departments were also a useful source of data, providing information on vacancies, alongside geographical and professional related information.
- Now a formal process. Each Board now has to submit a WFP narrative and projection templates for 1-3 years for all staff groups.
Example country: Scotland (Please see Section 4.2.1)

• **Approach** – The skills for health six step methodology underpins the primary approach to workforce planning in Scotland. A key aim of planning is to develop a consistent framework for future planning and ensure the right competencies and skills are available within the workforce.

• **Tools** – The workforce planners use a mixture of workforce trees, skill mix analysers, nursing and midwifery workforce tools and emergency department multi-professional tools.

• **Timeframe** – The planners are working toward all staff groups submitting annual three year outlook plans.

• **Data** – Collection and use of data has evolved from available baseline data, such as payroll data to education outputs; profile of deployment; human resources data, and so on.

• **Team composition** – Planners are striving toward more multidisciplinary planning but medical and nursing are still treated as separate workforces rather than interrelated disciplines

• **Resources** – Resources are focused on supporting a core workforce planning training group, this team are the gatekeepers for workforce planning and are key to engaging stakeholders.

• **Benefits** – The planners have developed a strong network across the health workforce to support and inform the workforce planning work. After ten years they are skilled enough to spot gaps, in data and so on, easily. They have forged better links with the third-level education sector.

• **Challenges** – An overreliance on quantitative data (numbers) may allow for repetition of mistakes in the wider planning context. Knowledge gleaned from the close work the planners do with stakeholders (health professionals, professional regulators, and educators) emphasises the need for qualitative data (experiences).
Modeling prerequisites

- Following the construction of a minimum data set, in line with recommendations from the WHO and the Joint action on health workforce planning and forecasting\textsuperscript{11} to begin to model the Irish health system effectively, one needs:
  - an initial database of the workforce as it stands, based on payroll data, data on health care which takes place in, or is provided by, the private sector, data on unfilled posts, retirement data, trainee-related data, gender, working patterns, emigration rates and FTE rates; and
  - an analysis of the current clinical programme models of care delivery, because these determine the strategic direction of each type of stock into the future.
- A dialogue with stakeholders needs to be started before and during the set-up of the initial database as stakeholder involvement in completing and validating the database is essential. Once a baseline exists, a more structured dialogue must take place with relevant representative bodies for sense-checking in terms of configuration, potential cross-overs, and the magnitudes involved, as well as beginning to understand which scenarios make sense to develop further.
Summary

To begin to model the Irish health system effectively, one needs:

1. an initial database of the workforce as it stands, based on payroll data, data on the private, unfilled post-related data, retirement data, trainee-related data, gender, working patterns, emigration rates and FTE rates; and
2. an analysis of the current clinical programme models of care delivery, because these determine the strategic direction of each type of stock into the future.
3. Once a baseline exists, a structured dialogue must take place with relevant representative bodies for sense-checking in terms of configuration, potential cross-overs, and the magnitudes involved, as well as beginning to understand which scenarios make sense to develop further.
4. Following these dialogues, a consensus model will emerge, and forecasts and scenarios can be created based on stock flow consistent principles.

In tandem with the development of a baseline model, a structured dialogue must take place with relevant representative bodies for sense-checking.
Focus areas and Enabling themes

**FOCUS AREA 1**
Address major health challenges

**FOCUS AREA 2**
Support healthcare interventions

**FOCUS AREA 3**
Address the research needs of the Irish health & social care system

**ENABLER A**
Support exceptional researchers and leaders

**ENABLER B**
Build a strong enabling environment

**ENABLER C**
Enhance organisational performance
hrb.ie

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