Working Together for Health

A National Strategic Framework for Health and Social Care Workforce Planning

Foreword

Global and regional health workforce demand is expected to increase in the coming decades as a consequence of population and economic growth, combined with demographic, epidemiological and other factors. In this context, the WHO has predicted a global deficit of 18 million skilled health workers by 2030 while the European Commission has estimated a potential shortfall of around 1 million health workers by 2020.

The health and social care sector in Ireland is already experiencing challenges in the recruitment and retention of health professionals, including doctors and nurses. While targeted efforts are underway to address current recruitment and retention issues, the potential impact of emerging and accelerating global and regional health workforce shortages on health professional recruitment and retention presents a significant strategic risk to the effective functioning of the Irish health system in the coming years.

In line with the Department of Health's Statement of Strategy 2016-2019, this National Strategic Framework for Health and Social Care Workforce Planning has been developed by a Cross-Sectoral Group led by the Department of Health. The Framework will support the recruitment and retention of the right mix of workers across the health and social care system to meet planned and projected service need.

The Cross-Sectoral Steering Group that developed the Framework included officials from the Departments of Education and Skills, Public Expenditure and Reform, Children and Youth Affairs, Justice and Equality, and Business, Enterprise and Innovation, as well as representatives of the HSE, Tusla, the HEA, SOLAS and regulatory bodies. The development of the Framework was also informed by a wide-ranging stakeholder consultation process.

Cross-sectoral and stakeholder involvement reflects our aspiration that all relevant stakeholders should feed into the process of health workforce planning on an ongoing basis. And I expect that the structures to be established in the Framework will be characterised by cross-sectoral collaboration and engagement.

Implementing the framework will be a multi-annual undertaking and I look forward to the commencement of implementation. The first action plan is for an 18 month period and focuses on the early actions that we need to take to build health workforce planning capacity in the health sector, and enhance engagement between the health and education sectors. Key actions will include:

- establishing the governance and oversight structures;
- building communications and engagement processes with stakeholders;
- developing protocols for engagement between the education and health sectors;
- building the evidence base.

I would like to take this opportunity to thank the Cross-Sectoral Steering Group members for their work and express my appreciation to the many stakeholders whose contributions have informed and assisted the development of this Framework.

Simon Harris TD
Minister for Health

Executive Summary

1. Background and Context

The provision of high quality health and social care services depends on having a sufficiently numerous and appropriately trained workforce in place at national, regional and local levels.

In June 2016, the Department of Health convened a Cross-Sectoral Steering Group to develop a strategic framework for health and social care workforce planning for Ireland that will support the recruitment and retention of the right mix of health workers across the health system to meet planned and projected service need.

Chaired by the Department of Health, the Group comprised representatives of key Government Departments and agencies, in addition to international and academic members.

The Steering Group met on 9 occasions between 1st July 2016 and 3rd October 2017 and, in the course of its work, undertook a stakeholder consultation process on its draft proposals during the second and third quarters of 2017.

In line with its Terms of Reference, this report sets out the Group's proposals for a national strategic framework for health and social care workforce planning in Ireland, taking into account relevant global, regional and national developments, and underpinned by the analysis and stakeholder engagement undertaken.

2. Perspectives on Workforce Planning and Human Resources for Health

To inform thinking around health workforce planning in an Irish context, the report offers two perspectives on workforce planning – a human resources perspective and a global health policy perspective.

While deriving from different disciplines, using different language and having different starting points, a number of common factors/themes emerge from these perspectives that we should pay attention to in the development of a national strategic framework for health and social care workforce planning in Ireland, including the following:

1. Workforce planning is a broad term that encompasses a range of approaches and activities within organisations;
2. Workforce planning – and related activities – should be aligned with organisational strategy;
3. There is a need to understand the drivers informing labour market dynamics;
4. Considering both workforce supply and demand sides is important;
5. High quality, complete and timely data, information and analysis are required to inform decision-making and identification of appropriate policies/strategies;
6. Whether termed 'policies' in a labour market dynamics context or 'HR strategies/activities' at an organisational level, identified actions should align with and support one another;
7. Appropriate whole-of-organisation and whole-of-system approaches are required to address workforce planning challenges.

Finally, both perspectives validate the need to develop a strategic framework within which data and information are used to inform national health labour market policies and organisational HR policies and practices.

3. The International Context for Strategic Health Workforce Planning

Understanding the global/regional contexts within which national workforce planning takes place is a key element of any workforce planning system. Chapter 3 of the report draws together thinking and developments at global and EU levels, in addition to international reviews that have been undertaken to support the development of the framework.

In the context of these developments, the Steering Group takes the view that Ireland's national strategic framework for health and social care workforce planning should be grounded in the principles of the WHO Global Code of Practice on the International Recruitment of Health Personnel, and take into account the need to manage health workforce demand and supply sustainably and insofar as possible within national resources.

In addition, managing migration of health and social care workers involves balancing the freedom of individuals to pursue work where they choose with the need to stem excessive losses from both internal migration (urban concentration) and international movements from less developed to more developed countries.

It should be recognised that, while national self-sufficiency is the ideal objective, there may be circumstances where it is neither possible nor practical. Due to Ireland's highly regarded educational standards, and that English is a first language, Irish healthcare staff are in high demand internationally and, consequently, have a high level of mobility.

Appropriate labour market policies and HR strategies are required to ensure, insofar as possible, adequate workforce supply and absorption of graduates into the health workforce from within Ireland's own resources, recognising the freedom of individuals to work where they choose.

The potential impacts of Brexit on the health sector and on free movement are also recognised and are a matter of considerable concern to the Steering Group.

4. The Context for Strategic Health and Social Care Workforce Planning in Ireland

In order to plan for the health workforce in Ireland, we need to understand the factors that will impact on the demand for health and social care workers over the coming years. In this context, Chapter 4 summarises key population health trends, as well as significant strategic and operational developments.

Due to growing and ageing populations and consequent increases in levels of chronic illnesses, demand for health and social care and, consequently, for health workers will continue to grow in Ireland over the coming years.

Ireland is not unique in facing future challenges to ensure the resilience of health and social care services. Across EU countries, the share of the population aged over 65 has increased from less than 10% in 1960 to nearly 20% in 2015 and is projected to increase further to nearly 30% by 2060 (EU/OECD, 2016). Currently, around 50 million EU citizens are estimated to suffer from two or more chronic conditions, and most of these people are over 65. According to the OECD, 'population ageing, combined with tight budgetary constraints, will require profound adaptations to the health systems of EU countries, in order to promote more healthy ageing and respond in a more integrated and patient-centred way to growing and changing health care needs'.

Demographic changes are informing and underlining the importance of a range of policy and operational initiatives, including: establishment of Hospital Groups and Community Healthcare Organisations; the shift to primary care; and the development of the National Clinical Programmes and Integrated Care Programmes.

Implementing these initiatives will undoubtedly impact on the shape and size of the health and social care workforce. Effective short-, medium- and long-term workforce planning will be vital to ensure that changes are planned and managed effectively from a health workforce perspective.

5. The Health Workforce in Ireland

As with demand side factors, we must also understand our current workforce and the factors that have informed its development. Chapter 5 of the report summarises the supply side environment in Ireland currently, in addition to identifying some key workforce trends on the basis of available workforce data.

The Steering Group concludes that traditional workforce planning activities in the Irish health service have tended to be profession specific and focussed on identifying the immediate gap between supply and demand, based on existing or projected demand for a given category of health worker, whether on a needs-based, utilisation-based or benchmark approach. Once the size of the gap has been identified, planners recommend actions aimed at reducing or eliminating the gap, usually through recruitment. This work should continue but limitations of this approach are that, given an inflexible labour market, scarce resources and fixed budgets, there may neither be the financial or human resources available, nor the structural flexibility, to implement identified actions.

The supply-demand-gap approach may quantify the potential size of the workforce problem, and provide short-term profession-specific solutions, but it does not necessarily contribute to long-term, or the most cost-effective, health sector solutions.

A combination of short-, medium- and longer-term approaches, taking a whole-of-organisation or whole-of-system approach, as appropriate, can support current and future sustainability of health workforce supply.

In addition, the demographics of the health workforce have significant implications for the workforce planning supply-side decisions. Factors, such as age and gender, impact on the replacement demands for health and social care workers and need to be considered when determining the supply of certain categories of health worker.

To support decision-making, improved data collection and information regarding entry and exit patterns and attrition rates, by categories of health worker, would be beneficial.

Finally, the Group recognises that the contribution of informal caregivers and volunteers is important to the provision of health services in Ireland. Any reduction in the care provided by this group could have a significant impact on health workforce requirements.

6. Key Interfaces with Other Government Departments, Sectors and Statutory Agencies

In order to fully understand workforce labour market factors and how they impact on the health workforce, it is important that we identify key interfaces with other sectors and agencies. Chapter 6 summarises the interfaces that have been identified by the Steering Group in the course of their work. These include:

- The Department of Education and Skills, and the education sector;
- The Department of Business, Enterprise and Innovation;
- The Department of Justice (INIS);
- The Department of Children and Youth Affairs;
- Professional regulatory bodies;
- HSE-funded service providers (Section 38 and 39 agencies).

The Group concludes that as health services evolve and further developments, such as technology, change health and social care delivery, it is important that skill needs in the sector are kept under review to enhance the responsiveness of the health system; and to ensure the development and retention of the appropriate competencies and skills in the system.

To provide for a strategic approach to workforce planning in the education component of the health labour market, a more formal and structured arrangement for engagement between our health and further and higher education systems is required.

It is essential that educational and training courses continue to provide health and social care professionals with the core competencies which are required for their future profession. This is turn requires ongoing close engagement between health and education and training systems, including the health regulatory and registration bodies. Practice at present remains less formal than it could be.

Curricula must be cognisant of developments in health and social care delivery and the health and education sectors must ensure developments are reflected in curriculum reviews and in the skills, competencies and behaviours being developed by health and social care students. It is important that meaningful engagement between the health and education sectors is embedded to ensure developments, including multi-disciplinary working and other team-based approaches, are reflected in the provision of courses in our education institutions.

For professionals, already practising in the system, a key issue will be to continue to foster a positive attitude to continuous professional development as this will increase the skills mix in the sector and provide more options for mobility of staff to support the effective delivery of services to patients.

In addition, any unintended misalignment between out-of-country recruitment procedures, the employment permit regime, the immigration services schemes and requirements, the requirements of regulatory bodies, and subsequent in-country recruitment systems and practices in the health sector may lead to unintended recruitment barriers and loopholes, which impact on service planning, delivery and quality.

Greater and more effective communication between principal stakeholders that will deliver the necessary staff to the required locations while maintaining the integrity of the State's immigration and labour market policies is required.

In addition, different arms of Government that facilitate the training and education of health sector workers and make them available through the work permit and immigration system need to be consulted and kept informed of developments, including the future skills need, in the health sector.

Finally, the Group notes that certain categories of health worker may receive some of their training in other jurisdictions, in particular the UK, and recognises that Brexit may have implications for health worker supply in the future.

7. A Strategic Framework for Health and Social Care Workforce Planning in Ireland

As clearly articulated by WHO, 'health systems can only operate with a health workforce'.

The Steering Group recognises the validity of this statement and the framework that the Group has developed is intended to support short -, medium- and long-term health and social care workforce planning – and associated activities – in the health and social care sector over the coming years.

The framework is intentionally solutions-focussed, with an emphasis on the identification of solutions at appropriate levels of the system based on good quality data and information, including qualitative stakeholder engagement. Some solutions reside in the HR domain – in practices and activities at either local or national HSE levels, while some solutions reside in the policy domain – either sectorally or cross-sectorally. This framework seeks to bring both communities together through a set of processes and structures intended to align our efforts to achieve health workforce sustainability in Ireland.

Ultimately, the desired long-term outcome from the implementation of this framework is improved health outcomes for citizens.

The following principles, as agreed by the Steering Group, underpin the framework:

i. Workforce planning must be focussed on identified current and future population health needs. It must consider what services will be required to meet the current and future health and social care needs of the population and plan, using the full range of solutions, to have a workforce in place with the right skills, competencies and geographical distribution to deliver these services. In this context, it should take into account the workforce dimensions of key strategic and operational developments including national health policies and strategies, agreed models of care, and other developments in clinical strategy such as the National Clinical Programmes, ICPs etc.

ii. Workforce planning should be a dynamic process where the starting point is (i) above. It must support service delivery and the process of service redesign. This includes planning for multi-disciplinary and other team-based working approaches, changing skill mixes, the creation of new health worker roles, job enrichment and the development of new competencies and behaviours among health workers. Planning for changes such as these requires consideration of the need for in-service training and coaching, and in some instances, up-skilling and retraining.

iii. Workforce planning has multiple time horizons: short- (1 year), medium- (3-5 years), and long-term (10+ years).

iv. Resources are finite and it is necessary to ensure long-term workforce planning strategies and solutions are sustainable, cost-effective and offer value for money. In addition, short- and medium-term workforce plans that are developed on the basis of 1 and 3 year projections – and any associated solutions - must be deliverable within determined allocations and budgets. Therefore, short- to medium-term workforce planning must be connected to other planning functions, particularly, financial planning and service planning.

v. Workforce planning solutions should be consistent with the articles of the WHO Global Code of Practice on the International Recruitment of Health Personnel. In this context, workforce planners should plan, as far as is possible, on the basis of national self-sufficiency of supply for health workers. Ireland is a signatory of the Code, which requires countries to strive to create a sustainable health workforce and work towards establishing effective health workforce planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel.

vi. When considering future workforce supply, with a 10+ year time horizon, workforce planning should take account of the workforce needs of the public, voluntary and private health and social care systems.

vii. Workforce planning must consider how current and future demand for services is to be measured and assessed, based on recent trends as well as on forecasts, in order to identify current and future gaps in service provision due to gaps in the workforce. This requires that workforce planners take a variety of factors into account, including: demographic changes; alterations in disease incidence and prevalence; medical and therapeutic innovations; policy initiatives; and technological advances.

viii. Workforce planning should ensure all relevant stakeholders can feed into the process of health workforce planning, and be characterised by cross-sectoral collaboration and engagement where required.
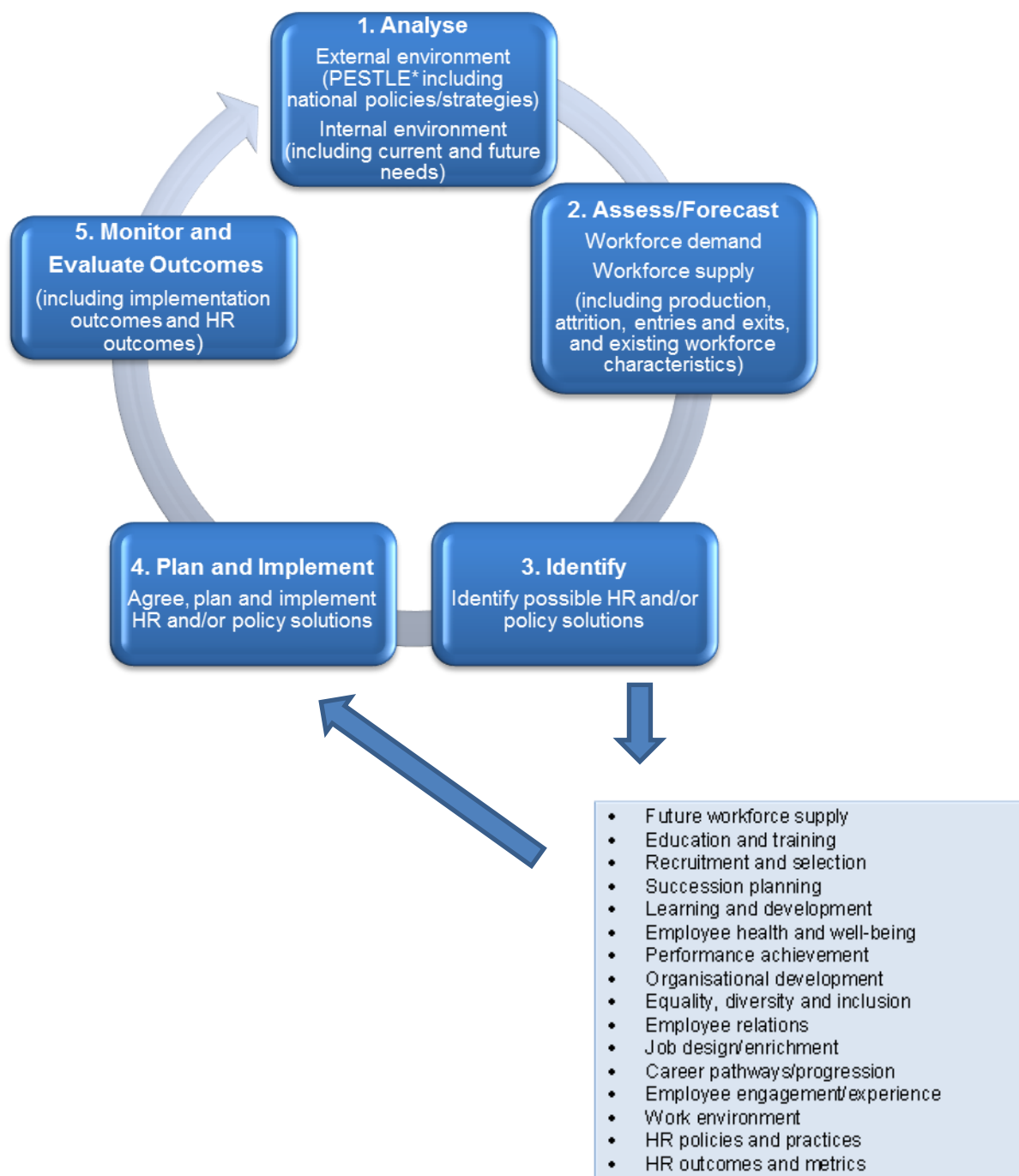
The framework comprises the following components:

- a Five Step Approach to workforce planning;
- structures and governance arrangements that support and enable the application of the Five Step Approach in the health sector and cross-sectorally, where appropriate.

8. A Five Step Approach for Strategic Workforce Planning

Underpinned by the principles above, and aligned with initiatives including the HSE NDTP: Stepwise Approach, the work of the Nursing Taskforce and the HSE People Strategy, this Five Step Approach commences with both external and internal environment analysis (Step 1).

Step 2 clearly situates employment planning/monitoring and workforce intelligence, planning and modelling, and forecasting activities as necessary enablers for identification and implementation of appropriate local and national HR solutions, and sectoral and cross-sectoral policy solutions (Steps 3 and 4).

Recognising that workforce planning is both an iterative and dynamic process, Step 5 proposes monitoring and evaluation of both implementation and HR outcomes in order to inform future workforce planning cycles and solutions.

1. Analyse
External environment (PESTLE* including national policies/strategies)
Internal environment (including current and future needs)

2. Assess/Forecast
Workforce demand
Workforce supply
(including production, attrition, entries and exits, and existing workforce characteristics)

3. Identify
Identify possible HR and/or policy solutions

4. Plan and Implement
Agree, plan and implement HR and/or policy solutions

5. Monitor and Evaluate Outcomes
(including implementation outcomes and HR outcomes)

- Future workforce supply
- Education and training
- Recruitment and selection
- Succession planning
- Learning and development
- Employee health and well-being
- Performance achievement
- Organisational development
- Equality, diversity and inclusion
- Employee relations
- Job design/enrichment
- Career pathways/progression
- Employee engagement/experience
- Work environment
- HR policies and practices
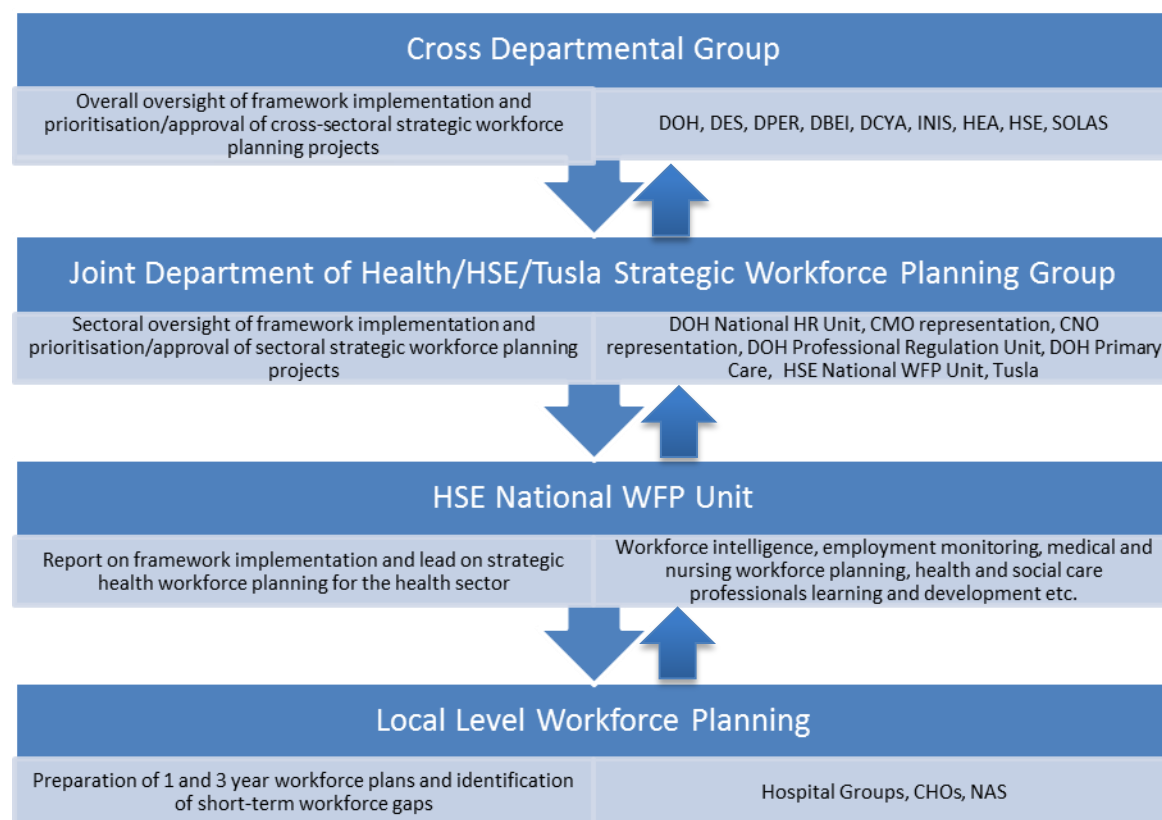- HR outcomes and metrics

9. Structures and Governance Arrangements

Taking into account the underpinning principles, the outcomes sought and the Five Step Approach outlined above, the following structures and governance arrangements are proposed.

The objective is to align the system both vertically and horizontally, in order to support effective information flows about the current workforce and current and future needs, in order to identify, agree and implement appropriate short-, medium- and long-term HR and policy solutions (either within the health sector or cross-sectorally with education and other partners), recognising that such strategies and solutions must be designed and considered within the overall architecture of public sector human resource management including having due regard to national agreements and existing structures.

In all, four levels of structure are proposed as set out below. The role of each level, together with key tasks and activities, and linkages with the Five Step Approach are outlined in further detail in Chapter 7. Where necessary, collaborative processes will be designed and rolled out as part of the implementation approach for the strategic framework.

Cross Departmental Group

Overall oversight of framework implementation and prioritisation/approval of cross-sectoral strategic workforce planning projects	DOH, DES, DPER, DBEI, DCYA, INIS, HEA, HSE, SOLAS

Joint Department of Health/HSE/Tusla Strategic Workforce Planning Group

Sectoral oversight of framework implementation and prioritisation/approval of sectoral strategic workforce planning projects	DOH National HR Unit, CMO representation, CNO representation, DOH Professional Regulation Unit, DOH Primary Care, HSE National WFP Unit, Tusla

HSE National WFP Unit

Report on framework implementation and lead on strategic health workforce planning for the health sector	Workforce intelligence, employment monitoring, medical and nursing workforce planning, health and social care professionals learning and development etc.

Local Level Workforce Planning

Preparation of 1 and 3 year workforce plans and identification of short-term workforce gaps	Hospital Groups, CHOs, NAS

10. Implementing the Framework

An 18 Month Action Plan with a Focus on Initial Implementation

The Steering Group recognises that implementing this framework is an ambitious multi-year undertaking, involving actions and activities at various levels of the system – both sectorally and cross-sectorally.

The Group also acknowledges the feedback from stakeholders regarding variable implementation of past workforce planning policies and initiatives in the Irish health system.

Accordingly, the focus of this first action plan is in on initial implementation – i.e. the early actions that we need to take to build workforce planning capacity in the health sector, and enhance engagement between the health and education sectors.

This initial implementation phase will also focus on identification of 2-3 priority workforce planning projects, relating to key national health policy or clinical strategy developments, in order to test, evaluate and refine the Five Step Approach.

This first action plan covers the period from Quarter 4 2017 to Quarter 1 2019.

Keeping Up the Momentum Through Rolling Action Plans

Recognising the absorptive capacity of the health and wider systems to take on board and implement system change, the Group proposes that following completion of the period covered by this first action plan, action plans are prepared on a bi-annual basis taking account of progress in

implementing the framework and submitted to the Minister for Health by the Cross Departmental Group for consideration and approval.

The Group recommends that this process should also include periodic strategic reviews of the continued relevance and effectiveness of the strategic framework, taking into account contextual and other changes that may occur.

Taking a Programmatic and Project Management Approach

Recognising the complex nature of system change, as well as the interdependencies between many of the actions, a programmatic and project management approach to implementation is required. This approach will include identification of risks and measures to mitigate against them, in addition to identifying critical dependencies.

Appropriate project management arrangements are currently being scoped out, in collaboration with the Department of Health's Programme Management Office, and will be put in place to support delivery of this action plan.

The Cross Departmental Group will act as programme board to oversee implementation and report on progress.

Communication and Engagement with All Stakeholders

Communications and engagement strategies will be a key component of the implementation approach in order to ensure that partners and stakeholders at all levels of the system – sectorally and cross-sectorally - have an understanding of work planned and/or underway, their roles in leading or supporting implementation, and the opportunities to feed into and inform the work.

Building the Evidence Base

Acknowledging that high quality, complete and timely data, information and analysis are required to inform decision-making and identification of appropriate policies and strategies, the action plan has a particular focus on building the evidence base for workforce planning in Ireland.

This key action area will also take on board the learning from current initiatives including the Taskforce on Staffing and Skill Mix for Nursing and the implementation of the MacCraith reports, and will seek to link up the workforce planning research and policy communities in Ireland appropriately.

Making maximum use of routinely collected data will also be important.

Monitoring and Accountability

Progress on implementing the strategic framework will be monitored by the Cross Departmental Group, with annual progress reports to be submitted to the Minister for Health.

In the course of this work, the Cross Departmental Group will consider the requirement for periodic strategic reviews of the framework, commencing with the preparation of the second annual progress report.

In line with learning from the implementation of the MacCraith reports, the Group recommends that stakeholder perspectives on implementation are sought in the context of the preparation of progress reports.

In addition, one of the three goals of DPER's forthcoming Public Service Development and Innovation Framework 2020 is to 'Develop our People and Organisations'. In this context, a key joint action for the Department and the HSE is 'An improved health service arising from better planning, including strategic workforce planning, and leadership development'. Progress in implementing the strategic framework will also be reported through the mechanisms established to track Public Service Development and Innovation Framework 2020.

Connecting Up the Work with Other Key Long-Term Planning Processes

A Health Service Capacity Review is currently underway, following a commitment in the Programme for a Partnership Government. The review is examining capacity requirements across key elements of primary care, acute care and services for older persons for the period 2017 - 2030.

The review is taking account of current activity and unmet demand, demographic projections, epidemiological trends and other factors influencing demand, productivity measures, and possible changes in models of care that are likely to have significant impact on capacity requirements. It is at an advanced stage and is expected to be completed by the end of the year.

Health system capacity and workforce planning are inextricably linked and it is envisaged that the implementation of this framework is a key enabler for future health service capacity reviews.

Key Action Area	Actions	Deliverables	Owner	Sign Off	Target Date
1. Establish governance and framework oversight arrangements	Convene Cross Departmental Group	Cross Departmental Group in place	DOH National HR Unit	-	Dec 2017/ Jan 2018
	Finalise Terms of Reference for Cross Departmental Group	Finalised Terms of Reference	DOH National HR Unit	Cross Departmental Group	Dec 2017/ Jan 2018
	Develop draft Terms of Reference for Joint DOH/HSE/Tusla Strategic Workforce Planning Group	Finalised Terms of Reference	DOH National HR Unit/HSE WFP Unit/Tusla	Cross Departmental Group	Dec 2017/ Jan 2018
	Convene Joint DOH/HSE/Tusla Strategic Workforce Planning Group	Strategic Workforce Planning Group in place	DOH National HR Unit/HSE WFP Unit/Tusla	-	Q1 2018
2. Communicate and engage with stakeholders	Develop purpose, aims, objectives and scope of communications and engagement strategy	Finalised stakeholder communications and engagement strategy	DOH National HR Unit/Department of Education and Skills, HSE WFP Unit/Tusla/HEA	Cross Departmental Group	Dec 2017/ Jan 2018
	Undertake sectoral/cross-sectoral stakeholder mapping exercise	Stakeholder mapping completed	DOH National HR Unit/Department of Education and Skills/HSE WFP Unit/Tusla/HEA	Cross Departmental Group	Q1 2018
3. Operationalise workforce planning in the health sector	Establish and resource HSE National Workforce Planning Unit at national level	HSE National Workforce Planning Unit fully in place	HSE National HR	-	Q3 2018

	Develop an operational workforce planning framework, that includes approaches to enhancing workforce planning capacity and capability at local level	Operational workforce planning framework agreed	HSE WFP Unit	Joint DOH/HSE/Tusla Strategic Workforce Planning Group	Q3 2018 – Q1 2019
4. Develop protocols for engagement between health and education sectors	Undertake consultation with HSE and health and social care representatives, education and training providers, representative bodies, SOLAS and HEA on issues to be covered by the protocol between the health and education sectors (e.g. information-sharing, responsibilities, prioritisation, resource planning, approach to determination of annual intakes for certain disciplines)	Consultation report completed	DOH National HR Unit/Department of Education and Skills/ HSE WFP Unit/HEA/Tusla/SOLAS	Cross Departmental Group	Q1 2018
	Develop and document the protocol in consultation with education and health representatives	Protocol agreed	DOH National HR Unit/Department of Education and Skills/ HSE WFP Unit/HEA/Tusla	Cross Departmental Group	Q2 2018
5. Build the evidence base underpinned by research and evaluation	Establish research team to: (1) build the evidence base to inform and test methodologies for 1- and 3-year workforce planning (2) develop a suite of HR metrics for inclusion in HSE Service Plans	Scoping completed and team established	DOH National HR Unit/HSE WFP Unit/Tusla	Cross Departmental Group	Dec 2017/ Jan 2018
		1- and 3-year workforce planning methodologies developed	DOH National HR Unit/HSE WFP Unit/Tusla and research team	Joint DOH/HSE/Tusla Strategic Workforce Planning Group /PER	Q4 2018

		Suite of HR metrics finalised	HSE WFP Unit/Tusla and research team	Joint DOH/HSE/Tusla Strategic Workforce Planning Group	Q1 2019
	Develop baseline health and social care workforce profile	Baseline developed using available data sources	HSE WFP Unit/Tusla	Joint DOH/HSE/Tusla Strategic Workforce Planning Group	Q2 2018
	Undertake horizon scan of main drivers for change impacting on skills demand/supply	Horizon scan completed	HSE WFP Unit/Tusla	Joint DOH/HSE/Tusla Strategic Workforce Planning Group	Q2 2018
6. Identify and commence implementation of priority workforce planning projects to test, evaluate and refine Five Step Approach	Develop criteria and prioritisation matrix for project selection	Matrix developed and criteria agreed	DOH National HR Unit/HSE WFP Unit/Tusla	Cross Departmental Group	Q1 2018
	Undertake scoping exercise to identify possible priority workforce planning projects across the health and social care system	List of possible projects developed	DOH National HR Unit/HSE WFP Unit/Tusla	Joint DOH/HSE/Tusla Strategic Workforce Planning Group	Q3 2018
	Select priority workforce planning projects	2-3 priority projects selected	Cross-Departmental Group	Cross-Departmental Group	Q4 2018

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Glossary

ABF: Activity-based funding

CIPD: Chartered Institute of Personnel and Development

CHO: Community Healthcare Organisation

CPD: Continuing professional development

CSPD: Clinical Strategy and Programmes Division (HSE)

EMS: Emergency medical services

FET: Further education and training

HEI: Higher education institute

HIPE: Hospital In-Patient Enquiry system

HRH: Human resources for health

HRM: Human resources management

HSCP: Health and social care professionals

HSOL: Highly Skilled Occupations List

HWFP: Health workforce planning

ICEL: Ineligible Categories of Employment List

ICP: Integrated Care Programme

JICF: HSE Joint Information and Consultation Forum

MET: HSE Medical Education and Training Unit (now NDTP)

NCP: National Clinical Programme

NMBI: Nursing and Midwifery Board of Ireland

MWP: Medical Workforce Planning Project

NAS: National Ambulance Service

NDTP: National Doctors Training and Planning Unit (HSE)

NMPDU: Nursing Midwifery Planning and Development Unit (HSE)

NPSO: National Patient Safety Office

OECD: Organisation for Economic Co-operation and Development

ONMSD: Office of the Nursing and Midwifery Services Director

QI: Quality improvement

QQI: Quality and Qualifications Ireland

TILDA: the Irish Longitudinal Study on Ageing

WHO: World Health Organization

1. Introduction

1.1 Background and Context

The provision of high quality health and social care services depends on having a sufficiently numerous and appropriately trained health and social care workforce in place at national, regional and local levels.

A shortage of certain categories of health and social care worker may create access problems to health and social care and may impact adversely on patient outcomes. At the same time, a surplus of health and social care workers can involve a waste of human capital and of the public resources that have been invested in the training of health workers.

The serious consequences that can result from health worker shortages have led to an increasing focus on the importance of health workforce planning in most developed economies and by international and regional institutions including the World Health Organization (WHO) and the European Union (EU).

Workforce planning is a challenge for the health sector because of the high mobility of health workers. Global and regional health workforce demand is expected to increase in the coming decades as a consequence of population and economic growth, combined with demographic, epidemiological and other factors.

In this context, the European Commission estimates a potential shortfall of around 1 million health workers[1] by 2020 (European Commission, 2012) and the WHO predicts a global deficit of 18 million skilled health workers[2] by 2030 (WHO, 2016).

The health sector in Ireland is experiencing challenges in the recruitment and retention of health workers including medical, nursing and midwifery (including mental health nursing), and other health and social care professions. The Irish health service has one of the highest proportions of foreign trained doctors and nurses in the countries of the OECD while experiencing significant outflows of domestically trained doctors and nurses.

While targeted efforts are underway to address current recruitment and retention issues (e.g. implementation of the Strategic Review of Medical Training and Career Structure, and the work of the Taskforce on Staffing and Skill Mix for Nursing), the capacity of the health sector – and the wider public system, including the education sector – to analyse and meet emerging health workforce challenges is limited.

In this context, and in line with the Department of Health's *Statement of Strategy 2016-2019*, the Department has developed this national strategic framework for health and social care workforce planning.

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[1] Physicians, nurses, dentists, pharmacists and physiotherapists
[2] Physicians, nurses/midwives, all other cadres (the seven other broad categories of the health workforce as defined by the WHO Global Health Workforce Statistics Database, i.e. dentistry, pharmacy, laboratory, environment and public health, community and traditional health, health management and support, and all other health workforce categories)

1.2   Establishment of Cross-Sectoral Steering Group

In June 2016, the Department of Health convened a Cross-sectoral Group to develop the national strategic framework for health workforce planning. The Terms of Reference for the Group are as follows.

1.2.1 Terms of Reference

The Department of Health is establishing a cross-sectoral Steering Group to develop a strategic framework for health workforce planning for health services in Ireland that will support the recruitment and retention of the right mix of health workers across the health system to meet planned and projected service need.

The framework will be developed to take account of emerging policy and service models in the provision of health and social care services delivered to adults and children. As such the framework, will take account of the needs of HSE provided and funded services, those provided and funded by Tusla, other health and social care agencies; and the needs and impact of workforce demands within the private health sector.

To inform the development of the strategic framework for health workforce planning, the Steering Group will:

1. Agree on a working definition of a) health workforce planning (HWFP) for Ireland and b) integrated health workforce planning for Ireland;
2. Agree on the principles underlying health workforce planning for Ireland;
3. Assess health system capability and capacity for implementation of strategic workforce planning;
4. Consider the adequacy of available health workforce information for workforce planning purposes;
5. Consider how workforce planning might best be conducted in Ireland to ensure that there is an adequate supply of appropriately trained health professionals to ensure the provision of high quality health services that are delivered safely and cost-effectively;
6. Identify what lessons from earlier and on-going HWFP initiatives in Ireland and from other jurisdictions can be incorporated into a national HWFP system, including the conclusions of the 2009 Workforce Planning Strategy;
7. Undertake an analysis of cross-sectoral activities that relate to health sector workforce planning, including identifying key interfaces and assessing the efficiency and effectiveness of current arrangements.

In the course of its work, the Steering Group will:

- Agree an approach and proposals for stakeholder engagement, including patient associations, staff associations, regulatory bodies and other actors;
- Produce and submit to the Minister for Health recommendations on the establishment of a governance and operational framework to guide the development of HWFP for Ireland including a high-level implementation plan and associated deliverables;
- Make recommendations to the Minister for Health regarding the appropriate cross-sectoral structures required to implement the framework.

1.2.2 Membership

The Group held 9 meetings during the period 1st July 2016 – 3rd October 2017. As at October 2017, the membership of the Steering Group was as follows.

- Ms Teresa Cody, Assistant Secretary, Department of Health (Chair)
- Professor Ruairi Brugha, Department of Epidemiology and Public Health Medicine, RCSI
- Professor James Buchan, Queen Margaret University, Scotland
- Mr Simon Conry, Assistant Principal Officer, Department of Children and Youth Affairs
- Ms Angela Fitzgerald, Deputy National Director of Acute Hospitals, HSE Acute Hospital Division
- Ms Gabrielle Jacob, Principal Officer, Department of Health*
- Mr Terry Jennings, Assistant Principal, Department of Public Expenditure and Reform
- Dr Siobhan Kennelly, National Clinical Advisor and Group Lead Social Care, HSE Social Care Division
- Ms Deirdre McDonnell, Principal Officer, Department of Education and Skills
- Ms Rosarii Mannion, National Director of HR, HSE
- Mr Alan McGrath, Senior Manager, Skills and Engagement, Higher Education Authority
- Mr Ivica Milicevic, SOLAS**
- Mr Phelim Quinn, Chief Executive, HIQA
- Ms Colette Walsh, Director of Human Resources, TUSLA
- Mr Michael Walsh, Principal Officer, Department of Justice and Equality
- Mr Gerard Walker, Senior Policy Advisor, Assistant Principal, Department of Jobs, Enterprise and Innovation
- Dr Philippa Ryan Withero, Deputy Chief Nursing Officer, Department of Health

Secretariat to the Steering Group was provided by Mr Eoin Dunleavy, Assistant Principal, Department of Health and Ms Diane Lynch, Administrative Officer, Department of Health.

Replaced Ms Lara Hynes, Principal Officer, February 2017

*** Replaced Ms Jasmina Behan, Solas, December 2016*

To inform the Steering Group's deliberations, a number of presentations were made to the Group by the following:

- Health workforce planning models, tools and processes in five countries: an evidence review (Dr Stephen Kinsella, University of Limerick);
- Report on output and recommendations from HSE workforce planning and development workshops (Paddy Duggan, Workforce Planning, Analytics and Informatics Unit, National HR Division, HSE);
- Six steps methodology for integrated health workforce planning (Sam Gallaher, Skills for Health).

1.3   Preparing for the Framework - Stakeholder Engagement

1.3.1   Stakeholder Engagement, 2014-2016

During 2014, the Department of Health and HSE jointly hosted an exploratory workforce planning workshop, which attracted participants from across the HSE Divisions and the Department of Health. The workshop identified key themes, benefits and factors that would influence the development of a strategic workforce planning framework and operating model.

Between June and October 2014, the HSE Workforce Planning, Analytics and Informatics Unit presented to staff unions at the Joint Information and Consultation Forum (JICF) on workshops undertaken with health staff to inform the development of the framework.

In October 2015, the Department hosted a seminar on *Integrated Care and the Health Workforce: Planning for the Future*. The seminar included national and international speakers, and provided an opportunity to discuss the emergence and future direction of integrated care and its relationship with the health workforce including future challenges. Attendance included officials of relevant Government Departments, senior HSE managers and clinicians engaged in the design and delivery of health services in Ireland. Key themes discussed:

- Global perspective on the link between integrated care and human resources for health;
- Integrated care and the future shape of human resources for health;
- Health workforce planning policies and drivers;
- Health workforce planning supports for EU Member States;
- Ireland's national response to strategic health workforce planning.

During 2016, the HSE Workforce Planning, Analytics and Informatics Unit ran a further series of workshops to contribute to the understanding of the workforce planning challenges faced by the health sector, in terms of capacity and capability. These challenges, and the restructuring of the public health service into Divisions, Hospital Groups and Community Healthcare Organisations, highlighted the need to implement strategic workforce planning. The requirement to resource emerging models of care within the new structures means there is a need to adopt a collaborative, sector wide approach to workforce planning and development based on these patient pathways and the new service delivery structures (see Appendix One for a summary of these workshops).

In addition, in keeping with the Terms of Reference of the Steering Group, and in order to inform the development of the framework, the Secretariat met with private health sector provider stakeholders during October/November 2016.

1.3.2   Stakeholder Consultation and Engagement, 2017

The Steering Group has endeavoured to ensure that a thorough process of stakeholder consultation and engagement has been conducted to inform the development of the framework.

In line with the proposals for stakeholder consultation and engagement agreed by the Steering Group, the purpose of stakeholder engagement has been twofold:

- To communicate and inform stakeholders of the development of the draft framework, with a particular focus on the elements of the framework;
- To seek feedback on the approach with a particular focus on identifying any gaps in information flows that should be addressed through the proposed Five Step Approach, and associated structures and governance arrangements.

A high-level stakeholder mapping exercise was undertaken by the Secretariat, with input from Steering Group colleagues, to identify stakeholders who were likely to have an interest in the development of the draft framework. This exercise informed the approach to consultation.

Communication and engagement on the draft framework commenced in April 2017 with presentations to the Department of Health's Policy Committee and the HSE's JICF.

Formal public consultation on the draft framework proposals commenced on 26th June 2017. The draft report and framework proposals were published online through the CIVIQ platform and stakeholder views were invited. In particular, to assist with the finalisation of the framework and associated implementation approach, stakeholder feedback was requested on the following questions:

1. Are there any other global, regional or national supply or demand side considerations that should be taken into account?
2. Are there any other key interfaces between the health sector and other sectors nationally that should be taken account of?
3. What gaps in information flows exist – either within the health sector or cross-sectorally – that should be taken into account in finalising the proposed structures and governance arrangements?

The consultation was featured on the Department of Health's public consultations page (http://health.gov.ie/consultations/) and a dedicated email address (workforceplanning@health.gov.ie) was established. Individual email invitations, notifying stakeholders of the consultation and including the link to the online consultation platform, issued to c. 260 colleagues across the health and wider systems. The closing date for receipt of submissions was 21st July 2017.

In parallel with the online consultation process, bi-lateral engagements took place with the following staff associations: Irish Hospital Consultants Association, Psychiatric Nurses Association, Craft Unions and the Irish Dental Association. A further engagement with unions and staff associations took place under the auspices of the HSE's National Joint Council Policies and Procedures Committee during September 2017.

In all, 49 submissions were received via the online platform and/or in writing. A full list of submissions is included as Appendix Two. An overview of the main themes emerging from the submissions in response to the consultation questions is also included in the Appendix.

Private individual	14
Internal HSE	8
Education institution / organisation	6
Union	5
Professional body	4
Section 38/39	4
Health institution / organisation	2
Body under the aegis of the Department of Health	1
Advocacy group	2
Other	3

It should be noted that a number of submissions raised concerns that the draft framework did not include an in-depth examination of recruitment and retention issues for particular categories of health and social care worker. Discipline-specific recruitment, retention and other issues were raised with regard to the following professions and disciplines in submissions:

Medical practitioners (including GPs and hospital-based consultants)	Speech and language therapists
Nurses and midwives (including mental health nursing)	Community workers
Physiotherapists	Clinical psychologists
Occupational therapists	Medical laboratory scientists
Clinical measurement scientists	Radiographers
Social workers	Dieticians
Healthcare assistants	Dentists

The purpose of the framework is to establish and implement structures and processes to tackle workforce planning issues on a sectoral or cross-sectoral basis, as appropriate. In this context, these submissions will be retained and provided to the new workforce planning structures for information and further consideration once they are established.

1.3.3 Acknowledgement

The Chair and members of the Steering Group would like to express their sincere thanks to all those who have contributed to these consultations and engagements for their interest in and commitment to working collaboratively towards achieving health workforce sustainability in Ireland.

2 Perspectives on Workforce Planning and Human Resources for Health

2.1 Introduction

The literature offers a range of perspectives on workforce planning, people management, and relationships with the labour market, which derive from different disciplines and starting points.

To inform thinking around health workforce planning in an Irish context, two perspectives are offered in this chapter – a human resources (HR) perspective and a global health policy perspective.

The chapter conclusions seek to draw out certain common threads and themes arising from these perspectives in order to inform the chapters that follow.

2.2 A Human Resources Perspective: The Chartered Institute of Personnel and Development (CIPD) View

2.2.1 Defining Workforce Planning

The CIPD's 2010 research report and guide *Workforce Planning: Right People, Right Time, Right Skills* succinctly describes workforce planning as 'having the people resources in place to deliver short- and long-term objectives', while noting that there is no commonly understood definition of workforce planning and that 'the term tends to embrace a range of activity' (CIPD, 2010: 3).

The report defines workforce planning as:

> '*A core process of HRM that is shaped by the organisational strategy and ensures the right number of people with the right skills, in the right place at the right time to deliver short- and long-term organisation objectives'* (2010: 4).

In the context of the CIPD Profession Map (2015), the report's authors emphasise the importance of workforce planning and its link with organisational strategy, as well as its linkages with other areas noting that:

> '*For some years, the HR literature has argued that workforce planning is a key aspect of people management and development, which links business strategy to people management. It might even be argued to be the starting point for people management as it seeks to define the labour force that is required now and in the future to deliver the products and services that customers demand'* (2010: 4).

In the report, CIPD distinguishes between 'hard' and 'soft' workforce planning (see Table 2.1), noting that the '… key is about getting the right balance between the two to ensure *good quality data is considered in the right context* to get *the best possible inputs into decision-making*'.

Table 2.1: Characteristics of 'hard' and 'soft' workforce planning (2010: 5)

Hard workforce planning	• Numbers focussed • Often involves looking at past trends to predict the future • Matching supply and demand for labour
Soft workforce planning	• Defining a strategic framework within which information can be considered • Good quality management information is key to identifying/maximising performance drivers • Gives managers the opportunity to consider a range of possibilities before they are forced into action by circumstance

In the course of their analysis, which spanned both public and private sectors in the UK, the authors identified the following common drivers that inform organisational workforce planning:

- Organisational strategy;
- Operational requirements;
- Stakeholders and customers;
- Market forces.

In this context, they note that 'being able to articulate the imperatives for planning is one of the criteria to get planning embedded and supported across the organisation'.

2.2.2 A Process Model for Workforce Planning

While acknowledging that there is no one-size-fits-all model for workforce planning in organisations, based on their research, the authors propose a process model for workforce planning including what information may be required and how workforce planning links to other HR and business activities (see Figure 2.1).

Figure 2.1: Process model for workforce planning (2010: 10)
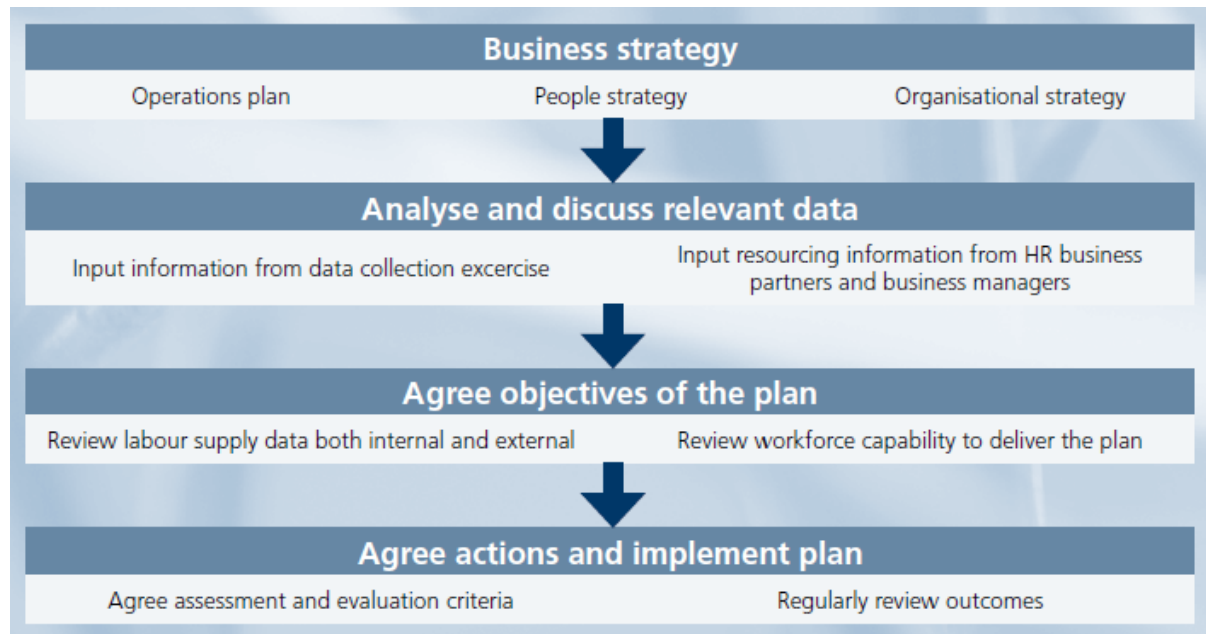
To inform planning and decision-making, they note that there is a need to identify likely requirements for:

- Future supply of labour – that is, what people are going to be available within the organisation and for hire in the labour market?
- Future demand for labour – that is, what does the organisational strategy tell us about the likely demand for labour? How many people are we going to need, in what jobs and what skills and capabilities will they need to have?

This is done on the basis of both qualitative and quantitative data and information pertinent to the organisational context. Data and information for workforce planning, as summarised by the authors on the basis of their research, is shown in Figure 2.2 overleaf.

Figure 2.2: Information used in workforce planning (2010: 13)

Qualitative – Internal

Information from strategic planners – potential new directions, technology scenario planning, new ways of working

Information from senior management – strategic

Information from line managers – operational

Information from HR on people – skills, training needs, attitudes and performance, potential

Quantitative – Internal

Workforce data – eg turnover, absence data, demographics, training spend, recruitment spend, working patterns, succession planning, talent planning, competence levels achieved, skills audit etc.

Organisation data – customer information, results of strategic assessments such as feasibility of offshoring or outsourcing, rostering requirements, orders

Information used in workforce planning

Quantitative – external

Labour market – eg demographics, skills provision, existence of training provision

Immigration/emigration

Population – demand for services/goods

Benchmarking information, eg CIPD survey data

Qualitative – external

Social trends

Developments in technology

Changing patterns of consumer spending and lifestyle

Social attitudes

Through their research, the CIPD identifies clear linkages between workforce planning and a number of other HR practices/activities (Figure 2.3), noting that:

> *'In some cases the practices were integral and in others it was more about managing the flow of knowledge from one to another. Whatever the relationship looks like, in practice the crucial issue is that there is alignment between the different activities and that they support each other. In larger organisations this will require communication and co-operation with colleagues elsewhere in the business.'*

Figure 2.3: How workforce planning links to other HR activities (2010: 15)

Workforce planning as an organisation-wide activity which 'requires buy-in from all parts of the organisation and at all levels' is emphasised and the authors also identify a number of barriers and enablers for implementing workforce planning (Table 2.2).

Table 2.2: Barriers and enablers to workforce planning (2010: 23)

Barriers	Enablers
• Lack of clarity or focus in the organisation strategy • A constantly shifting strategy • Too much focus on the operational and budgetary planning at expense of longer-term planning or a strategic direction for planning • Processes that don't join up, meaning information is not fed into the planning cycle or that effort is duplicated • Failure to develop plans that are responsive enough to adapt to a changing environment • Failure to review plans in the light of new information that indicates change • Poor-quality data/systems • Too much focus on the numbers of people required and not enough on capacity and potential to develop new skills and abilities in the future • An overcomplicated system or trying to do too much too soon • Lack of planning skills and good guidance on workforce planning	• A 'triangle' of conversation about future requirements between the business, HR and finance • Workforce champions in the business • Having a good process that enables everyone to feed in information and is informed by the needs of the business • HR and the line working together to understand future people needs • Understanding the difference between supply and demand for labour • Bottom-up communication feeding the planning process • Good-quality data that people can believe, accompanied by adequate analysis to explain what it means for the business • Leaders acting on the data to make informed decisions • Regular planning cycle and reviews with feedback into the planning process • Developing managers' workforce and resource planning skills

2.3 A Global Health Policy Perspective: A Comprehensive Labour Market Framework for Universal Health Coverage

2.3.1 Background

From a global health perspective, policy researchers have also been considering workforce planning issues, with a particular focus on labour market dynamics and drivers.

In the context of universal health coverage, Sousa *et al* (2013), highlight the importance of developing effective policies to optimise the supply of health workers noting that:

> '*this can only be accomplished through comprehensive planning of the health workforce based on an in-depth analysis of the health labour market to understand the driving forces affecting workforce supply and demand, both within countries and at the global level*.'

The authors consider that needs-based estimates and a focus on training more health workers are insufficient to address health workforce shortages, noting that 'although these estimates are useful to inform the demand for health workers, they are not enough to formulate effective health workforce policies because they ignore the dynamics of the health labour market'.

They identify a number of factors that influence the health labour market:

- Population health needs;
- Demand for health services;
- Supply of health workers;
- Governance of health workers.

2.3.2 Health Labour Market Framework

Defining the *supply of health workers* as 'the pool of qualified health workers willing to work in the healthcare sector' and the *demand for health workers* as 'represented by the public and private institutions that constitute the healthcare sector', the authors present a framework for considering the health labour market and the policy levers that shape it (Figure 2.4).

Figure 2.4: Comprehensive labour market framework (Sousa *et al*, 2013)
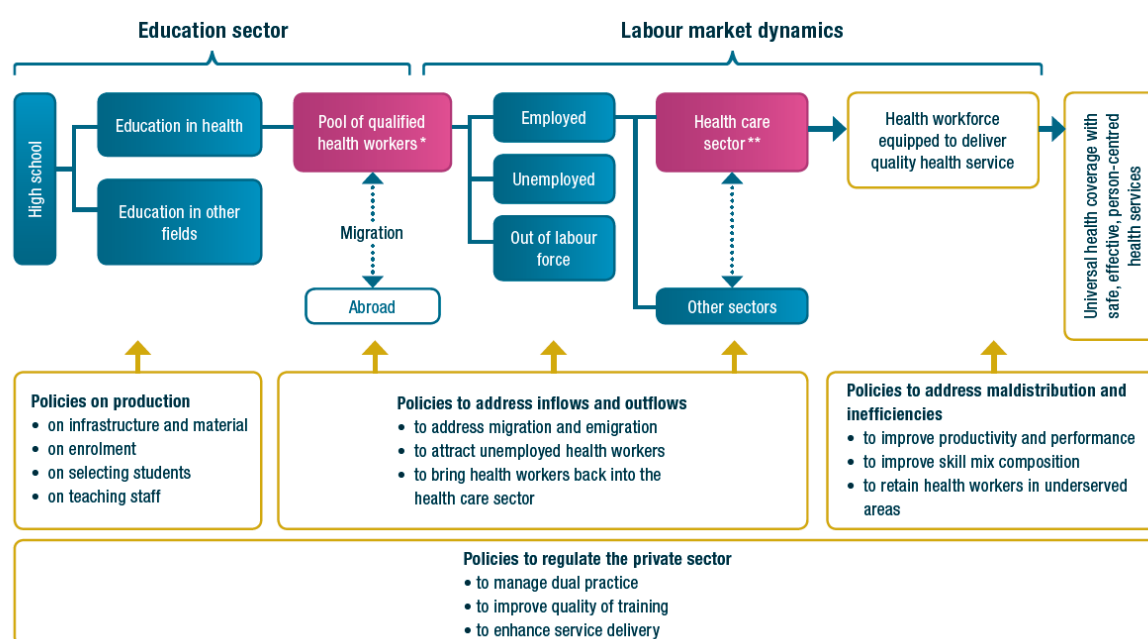
They divide the policy levers into four groups that contribute to health labour market dynamics:

- Policies on production;
- Policies to address inflows and outflows;
- Policies to address maldistribution and inefficiencies;
- Policies to regulate the private sector.

Their analysis of these levers is summarised in Table 2.3 below.

Table 2.3: Policy levers that contribute to health labour market dynamics (Sousa *et al*, 2013)

Policies on production	- Training of health workers is a key determinant of a country's supply of new graduates - Examples of production policies include opening new training institutions, provision of scholarships, incentives for teaching staff, alignment of health worker education with population health needs, training of new cadres of health worker - Production policies will only succeed if they are designed in parallel with policies to ensure absorption of new graduates into the health workforce and to correct workforce maldistribution and inefficiencies
Policies to address inflows and outflows	- Supply of health workers is determined by wages, working conditions, safety, and career opportunities - Available supply is impacted by migration and attrition of those who choose to work outside the health sector - Examples of inflow/outflow policies include increasing wages, providing allowances, improving working conditions, revising recruitment strategies, offering training opportunities - Policies need to be designed to take account of factors including geographical distribution, productivity and performance, skill-mix composition etc.
Policies to address maldistribution and inefficiencies	- Health worker maldistribution, inappropriate training, and productivity/performance issues can impact on the capacity of the existing health workforce to deliver services - Examples of policies include adoption of recruitment strategies to increase the supply of health workers in underserved areas, provision of allowances, granting of scholarships, matching of health workers' skills and tasks
Policies to regulate the private sector	- Virtually all countries have growing private health labour markets - Examples of regulatory policies include staff training, service quality and dual practice

The authors note that 'the precise combination of health workforce policies intended to address worker shortages and maldistribution should be tailored to each country's particular context and to its population's health needs', and they recommend in conclusion that a health labour market framework 'can provide the comprehensive approach needed to understand the forces behind health workforce supply and demand'.

2.4   Conclusions

While deriving from different disciplines, using different language and having different starting points, a number of common factors/themes emerge that we should pay attention to in the development of a national strategic framework for health and social care workforce planning in Ireland, including the following:

1. Workforce planning is a broad term that encompasses a range of approaches and activities within organisations;
2. Workforce planning – and related activities – should be aligned with organisational strategy;
3. There is a need to understand the drivers informing labour market dynamics;
4. Considering both workforce supply and demand sides is important;
5. High quality, complete and timely data, information and analysis are required to inform decision-making and identification of appropriate policies/strategies;
6. Whether termed 'policies' in a labour market dynamics context or 'HR strategies/activities' at an organisational level, identified actions should align with and support one another;
7. Appropriate whole-of-organisation and whole-of-system approaches are required to address workforce planning challenges.

Finally, both perspectives validate the need to develop a strategic framework within which data and information are used to inform national health labour market policies and organisational HR policies and practices.

3 The International Context for Strategic Health Workforce Planning

3.1 Introduction

Understanding the global and regional contexts within which national workforce planning takes place is a key element of any workforce planning system. This chapter seeks to draw together key thinking and developments at global and EU levels, in addition to international reviews that have been undertaken to support the development of the strategic framework.

3.2 WHO Global Code on the International Recruitment of Health Personnel

3.2.1 About the Global Code

WHO has been setting the agenda on health workforce issues since the *World Health Report 2006 – Working Together for Health* (WHO, 2006), which brought unprecedented attention to human resources for health (HRH). The report called for a decade of action on HRH, and acted as a catalyst for numerous policy initiatives and the adoption of several World Health Assembly resolutions including the WHO Global Code of Practice on the International Recruitment of Health Personnel, adopted by the Assembly in 2010.

The Code establishes and promotes voluntary practices for the ethical international recruitment of health personnel in a manner that strengthens health systems, including through effective health workforce planning, education and retention strategies.

The Code discourages the active recruitment of health personnel from developing countries facing critical shortages and emphasises the importance of equal treatment for migrant health workers and the domestically trained health workforce. It requires countries to implement effective health workforce planning, education, training and retention strategies to sustain a health workforce that is appropriate for the specific conditions of each country and to reduce the need to recruit migrant health personnel. Appendix Three outlines the Articles of the Code.

The WHO recognise that mobility is a reality and does not want to restrict travel, but wants to manage the negative effects. The Code is intended to help shape national policies to focus on: optimising existing workforce, anticipating future needs, and strengthening institutional capacity, data, evidence and knowledge.

3.2.2 First Review of the Relevance and Effectiveness of the Global Code

The Code includes mechanisms for review and monitoring and, in this context, in February 2015, WHO convened an Expert Advisory Group to conduct the first review of the relevance and effectiveness of the Code. Ireland and Thailand were nominated as co-chairs for the review, which took place during March-April 2015.

Ultimately, the Group concluded that the Code is highly relevant in the context of growing regional and inter-regional labour mobility. Notwithstanding this, they considered that it should be subject to periodic review to ensure that it continues to be a key framework to address health workforce challenges. They concluded that evidence of the effectiveness of the Code is emerging in some countries but considered that issues relating to low awareness, advocacy and Code dissemination should be addressed. They also concluded that work to develop and maintain Code implementation should be a continuing process for all Member States and stakeholders.

In the context of these conclusions, the Group made three recommendations. First, that full realisation of Code objectives requires Member States and other stakeholders to expand awareness and implementation, including strengthening capacity and resources to complete the second round of national reporting. Second, that the WHO Secretariat should expand capacity, at all levels, to raise awareness, provide technical support and promote effective implementation and reporting of the

Code. Finally, that a further assessment of the relevance and effectiveness of the Code should be considered in line with the third round of national reporting and the scheduled progress report to the 72nd World Health Assembly in 2019.

3.3   Global Strategy on HRH

In the context of projected global worker shortages of 18 million skilled health workers[3] by 2030 (WHO, 2016a), the overall goal of the *Global Strategy on Human Resources for Health: Workforce 2030*; is to 'improve health, social and economic development outcomes by ensuring universal availability, accessibility, acceptability, coverage and quality of the health workforce through adequate investments to strengthen health systems, and the implementation of effective policies at national, regional and global levels'.

The Strategy's principles include the promotion of 'international collaboration and solidarity in alignment with national priorities' as well as ensuring 'ethical recruitment practices in conformity with the provisions of the WHO Global Code'.

The objectives of the Strategy are:

1. To optimise performance, quality and impact of the health workforce through evidence-informed policies on HRH, contributing to healthy lives and well-being, effective universal health coverage, resilience and strengthened health systems at all levels;
2. To align investment in HRH with the current and future needs of the population and of health systems, taking account of labour market dynamics and education policies;
3. To address shortages and improve distribution of health workers, so as to enable maximum improvements in health outcomes, social welfare, employment creation and economic growth;
4. To build the capacity of institutions at sub-national, national, regional and global levels for effective policy stewardship, leadership and governance of actions on HRH;
5. To strengthen data on HRH, for monitoring and ensuring accountability for the implementation of national and regional strategies, and the Global Strategy.

The Strategy suggests building forecasting and planning capacity to develop or improve HRH policy and strategies that quantify health workforce needs, demands and supply under different possible future scenarios, in order to manage health workforce labour markets and devise effective and efficient policies that respond to today's needs while anticipating tomorrow's.

The Strategy recommends a number of policy options that should be considered by countries including the following:

- Strengthen the content and implementation of HRH plans as part of long-term national health and broader development strategies to strengthen health systems, ensuring consistency between health, education, employment, gender, migration, development cooperation and fiscal policies;
- Promote decent working conditions in all settings;[4]
- Optimise health worker motivation, satisfaction, retention, equitable distribution and performance;

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[3] Physicians, nurses/midwives, all other cadres (the seven other broad categories of the health workforce as defined by the WHO Global Health Workforce Statistics Database, i.e. dentistry, pharmacy, laboratory, environment and public health, community and traditional health, health management and support, and all other health workforce categories)

[4] The notion of decent work entails opportunities for work that is productive and delivers a fair income, security in the workplace and social protection for families, better prospects for personal development and social integration, freedom for people to express their concerns, organize and participate in the decisions that affect their lives, and equality of opportunity and treatment for all women and men (http://www.ilo.org/global/topics/decent-work/lang--en/index.htm).

- Harness - where feasible and cost-effective – information and communication technology (ICT) opportunities;
- Build planning capacity to develop or improve HRH policy and strategies that quantify health workforce needs, demands and supply under different future scenarios;
- Catalyse multi-sectoral action on health workforce issues to generate the required support from ministries of finance, education and labour (or equivalent), collaborating with and facilitated by the health sector;
- Ensure that all countries have an HRH unit or department reporting to a senior level within the Ministry of Health (Director General or Permanent Secretary);
- Establish the national case for investment in HRH as a vital component of the SDGs, UHC and universal access to healthcare;
- Strengthen technical and management capacity in ministries of health and other relevant sectors and institutions to develop and implement effective HRH policies, norms and guidelines;
- Ensure that the public health workforce aligns development efforts with the social services workforce and wider social determinants of health;
- Invest in the analytical capacity of countries for HRH and health system data;
- Put in place incentives and policies to collect, report, analyse and use reliable and impartial workforce data to inform transparency and accountability, and enable public access to different levels of decision-making;
- Strengthen HRH information systems and build the human capital required to operate them in alignment with broader health management information systems, including the ability to utilise such systems during emergencies and disasters.

At the time of writing the Global Strategy is being translated into a regional framework of action by WHO Regional Office (Europe).

3.4 UN High-level Commission on Health Employment and Economic Growth

In March 2016, the United Nations Secretary General announced the appointment of a Commission on Health Employment and Economic Growth, co-chaired by France and South Africa. The Commission was tasked with proposing actions to stimulate the creation of at least 40 million new jobs in the health and social sectors, and to reduce the projected shortfall of 18 million health workers, primarily in low- and middle-income countries, by 2030.

The Commission's report (WHO, 2016b) emphasised the fact that the health sector is a key economic sector and a job generator, pointing out that economic growth and development depends on a healthy population and explicitly recognised the health workforce not as a cost but as a driver of growth; an investment with tangible socio-economic returns.

The Commission made ten recommendations in their report including the following:

- Reform service models concentrated on hospital care and focus instead on prevention and on the efficient provision of high-quality, affordable, integrated, community-based, people-centred primary and ambulatory care, paying special attention to underserved areas;
- Harness the power of cost-effective information and communication technologies to enhance health education, people-centred health services and health information systems;
- Promote intersectoral collaboration at national, regional and international levels; engage civil society, unions and other health workers' organisations and the private sector, and align international cooperation to support investments in the health workforce, as part of national health and education strategies and plans;
- Undertake robust research and analysis of health labour markets, using harmonised metrics and methodologies, to strengthen evidence, accountability and action.

The report also outlined five immediate actions that should take place between December 2016 and March 2018, as follows:

- Development of an implementation plan;
- Establishment of a global framework to track commitments;
- Building of institutional capacity to conduct robust labour market analysis;
- Development of intersectoral action plans to transform education, skills and job creation;
- Development of an international platform on health worker mobility.

Implementation is being taken forward by the HRH Cluster WHO, together with the International Labour Organisation (ILO) and the OECD.

3.5 EU Joint Action on Health Workforce Planning and Forecasting

A Joint Action (JA) is a collaboration between EU and European Free Trade Association (EFTA) competent authorities on an issue that has a clear EU added value. JAs are co-financed by both the European Commission and countries taking part in the programme.

In July 2012, the European Commission approved the JA on Health Workforce Planning to: share good practice; develop forecasting methodologies on health workforce needs and effective workforce planning; and improve EU-wide data on the health workforce. Ireland was a participant country and the Department of Health was a collaborating partner in the initiative.

The JA was composed of seven Work Packages (WP), each dealing with a specific aspect of the project, including: WP4 (Data for Improved Health Workforce Planning); WP5 (Exchange of Good Practices in Planning Methodologies); and WP6 (Horizon Scanning).

Reports produced during the three year programme included documents on mobility, future skills requirements and sustainability, and a handbook on health workforce planning methodologies which describes and analyses the planning practices developed in a number of EU countries. These documents can be accessed at www.healthworkforce.eu.

The JA's *Report on Health Workforce Planning Data* (Kovacs *et al*, 2016) summarised evidence and experiences regarding challenges in health workforce planning data. Health workforce planning processes related to health workforce planning data (e.g. data collections, reporting, data flow and information exchange) were investigated and data availability gaps and critical points of planning data were identified. As part of this work a toolkit on health workforce planning was designed to provide support around managing and developing health workforce planning.

The toolkit is a collection of practical tools including protocols, guidelines, checklists and rating scales developed and designed to help countries to adapt standardised health workforce planning processes. It is intended to help planners to understand the current state and existing weaknesses of health workforce planning and directs attention to possible points of improvement. The tools support and facilitate the implementation of the minimal steps, processes and actions, thereby enabling an overall improvement in health workforce planning.

As an example of good practice the 'HWF Planning Pathway Model' within the toolkit offers minimal steps towards developing systematic health workforce planning with a specific emphasis on modelling and forecasting activities:

1. Setting the goals: shall provide clear and explicit objectives (transparency);
2. Organising stakeholder involvement and linking plans with policy actions: focuses on legislation issues, how regulations can be implemented in policy, and stakeholder involvement which covers strengthening commitment with accountability;
3. Knowing about the current HWF inventory: examine data coverage (e.g. whether data collections are appropriate – how information gathering occurs, whether clear indicators

exist – best available information, further cleansing necessary); review and develop data warehouse, expanded datasets and linking with additional data sources (data exchange);

4. Assessing the current HWF situation: conduct data analysis and HWF monitoring (environment scan, reflecting changes, interpretation of data and trends);
5. Making future HWF forecasts: introducing forecasting models (basic planning principles, simple scenarios with HWF to population ratio);
6. Planning capacity evaluation: covers regular revisions of the HWF planning system.

The toolkit also includes a maturity assessment tool for systematic health workforce planning, designed for authorities responsible for health workforce planning.

3.6 OECD Report on Health Workforce Planning

The 2016 OECD report; *Health Workforce Policies in OECD Countries – Right Jobs, Right Skills, Right Places*, analyses recent trends and policies adopted by OECD countries affecting the demand and supply of health workers. The analysis identifies that addressing the future health needs of ageing populations, with many more people living with one or more chronic conditions, will require innovations in health services including more effective use of new technologies and the development of skills of different categories of health workers at all levels.

The report makes a number of recommendations in relation to planning the supply and demand of the health workforce, including the following:

- Health workforce planning is not an exact science and needs regular updating: Assessing the future supply and demand for doctors, nurses or other health workers 10 or 15 years down the road is a complex task, fraught with uncertainties on the supply side and to a greater extent on the demand side. Projections are inevitably based on a set of assumptions about the future, which need to be regularly re-assessed in light of changing circumstances, new data, and the effect of new policies and programmes;
- Need to know first where we are before we can know where we're heading: The first step of any good health workforce projection is reliable data about the current situation. One of the main benefits of strengthening health workforce planning efforts is that it often triggers improvements in this crucial first step;
- Supply-side improvements need to focus more on retirement patterns: Most health workforce projection models have focussed their attention on new entry into different professions, but have paid less attention to exit through retirement. There is a need to consider more closely the complex issue of work-to-retirement patterns, particularly for doctors but also for other professions, as a large number of health workers are approaching retirement age and their retirement decisions will have a major impact on supply in the coming years;
- Need to move from uni-disciplinary to multi-disciplinary health workforce planning: Health workforce projection models need to be able to assess in a more integrated way the impact of different healthcare delivery models, as many countries are looking at ways to re-organise the delivery of services to better respond to population ageing and the growing burden of chronic diseases. Moving from uni-disciplinary to multi-disciplinary approaches is particularly important in the primary care sector where the roles and responsibilities of different providers (doctors, nurses and other providers) is rapidly evolving in some countries;
- Health workforce planning models need to address the geographic distribution of health workers adequately: Any nationwide balance of health workers does not necessarily mean that regional shortages or surpluses do not exist. A proper assessment of gaps between supply and demand needs to go below the national level to assess the geographic distribution of health workers and how this might evolve over time under different scenarios.

3.7 Review of Health Workforce Planning Strategies/Frameworks in Other Jurisdictions

3.7.1 Desk-based Review

As part of the preparatory work carried out by the Department for Health for this project, a desk-based review of workforce planning strategies/frameworks in other jurisdictions was carried out. The countries examined were England, Scotland, Wales, Canada, Australia and New Zealand. A number of themes were prominent in these strategies as follows.

Leadership

Leadership and management of the development of workforce planning frameworks/strategies has, in the main, been driven by the respective Departments of Health (or equivalent) along with employers (e.g. NHS Trusts), clinicians (doctors, nurses and midwives) and education and training institutions, i.e. schools of medicine and/or colleges of physicians.

Challenges and Drivers

These broadly cover three areas which are common in all jurisdictions to a greater or lesser extent:

- People management - ageing workforce, staff shortages and poor workforce distribution are compounding turnover and attrition rates;
- The environment - on-going global developments, increasing rates of consumer participation, demographics and advances in technology all place additional pressure on a health system;
- Delivery of services - greater emphasis is being placed on the development of multi-disciplinary and other team-based approaches.

With regard to timeframes, these vary from fifteen years in England to seven years in Scotland. Australia revised their original ten-year plan (2004 – 2014) to a five-year plan in 2011. In England, the NHS Foundation Trusts have five year plans and the Local Education and Training Boards produce a plan annually. Wales too, has a ten-year plan, however, it is noted that this is a living document that is intended to incorporate continuous changes with a strategic review to be carried out every three years. Scotland's plan covers a seven-year timeframe.

Main Themes and/or Principles

All jurisdictions include: education and career development; training and upskilling of staff; integrated workforce planning approaches, specifically financial and service planning; collaborative approaches to workforce planning and development; and the inclusion of the broader system and community in system design and workforce planning. Notably, only New Zealand specifically includes integrated, interdisciplinary and intersectoral working.

Action Plans for Delivery

Areas of action are identified in all of the strategies examined. Some go further than identifying action areas, with allocation of responsibilities to government departments, agencies or education boards.

Monitoring and Review

Australia, Canada and Wales all acknowledge the importance of monitoring, reviewing, evaluating and reporting of workforce planning, however none identify specific mechanisms or structures to do so; instead, they point to mechanisms being planned. Jurisdictions with a specified reporting and measuring instrument are: New Zealand, England and Scotland.

3.7.2 Health Workforce Planning Models, Tools and Process in Five Countries

To support enhanced workforce planning capacity and capability in the health service, the Department of Health via the Health Research Board (HRB) commissioned an evidence review of operational health workforce planning models, tools and processes used in five countries: Australia; New Zealand; Scotland; Wales; and the Netherlands (Kinsella and Kiersey, 2016).

The review was systematic and targeted at official repositories, reports, and journal articles from 2009-2015 across each country's Department/Ministry of Health websites and associated online workforce planning resources, and the following databases: Web of Knowledge, PubMed, CINAHL, Embase, Psycinfo, PsycArticles and TRIP. Only data sources and documents in the English language were included. Structured expert interviews were conducted with key workforce planning personnel in four of the five countries to get a better understanding of the evolution of workforce planning processes and the institutional context within which the models sit.

The review, published in September 2016, found that the onset of health workforce planning emerged independently in each country as a response to either financial constraints, forecasts of the changing demands on health systems from demographic pressures, or issues surrounding future supply.

Most countries did not necessarily begin with an integrated approach in mind and tend to begin their journey by focussing on the medical profession with other professions coming afterwards. It was identified that workforce planning is a process as much as a modelling tool with advancements on data collection and modelling evolving with the evolution of the planning system.

The report noted that basic workforce planning models consist of separate supply and demand forecasting, analysis of the outcomes of the forecasting and action planning. Consultation and engagement with stakeholders throughout the workforce planning process facilitates their input into broader health workforce policy, which means that workforce planning is as much a qualitative as a quantitative process; and that modelling tools that make demand and supply forecasts, are relevant only to the extent that they are informed by a qualitative understanding of the system from service-level inputs. Ultimately the review found that using data collection and modelling processes as part of a structured dialogue with health professionals is key to any workforce planning model's success.

The review goes on to confirm that consistent, reliable data is vital for effective modelling. Once a credible baseline measure exists, any number of forecasts or policy-change scenarios can be performed. Consequently, countries must start where they have existing data. None of the countries examined instigated data collection before beginning workforce planning.

Most countries use advanced spreadsheets (typically Microsoft Excel) to undertake their forecasting and scenario modelling. These models are not complex and are easily replicated and expanded upon. Thus, workforce planning can be engaged without a high expenditure on database design at inception. Expenditure is necessary on core staff, to oversee and implement any workforce planning, as they are the gatekeepers of the process, particularly the planners (experts). Those interviewed for the review emphasised that the input of planning experts is vital to the success of the process in order to help shape the attitudes of those involved in frontline workforce planning.

The impact of these findings is that financial resources will be necessary to develop a sophisticated WFP model but that this can emerge gradually in conjunction with improving the approach to workforce planning within the system.

The full report is available online at http://www.hrb.ie/uploads/tx_hrbpublications/Health_Workforce_Planning_Models_2016.pdf and Appendix Four sets out examples, taken from the report, of how workforce planning is structured in some of the jurisdictions studied.

3.8   Brexit and the Irish Health Workforce

At the time of writing, there is still a large degree of uncertainty surrounding Brexit and the impact it might have on Irish health and social care services. For example, we don't yet know what new arrangements may emerge as regards the UK's future relationship with the EU. This context of uncertainty makes conducting work to examine and address the implications of Brexit challenging.

The Department of Health has put in place a process and work is underway to examine and address any implications for the health sector over the longer term. All the Department's work relating to Brexit is informed by the following key priorities – to ensure continuity in the provision of health services and to avoid any changes to the current situation that would have a negative impact on human health.

The principal possible impacts of Brexit for the health sector cover a number of areas including:

- Free movement;
- Rights to health services;
- Regulatory issues.

The issue of free movement will obviously have an impact on health workforce planning. Brexit raises a number of issues relating to free movement including the mobility for cross-border health workers and this will need to be given due consideration.

The Common Travel Area has been in existence since Irish independence. It allows freedom of travel between the two jurisdictions for Irish and UK citizens, and provides for largely reciprocal benefits of citizenship, in terms of entitlements to reside, work and access services. These arrangements stem from the close historic relationship between the two countries and predate the entry of both to the EU. Both the Irish and British Governments have set out their desire to maintain these arrangements. This, of course, will have relevance for the health sector.

During consultation on this report, it has been suggested that the possibility of Ireland retaining common travel rights while restrictions apply to other EU countries may act as a driver for increased recruitment of Irish health staff from the UK. On the other hand, one submission gave the view that a hard Brexit with regards to working permits could result in a number of Irish health and social care workers currently working in the UK returning back to the Irish market.

An extensive programme of Government engagement is underway on Brexit. Ministers are meeting with their EU partners at Council meetings and at other events, while officials are maintaining contact with their counterparts in other countries.

The Department of Health is building on initial work undertaken to conduct a more detailed analysis on the impacts of Brexit in the area of health. Individual Units in the Department and agencies are conducting analysis and are continuing their contingency planning to identify the best strategies to mitigate each of those impacts. In addition to regular contact with agencies, Brexit is now being formally included as a standing item on the agenda of governance meetings between agencies and their responsible line Unit in the Department.

Until such time as the UK's relationship with the EU following its withdrawal becomes clear, the precise implications of Brexit for the area of health will remain unclear. A comprehensive analysis of the health implications of Brexit will have to be informed by the UK's intentions in this area. The Department's focus will remain on ensuring that services for patients are maintained and human health protected.

3.9 Conclusions

A national strategic framework for health and social care workforce planning should be grounded in the principles of the WHO Global Code, and take into account the need to manage health workforce demand and supply sustainably and insofar as possible within national resources.

In addition, managing migration of health and social care workers involves balancing the freedom of individuals to pursue work where they choose with the need to stem excessive losses from both internal migration (urban concentration) and international movements from less developed to more developed countries.

It should be recognised that, while national self-sufficiency is the ideal objective, there may be circumstances where it is neither possible nor practical. Due to Ireland's highly regarded educational standards, and that English is a first language, Irish healthcare staff are in high demand internationally and, consequently, have a high level of mobility.

Appropriate labour market policies and HR strategies are required to ensure, insofar as possible, adequate workforce supply and absorption of graduates into the health workforce from within Ireland's own resources, recognising the freedom of individuals to work where they choose.

Finally, the potential impacts of Brexit on the health sector and on free movement are recognised and are a matter of considerable concern to the Steering Group.

4 The Context for Strategic Health and Social Care Workforce Planning in Ireland

4.1 Introduction

In order to plan for the health and social care workforce in Ireland, we need to understand the factors that are likely to impact on the demand for health and social care workers in Ireland over the coming years. In that context, this chapter summarises key population health trends, as well as significant health sector strategic and operational developments.

4.2 Demographic and Epidemiological Trends

4.2.1 A Growing Population

Ireland experienced rapid population growth during the period 2000 to 2008, increasing by 696,000 people. The average annual growth rate moderated to 0.5% per year between 2009 and 2013 but increased again from 2014 to 2016 to bring our population to 4.7 million people (CSO, 2016). Based on CSO population projections, Ireland's population is expected to increase by 370,000 by 2026; a rise of almost 8%. This will have significant implications for demand for health services.

Figure 4.1: Growth in population in Ireland, 1992 - 2016 and projected growth to 2026
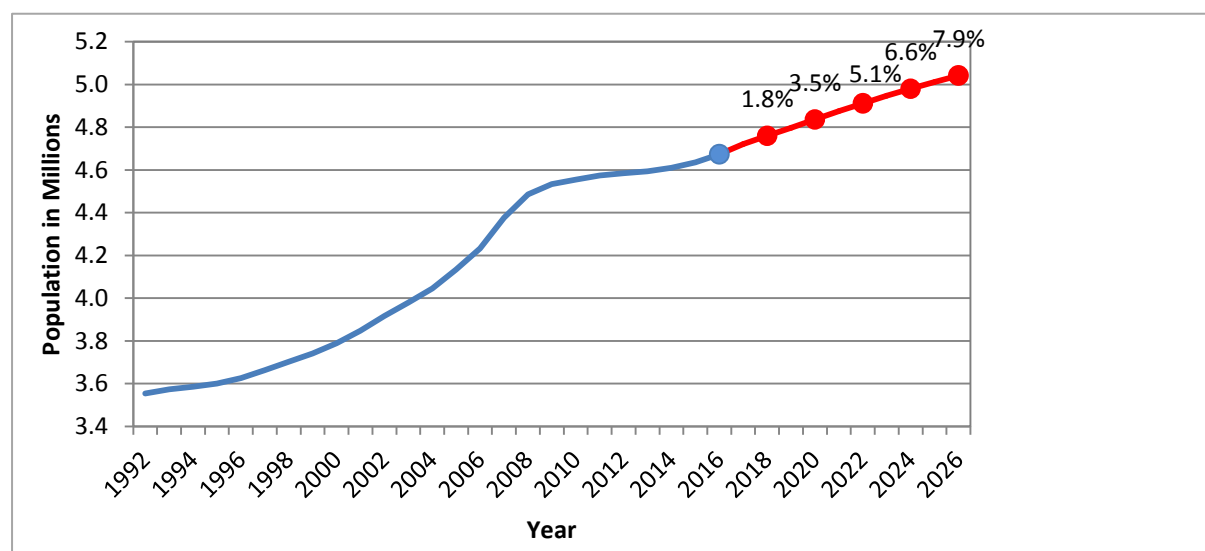
(CSO, 2016)

4.2.2 An Ageing Population

In addition to sustained increases in population over recent decades, Ireland in common with other developed countries is also experiencing population ageing.

The number of people in the 60+ age group is growing rapidly, increasing from 15.3% of the total population in 2006 to 18.4% in 2016. In absolute terms, between 2006 and 2016, the number of people aged 60+ years grew by 210,000 to 860,000.

From 2016 to 2026, the average yearly increase in the 60+ age group is projected to be 28,500 people per annum (or 4% p.a.) to 1.15 million. This will result in the 60+ age group increasing to 23% of the total population by 2026; an additional 290,000 people from 2016.

Furthermore, the population aged 85+ years increased by more than 20,000 between 2006 and 2016, and is projected to increase by a further 36,000 by 2026 to 104,000, meaning this age group is expected to more than double between 2006 and 2026.

Based on current CSO population projections, it is expected that population ageing will continue in the forthcoming decades. This has direct implications for health and social care services as demand is highest among older age groups.

Figure 4.2: Population by age category Census 2006 & 2011 and projections for 2021 & 2026
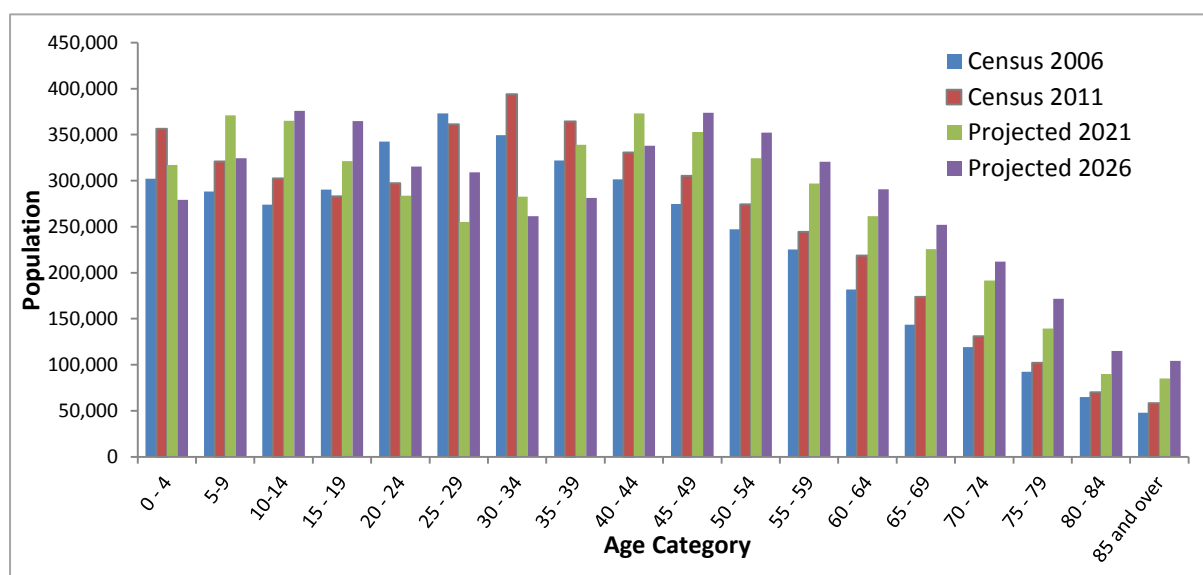
4.2.3 Longer Life Expectancy

Ireland's life expectancy at birth has increased by almost 2.5 years between 2005 and 2014. While Irish females are expected to live in excess of 83 years, in line with the EU average, Irish males are expected to live in excess of 79 years which is approximately 1 year longer than the EU average. The gap between male and female life expectancy in Ireland has narrowed over the last decade.

Figure 4.3: Life expectancy at birth for Ireland and EU-28 by gender, 2005 - 2014
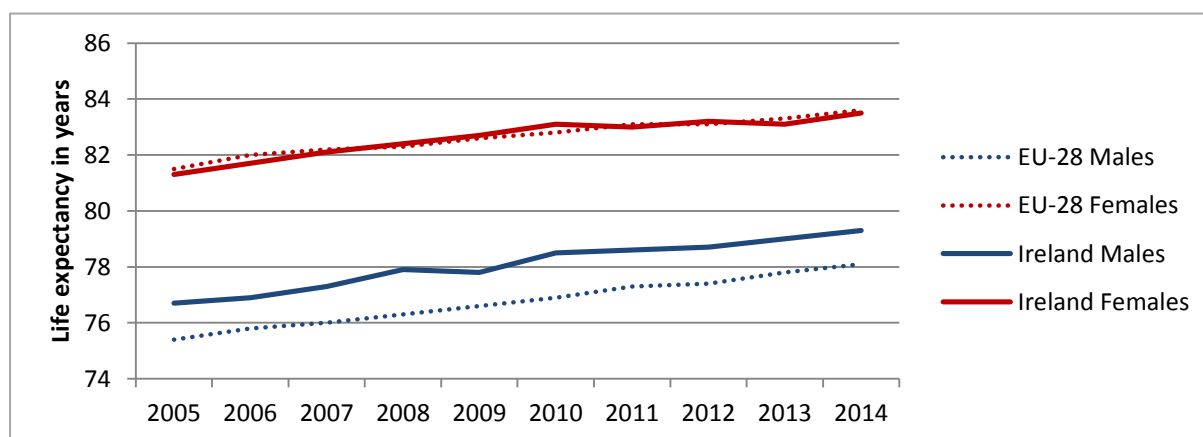
4.2.4 Increase in Chronic Diseases

In tandem with an increase in the size and age of the population, Ireland has an increasing number of people living with chronic diseases. Risk factors for chronic diseases are being targeted through strategies on tobacco, alcohol, physical activity and obesity under the Healthy Ireland Framework (Department of Health, 2013). These strategies have set ambitious targets for risk factor reduction but it will likely take a number of years before they impact on national levels of chronic disease.

Chronic diseases, by definition, are largely irreversible and the health sector response is oriented towards prevention or reducing the progression of these conditions and their complications. This means that the number of people with chronic conditions is likely to increase, however there is scope to reduce the burden of these conditions for individuals and the health system.

One of the successes of the health system has been the substantial improvement in patient outcomes for those diagnosed with non-communicable diseases. Ireland experienced a 28% decrease in the mortality rate from cardiovascular diseases, and a 13% decrease in the mortality rate from cancer between 2006 and 2015. The HSE has established a number of clinical programmes that have significantly improved clinical outcomes for those with chronic diseases, as well as enhancing hospital productivity. For example, the Stroke Programme now has one of the highest 'clot busting' rates in Europe with the potential to reverse a stroke, reduce bed days and reduce disability following the event.

Figure 4.4: Trend in age-standardised mortality rates for circulatory, cancer and respiratory diseases, 1999-2015
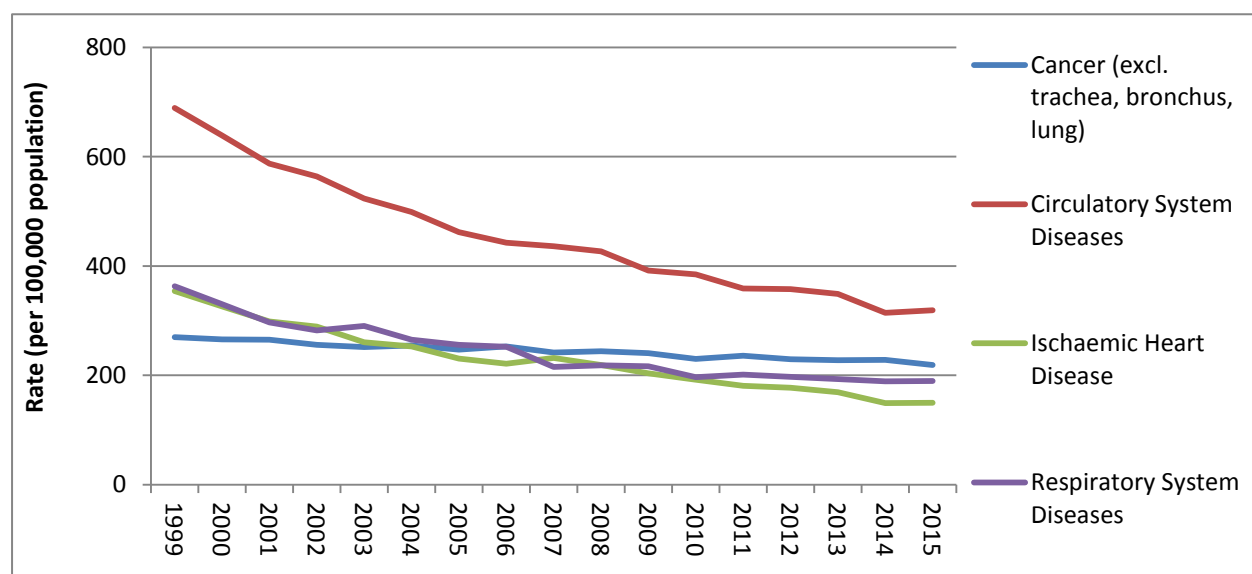
(Department of Health, 2016a)

These improvements in mortality rates are very welcome and have contributed to increases in life expectancy. However, it does mean that there have been increases in morbidity as people live longer. For example, better management of heart attacks reduces mortality rates, but there may be residual morbidity i.e. the rate of disease in a population.

Over the past 15 years, the number of people with chronic diseases has increased by 20-40% (depending on the condition) and this trend is expected to continue into the future. Currently there are 1 million people in Ireland living with cardiovascular disease, diabetes or chronic respiratory disease.

The level of co-morbidity is also increasing. As people age, they are more likely to be living with two or more chronic diseases in combination (co-morbidity); approximately two thirds of those aged ≥65 years, and four out of five of those aged ≥85 years, have two or more chronic conditions. It has been

shown that the addition of each chronic condition leads to an associated increase in: primary care consultations; hospital out-patient visits; hospital admissions; and total healthcare costs.

4.3 Demand for Health Services in Ireland

According to the Healthy Ireland Survey (Department of Health, 2016) the trends discussed above are key drivers of demand for healthcare. For example, just four non-communicable diseases – cancer, cardiovascular disease (heart disease and stroke), respiratory disease and diabetes – currently account for:

- 40% of hospitalisations as either a direct (19%) or contributing factor (22%);
- 76% of bed days used annually as either a direct (46%) or contributing factor (30%);
- 55% of the acute hospital budget.

4.3.1 Health Services Attended by Age

The Healthy Ireland Survey identifies that the percentage of adults attending various services increased with age, with the exception of those attending Emergency Departments where a higher proportion of younger adults had attended in the previous 12 months.

Figure 4.5: Health services attended in 12 months prior to interview by age group, 2016
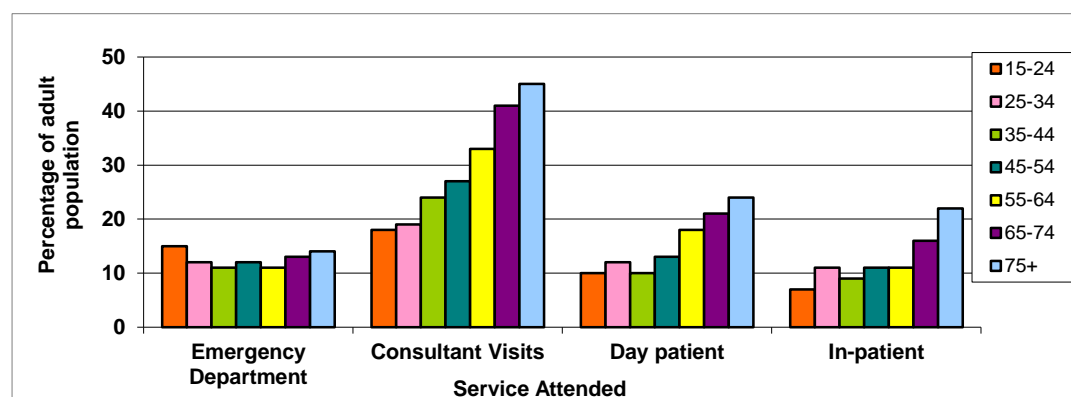
(Department of Health, 2016b)

4.3.2 Growth in Demand in Public Acute Hospital Services

It is, therefore, not surprising that, over the last four years, demand for public acute hospital services has increased on a year-on-year basis, with an average annual growth rate of 2.5% between 2012 and 2015. By 2015, the annual number of discharges had increased by 120,000 to over 1.66 million which is 8% higher than 2012.

HSE Hospital In-Patient Enquiry (HIPE) data reveals this increase in demand for acute hospital services is being driven by significant increases in day case and in-patient emergency discharges. More than 1 million day case discharges occurred in 2015 (a 12% increase from 2012), while in-patient emergency discharges had increased to 417,329 in 2015 (a 7% increase from 2012). The fact that Ireland's population is growing and ageing, and that older age groups are significant users of day case and in-patient emergency services, presents substantial challenges to the sustainability of the current model of health service delivery.

Figure 4.6: Number of in-patient emergency discharges by age category, 2015
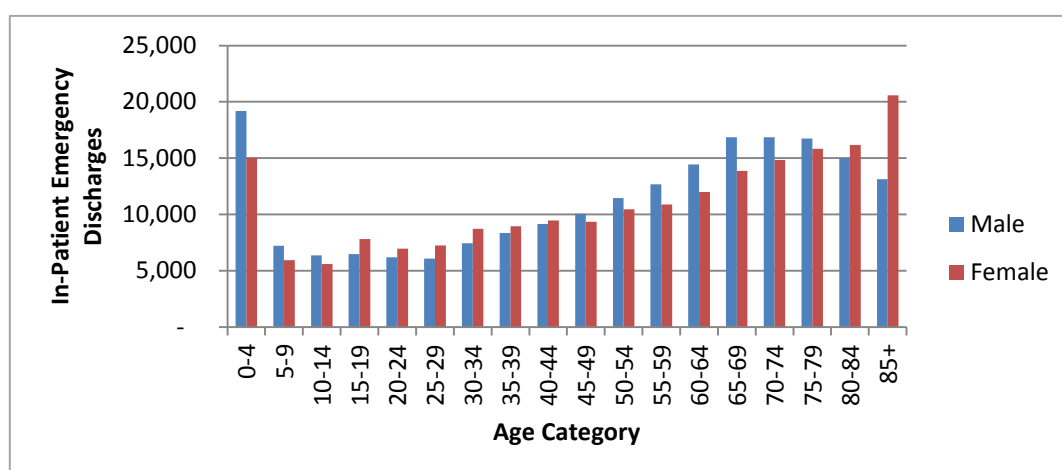
It should be pointed out that the current utilisation rate of acute hospital services is also a reflection of current available supply and does not take account of unmet need in the community.

Based on Ireland's changing demographics and current age and utilisation profile, and assuming unchanging age and gender-specific healthcare utilisation, the Department's own projections are that demand for acute services will continue to increase significantly in future years. In particular, from a 2015 base, demand for day case services is projected to increase to almost 1.24 million discharges by 2026; an increase of almost 23%. The primary reason for this projected increase in day cases is projected population ageing and the subsequent increase in demand from the 55+ age group, which is expected to account for 95% of the increase in demand.

Continued growth in demand for in-patient emergency services is also projected for future years, with an average growth rate of 1.8% per annum between 2015 and 2026. This would result in an additional 88,000 in-patient emergency discharges annually by 2026, of which 94% arise from the provision of health services to the 60+ age groups.

It should be noted, however, that the current policy imperative to implement integrated care services is anticipated to impact on these growth levels. In the context of health workforce planning, it is hoped that the increase in demand for services can be somewhat mitigated by a shift in demand towards primary/community care with an appropriate proportion of demand being met in these settings.

4.3.3   Demand for Primary Care Services

Two key indicators of demand for primary care services are the number of Medical Cards and GP Visit Cards issued.

According to PCRS data, at the end of 2016, there were in excess of 1.7 million Medical Cards in the system, representing a 37% coverage rate amongst the total population. As a percentage of the population more Medical Cards are issued to the 65+ age group than younger age groups. While only 25% of the 1.7 million Medical Cards are currently held by the 65+ age group, population ageing will result in substantial increases in this number. These projected growth rates are depressed due to the impact from the youngest (0-9 years old) and middle aged group (30-44 years old), whose numbers are expected to fall in the coming years. While the projected decline of 120,000 children in the 0-9 age group by 2026 would lead to a substantial reduction in service demand, this impact would be offset by the projected population growth of 230,000 people aged 65+ in the same time period.

Similar to Medical Card coverage, with the exception of the youngest age group (the under 6's), as a percentage of the population more GP Visit Cards are issued to the 70+ age group than younger age

groups. In excess of 20% of the 470,505 GP Visit Cards are held by those aged 70 and over, with the 70-74 years group having the second highest utilisation rate at 28% of the population. The current number of GP Visit Cards issued to children under 6 represents 53% of all cards; a reflection of the free GP Visit Card scheme for children under 6.

The total number of GP Visit Cards is projected to decline in coming years by an estimated 2.3%, in large part due to a reduction in those in the 0-5 years group. If the 0-5 years group is excluded from this analysis, the number of GP Visit Cards is conversely projected to increase by 43,000 with the 70+ years group accounting for 85% of this increase.

By 2026, the number of Medical Cards issued is projected to have grown to over 1.95 million cards; an additional 235,000 cards over the July 2016 base. Again, population ageing will be a significant driver of this increase, with 84% of the increase by 2026 associated with the 60+ years group.

4.3.4 Other Health and Social Care Services

Demographic and population health trends will also have implications for the demand for other health and social care services; in particular, residential care and homecare for older people.

Data from the Nursing Home Support Scheme, for example, shows that half of all those in residential care at the end of 2015 were aged 85 years and over. This represented 17% of the total population aged 85+ years. As this age group is expected to increase by a further 58% by 2026, this will have implications for residential care capacity.

Services provided to people in their own homes, e.g. community nursing and homecare packages, are also likely to be affected by an ageing population. Wave 2 data from the Irish Longitudinal Survey on Ageing (TILDA) showed that almost 7% of those aged 50 years and over have limitations in activities of daily living, e.g. dressing, bathing and eating. This increases to 16.5% for those aged 75 years and over. Growing numbers of older people in the coming years is likely to mean additional demand for homecare supports including a well-developed, responsive community nursing service.

4.4 Key Developments in the Health Sector

A number of current and recent reforms to the way health services are delivered are likely to impact on the way health workforce planning will be carried out in the future. These include the establishment of Tusla, the development of National Clinical Programmes, Integrated Care Programmes, the establishment of Hospital Groups and Community Healthcare Organisations, and the move towards delivering more care in the primary care sector.

4.4.1 Tusla Child and Family Agency

On 1st January 2014, Tusla became an independent legal entity, merging HSE Children and Family Services, the Family Support Agency and the National Educational Welfare Board.

In addition, certain psychology services and a range of services relating to domestic, sexual and gender-based violence were integrated under the new agency's remit.

The integration of three distinct organisations has resulted in a cohesive agency providing services to children and families.

The agency operates under the Child and Family Agency Act 2013 and has responsibility for a wide range of services that fall under the overarching frameworks for:

- Child Protection and Welfare services;
- Alternative Care services;
- Prevention Partnership and Family Support (PPFS) services;
- Educational Welfare Services (EWS).

4.4.2 Establishment of Hospital Groups and Community Healthcare Organisations

Establishment of the Hospital Groups

The bringing together of acute hospitals into a small number of Hospital Groups, each with its own governance and management, is intended to support the delivery of high quality, safe patient care in a cost-effective manner. Seven Hospital Groups have been created on an administrative basis as follows.

Hospital Group
1 Ireland East Hospital Group – Academic partner: University College Dublin (UCD)
2 RCSI Hospital Group – Academic Partner: Royal College of Surgeons (RCSI)
3 Dublin Midlands Hospital Group – Academic Partner: Trinity College Dublin (TCD)
4 University Limerick Hospital Group – Academic Partner: University of Limerick (UL)
5 South / South West Hospital Group – Academic Partner: University College Cork (UCC)
6 Saolta Hospital Group – Academic Partner: National University of Ireland Galway (NUIG)
7 The Children's Hospital Group

Each Hospital Group includes a primary academic partner, with the objective of supporting a culture of learning within the Group. Smaller hospitals are supported within the Group in terms of education and training, continuous professional development, the sustainable recruitment of high quality clinical staff, and the safe management of deteriorating and complex patients.

Key to the Hospital Group approach is the development of a more coordinated approach to the planning and delivery of services. It is potentially a key enabler for reorganisation of services across hospitals, with associated benefits in terms of providing care in the most appropriate setting and delivering a safe quality service.

Significant progress has been made in the implementation of the Hospital Group construct to progress from disparate individual hospitals towards an integrated group with a more a co-ordinated approach to the planning and delivery of services across all the hospitals within a Group.

Each Hospital Group is required to develop a strategic plan to describe how it will provide more efficient and effective patient services, taking into account the shift to a consultant-provided service; reorganise these services to provide optimal care to the populations they serve; and how they will achieve maximum integration and synergy with other Groups and all other health services; particularly primary care and community care services.

In developing their plans, Hospital Groups will be expected to demonstrate a co-ordinated approach to the planning and delivery of services within and across the Hospital Groups, with an increased focus on small hospitals managing routine urgent or planned care locally and more complex care managed in the larger hospitals.

Implementation of Hospital Groups is continuing on an administrative basis. Pending the enactment of any future legislation, Hospital Groups will continue to operate within existing legislative frameworks governing the health services, and the policy and accountability frameworks of the Department of Health and the HSE.

Establishment of Community Healthcare Organisations

Community Healthcare Organisations (CHOs) are responsible for providing all community healthcare services outside of acute hospitals, including primary care, social care, mental health, and other health and well-being services. Social care services encompass those for older people and people with disabilities. The establishment of the CHOs follows the publication of the report and recommendations of the Integrated Service Area review group in October 2014 (HSE, 2014). Nine Community Healthcare Organisations (CHOs) have been established on an administrative basis, to deliver health services at a local level across both the statutory and voluntary sector. In each CHO, a

Chief Officer will lead a local management team which focuses on all of the specialist services in their area. Currently, CHO Chief Officers are accountable to the four National Directors for Community Services.

As part of this, 96 Primary Care Networks, covering an average 50,000 population and placing an identified person as being responsible for service delivery to that population, are being set up across the country, with an average of ten Networks assigned to each CHO. Family doctors will play a strengthened role in delivering primary care through the appointment of a GP Lead to each Network, while a key worker will also work within each Network to support people with complex needs.

Across the 9 CHOs there are currently 484 Primary Care Teams (PCTs), which operate at the level below Primary Care Networks. PCTs are multi-disciplinary groups of health and social care professionals who work together to deliver local accessible health and social services to a defined population of between 7,000-10,000 people at 'primary' or first point of contact with the health service.

4.4.3   Shifting the Delivery of Care to Primary Care

The Government is committed to reforming the public health system to ensure that more care is delivered in the community. It is intended that 90-95% of people's health and personal social care needs should be met in the primary care sector. Patients will be referred from primary care only when their needs for care are sufficiently complex; otherwise they will be managed through primary care.

Primary Care Teams are comprised of GPs, nurses, midwives, speech and language therapists, occupational therapists, physiotherapists, social workers, healthcare assistants, home helps, managers and administrative staff. Primary Care Networks provide additional resources depending on assessed needs, such as dieticians and psychologists, to a number of PCTs. Primary care infrastructure, which is being delivered through a combination of public and private investment, will facilitate the delivery of multi-disciplinary primary care and represents a re-focussing of the health service to deliver care in the most appropriate and lowest cost setting.

Chronic Disease Management Programmes will shift the management of certain chronic diseases such as diabetes, stroke, heart failure, asthma and chronic obstructive pulmonary disease (COPD) from acute hospitals to the community. The focus of such programmes will be on primary prevention, early identification, simple and early interventions, patient empowerment, care in the community and on preventing acute episodes from occurring.

Improved management of chronic diseases will involve a reorientation towards primary care and the provision of integrated health services across the continuum of care that are focussed on prevention and returning individuals to health and a better quality of life.

These developments will have implications for the size and shape of the primary care workforce over the coming years.

Community Health Nurses and Midwives

To assist in this care delivery shift, along with developing a more integrated model of care as a whole system approach, the Department of Health has published a draft policy paper on *Developing a Community Nursing and Midwifery Response to an Integrated Model of Care*. Community health nurses and midwives are involved in the delivery of care to service users of all ages and form an important link between primary and secondary care settings, and also between public, private and voluntary services. Following on from *Primary Care – A New Direction* (Department of Health and Children, 2001), this draft policy proposes to maximise the potential for nurses and midwives to deliver patient services as near to the home as possible within an interdisciplinary team. This approach is based on an interdisciplinary model of integrated care built on pathways that support a holistic approach to patient and community needs.

A key aim of the draft policy is to ensure that all people in Ireland are able to access a community nursing and midwifery service that both promotes health and wellbeing, and also provides appropriate care for those who require it.

The policy vision is to deliver, within the community, all nursing and midwifery care that does not need to be delivered in a hospital setting. This integrated model of care will be based and managed within the community, with referral pathways of care that transit seamlessly into a hospital setting to be used only when required. The policy sets out an approach that can contribute to improving patient and family independence, maintaining well-being and reduce demand on acute services. It is the aim of the policy to meet service users' choices and needs as close to home as possible, improve hospital avoidance and patient flow, ensure timely access to services, and early discharge.

To enable the development and optimisation of the skills of nurses and midwives in the community, and indeed the wider health service, the Department has also published a draft policy paper on the *Development of Graduate, Specialist and Advanced Nursing and Midwifery Practice*. The policy paper proposes a framework for graduate, specialist and advanced nursing and midwifery practice capable of developing a critical mass of nurses and midwives to address emerging and future service needs including driving integration between services.

Collectively these two policies on implementation aim to make a substantial contribution to the realisation of an integrated service for patients and service users across our health services.

General Practitioners (GPs)

There are about 2,500 GPs working in group practices, primary care centres, single practices and health centres around Ireland. The GP plays a central role in the health system and is often the first medical advice a person seeks when they feel unwell.

GPs provide a broad service to their patients on all health issues, and may refer patients to see specialists or hospital consultants if more specific investigation is required. GPs play a central role in the health of our community, caring for people from birth and childhood, through to older age and end of life care.

Most GPs in Ireland are private practitioners, but the majority of GPs provide services on behalf of the HSE, to people with Medical Cards, GP Visit Cards and other schemes. The first two phases of universal GP care without fees were introduced in 2015; for all children under the age of 6 years and for all people aged 70 years and older respectively. This has resulted in approximately 800,000 people now being eligible for GP care without fees without having to undergo a means test. The Programme for Government commits to extend in phases, and subject to negotiation with GPs, free GP care to all children under 18 years of age. Legislative changes will be required for any such extension of free GP care to further cohorts of the population.

The HSE's National Doctor Training and Planning Unit has estimated in its report, *Medical Workforce Planning: Future Demand for General Practitioners 2015-2025* (HSE, 2015c), that as many as 2,055 additional GPs, a more than 50% increase in the current GP workforce, would be required to provide medical services in general practice to patients by 2025 were universal GP care extended to the entire population.

Health and Social Care Professionals (HSCPs)

The HSCP workforce within primary care will be a key enabler and vital resource in facilitating the shift of care from the acute to primary care setting. The importance of fully harnessing this section of our clinical workforce is increasingly recognised in Ireland. This recognition was signalled in early 2017 with the establishment of the first National HSCP Office in the HSE.

Within HSE primary care a review has taken place of the model of care for speech and language therapy and reviews are underway to develop new models of care for physiotherapy and occupational therapy, encompassing mental health and social care. A model of care is also being

developed for dietetics in the community. These professions have much to offer in addressing key health priorities around prevention and management of chronic disease, proactive interdisciplinary management of care and support for the older population and other groups with complex needs (stroke, neuro rehabilitation etc) supporting patient flow by preventing admissions to acute hospitals and supporting early discharge back to the community. Historically the numbers of some of these professions (i.e. physiotherapy, occupational therapy, dietetics) has been lower in the community setting with more resource being centred on the acute hospitals. Comprehensive integrated workforce planning based on the new models of care will assist in determining the primary care workforce needed in these disciplines to deliver on the huge potential benefits. In particular the potential for direct access to some of these professions, for example, physiotherapy has the potential to assist with the pressure on GP workloads as well as referral level into acute and specialist services.

The development of specific areas of HSCP advanced practice offers further opportunities to deliver previously hospital-based services in the community, improve patient satisfaction and flow as well as the opportunity to relieve pressure on GP practices.

4.4.4 Committee on the Future of Healthcare

In line with the commitment in the Programme for a Partnership Government, the Oireachtas Committee on the Future of Healthcare was established in June 2016 to develop a single long term vision for healthcare over a 10-year period, with cross party support. The Committee published its report on 30th May 2017. The Government has given its approval to move ahead with the establishment of a Sláintecare programme office. This office will be led by a senior executive with a strong track record in implementing reform. Planning for the establishment of this office is underway. In parallel, a detailed response to the report is being prepared and will be submitted to the Government by the end of 2017.

4.4.5 National Clinical Programmes and Integrated Care Programmes

Development and Implementation of the National Clinical Programmes

The set-up of a National Clinical Programme (NCP) brings together experts in the fields of healthcare including medicine, nursing, therapy and allied health, along with patients and patient organisations. Governance of a Programme includes the establishment of a National Working Group and Consultants' Clinical Advisory Group. The role of these expert groups is to guide and govern the solutions put forward by the Programme's Working Group and this is further enhanced by collaborating and consulting with a range of significant stakeholders across the Irish healthcare system. The achievements of many of the Programmes clearly demonstrate a strong commitment to clinical practice improvement through effective clinical leadership.

The NCPs have provided a foundation of valuable learning of the need to maintain and enhance clinical leadership and develop clinical pathways that are truly patient-centred. To this end, the NCPs are being restructured into Integrated Care Programmes.

Integrated Care Programmes

The HSE's Clinical Strategy and Programmes Division (CSPD) is leading a large-scale programme of work to develop a system of Integrated Care within health and social care services.

Integrated care places the patient perspective as the organising principle of service delivery. It is based on illness prevention, patient empowerment, multi-disciplinary cross-service care planning and delivery, where all health and social care services work together to provide a flexible network of care responsive to the changing needs of patients and their families.

Building on the work of the NCPs, CSPD is establishing four interdependent Integrated Care Programmes (ICPs), to deliver better, more integrated and responsive services to people in the most

appropriate setting. The first phase of NCPs was based on strong clinical leadership and developing excellence in specialties/specific conditions and specific populations. The ICPs (represent the next stage and will address integration of these programmes, to provide a more effective end-to-end patient journey, particularly where patient needs are complex and involve multiple encounters delivered across a range of providers. The four ICPs are

- Integrated Care Programme for Children;
- Integrated Care Programme for Chronic Diseases;
- Integrated Care Programme for Older People;
- Integrated Care Programme Patient Flow.

4.4.6 Patient Safety and the Establishment of the National Patient Safety Office

The Department of Health recognises patient safety as the cornerstone to quality healthcare. The National Patient Safety Office (NPSO) is focussed on leading key patient safety policy initiatives.

Patient Safety Surveillance

A national patient safety surveillance system will be established in 2017 which will provide evidence to inform patient safety policy and leadership decisions, bringing data from many sources together to inform prioritisation and monitoring of implementation. This creates the opportunity to address the 'precursors to harm, and not just the harm itself', and help to develop a 'problem sensing' culture that actively seeks patient safety alerts. The collection of data is not an endpoint and it is important that the surveillance of patient safety profiles for patients, service and clinical cohorts is part of the quality improvement cyclical process. It will also assist in identifying and developing processes to address data gaps of importance. Addressing identified gaps through a Quality Improvement (QI) process is likely to have implications for health worker skill sets, competences and behaviours over time.

Clinical Effectiveness

Clinical effectiveness is a key component of patient safety. The integration of best evidence in service provision, through clinical effectiveness processes, promotes healthcare that is up to date, effective and consistent. Clinical effectiveness processes include guidelines, audit and practice guidance. The Clinical Effectiveness strand of the NPSO supports the National Clinical Effectiveness Committee established by the Minister for Health.

The Clinical Effectiveness Unit has also commissioned research on curriculum development and competency frameworks in the undergraduate and postgraduate sectors. The outputs of this research will be used to develop a competency framework and entrustable professional activities for competency-based education and training for multi-disciplinary health professionals in clinical effectiveness and patient safety. Enhancing clinical effectiveness and ensuring the implementation of clinical effectiveness guidelines, with purpose and fidelity, will inform workforce development over the coming years.

Patient Safety and Advocacy Policy

Patient advocacy is where the patient's will and preference is expressed by an independent individual when a patient may feel unable to represent themselves. The NPSO will define and set the model and core components required of the national advocacy service, and oversee its introduction. The impact of the introduction of this service is likely to inform development of health workforce planning initiatives in the future.

4.4.7 Healthy Ireland and Workplace Health and Well-being

The Healthy Ireland Framework (Department of Health, 2013) was adopted by the Irish Government in 2013 in response to Ireland's changing health and well-being profile. While life expectancy has

increased, and mortality from a range of diseases has fallen significantly, there are many trends that are leading us toward an unhealthy and extremely costly future. It envisions a Healthy Ireland; where everyone can enjoy physical and mental health and wellbeing to their full potential; where wellbeing is valued and supported at every level of society and is everyone's responsibility.

Significant work has been undertaken across the health services since the publication of the *Healthy Ireland in the Health Services Implementation Plan 2015 – 2017* (HSE, 2015b). Governance structures have been put in place at national and local level to support implementation of health and well-being initiatives in the HSE, with leadership from across the health services, co-ordinated through the work of the Planning, Performance and Programme Management function within Health and Well-being.

Tusla's Health, Well-being and Employee Assistance Programme is a national service that is available to all Tusla employees. The Programme designs and develops evidence-based staff well-being workshops on workplace resilience and self-care, which are specifically tailored for the children and families workforce.

4.5   Health Sector Funding

With the recent improvement in the public finances, healthcare funding has increased over the past couple of years. Nevertheless, it must be recognised that this funding is a public resource and cognisance must be taken of the fact that public resources are finite.

Cost containment and the sustainability of current levels of health and social care services are, and must continue to be, a priority for policy-makers and those delivering services. Health sector workforce planning must take account of the wider economy necessitating an on-going evaluation of the resources available for health service delivery.

Acknowledging the limited public funding available, the health service receives delegated sanction to recruit from Department of Public Expenditure and Reform, subject to compliance with overall pay ceilings. The health service pay envelope constitutes almost 50% of all public health sector funding.

Table 4.1: Public health sector spending 2009 – 2016

	2010	2011	2012	2013	2014	2015	2016
Public Expenditure Non-capital	13,818	13,181	13,218	13,084	13,276	13,889	14,562
Public Expenditure Capital	366	347	350	347	386	398	414
Total Public Expenditure on Health	14,184	13,528	13,568	13,431	13,662	14,287	14,976

(*Figures displayed in millions of Euro, Department of Health, 2016)

An Activity Based Funding (ABF) system is being introduced in public acute hospitals on a phased basis. January 2016 represented a major milestone in the implementation process because the ABF system was introduced for inpatient and day case activity in the 38 largest public hospitals. Inpatient and day case activity will continue to be funded on an ABF basis into the future with the intention of extending to other activity over time.

The introduction of ABF represents a fundamental change in how healthcare is funded in Ireland and has implications for the way hospitals are staffed and resourced. Implementation of ABF involves moving away from inefficient block grant budgets to a new system where hospitals are paid for the actual level of activity undertaken, subject to budgetary limits. As such, there will be a fundamental shift from funding facilities and settings to instead funding episodes of care.

Under ABF, the prices to be paid to hospitals are set by reference to the average cost of treatment across all public hospitals. These prices are determined by the Healthcare Pricing Office (HPO), which is an office of the HSE. By setting prices based on average costs, hospitals are incentivised to better understand their cost-base and improve efficiency. This process is likely to highlight situations where hospitals' costs are above or as importantly below that of their peers. This could include staff costs because such costs are a major component of hospitals' overall cost base. When costing data suggest that a hospital's staffing costs are not in line with comparable providers, the ABF system will incentivise further investigation and action from hospital management.

It is important to note that quality and safety of patient care is at the core of ABF. In this regard, it is intended that adherence to standardised models of care, best practice guidelines and integrated care pathways developed by HSE CSPD will be incentivised by the new funding model. The identification of such guidance will also influence decisions in relation to the most appropriate staffing levels and mix.

4.6   Conclusions

Due to growing and ageing populations and consequent increases in levels of chronic illnesses, demand for health and social care and, consequently, for health workers will continue to grow in Ireland over the coming years.

Ireland is not unique in facing future challenges to ensure the resilience of health and social care services. Across EU countries, the share of the population aged over 65 has increased from less than 10% in 1960 to nearly 20% in 2015 and is projected to increase further to nearly 30% by 2060 (European Commission, 2016). Currently, around 50 million EU citizens are estimated to suffer from two or more chronic conditions, and most of these people are over 65. According to the OECD (2016b), 'population ageing, combined with tight budgetary constraints, will require profound adaptations to the health systems of EU countries, in order to promote more healthy ageing and respond in a more integrated and patient-centred way to growing and changing health care needs'.

Demographic changes are informing and underlining the importance of a range of policy and operational initiatives, as set out in this chapter.

Implementing these initiatives will undoubtedly impact on the shape and size of the health workforce. Effective short-, medium- and long-term workforce planning will be vital to ensure that changes are planned and managed effectively from a health workforce perspective.

5 The Health Workforce in Ireland

5.1 Introduction

As with demand side factors, we must also understand our current workforce and the factors that have informed its development. This chapter summarises the supply side environment in Ireland currently, in addition to identifying some key workforce trends on the basis of available workforce data.

5.2 Demographic Profile of HSE Staff

5.2.1 Age Profile

In all, some 149,593 people are estimated to be working in the health and social sector in Ireland. Of these approximately 108,223 are directly employed by the HSE and Section 38 agencies.

The HSE workforce is ageing, with approximately 65% of all HSE staff aged over 40 years with 21% aged under 35 years. In contrast 31.6% of those employed in the general population are aged under 35 years (SOLAS, 2016). Figure 5.1 shows the age profile of staff currently employed by the HSE.

Figure 5.1: Age profile of HSE staff at September 2016
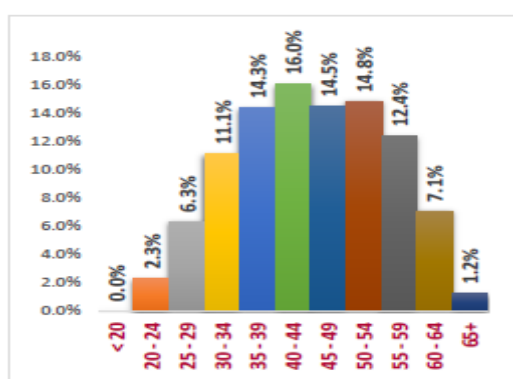
(HSE, 2017)

Table 5.1: Age profile of HSE by staff category at September 2016

Age Band	Medical/ Dental	Nursing	Health & Social Care	Mgt/ Admin	General Support	Other Patient & Client Care	Total
< 20 years	1	3	1	1	4	14	24
20-24 years	209	926	238	126	75	207	1,781
25-29 years	1,307	1,681	960	311	180	548	4,987
30-34 years	1,376	3,049	1,749	1,134	371	1,042	8,721
35-39 years	835	4,175	2,155	2,047	598	1,451	11,261
40-44 years	804	5,077	1,782	2,116	794	1,941	12,514
45-49 years	774	4,233	1,154	1,985	978	2,083	11,207
50-54 years	706	4,060	855	2,209	1,296	2,445	11,571
55-59 years	551	3,177	685	1,812	1,243	2,146	9,614
60-64 years	311	1,375	339	989	1,034	1,348	5,396
65+ years	121	125	54	83	214	214	811
Total	**6,995**	**27,881**	**9,972**	**12,813**	**6,787**	**13,439**	**77,887**

(HSE, 2017)

5.2.2 Gender Profile

The majority (79.3%) of the workforce in the HSE and Section 38 agencies is female and this is almost unchanged since 2000. This compares with women making up 45.9% of the workforce across Ireland in general (SOLAS, 2016).

Figure 5.2: Percentage of female staff in the HSE and Section 38 agencies workforce
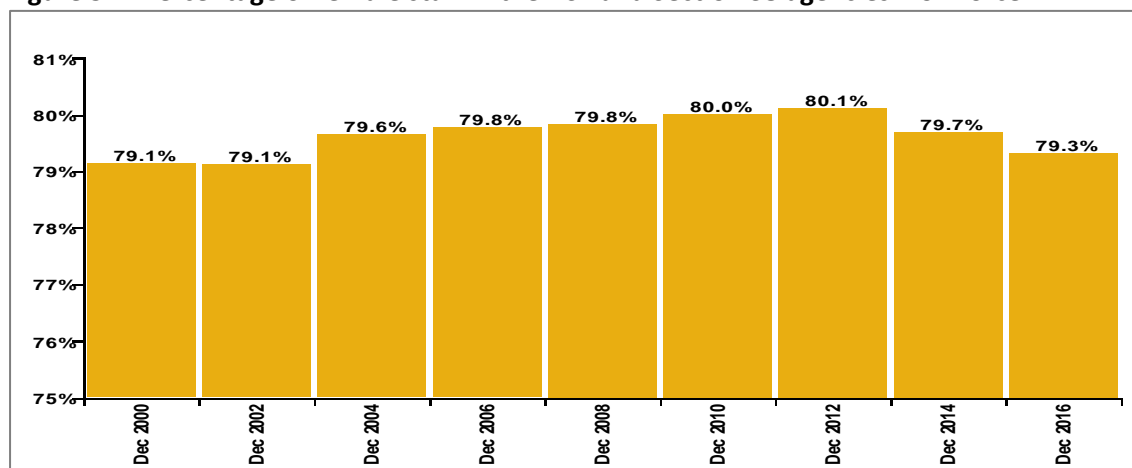
(HSE, 2016)

Table 5.2 shows changes in the level of female representation in the main staff categories for time periods between 1991 and 2016. There have been some significant changes over the 25 year period including:

- 1 in 2 doctors or dentists (50.1%) are now female (up from 36% in 2000, or 1 in 3, in 1991);
- 87% of nurse managers are female (up from 81% in 2000);
- The number of women in senior managerial posts (Grade VIII and above) has increased from 15% to 58% of the total in those grades.

Table 5.2: Percentage of female staff in the HSE and Section 38 agencies by staff category / group

	Dec 1991	Dec 1996	Dec 2001	Dec 2006	Dec 2011	Dec 2016
Consultants	19.6%	20.8%	24.2%	30.5%	35.6%	39.3%
NCHDs	34.4%	38.5%	38.8%	43.1%	51.1%	53.1%
Medical (other) & Dental	49.4%	50.5%	56.5%	57.4%	59.9%	64.2%
Medical/ Dental	**32.6%**	**35.3%**	**37.7%**	**41.3%**	**47.3%**	**50.1%**
Nurse Manager	81.2%	82.1%	86.9%	87.8%	89.0%	88.6%
Nurse Specialist	93.8%	100.0%	94.9%	90.1%	92.4%	92.0%
Staff Nurse	90.0%	91.4%	92.3%	91.9%	92.1%	92.1%
Public Health Nurse	100.0%	99.9%	99.9%	99.9%	99.6%	99.5%
Nursing Student	97.3%	93.6%	98.3%	99.2%	96.5%	96.0%
Nursing (other)	75.1%	84.2%	75.7%	94.2%	94.1%	94.2%
Nursing	**90.4%**	**90.9%**	**91.4%**	**91.6%**	**91.9%**	**91.8%**
Therapists (OT, Physio, SLT)	97.3%	96.6%	93.5%	89.9%	89.7%	89.9%
Health Professionals (other)	72.6%	76.9%	79.6%	81.3%	82.1%	82.3%
Health & Social Care	**77.4%**	**80.8%**	**82.4%**	**83.0%**	**83.8%**	**84.4%**
Management (VIII+)	14.5%	20.3%	39.3%	48.1%	52.5%	57.9%
Clerical & Executive (III to VII)	79.0%	82.5%	86.4%	87.2%	87.5%	86.3%
Management/ Admin	**78.0%**	**81.5%**	**84.6%**	**85.0%**	**85.3%**	**84.0%**
General Support Staff	**66.6%**	**68.2%**	**62.8%**	**61.5%**	**60.3%**	**58.4%**
Ambulance			11.8%	15.4%	18.3%	22.3%
Care			80.8%	80.9%	79.3%	76.8%
Patient & Client Care			**77.6%**	**77.4%**	**74.9%**	**72.8%**

(HSE, 2017)

5.2.3 Gender Variation in Work Patterns

In 2016, the HSE reported that 88% of male staff and 63% of female staff were working on a full-time basis (OECD, 2016). A gender breakdown of work patterns across HSE staff categories is set out in Table 5.3 overleaf.

Table 5.3: Work pattern breakdown by category and gender for HSE and Section 38 agency staff

Staff Group	% No. Male Full-time	% No. Female Full-time
Total HSE Staffing	88%	63%
Consultants	86%	78%
NCHDs	99%	97%
Medical other	46%	45%
Nurse Manager	96%	72%
Nurse Specialist	98%	65%
Staff Nurse	90%	59%
Public Health Nurse	100%	67%
Nursing Student	84%	87%
Nursing other	95%	72%
Therapists (OT, Physio, SLT)	90%	71%
HSCP other	87%	67%
Management	99%	91%
Clerical & Administrative	94%	66%
Ambulance	100%	99%
Care	78%	56%
Support	88%	48%

(HSE, 2017)

A 2013 RCSI study showed that more women are entering the medical profession than ever before, with females comprising more than 50% of medical graduates since 1992, a trend referred to as 'the feminisation of medicine' (McAleese, 2013).

The study pointed to a number of trends associated with 'feminisation'. These included:

- Gender differences in medical specialty career choice – resulting in potential shortages in some specialties;
- Gender differences in working hours – females are more likely to work less than full time due to maternity and parental leave reasons;
- Gender bias in medicine – including obstacles to career progression.

It was suggested in the study that these trends 'may result in a decline in the number of Whole Time Equivalents in specialties that become highly feminised' resulting in 'decreased availability of the medical workforce overall'. It is however, highlighted in the report that these issues are 'gender relevant rather than gender specific'. Pointing to the fact that desire for a good lifestyle 'goes beyond a gender stereotype there is a generational issue in this as well'. The general conclusion being that younger doctors are 'more likely, regardless of gender, to be interested in and influenced by lifestyle factors in their medical career'.

The study notes that workforce planners will need to incorporate the demand for flexible working practices 'into their forecasting to ensure that there are sufficient WTEs of doctors in the health system to maintain service provision'.

5.2.4 Entry and Exit Patterns to the Health Workforce

Data on entry and exit patterns to the health workforce in Ireland is limited.

The HEA's 2016 *What Graduates Do? The Class of 2015: An Analysis of the First Destination of University Graduates* report found that 82% of level-8 degree Health and Welfare graduates and 83% of postgraduate Health and Welfare graduates were in employment in Ireland or elsewhere nine months after graduation.

67% of degree graduates and 72% postgraduates were employed in Ireland. Of the degree graduates in employment, 84% felt their qualification was relevant or very relevant to their area of employment. This figure was 89% for postgraduate graduates, and both these figures were significantly higher than the averages for all graduates of 62% and 68% respectively.

Table 5.4: First destination of undergraduate Honours Bachelor Degree graduates by field of study, 2015

	EDUCATION	ARTS & HUMANITIES	SOCIAL SCIENCES, JOURNALISM AND INFORMATION	BUSINESS, ADMINISTRATION AND LAW	NATURAL SCIENCES, MATHEMATICS AND STATISTICS	ICT	ENGINEERING, MANUFACTURING AND CONSTRUCTION CONSTRUCTION	AGRICULTURE, FOREDTRY, FISHERIES AND VETERINARY	HEALTH AND WELFARE	SERVICES	ALL GRADUAATES
Respondents	71%	72%	74%	76%	78%	84%	79%	79%	78%	83%	76%
In Employment	84%	46%	55%	63%	49%	77%	70%	76%	82%	57%	62%
In Employment in Ireland	*72%*	*37%*	*47%*	*57%*	*42%*	*70%*	*60%*	*51%*	*67%*	*48%*	*53%*
In Employment Overseas	*12%*	*9%*	*8%*	*6%*	*7%*	*6%*	*10%*	*25%*	*15%*	*9%*	*10%*
Further Studies/Training	7%	44%	38%	32%	42%	16%	23%	20%	16%	35%	31%
Work Experience Schemes	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Seeking Employment	8%	6%	5%	4%	6%	6%	6%	4%	2%	7%	4%
Unavailable for Work/Study	1%	4%	3%	1%	2%	1%	1%	0%	1%	0%	2%

(HEA, 2016)

Table 5.5: First destination of Master and Doctor Graduates by field of study, 2015

	EDUCATION	ARTS & HUMANITIES	SOCIAL SCIENCES, JOURNALISM AND INFORMATION	BUSINESS, ADMINISTRATION AND LAW	NATURAL SCIENCES, MATHEMATICS AND STATISTICS	ICT	ENGINEERING, MANUFACTURING AND CONSTRUCTION CONSTRUCTION	AGRICULTURE, FOREDTRY, FISHERIES AND VETERINARY	HEALTH AND WELFARE	SERVICES	ALL GRADUAATES
Respondents	62%	65%	68%	71%	68%	74%	63%	76%	66%	70%	68%
In Employment	86%	67%	77%	87%	69%	85%	81%	77%	83%	84%	80%
In Employment in Ireland	*78%*	*51%*	*60%*	*65%*	*57%*	*78%*	*71%*	*38%*	*72%*	*62%*	*64%*
In Employment Overseas	*8%*	*15%*	*17%*	*22%*	*12%*	*8%*	*9%*	*38%*	*11%*	*22%*	*16%*
Further Studies/Training	3%	14%	9%	4%	17%	5%	11%	0%	9%	2%	8%
Work Experience Schemes	0%	1%	1%	0%	0%	0%	0%	0%	0%	0%	0%
Seeking Employment	8%	16%	11%	7%	11%	9%	7%	23%	6%	13%	9%
Unavailable for Work/Study	4%	3%	2%	1%	3%	1%	1%	0%	1%	0%	2%

(HEA, 2016)

Currently, the Medical Council is the only registration body that collects data at a level of detail that enables tracking movements and patterns of entries and exits.

According to the Council's 2016 *Medical Workforce Intelligence Report* (Medical Council, 2016), over 17,500 doctors retained registration with the Council in 2015; of whom two thirds had graduated from an Irish medical school. The report notes that 6.4% of doctors exited the Register at the time of the annual retention process, with a 4.4% exit rate for graduates of Irish medical schools. Notably, among graduates of Irish medical schools aged 25-29 years, there was a relative increase of 16% in the exit rate between 2014 and 2015.

Table 5.6: Exits from the Register 2015 by age and gender

Characteristics	Exit Rate (all doctors)	Exit Rate (graduates of Irish medical schools)
All doctors	6.4%	4.4%
Gender		
Male	6.7%	4.7%
Female	5.9%	4.1%
Age Category		
Under 25 years	6.3%	8.3%
25-34 years	8.7%	6.4%
35-44 years	6.4%	3.5%
45-54 years	3.2%	1.1%
55-64 years	4.5%	2.6%
65 years and over	11.6%	10.9%

(Medical Council, 2016)

5.2.5   Staff Turnover Data

Turnover rate is the percentage of staff that leave during a certain period of time. As part of their employment reporting, the HSE collects details of leavers and turnover rates across staff categories and service areas. Leaver data is broken down by reason, including: resignation, end of contract, retirement and other. Data can also be viewed by CHO, Hospital Group and individual hospital. Staff turnover reports are published on the HSE website on an annual basis and can provide valuable information to guide retention policies.

5.3   Funding the Health Workforce

5.3.1   Pay and Numbers Strategy

As part of Budget 2015, the Minister for Public Expenditure and Reform announced that the previous Employment Control Framework, primarily based on a general moratorium on recruitment and promotion, would be replaced by a Pay and Numbers Strategy which would focus on operating within pay allocations. The purpose of this change was to allow for greater recruitment flexibility; for example, where it is determined that offering permanent contracts can achieve more economical service delivery than agency usage.

The overriding principle of the Pay and Numbers Strategy approach is one of affordability and compliance with allocated pay budgets. Service delivery units must operate within pay allocations/budgets as set out in National Service Plans. The responsibility rests with National Directors of Service Divisions, Chief Executive Offices of Hospital Groups, Chief Officers, CHOs, and Heads of National Services /Corporate Functions, in the first instance, to ensure strict compliance with pay allocations and affordability of their workforces.

Key drivers to ensure compliance with pay ceilings include the following:

- Adherence with public sector pay policy;
- Using every vacancy as an opportunity to reform and reduce costs through changes to skill-mix, in line with effective scope of practice, substitution and possible alternative more cost-effective methods of delivering existing levels of service;
- Targeting of reductions to more costly agency and overtime usage;
- Ensuring responsibility and accountability operates for all recruitment decisions and managers are both empowered and held accountable for such decision-making;
- Putting in place robust and immediate remedial actions where projected pay overruns/forecasts are identified.

5.3.2   National Integrated Staff Records and Pay Programme

Central to the efficient running of a large organisation, such as the HSE, is its capacity to access comprehensive employee data in order to control staffing costs, manage absenteeism and assist in strategic management decision-making.

Current health service payroll and personnel records operations are distributed throughout the country across 9 separate payroll operational units, and 8 personnel administration / records management units. Four separate payroll systems are used to pay employees and two HR systems are used for personnel records administration. The existence of multiple systems impacts on the HSE's ability to obtain management information across the whole service, with timely, comprehensive and accurate management information difficult to provide.

The HSE recently established a National Integrated Staff Records and Pay Programme. The Programme incorporates projects that include the implementation of a single national system for Personnel records and payroll. This implementation will support the HG and CHO organisational structures, and facilitate progress towards the implementation of a National Personnel Records and National Payroll Business Services Strategy.

A timescale of 4-5 years is envisaged for the completion of the programme following which all employee records will be administered on one HR platform capturing employee demographic information; time and attendance information; and absence details leading to full service history records for all employees.

5.4   Health Workforce Training and Planning in Ireland

The purpose of this section is to provide an overview of the way workforce planning, training and education is currently undertaken in Ireland. Currently, at national level, there are small teams with dedicated resources and significant expertise in workforce planning within HSE National HR Division including in NDTP (for doctors) and in the OMNSD (for nurses in NMPDU) however, there is very little beyond this across the organisation. The range of knowledge and skills developed is concentrated on completing the workforce planning process within these individual staff categories and reported activities include:

- Communications and teamwork: development and management of team; stakeholder consensus development; inter-departmental collaboration and evaluation of stakeholder recommendations;
- Systems and data: development and implementation of planning systems; data collection, analysis and tool development; data sources, relationship between service data and HR data and data modelling using workforce planning software;
- Project management: methodologies and implementation;
- Strategies: identification and implementation;
- Research: health workforce and services research; economic analysis; international network development and evidence reviewing;
- Supply and demand principles: understanding data sources; relationship between service data and HR data and data modelling using various workforce planning software packages;
- Forecasting: strategic thinking; strategy development; scenario planning; horizon scanning; risk assessment/risk management; trend and demographic analysis and assessing demand now and in the future;
- Workload measurement: direct workload; indirect workload and associated work and expertise in the use of acuity/dependency tools in a variety of settings;
- Staff deployment: rostering; understanding safe staffing levels; skill mix; competencies and diversity;
- Reports: report development and publication.

5.4.1   National Doctor Training and Planning (NDTP)

In 2007, the Medical Education and Training Unit (MET) was established in response to the role for the HSE outlined in the Health Act 2004 and, in particular, the Medical Practitioners Act 2007.

In 2013, MET established a Medical Workforce Planning function to undertake a review of current medical staffing in Ireland, projected requirements in future years and to compare Ireland with other countries.

Traditionally, there had been limited advance/forward planning of medical specialist posts in the public health system. In order to address this deficit, in July 2013, HSE-MET commissioned the Strategic Medical Workforce Planning (MWP) Project.

The core objective of the MWP Project was to develop a workforce planning model that would produce medical workforce projections based on the health needs of the population. These projections would be updated regularly based on drivers including changes in healthcare delivery, patient needs and supply of doctors. The projections would also be used to inform the annual intake into the various postgraduate medical training programmes and would facilitate the alignment of training intakes with service requirements. Phase 2 of the MWP Project included a current state

analysis of the Medical Workforce, including the population of the FÁS Quantitative Tool for Workforce Planning in Healthcare (FÁS, 2009). It was concluded that a model would be developed that would involve building more complex demand variables into the mainly supply focussed Quantitative Tool for Workforce Planning in Healthcare.

In September 2014, National Doctors Training and Planning (NDTP) was established and incorporates MET, Consultant Appointments and Medical Workforce Planning. The alignment of the functions provides NDTP with a strategic overview of medical training from internship through to appointment of hospital consultants.

In September 2015, NDTP published its first medical workforce planning report, *Future Demand for General Practitioners 2015-2025* (HSE, 2015b)*,* which includes a number of recommendations relating to GP training, and recruitment and retention measures.

In December 2016, NDTP published *Medical Workforce Planning Ireland: A Stepwise Approach* (HSE, 2016b) which outlines a simple methodology that guides the user through a series of phases to support workforce planning for a specific or multiple groups of medical health professionals within the Irish healthcare system. Using context analysis, analysis of change drivers, expert panel scenario development, and supply and demand analysis, the approach supports the development of a plan to 'clearly outline how the workforce functions today, how it might function 10 years into the future, and staffing requirements based on future scenario-based service developments'. The aim is that these plans can be used to inform decisions around labour market interventions e.g. training requirements, recruitment and retention strategies, and policies around workforce feminisation and workforce ageing.

5.4.2   Office of the Nursing and Midwifery Services Director (ONMSD)

The Report of the Commission on Nursing (1998), set out for the first time, a national, detailed examination of nursing and midwifery in Ireland. The report included a wide range of recommendations as a framework for the development of nursing and midwifery as a key profession within the health service. One of the recommendations concerned the establishment of nursing and midwifery planning and development units in each health board, which subsequently led to the establishment of the HSE Office of the Nursing and Midwifery Services Director (ONMSD) in 2006.

ONMSD Role and Function

The ONMSD has a primary focus on the strategic development of nursing and midwifery to provide optimum patient-centred care, leadership, supporting excellence and innovation and building capacity in nursing and midwifery to enhance patient care and service delivery. It is led by a Director, supported by a leadership team, Nursing and Midwifery Planning and Development Units, and Centres for Nursing and Midwifery Education. The Office:

- Provides professional guidance and expertise at a corporate level and to health service providers locally;
- Provides a focal point for nursing and midwifery within the public health system and is the critical professional link between the Department of Health and in particular the Office of the Chief Nursing Officer, the Nursing and Midwifery Board of Ireland (NMBI), the HSE Directorate and its Divisions, higher education institutes (HEIs), Directors of Nursing and Midwifery, and other stakeholders;
- Provides expertise in the analysis, application, implementation and evaluation of legislation and health policy to the nursing and midwifery resource within health services nationally;
- Supports the CSPD by providing individual staff resources leading on specific aspects of programmes as well as the collective contribution of the ONMSD to the integrated care programmes;

- Supports QI by providing individual staff resources to the Quality Improvement Division leading on specific QI projects as well as the collective contribution to QI education, practice, project development, research and resources;
- Uses an integrated evidence-based approach, underpinned by data intelligence, gathered nationally to inform and support decisions regarding nursing and midwifery;
- Is a budget holder and provider for design, development and delivery of continuous professional development (CPD) across a range of areas e.g. education, research and leadership.

The ONMSD and Office of the Chief Nursing Officer (CNO) in the Department of Health have, in particular, strong linkages and a professional collaborative. The CNO has responsibility for nursing and midwifery policy, and to ensure a nursing and midwifery perspective is brought to bear on the development of policy. A key element in this role is the support and engagement of the ONMSD, in providing the critical operational input to the development and implementation of policy, along with engagement in a number of collaborative initiatives including the Nursing and Midwifery Values initiative, and support for the implementation of the Safe Nurse Staffing and Skill Mix Framework.

Workforce Planning, Education and Training

As reported in February 2017, nurses and midwives comprise 34% of the overall public health workforce.

The ONMSD carries out workforce planning by engaging with key stakeholders to plan for the right number of nurses and midwives, healthcare assistants (HCAs) and maternity care assistants; with the right skills, in the right places, doing the right work to deliver quality care. This includes:

- Working with the Department of Health National Taskforce on Staffing and Skill Mix for Nursing in relation to implementing the Framework;
- Estimating current and future capacity;
- Contributing to the development, monitoring and review of nursing and midwifery roles e.g. role expansion, development of Clinical Nurse/Midwife Specialist, and Advanced Nurse/Midwife Practitioners;
- Supporting the development of appropriate education to increase capacity to undertake nursing and midwifery workforce planning within services;
- Developing and maintaining professional skills and competencies of nurses and midwives;
- Developing the capacity of the HCA workforce, including the delivery of QQI (FETAC) level 5 education to meet current and future requirements as part of the overall skill mix.

As part of their role in workforce planning, the ONMSD, in partnership with thirteen HEIs deliver undergraduate nursing and midwifery education for the whole health sector. In 2017, 1690 undergraduate nursing (general, psychiatric, intellectual disability and children's) and 140 undergraduate midwifery degree places were commissioned. The provision of these programmes requires the HSE to provide clinical placement opportunities for these students in accordance with the requirements and standards identified by the NMBI for each individual programme. These are governed under a Memorandum of Understanding between the HEI and approved sites for clinical placement. The ONMSD through the Local Joint Working Groups between HEIs monitors the supply of nurses and midwives from the undergraduate programmes. In 2012, the ONMSD informed the decisions through analysis of the current and required future supply of nurses and midwives, as part of the review of the undergraduate nursing and midwifery degree by the Department of Health.

Currently, some services recruit international nurses and midwives whose undergraduate preparation does not meet the NMBI qualification requirement for registration. The HSE provides programmes that support the period of adaptation and assessment for these nurses and midwives. As an alternative, the Faculty of Nursing in the RCSI provides an aptitude test for overseas nurses applying to register as a general nurse with the NMBI.

The HSE via the ONMSD also offers sponsorship to a small number of public service employees to train as a nurse/midwife on an annual basis and provides additional post registration programmes leading to a second registration which offers an additional supply of registered nurses to Children's services and mental health (from 2017) and of midwives to maternity services.

Workforce Capacity and Capability

The ONMSD develops nursing and midwifery capacity through the identification of opportunities for role development and expansion across the Hospital Groups and CHOs and develops strategies for their national implementation.

Advanced Practice and Clinical Specialists

The ONMSD supports the development of Registered Advanced Nurse Practitioners and Registered Advanced Midwife Practitioners within the HSE. This is achieved through a structured process in collaboration with the NMBI. The ONMSD also supports the development of Clinical Nurse and Midwife Specialist posts, and provides a standardised methodology for the approval of posts across the HSE. The development of both advanced and specialist posts are supported in conjunction with the NCPs and ICPs, to provide for a responsive nursing and midwifery service.

Education commissioning and sponsorship

Education commissioning, both professionally accredited and formal academic programmes such as specialist education programmes, in addition to leadership and management development programmes, are supported to enable delivery of the integrated care programmes, build capacity and support high quality care environments by an educated and skilled workforce.

Substantial sponsorship for postgraduate education, for example to enable the development of Advanced and Specialist practice, is provided by the ONMSD through a structured process that is prioritised on the basis of service need to meet these goals of service delivery.

Education and professional development

The educational delivery role of the ONMSD is delivered through the Centres for Nursing and Midwifery Education (CNMEs). The function of the CNME is to support nurses and midwives in their mandatory education, CPD, and in the development of new competencies, maintenance of core competencies and engagement in evidence based practice. These centres offer a range of programmes at varying levels. In addition, the ONMSD provides HCA education and training.

Workload and Workforce Analysis Projects

The ONMSD assists Hospital Groups and CHOs in reviewing existing workforce requirements using various evidence-based methodologies. A number of initiatives have been undertaken to examine aspects of the supply of and demand for nurses and midwives over the last decade. Some of these have been service specific and some have been national.

The ONMSD has equally supported national efforts for workforce analysis and planning including that by the Office of the CNO in the Department of Health, which established a Taskforce for Staffing and Skill Mix in 2014, with the overall aim of stabilising the nursing and midwifery workforce. In addition, a number of other workforce projects have also been undertaken to support the work of the National Clinical Programmes e.g. determining the required number of Advanced Nurse Practitioners for Emergency Departments and the numbers to support the epilepsy model of care, establishing staffing requirements for Critical Care Units/services, determining staffing requirements for Local Injury Units. (See Appendix Five for a sample of the most recent projects.)

5.4.3   Health and Social Care Professions Office (HSCP)

From 2006 to 2016, a HSCP Education and Development Unit was in place in the HSE. Its overall function was to provide organisational leadership to the HSE on all matters relating to the education

and development of health and social care professionals. This Unit was central to the development and implementation of practice education structures in three therapies following the Government decision in 2005 to expand training places, as recommended in the Bacon Report, and subsequent investment of €4 million for practice placement tutor posts. It also supported particular developments in the disciplines of radiography, audiology and podiatry.

These education and development functions have now been subsumed into a new wider brief.

On 1st January 2017, the National Health and Social Care Professions Office was established in the HSE's National HR Division. This is a new function and its primary focus is to strategically lead and support the health and social care professions to maximise their potential and achieve the greatest impact for the design, planning, management and delivery of people centred, integrated care for the benefit of the population they serve.

Some of the core functions of the new expanded HSCP function are as follows:

1. To provide a focal point for HSCP within the public health system and critical professional linkage between the HSE, the Department of Health, the HSCP professional bodies, HSE services, HSCP managers, CORU, the HEIs and other stakeholders;
2. To model and support inter-professional learning and collaborative practice for integrated care and ensure mechanisms are in place for on-going engagement with all stakeholders;
3. To collect and analyse data and evidence to support decisions on HSCP roles and development that maximise service user outcomes and achieve highest levels of effectiveness, efficiency and value;
4. To put mechanisms in place to support CPD and a learning culture, and ensure a strong focus on enhancing outcomes for service users through supporting staff in their education and development;
5. To provide HSCP input to strategic workforce planning and work to ensure a match between educational provision and service need.

There are approximately 20 different professions (see Table 5.9) in the HSCP grouping, totalling approximately 16,000 people (HSE and Section 38s); the majority of whom provide direct patient/service user care with others, such as medical scientists and clinical biochemists, providing vital diagnostic services.

Table 5.9: Health and social care professions

Audiology	Phlebotomy
Clinical Biochemistry	Physiotherapy
Clinical Engineering	Play Therapy
Clinical Measurement (umbrella for 5 disciplines)	Podiatry
Dietetics	Psychology
Medical Physics	Radiation Therapy
Medical Scientist	Radiography
Occupational Therapy	Social Care Work
Orthoptics	Social Work
Perfusionists	Speech and Language Therapy

Student Practice Placements

Under Section 7 of the Health Act 2004 specific accountability and responsibility is assigned to the HSE in relation to the education and training of 'students training to be registered medical practitioners, nurses or other health professionals'. Student placements are now a core part of most professional and healthcare training programmes. These placements take a variety of forms depending on the discipline and range from weekly to block placements in many professions to longer periods and sometimes trainee positions in others.

5.5   Tusla Workforce Demographics and Workforce Planning

5.5.1   Workforce Demographics

More than 70% of Tusla's workforce is social work (40.5%) and social care (31.1%). Administration staff (14.38%) and management (3%) make up the bulk of the remaining staff. The numbers in other health and allied health sectors represent small percentages and numbers. Tusla has a relatively young workforce with almost 70% of the workforce aged under 50.

Table 5.10: Tusla workforce by staff category at December 2016

Category	WTE	% of workforce
Social Work	1,457.67	40.52%
Social Care	1,119.37	31.12%
Psychology and Counselling	23.23	0.65%
Other Support Staff incl. catering	62.72	1.74%
Other Health Professionals	9.82	0.27%
Nursing	50.60	1.41%
Management VIII+	107.57	2.99%
Family Support	162.61	4.52%
Education and Welfare Officer	86.22	2.40%
Admin Grade III-VII	517.46	14.38%
Total	**3,597.27**	**100.00%**

(DCYA, 2017)

Table 5.11: Age profile of Tusla workforce at October 2016

Age band	Number	% of workforce
19-24 years	33	0.79%
25-29 years	194	4.62%
30-34 years	559	13.32%
35-39 years	805	19.18%
40-44 years	722	17.20%
45-49 years	596	14.20%
50-54 years	531	12.65%
55-59 years	469	11.17%
60-64 years	262	6.24%
65+ years	27	0.64%
Total	**4198**	**100.00%**

(DCYA, 2017)

5.5.2   Workforce Planning and Capability

Tusla's service delivery is, and will remain, focussed on the use of social work and social care staff. Accordingly, social work and social care are the main focus of Tusla's workforce planning. Funding provided in Budget 2017 provides Tusla with increased capacity to respond to areas of identified risk and anticipated demand. The annual funding provided to Tusla has increased by over €100m (17%) since its establishment on 1st January 2014 to €713m in 2017, reflecting the Government's commitment to supporting vulnerable children and families. Tusla expects to expand the number of social work and social care staff employed over the coming years to address priority areas such as child protection cases awaiting allocation to a dedicated social worker and the introduction of mandatory reporting under the Children First Act 2015.

Currently, there is a limited supply of social work graduates in Ireland as approximately 250 social work students graduate each year and Tusla is competing with the wider health sector for this small

pool. Planned recruitment for 2017 includes targeted recruitment in Ireland, Northern Ireland and the UK to compensate for the limited number of available social work graduates.

Tusla is still developing its workforce planning capability. To date, Tusla has made a number of improvements to support its workforce planning capability. During 2016, Tusla established its in-house recruitment function, Tusla Recruit, to manage bespoke recruitment campaigns including the annual social work graduate campaign and the 2016 social care recruitment campaign.

A review of social work graduate recruitment was completed in 2016. A workforce supply analysis of social workers, social care worker and family support grades in Ireland and the UK was also completed during 2016.

Tusla has identified workforce planning as a key priority for 2017. An evaluation of the existing workforce will be undertaken during 2017, with a view to developing an evidence-informed resource allocation profiler to ensure appropriate resources are allocated to services.

Tusla expects to develop a robust strategic workforce plan that is responsive to the changing needs of the agency, taking account of the current and predicted employment market. Tusla's workforce plan will be developed in partnership with all other directorates to assist Tusla plan its workforce over a three-year period.

5.6   Private Sector Health Workforce Planning

5.6.1   Private Hospitals Sector

There are approximately 19 private hospitals in Ireland, employing in the region of 8,000 staff. In addition, about 800 medical consultants have practising privileges at one or more member hospital. At enterprise level, workforce planning is part of the ongoing work of the HR Director in each hospital or group of hospitals in membership.

Issues that are identified and appropriate solutions are discussed, as required, by the hospitals' management teams and Boards and are built into annual business plans and long term strategies as appropriate.

At sectoral level, the HR sub-committee of the Private Hospitals Association brings together the HR Directors of member organisations regularly, equipping the Association with very considerable expertise on the issues underlying workforce planning. The sub-committee is a forum for collaborative work on issues of common concern and would be well positioned to contribute a private hospitals' perspective to a national dialogue on workforce planning as and when such a process is established.

There is no structured dialogue between the PHA and the education sector, however most members have relationships with the relevant HEI faculties.

5.6.2   Private Nursing Home Sector

There are c. 437 private/voluntary residential care services for older people in Ireland.

In response to a request from the Department of Health, Nursing Home Ireland engaged a small sample of members in order to provide information about workforce planning in the sector. It was reported that:

- Members currently undertake workforce planning strategically and practically;
- The most important factors are revenue streams and bed capacity. This is an essential part of day-to-day roster planning;
- On a more strategic level, nursing homes are now monitoring trends in recruitment, in particular new nursing homes or extensions of existing nursing homes require long-term workforce planning to ensure adequate and suitable staff are hired and in place in advance of any new bed capacity;

- Members then look to regulatory requirements such as HIQA requirements and employment legislation;
- Members can then plan staffing requirements; however, staff skills, rosters, absenteeism and environmental factors (e.g. flu epidemic) as well as many external factors will have an impact on this;
- The skills used to undertake workforce planning are largely the same irrespective of the size of the Nursing Home;
- The impact of dependency levels is a consideration when workforce planning.

There is no structured dialogue between NHI members and the education sector, however most members have relationships with the relevant HEI faculties.

5.6.3 Homecare Sector

Home and Community Care Ireland (HCCI) is the trade association for private homecare providers in Ireland. Providers are independently owned and managed, and therefore develop their own initiatives in relation to some HR related matters (e.g. retention strategies, rewards, recognition). There are variations in how workforce planning is currently undertaken among HCCI members. Further, there is a recognition that the capacity, capability and skills to undertake workforce planning activities is somewhat limited due to the size of the HR function amongst members. This presents particular challenges with regard to recruitment and retention of staff in the sector.

In response to a request from the Department of Health, one provider advised that they currently employ 1,370 care staff, excluding management and administration staff. Each of their offices interacts with local QQI training providers to provide insight into employment and prospect with their particular organisation.

5.7 Volunteers / Informal Caregivers

Informal caregivers play a significant role in the health and social care sectors. A carer is described as someone who is providing an ongoing significant level of care to a person who is in need of care in the home due to illness or disability or frailty. The care that family and other carers provide involves looking after the needs of people with a wide range of care and support needs across all age groups. The type of care provided could include, personal care, such as bathing, dressing, personal hygiene, preparing meals, helping with feeding, cleaning, shopping and companionship.

A 2010 report on caring for older people in Ireland stated that the estimated value of care provided by unpaid carers would rise to €3.16 billion by 2021 (Barry and Conlon, 2010). The report also found that changing demographic trends, (with overall dependency rates projected to rise from 45.7 in 2006 to 52.8 in 2021 and 56.3 in 2031), are likely to increase the demand for carers in the future and that changes in family structures, labour market participation and population ageing are making the informal care model less sustainable.

5.8 Key Workforce Planning Policy Developments in Ireland, 1998 - Present

Developments in workforce planning, and health workforce education and training, have been informed by a number of key workforce planning policy reports over the past twenty years as set out in Table 5.12.

While the Steering Group notes these reports in particular, they are cognisant of other reports that have referenced the importance of workforce planning such as the *Report of the Commission on Patient Safety and Quality Assurance: Building a Culture of Patient Safety, 2008* (the Madden Report) which noted that:

> '*Modern and effective human resource management strategies are required to ensure the recruitment, retention and development of managerially and professionally talented people who are committed to and capable of delivering on the quality agenda, able to embrace change and able to work individually or in teams towards agreed organisational objectives. Human resource strategies for the healthcare workforce should be developed to address the issue of workforce capacity in terms of workforce planning, recruitment and retention and training and development needs, assessment of need and horizon scanning, supervision and training of junior staff and the quality of working life for those involved in the health services.*'

The Group also recognises the importance of health workforce planning research that has been undertaken by number of Ireland's HEIs including by the RCSI, the RCPI, TCD and as part of the RN4CAST[5] programme.

Table 5.12: Key workforce planning developments 1998 to present

Date	Report	Theme
1998	The Report of the Commission on Nursing: A Blueprint for the Future	The development of nursing and midwifery as a key profession within the health service, to provide for a secure basis for the future professional development of nursing and midwifery in the context of anticipated changes in the health services, their organisation and delivery.
2000	Expert Group on Various Health Professionals	Recommended the development of a strategy for workforce planning for health and social care professional groups. The report drew attention, in particular, to the need to boost the output of the training and education system to keep pace with the demand for skilled staff.
2001	Report of the Forum on Medical Manpower	The purpose of the Forum was to facilitate the development and implementation of a comprehensive manpower policy relating to training, career structure, and service delivery
2001	Report of the National Joint Steering Group on the Working Hours of NCHDs	This report focussed on the implications of the introduction of a maximum 48 hour working week for NCHDs for both medical training and service delivery.
2001	Current and Future Supply and Demand Conditions in the Labour Market for Certain Professional Therapists (The Bacon Report)	A comprehensive assessment of workforce needs for qualified personnel in the therapy healthcare sector for the period to 2015. The study was commissioned in response to significant labour shortages affecting the therapy professions.
2002	The Nursing and Midwifery Resource	A comprehensive approach to workforce planning for nursing and midwifery, resulting in a framework for the future planning and supply of the nursing and midwifery. The report identified the need for a formal and comprehensive approach to workforce planning.
2003	Report on the National Task Force on Medical Staffing (The Hanly Report)	Proposed implementation plan for reducing substantially the average working hours of NCHDs to meet the requirements of EWTD. Recommendations for the

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[5] RN4CAST studied how organizational features of hospital care impact on nurse recruitment, nurse retention and patient outcomes across 12 European countries (http://www.rn4cast.eu).

		implementation of a consultant-provided service. Identified the medical education and training needs associated with the EWTD and the move to a consultant-provided service.
2006	Report of the Working Group on Undergraduate Medical Education and Training (The Fottrell Report)	The reports set out an integrated implementation strategy to enhance and modernise medical education and training across the continuum from undergraduate education through to specialist training, with the aim of ensuring that Ireland had a sufficient number of highly trained doctors to service the needs of its growing population. They aimed to underpin the wider health reform programme, including the shift from a consultant-led to a consultant-provided service and an increasing emphasis on doctors, nurses and other health professionals working in multi-disciplinary teams.
2006	Report of the Postgraduate Medical Education and Training Group (The Buttimer Report)	
2007	A Quantitative Tool for Workforce Planning in Healthcare (FAS)	The study provided detailed projections of future demand and supply for twelve healthcare occupations. Provided a tool for workforce planning for health, which has since been utilised by NDTP.
2009	An Integrated Workforce Planning Strategy for the Health Services 2009-2012	The strategy was developed to ensure integration of workforce planning activity with the broader objectives of financial and service planning in the Irish healthcare and social care system. The strategy supported the development of health service human resources including initiatives already underway such as improved consultant/NCHD ratios, nurse prescribing and development for support staff. It also recommended the establishment of a dedicated Workforce Planning Unit within the HSE and provided health service planners with the tools to assess other sources of supply through redeployment, retraining or changed skill mix.
2012	Review of the Undergraduate Nursing and Midwifery Degree Programmes	This review took place at a time of significant developments in the delivery of healthcare e.g. advances in treatment and care, the greater use of technology and diagnostics and an increasing understanding of how services can be organised to achieve better outcomes for the public's health. It was recognised that nurses and midwives make up the largest component of the professional workforce, delivering care 24/7 across hospital and community boundaries. Their skills, expertise and flexibility were required to develop and expand new and more autonomous nurse- and midwife-led roles, in areas such as nurse-led patient discharge, chronic disease management, palliative care, nurse/midwife prescribing and nurse-/midwife-led care.
2013	Strategic Review of Medical Training and Career Structure (The MacCraith Reports)	This strategic review of training and career pathways for doctors was carried out with a view to: improving graduate retention in the public health system; planning for future service needs; and realising maximum benefit from investment in medical education and training. The first report included nine recommendations which focussed primarily on the quality of the training experience. The second report focussed on medical career structures and

		pathways following completion of specialist training. The final report addressed issues relating to strategic medical workforce planning, and career planning and supports for trainee doctors. It also addressed specific issues in relation to the specialties of Public Health Medicine, Psychiatry and General Practice.
2014	The Taskforce on Staffing and Skill Mix for Nursing	In September 2014, the Taskforce was established to develop a framework to support the determination of staffing and skill mix in nursing in a range of specialties. Phase I of the Taskforce work has focussed on the development of a Framework for Safe Nurse Staffing and Skill Mix for Nursing in general and specialist medical and surgical care settings. The pilot is currently in progress in three hospitals, supported by a research team appointed by the HRB to formally evaluate the pilot. Phase II of the work of the Taskforce commenced in January 2017, to develop a Framework for Safe Nurse Staffing and Skill Mix in Emergency Care Settings.
2015	Health Services People Strategy 2015 – 2018	The HSE People Strategy is focussed on engaging, developing, valuing and retaining the organisation's workforce. The strategy aims to provide a cohesive framework to lead, manage and develop the contribution of all staff in an environment that is conducive to learning and wellbeing while ensuring it can attract and retain high calibre staff to meet workforce demands.
2016	Medical Workforce Planning Ireland: A Stepwise Approach	A methodology that guides the user through a series of phases to support workforce planning for a specific or multiple groups of medical practitioners in the Irish healthcare system.

5.9   Conclusions

Traditional workforce planning activities in the Irish health service have tended to be profession specific and focussed on identifying the immediate gap between supply and demand, based on existing or projected demand for a given category of health worker, whether on a needs-based, utilisation-based or benchmark approach. Once the size of the gap has been identified, planners recommend actions aimed at reducing or eliminating the gap, usually through recruitment. This work should continue but limitations of this approach are that, given an inflexible labour market, scarce resources and fixed budgets, there may neither be the financial or human resources available, nor the structural flexibility to implement identified actions.

The supply-demand-gap approach may quantify the potential size of the workforce problem, and provide short-term profession-specific solutions, but it does not necessarily contribute to long term, or the most cost effective, health sector solutions.

A combination of short-, medium- and longer-term approaches, taking a whole-of-organisation or whole-of-system approach, as appropriate, can support current and future sustainability of health workforce supply.

In addition, the demographics of the health workforce have significant implications for the workforce planning supply-side decisions. Factors, such as age and gender, impact on the replacement demands for health and social care workers and need to be considered when determining the supply of certain categories of health worker.

To support decision-making, improved data collection and information regarding entry and exit patterns and attrition rates, by categories of health worker, would be beneficial.

Finally, the Group recognises that the contribution of informal caregivers and volunteers is important to the provision of health services in Ireland. Any reduction in the care provided by this cohort could have a significant impact on health workforce requirements.

6 Key Interfaces with Other Government Departments, Sectors and Statutory Agencies

6.1 Introduction

In order to understand health labour market factors fully and how they impact on the health workforce, it is important that we identify key interfaces with other sectors and agencies. This chapter summarises the interfaces that have been identified by the Steering Group in the course of their work.

6.2 HSE-funded Service Providers

The HSE is responsible for the provision of publicly-funded health and personal social services for everyone living in Ireland. The HSE is Ireland's largest employer with almost 69,000 direct employees, and another 40,000 in funded health care organisations (as at July 2017).

The HSE funds a range of services under either section 38 or section 39 of the Health Act 2004. Section 38 arrangements involve organisations that are funded to provide a defined level of service on behalf of the HSE. Under Section 39, the HSE grant-aids a wide range of organisations, to a greater or lesser extent. Employees of agencies that are funded under Section 38 of the Health Act 2004 are classified as public servants, while employees of agencies that receive grant-aid from the HSE under Section 39 are not public servants and are not included in public service employment numbers.

6.3 Department of Education and Skills and the Education Sector

The education and training system in Ireland is the responsibility of the Department of Education and Skills. Post-second level, SOLAS and the Higher Education Authority (HEA) manage the further education and training (FET), and higher education (HE) systems respectively.

National Skills Strategy

The Department of Education and Skills published a new National Skills Strategy in 2016. The Strategy sets out a wide range of actions under six key objectives aimed at improving the development, supply and use of skills over the next decade. The objectives are:

1. Education and training providers will place a stronger focus on providing skills development opportunities that are relevant to the needs of learners, society and the economy;
2. Employers will participate actively in the development of skills and make effective use of skills in their organisations to improve productivity and competitiveness;
3. The quality of teaching and learning at all stages of education will be continually enhanced and evaluated;
4. People across Ireland will engage more in lifelong learning;
5. There will be a specific focus on active inclusion to support participation in education and training and the labour market;
6. We will support an increase in the supply of skills to the labour market.

The Strategy acknowledges that the public sector as a whole is essential to Ireland's overall development and, like the enterprise sector, is facing significant skills issues. It references the impact of changing healthcare delivery models and how this influences the future roles of healthcare professionals and the competencies that will determine success. It also highlights that changing consumption patterns mean that there will be a growing demand for health and social care skills in response to the needs of an ageing population.

The Strategy acknowledges that the health sector is experiencing some skills shortages and that if fiscal policy becomes expansionary in the short- to medium-term, growth in education and

healthcare occupations is likely to be higher than that projected. It also notes that, given the size of the workforce in education, health and care activities, any positive rate of change is likely to translate to substantial increases in employment in absolute terms.

The Strategy highlights that the better the skills capability of critical areas such as Health and Education, the better the experience of the recipients, i.e. the citizens. This in turn has a knock-on effect in making Ireland an attractive location internationally in which to live and work.

The Strategy has a specific action under Objective 2 relating to the improvement of workforce planning in the public sector.

A key theme in the Strategy is the need for greater alignment between the further education and training and higher education sectors in providing coherent portfolio of skills development opportunities across the FET and HE sectors. Engagement with employers is key to achieving this, particularly in the context of new models of delivery, including the potential to develop new apprenticeships and traineeships in the coming years.

The National Skills Strategy also provides for the establishment of a new national skills architecture. This includes the new National Skills Council which will oversee research, forecasting and prioritisation of skills needs in the economy and report on delivery of responses by the education and training system to those needs. It also includes the nine new Regional Skills Fora that have already been established and will provide a valuable mechanism for employers and the education and training system to work together to build the supply of skills to support job creation and the growth and development of each region.

Higher Education Authority (HEA)

The HEA has a statutory responsibility, at central government level, for the effective governance and regulation of higher education institutions and the higher education system. The HEA is accountable to the Minister for Education and Skills and leads the strategic development of the Irish higher education and research system with the objective of creating a coherent system of diverse institutions with distinct missions, which is responsive to the social, cultural and economic development of Ireland and its people and supports the achievement of national objectives.

In exercising its mandate the HEA works to ensure that:

- It has due regard to institutional autonomy and academic freedom;
- Institutional strategies are aligned with national strategic objectives;
- Agreed objectives (detailed in compacts with institutions) are delivered through effective performance-management at institutional and system-levels.

In support of its mandate the HEA exercises functions in respect of:

- Funding;
- Accountability;
- The quality of outcomes;
- Policy research and advice to the Minister;
- Data analytics and knowledge management;
- Advocacy and communicating higher education;
- Co-ordination of interaction between public bodies and the higher education system.

The HEA provides funding to the institutions to undertake core educational and research activities. Funding is allocated based on a calculation of student numbers weighted by subject groups, however, it is a matter for the institution as to how it spends this core funding across activities and subject areas.

The HEA also provides ring-fenced funding for a number of healthcare programmes and this is set out overleaf.

Higher Education Health Related Provision

The development of the health and social care workforce requires significant education and training, as well as supervised clinical placement experience. The vast majority of health and social workers obtain their professional training from further or higher education institutions.

The further development of professional expertise is honed through on-the-job professional practice or additional training / continuous professional development. Education providers must meet the accreditation standards set by the relevant professional regulatory bodies, including standards for clinical placements.

Figures provided by the HEA show there are currently nearly 36,661 students enrolled in Health and Welfare programmes[6]. This represents an increase of 21.4% over the last six years and 17% of total enrolments.

Figure 6.1: Trends enrolments in health and welfare 2009-2016
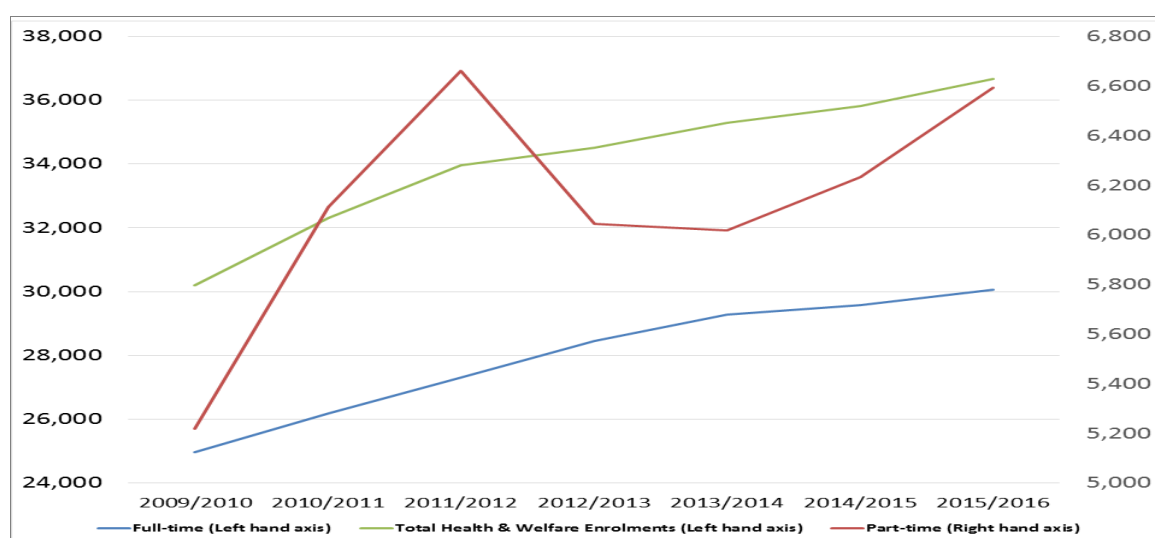
(HEA, 2017)

Table 6.1: Trends in enrolments by health and welfare programmes 2009-2014[7]

	2009-10	2010-11	2011-12	2012-13	2013-14
Combined health and welfare	193	264	467	771	689
Combined health	313	717	710	745	717
Combined social services	424	522	1,093	1,138	1,018
Dental studies	705	703	720	713	681
Pharmacy	1,493	2,077	1,828	2,020	2,337
Child care and youth services	2,294	2,648	3,177	3,547	3,594
Medical diagnostic and treatment technology	3,032	1,343	1,306	1,378	1,419
Therapy and rehabilitation	3,055	3,225	3,468	3,568	3,543
Social work and counselling	4,623	4,547	4,552	4,329	4,192

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[6] This includes Combined Health and Welfare, Combined Health, Combined Social Services, Dental Studies, Pharmacy, Child Care and Youth Services, Medical Diagnostic and Treatment Technology, Therapy and Rehabilitation, Social Work and Counselling, Medicine, and Nursing and Caring
[7] New International Standard Classification of Education (ISCED) fields of education and training were implemented in 2016 therefore like-for-like data by programme for 2015/2016 are not available.

Medicine	5,364	7,051	7,569	7,564	8,232
Nursing and caring	9,380	9,941	9,571	9,143	9,434
Total	**30,876**	**33,038**	**34,461**	**34,916**	**35,856**

(HEA, 2017)

In 2015/16, nearly half of all enrolments were made up of nursing and midwifery (9,566, i.e. 26%) and medicine (8,513, i.e. 23%). This is relatively consistent with preceding years. Nursing numbers during this period remained relatively constant, while medical enrolments increased significantly.

In other programmes, notable trends include the increases in social services (up 140%), combined health and welfare (257%), combined health (129%), pharmacy (57%) and childcare and youth services (57%). A more modest increase was seen in therapy and rehabilitation (16%), while enrolments in dental studies and medical diagnostic and treatment technology declined (by 3% and 53% respectively).

With regard to higher education programmes and the level of provision, this generally involves the HSE identifying needs within the healthcare system for certain disciplines and setting quotas periodically for the number of students that should be taken onto such education programmes. At that stage, the health and higher education systems engage as to the training needs and funding for that quota of students is allocated. At higher education level the funding is usually ring-fenced by the HEA for a period and then mainstreamed into the HEA's general funding allocation model.

In 2014, the total ring-fenced funding for health programmes stood at €62.7m and includes nursing (€43m), medicine (€18.5m for additional EU places above the 2006 baseline plus a contribution to academic medical consultant posts), as well as pharmacy/physiotherapy in RCSI (€0.6M), podiatry in NUIG (€0.4m) and audiology in UCC (€0.2m). In addition, the tuition fees of all eligible EU students on all undergraduate programmes (including healthcare programmes) are paid on their behalf by the State).

The HEA has been represented in the review of a range of third level healthcare programmes including medical education and training, nursing and midwifery, and pharmacy.

SOLAS

SOLAS was established in 2013 as the overall FET authority, providing strategic direction, co-ordination and funding to the overall sector. It is responsible for funding, planning and coordinating a wide range of training and further education programmes and has a mandate to ensure the provision of 21st century high-quality programmes to jobseekers and other learners. FET is largely funded by SOLAS and delivered or contracted by the 16 Education and Training Boards (ETBs). FET programmes are delivered in a wide range of settings including Post Leaving Certificate and Further Education Colleges, Training Centres, Youthreach and adult education centres.

A new five-year strategy has been developed by SOLAS for the 2014-2019 period. This strategy sets out the vision for the FET sector response to needs and opportunities for the short, medium and longer term.

Further Education and Training Health Related Provision

The 2016 Education and Training Board Services plan shows that there were 15,756 people on Health, Family and other Social Services courses as at 1st January 2016, with a further 30,505 beginning courses during the year. Nursing Studies is the PLC course with the second largest enrolment and Community and Health Services come fifth.

In 2013, QQI reported 45,305 awards were made in the Health and Welfare area (by ISCED definition). 22,500 FETAC awards were made in healthcare support and 4,500 in nursing – allied skills, with over 6,000 level 5 major awards issued in healthcare support. Substantial numbers of

awards were made in the emergency services personnel area (over 37,000) and primarily relate to occupational health, and safety and first aid.

Special Educational Needs

In addition to skills provision, another area of engagement of particular relevance to this Framework is the delivery of education services to persons with special educational needs arising from disabilities with particular emphasis on children.

The Department of Education and Skills works with service-providing partners in the health and disability sectors to support and plan for the co-ordinated delivery of services to families of children with special educational needs across the disability sector. The interdepartmental Cross-Sectoral Team, which is chaired at Assistant Secretary level, comprises representatives of the Department, National Educational Psychological Service (NEPS), Department of Health, Department of Children and Youth Affairs, the National Council for Special Education (NCSE) and the Health Service Executive.

In addition, the Department was a member of the Health and Education Steering Committee which was established to progress the HSE's National Programme on Progressing Disability Services for Children and Young People. This Programme is based on the recommendations of the *Report of the National Reference Group on Multidisciplinary Services for Children aged 5-18 Years* (2009) produced by representatives of the professions and management involved in delivering multi-disciplinary services to children. The long-term goal of this Programme is to bring consistency in service delivery and a clear pathway to services for all children with disabilities according to need. The NCSE and NEPS work with HSE service providers at local level in the delivery of supports to children and young people with disabilities.

Quality and Qualifications Ireland (QQI)

QQI is the independent statutory agency responsible for promoting quality and accountability in education and training services in Ireland. Established in 2012 with a board appointed by the Minister for Education and Skills. QQI's main statutory functions are:

- To maintain the National Framework of Qualifications;
- To agree, and review the effectiveness of procedures for quality assurance of education and training established by providers;
- To validate programmes of education and training leading to QQI awards;
- To establish and review the standards of knowledge, skill or competence associated with awards;
- To make awards and, where appropriate, delegate authority to make awards to providers;
- To determine and monitor policies and criteria for access, transfer and progression;
- To establish a Code of Practice for the provision of education to international learners and the related International Education Mark (IEM) and to authorise use of the Mark.

They also operate Qualifications Recognition Ireland as a single point of contact for all queries concerning the recognition of international awards.

Professional Qualifications Directive

The Department for Education and Skills has national coordinating responsibility for Directive 2005/36/EC on the recognition of professional qualifications. The Directive applies to European Economic Area (EEA) nationals with EEA qualifications who wish to practice a regulated profession in an EEA State other than the one in which they obtained the professional qualifications. Its intention is to make it easier for qualified professionals to practice their professions in European countries other than their own. Public health and safety and consumer protection are safeguarded through the qualification process. The health professions are the largest single group to exercise rights under

the Directive and, in Ireland, health professional regulators act as competent authorities under the Directive for their respective professions.

6.4 Department of Business, Enterprise and Innovation (Employment Permit Policy)

Since 2004, Irish labour market policy has been to ensure that general labour and skills needs are met from within the workforce of the EU. Policy in relation to applications for employment permits remains focussed on facilitating the recruitment from outside the EEA of highly skilled personnel, on a vacancy-led basis, where the requisite skills cannot be met by normal recruitment or by training.

Employment permit policy is part of the response to addressing skills deficits that exist and are likely to continue into the short- and medium-term. It is not intended over the longer-term to act as a substitute for meeting the challenge of up-skilling our resident workforce, with an emphasis on lifelong learning, and on maximising the potential of EEA nationals to fill our skills deficits in accordance with the requirements of EU Preference.

The employment permits regime is designed to facilitate the entry of appropriately skilled non-EEA migrants to fill skills shortages where specific vacancies exist. However, this objective must be balanced by the need to ensure that there are no suitably qualified Irish/EEA nationals available to undertake the employment and that the shortage is a genuine one. The system is managed through use of two lists: the Highly Skilled Eligible Occupations List, which lists occupations in high demand in the labour market; and the Ineligible Categories of Employment List, which lists occupations for which no shortage of prospective employees exists in the Irish/EEA labour market. The lists are compiled using the research of the Expert Group on Future Skills Needs (specifically the annual National Skills Bulletin and the annual Vacancy Overview Report), with inputs from stakeholders. These lists are reviewed bi-annually.

An occupation may be considered for inclusion on the Highly Skilled Eligible Occupations List or removal from the Ineligible Categories of Employment List provided that:

- There are no suitable Irish/EEA nationals available to undertake the work;
- Development opportunities for Irish/EEA nationals are not undermined;
- A genuine skills shortage exists and that it is not a recruitment or retention problem;
- Government education, training, employment and economic development policies are supported;
- The skill shortage exists across the occupation, despite attempts by industry to train and attract Irish/EEA nationals to available jobs.

In order to keep the employment permits regime precisely focussed, submissions are sought from stakeholders on the appropriateness of the lists to the labour market during the bi-annual review process. In order to assess the value of adding or removing occupations to the HSEOL/ICEL, inputs from stakeholders who have oversight in the particular sectors where demand arises is invaluable, in order to determine the nature of the demand, so that proper function of the employment permits system as a short-term source of skills while the resident labour market is reskilled to meet those skills needs in the medium/long term. In particular, the views of Government Departments/agencies with interest in particular sectors where demand is indicated is key to ensuring that the system functions in harmony with the wider labour market.

6.5 Department of Justice (INIS)

Ireland has a long-established reputation as an open and welcoming society both for those coming to work, visit, or intending to settle here more permanently. There are a wide range of schemes and policies to facilitate legal migration into the State. In that regard, it should be noted that over the past 5 years in the region of 100,000 persons have been naturalised. There is also not just an

entitlement, but a duty, to ensure that Ireland's borders are protected in the interests of public policy. It is the same in all democracies; therefore, the State rightly has the power to control entry to, residence in and departure from the State. A non-EEA national requires, as well as an employment permit, immigration permission to remain in the State. Non-EEA national skilled health sector workers who are successful in securing an employment offer will be permitted to work in Ireland (normally through the Highly Skilled Occupations List) and will be granted immigration permission commensurate with the type of employment permit secured.

The Critical Skills Employment Permit, for example, is designed to attract highly skilled people into the labour market with the aim of encouraging them to remain in Ireland. They are regarded as being most important to Ireland's economic development, in circumstances where the skills in question are in high demand and are in short supply. Equally, it is reasonable to expect that persons who are granted immigration permission will respect the conditions attaching to it.

From an immigration perspective, such employment permit holders can also apply for immediate family reunification and dependents are eligible to seek employment through a Department of Business, Enterprise and Innovation issued employment permit.

Health sector workers who successfully complete two years with an employer under a Critical Skills Employment Permit may then apply to the Immigration Service for permission to reside and work without the requirement for an employment permit. This is an extremely valuable immigration permission as it affords the holder a degree of mobility that is not possible to employment permit holders, whose continued residence in the State is contingent on their remaining with the employer to whom the employment permit was issued.

6.6   Department of Children and Youth Affairs

The Department of Children and Youth Affairs focuses on harmonising policy issues that affect children in areas such as early childhood care and education, youth justice, child welfare and protection, children and young people's participation, research on children and young people, youth work and cross-cutting initiatives for children. In this regard, the Department has a mandate to put in place a unified framework of policy, legislation and service provision across Government for children and young people.

Key pieces of legislation underpinning the Department's core functions include:

- Child Care Act 1991;
- Education (Welfare) Act 2000;
- Children Act 2001;
- Youth Work Act 2001;
- Adoption Act 2010;
- Child and Family Agency Act 2013;
- Children First Act 2015.

The Department comprises four divisions:

- Child and Family Policy;
- Governance and Performance;
- Youth Justice, Adoption and Legal;
- Early Years, Education, Youth Participation and Research.

The Department has direct responsibility for Tusla, Oberstown Children Detention Campus, the Adoption Authority of Ireland and the Ombudsman for Children's Office as well as an on-going relationship with an ever-growing sector. Given the nature of the workforce in some of the agencies, notably the Tusla workforce, and its overlap with the health workforce, ongoing engagement with DCYA is important to ensure a sufficient supply of health/social care workers for both sectors.

6.7 Professional Regulation

6.7.1 Medical Practitioners

The Medical Council is the regulatory body for doctors. It has a statutory role in protecting the public by promoting the highest professional standards amongst doctors practising in the Republic of Ireland. The Council maintains the register of medical practitioners - the register of all doctors who are legally permitted to carry out medical work in Ireland. The Council also sets the standards for medical education and training in Ireland. In addition, it oversees lifelong learning and skills development throughout doctors' professional careers through its professional competence requirements. It is charged with promoting good medical practice and the Council is also where the public may make a complaint against a doctor.

Maintenance of Professional Competence and CPD

The Medical Practitioners Act 2007 modernised the system of medical regulation overseen by the Medical Council and established new arrangements through which doctors will be responsible and accountable for maintaining their professional competence.

Part 11 of the Act sets out three complementary duties:

- Doctors will maintain their professional competence on an ongoing basis pursuant to a professional competence scheme and will cooperate with requirements set by the Medical Council;
- The HSE and other employers of doctors will facilitate the maintenance of professional competence;
- The Medical Council will satisfy itself as to the ongoing maintenance of professional competence of doctors. To do this, it will establish professional competence schemes.

Professional competence schemes are the formal structures to ensure that all doctors registered and working in Ireland maintain their education, knowledge and skills (competence) at an acceptable level. Practitioners are enrolled in CPD activities as defined by the training body for that specialty and are required to submit evidence of their participation in educational activities.

It is expected that, on average, each doctor will complete 50 hours (250 hours over a five-year period) of CDP activity per year. In addition, each doctor is expected to complete one clinical audit per year.

6.7.2 Nurses and Midwives

The Nursing and Midwifery Board of Ireland (NMBI), formerly An Bord Altranais, is the independent, statutory organisation that regulates the nursing and midwifery professions in Ireland. NMBI works with nurses and midwives, the public and key stakeholders to enhance patient safety and patient care. Among the core functions are:

- Maintaining the register of nurses and midwives;
- Evaluating applications from Irish and overseas applicants who wish to practise as nurses and midwives in Ireland;
- Supporting nurses and midwives to provide care by developing standards and guidance that they can use in their day-to-day practice;
- Setting requirements for nursing and midwifery educational programmes in HEIs;
- Investigating complaints made from patients, their families, health care professionals, employers and holding Fitness to Practice inquiries.

Maintenance of Professional Competence and CPD

The Nurses and Midwives Act 2011 modernised the regulation of nursing and midwifery overseen by the NMBI. Part 11 of the Act sets out the requirements and those responsible for the maintenance of professional competence by nurses and midwives as follows:

1. Duty of registered nurses and registered midwives to maintain professional competence;
2. Duty of registered nurses and registered midwives to demonstrate professional competence to the satisfaction of the Board;
3. Duty of the Board in relation to maintenance of professional competence of registered nurses and midwives;
4. Duty of employers in relation to maintenance of professional competence of registered nurses and midwives;
5. Confidentiality.

This section of the Act requires a commencement order prior to enactment and had not commenced at the time of writing. It is envisaged that the NMBI will prepare a professional competence scheme, to be approved by the Department, in advance of the commencement of this Act.

The NMBI has also published guidance to nurses and midwives on the scope of practice. The purpose of the Scope of Nursing and Midwifery Practice Framework (2015) is provide nurses and midwives with professional guidance and support on matters relating to the scope of their clinical practice. Since the first Scope of Nursing and Midwifery Practice Framework was published in 2000, there have been many changes and developments in the Irish health service and in nursing and midwifery roles. These include changes in systems of care provision, reforms in professional education and expansion of the scope of nursing and midwifery practice roles.

6.7.3   Dentists

An Chomhairle Fiaclóireachta, the Dental Council, was established under the provisions of the Dentists Act 1985. Its general concern is to promote high standards of professional education and professional conduct among dentists.

The main functions assigned to the Council under the Act are:

- To establish, maintain and publish a register of dentists and a register of dental specialists and to provide for the registration and the retention of dentist's names in these registers;
- To satisfy itself as to the adequacy and suitability of the dental education and training provided in the State's dental schools and to the standards required at examinations for primary qualifications;
- To inquire into the fitness of a registered dentist to practise dentistry on the grounds of his/her alleged professional misconduct or his/her alleged unfitness to practise by reason of physical or mental disability and to take appropriate action;
- To make, with the consent of the Minister, schemes for the establishment of classes of auxiliary dental workers;
- To discharge the duties assigned to the Council pursuant to the provisions of EU Dental Directives;
- To advise the dental profession and the public on all matters relating to dental ethics and professional behaviour;
- To advise the Minister on all matters relating to the functions of the Council under the Act.

Maintenance of Professional Competence and CPD

The Dental Council's Code pertaining to Professional Behaviour and Dental Ethics states that all dentists have an obligation to maintain and update their knowledge and skills through CPD. The Dental Council recommends completing and keeping records of at least 50 hours of CPD every year. Twenty of these hours should be 'verifiable' CPD. Generally, only activities approved in advance by

the Dental Council can be regarded as verifiable CPD activities. While the amount of CPD hours completed may vary from year to year, it is recommended that at least 250 hours of CPD every five years, of which a minimum of 100 hours should be verifiable CPD. It is recommended that core CPD activities should take a minimum of 50 verifiable hours over a five-year period.

6.7.4 Pharmacists

The Pharmaceutical Society of Ireland (PSI) protects the health and safety of the public by regulating pharmacists and pharmacies in Ireland. The PSI sets the standard for pharmacists' education and training, creates the standards and supports to promote good professional practice in pharmacy as well as registering pharmacists, pharmaceutical assistants and pharmacies, carrying out inspections of pharmacies, and taking action when there is a concern about a pharmacist or a pharmacy, including when on receipt of a complaint from a member of the public.

The Pharmacy Act 2007 established the role and responsibilities of the PSI, which include:

- Registration of pharmacists, pharmaceutical assistants and pharmacies;
- Setting standards for pharmacy education and training at undergraduate and postgraduate level, including ensuring all pharmacists are undertaking appropriate continuing professional development (CPD);
- Development of pharmacy practice for the benefit of patients and the wider health system;
- Regulation through inspection and enforcement, and considering complaints made against a pharmacist or a pharmacy, including the imposition of sanctions;
- Providing advice and guidance to the public, pharmacy profession and to the Government on pharmacy care, treatment and service in Ireland.

Maintenance of Professional Competence and CPD

The PSI (Continuing Professional Development) Rules 2015 set out the CPD obligations for pharmacists. It states that pharmacists must maintain a record of their CPD and demonstrate evidence of this to the Irish Institute of Pharmacy (IIOP) on request. All pharmacists must undertake CPD in order to be eligible to continue their registration as a pharmacist on an annual basis.

The IIOP oversees the management and support mechanisms for CPD, and accredits and commissions education and training programmes in line with national policy, evolving healthcare needs and the needs of the profession.

Pharmacists are encouraged to adopt a reflective approach to learning, and to identify their own learning and development needs in a style that best suits their requirements. This flexible model of CPD offers pharmacists the opportunity to consider the wider scope of learning and development, and their influence and benefit to their practice, the pharmacy profession and the patient.

The CPD system is not based on a traditional CPD points or accumulation of contact hours. The system is flexible, enabling the demonstration of professional development in a style that best suits each individual. A pharmacist's development should encompass a balanced range of activities. This model of CPD is about retaining capacity to practice safely, effectively and legally within a pharmacist's evolving career and scope of practice.

6.7.5 CORU

CORU is the body responsible for regulating health and social care professions. It comprises the Health and Social Care Professional Council, established in 2007, its disciplinary committees and the registration boards established under the Health and Social Care Professionals Act 2005 for the designated professions. Its role is to protect the public by promoting high standards of professional conduct, education, training and competence through statutory registration of designated health and social care professions (currently 14 in number). With the Minister for Health's recent decision

to designate the professions of counsellors and psychotherapists, CORU will be responsible for the regulation of 16 health professions overall.

Table 6.2 Professions to be regulated under the Health and Social Care Professionals Act 2005 (as amended)

Registers currently open	Professions to be regulated
Dieticians	Clinical Biochemists
Occupational Therapists	
Physiotherapists	Orthoptists
Radiographers and Radiation Therapists	Podiatrists
Social Workers	
Speech and Language Therapists	
Optometrists and Dispensing Opticians	
Medical Scientists	
Psychologists	
Social Care Workers	

To regulate these professions, CORU:

- Sets the standards that health and social care professionals must meet;
- Ensures that the relevant educational bodies deliver qualifications that prepare professionals to provide safe and appropriate care;
- Maintains and publishes a register of health and social care professionals;
- Ensures that registered professionals keep their skills up to date by promoting CPD;
- Runs fitness to practise hearings into the conduct and competence of a registrant.

Maintenance of Professional Competence and CPD

The Code of Professional Conduct and Ethics adopted by the registration board for a given profession confirms the responsibility of each registrant to keep their knowledge, skills and performance up to date, of a high standard and relevant to their practice. According to the Code, registrants must participate in CPD on an on-going basis and comply with the CPD requirements of their registration board.

A registrant must, upon request from the relevant registration board, submit their CPD portfolio for periodic audits of compliance with the CPD standard and requirements. To ensure compliance with the CPD standard and requirements a random selection of registrants will be required to submit their CPD portfolio for audit following each 24-month cycle. Normally only registrants who have been on the register for two years or more will be eligible for selection for audit. This is to enable registrants to build up evidence of their CPD before they are audited. CORU will publish the audit cycle for each profession. Portfolios will be assessed against the requirements and the assessors will make recommendations to the registration board.

6.7.6   The Pre-Hospital Emergency Care Council (PHECC)

Pre-hospital emergency care is any clinical care or intervention that an acutely ill or injured person receives from trained personnel in the pre-hospital environment. PHECC is the regulator for emergency medical services (EMS) in Ireland. It is an independent statutory body which publishes clinical practice guidelines (CPGs), sets the standards for education and training for pre-hospital emergency care in Ireland, and recognised institutions to provide pre-hospital emergency care training and education. PHECC also maintain a statutory register of EMS practitioners.

For an EMS practitioner to practice in Ireland, a triple-lock system must be in place:

1. The practitioner must be credentialed and registered with PHECC as an Emergency Medical Technician, Paramedic or Advanced Paramedic;

2. The organisation on whose behalf the practitioner is practising must be approved and licensed by PHECC to implement CPGs at an appropriate level;
3. The licensed service provider privileges (empowers) practitioners, operating on their behalf, to implement PHECC CPGs in accordance with each practitioner's current competency.

Maintenance of Professional Competence and CPD

One of PHECC's statutory functions is to set and review standards of education in pre-hospital emergency care. The Council publishes CPGs and recognises institutions to provide pre-hospital emergency care training and education. In addition to maintaining a statutory register of practitioners, the Council approves pre-hospital emergency care service providers to implement CPGs.

CPGs guide the practitioner in assessment, treatment and disposition of patients who present with an acute illness or injury.

PHECC also implements a code of professional conduct that confers responsibility on every registered practitioner to maintain competence and participate in CPD activities.

6.8   Conclusions

As health services evolve and further developments, such as technology, change health and social care delivery, it is important that skill needs in the sector are kept under review to enhance the responsiveness of the health system; and to ensure the development and retention of the appropriate competencies and skills in the system.

To provide for a strategic approach to workforce planning in the education component of the health labour market, a more formal and structured arrangement for engagement between our health and further and higher education systems is required.

It is essential that educational and training courses continue to provide health and social care professionals with the core competencies which are required for their future profession. This is turn requires ongoing close engagement between health and education and training systems, including the health regulatory and registration bodies. Practice at present remains less formal than it could be.

Curricula must be cognisant of developments in health and social care delivery and the health and education sectors must ensure developments are reflected in curriculum reviews and in the skills, competencies and behaviours being developed by health and social care students. It is important that meaningful engagement between the health and education sectors is embedded to ensure developments, including multi-disciplinary working and other team-based approaches, are reflected in the provision of courses in our education institutions.

For professionals already practising in the system, a key issue will be to continue to foster a positive attitude to CPD as this will increase the skills mix in the sector and provide more options for mobility of staff to support the effective delivery of services to patients.

In addition, any unintended misalignment between out-of-country recruitment procedures, the employment permit regime, the immigration services schemes and requirements, the requirements of regulatory bodies, and subsequent in-country recruitment systems and practices in the health sector may lead to unintended recruitment barriers and loopholes, which impact on service planning, delivery and quality.

Greater and more effective communication between principal stakeholders that will deliver the necessary staff to the required locations while maintaining the integrity of the State's immigration and labour market policies is required.

In addition, different arms of Government that facilitate the training and education of health sector workers and make them available through the work permit and immigration system need to be consulted and kept informed of developments, including the future skills need, in the health sector.

Finally, the Group notes that certain categories of health worker may receive some of their training in other jurisdictions, in particular the UK, and recognises that Brexit may have implications for health worker supply in the future.

7 A Strategic Framework for Health and Social Care Workforce Planning in Ireland

7.1   Introduction

As clearly articulated by WHO, 'health systems can only operate with a health workforce' (WHO/GHWA, 2013).

The Steering Group recognises the validity of this statement and the framework that follows is intended to support short -, medium- and long-term health and social care workforce planning – and associated activities – in the health and social care sector over the coming years.

Acknowledging that there is no one definition of workforce planning, recognising that there is no one-size-fits-all model, and noting the importance of balancing the 'hard' and 'soft' elements of workforce planning, the framework is intentionally solutions-focussed, with an emphasis on the identification of solutions at appropriate levels of the system based on good quality, timely data, information and evidence, including qualitative stakeholder engagement.

Some solutions reside in the HR domain – in practices and activities at either local or national HSE levels, while some solutions reside in the policy domain – either sectorally or cross-sectorally.

This framework seeks to bring both communities together through a set of processes and structures intended to align our efforts to achieve health workforce sustainability in Ireland – in the near and longer-term.

Ultimately, the desired long-term outcome from the implementation of this framework is improved health outcomes for citizens.

Desired intermediate outcomes from the framework implementation include:

- An enhanced strategic and long-term approach to determination of appropriate sectoral and cross-sectoral HRM strategies and solutions;
- Improved recruitment rates and enhanced retention of the current workforce;
- Increased career and role flexibility, adaptability, mobility and more efficient training;
- Optimisation of the existing workforce, including optimum skill mix, competences and geographical distribution;
- Increased multi-disciplinary and inter-professional training, learning and practice;
- Enhanced engagement of stakeholders in future workforce planning and development;
- Authoritative, robust and needs-based planning and modelling capacity, building on and learning from current initiatives, notably the work of NDTP and ONMSD;
- Sustainable collaboration between health service providers and educators in preparing and developing the health workforce.

7.2   Principles Underpinning the Framework

The following principles, as agreed by the Steering Group, underpin the framework:

i.   Workforce planning must be focussed on identified current and future population health needs. It must consider what services will be required to meet the current and future health and social care needs of the population and plan, using the full range of solutions, to have a workforce in place with the right skills, competencies and geographical distribution to deliver these services. In this context, it should take into account the workforce dimensions of key strategic and operational developments including national health policies and strategies, agreed models of care, and other developments in clinical strategy such as the National Clinical Programmes, ICPs etc.

ii. Workforce planning should be a dynamic process where the starting point is (i) above. It must support service delivery and the process of service redesign. This includes planning for multi-disciplinary and other team-based working approaches, changing skill mixes, the creation of new health worker roles, job enrichment and the development of new competencies and behaviours among health workers. Planning for changes such as these requires consideration of the need for in-service training and coaching, and in some instances, up-skilling and retraining.

iii. Workforce planning has multiple time horizons: short- (1 year), medium- (3-5 years), and long-term (10+ years).

iv. Resources are finite and it is necessary to ensure long-term workforce planning strategies and solutions are sustainable, cost-effective and offer value for money. In addition, short- and medium-term workforce plans that are developed on the basis of 1 and 3 year projections – and any associated solutions - must be deliverable within determined allocations and budgets. Therefore, short- to medium-term workforce planning must be connected to other planning functions, particularly, financial planning and service planning.

v. Workforce planning solutions should be consistent with the articles of the WHO Global Code of Practice on the International Recruitment of Health Personnel. In this context, workforce planners should plan, as far as is possible, on the basis of national self-sufficiency of supply for health workers. Ireland is a signatory of the Code, which requires countries to strive to create a sustainable health workforce and work towards establishing effective health workforce planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel.

vi. When considering future workforce supply, with a 10+ year time horizon, workforce planning should take account of the workforce needs of the public, voluntary and private health and social care systems.

vii. Workforce planning must consider how current and future demand for services is to be measured and assessed, based on recent trends as well as on forecasts, in order to identify current and future gaps in service provision due to gaps in the workforce. This requires that workforce planners take a variety of factors into account, including: demographic changes; alterations in disease incidence and prevalence; medical and therapeutic innovations; policy initiatives; and technological advances.

viii. Workforce planning should ensure all relevant stakeholders can feed into the process of health workforce planning, and be characterised by cross-sectoral collaboration and engagement where required.

7.3 Framework Overview

The framework comprises the following components:

- a Five Step Approach to workforce planning;
- structures and governance arrangements that support and enable the application of the Five Step Approach in the health sector and cross-sectorally, where appropriate.

7.3.1 Five Step Approach for Strategic Workforce Planning

Underpinned by the principles set out in Section 7.2 above, and aligned with initiatives including the NDTP: Stepwise Approach, the work of the Nursing Taskforce and the People Strategy, this Five Step Approach commences with both external and internal environment analysis (Step 1).

Step 2 clearly situates employment planning/monitoring and workforce intelligence, planning and modelling, and forecasting activities as necessary enablers for identification and implementation of appropriate local and national HR solutions, and sectoral and cross-sectoral policy solutions (Steps 3 and 4).

Recognising that workforce planning is both an iterative and dynamic process, Step 5 proposes monitoring and evaluation of both implementation and HR outcomes in order to inform future workforce planning cycles and solutions (see Appendix Six for examples of HR metrics).

Figure 7.1: Five Step Approach for strategic workforce planning

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1. Analyse
External environment (PESTLE* including national policies/strategies)
Internal environment (including current and future needs)

2. Assess/Forecast
Workforce demand
Workforce supply
(including production, attrition, entries and exits, and existing workforce characteristics)

3. Identify
Identify possible HR and/or policy solutions

4. Plan and Implement
Agree, plan and implement HR and/or policy solutions

5. Monitor and Evaluate Outcomes
(including implementation outcomes and HR outcomes)

- Future workforce supply
- Education and training
- Recruitment and selection
- Succession planning
- Learning and development
- Employee health and well-being
- Performance achievement
- Organisational development
- Equality, diversity and inclusion
- Employee relations
- Job design/enrichment
- Career pathways/progression
- Employee engagement/experience
- Work environment
- HR policies and practices
- HR outcomes and metrics

*PESTLE analysis: A PESTLE analysis (political, economic, sociological, technological, legal, environmental) is an audit of an organisation's environmental factors, with the purpose of informing strategic decision-making.

7.3.2 Structures and Governance Arrangements

Taking into account the underpinning principles, the outcomes sought and the Five Step Approach outlined above, the following structures and governance arrangements are proposed.

The objective is to align the system both vertically and horizontally, in order to support effective information flows about the current workforce and current and future needs, in order to identify, agree and implement appropriate short-, medium- and long-term HR and policy solutions (either within the health sector or cross-sectorally with education and other partners), recognising that such strategies and solutions must be designed and considered within the overall architecture of public sector human resource management including having due regard to national agreements and existing structures.

In all, four levels of structure are proposed as set out in Figure 7.2 below. The role of each level, together with key tasks and activities, and linkages with the Five Step Approach are outlined in Table 7.1 overleaf.

Where necessary, collaborative processes will be designed and rolled out as part of the implementation approach for the strategic framework.

Figure 7.2: Structures and governance arrangements

Cross Departmental Group	
Overall oversight of framework implementation and prioritisation/approval of cross-sectoral strategic workforce planning projects	DOH, DES, DPER, DBEI, DCYA, INIS, HEA, HSE, SOLAS

Joint Department of Health/HSE/Tusla Strategic Workforce Planning Group	
Sectoral oversight of framework implementation and prioritisation/approval of sectoral strategic workforce planning projects	DOH National HR Unit, CMO representation, CNO representation, DOH Professional Regulation Unit, DOH Primary Care, HSE National WFP Unit, Tusla

HSE National WFP Unit	
Report on framework implementation and lead on strategic health workforce planning for the health sector	Workforce intelligence, employment monitoring, medical and nursing workforce planning, health and social care professionals learning and development etc.

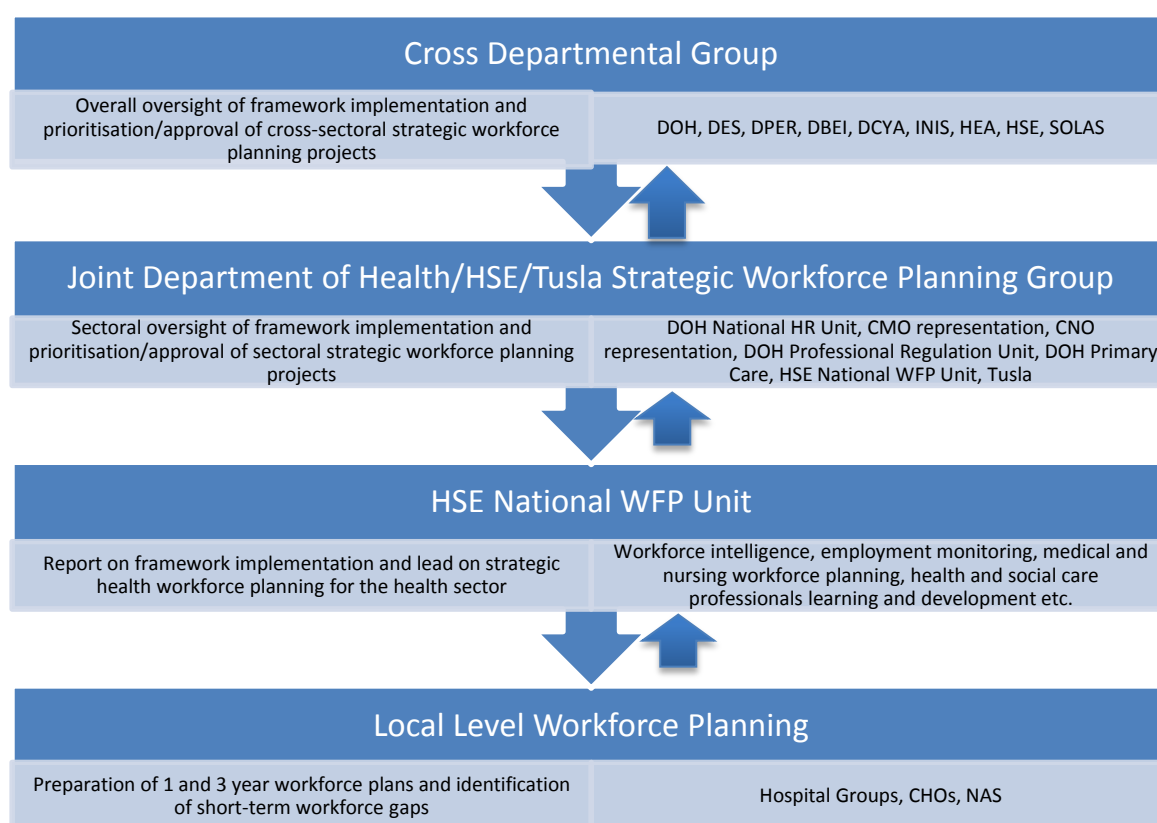| Local Level Workforce Planning	
Preparation of 1 and 3 year workforce plans and identification of short-term workforce gaps	Hospital Groups, CHOs, NAS

Table 7.1: Structures and governance arrangements for strategic workforce planning

Structure	Key Tasks and Activities	Linkages with Five Step Approach
Cross Departmental Group *Overall oversight of framework implementation and prioritisation/approval of cross-sectoral strategic workforce planning projects*	• Act as Programme Board to oversee framework implementation, including agreeing implementation action plans and programme management arrangements • Prioritise, approve and oversee cross-sectoral strategic workforce planning projects and associated HR/policy solutions, including approval of project plans, project management arrangements and funding proposals • Approve protocol for engagement between health / social care and education sectors (including education and training providers) regarding health and social care sector workforce requirements and future supply. Protocol to include approach to determination of annual intakes for certain disciplines • Submit annual reports to Minister for Health on framework activities and implementation	Steps 3. 4, 5
Joint DOH/HSE/TUSLA Strategic Workforce Planning Group *Sectoral oversight of framework implementation and prioritisation/approval of sectoral strategic workforce planning projects*	• Oversee framework implementation in the health and social care sector, in line with agreed implementation action plans and programme management arrangements • Prioritise, approve and oversee sectoral strategic workforce planning projects and associated HR/policy solutions, including approval of project plans, project management arrangements and funding proposals • Identify possible priority areas for cross-sectoral strategic workforce planning projects for consideration and approval by Cross Departmental Group • Approve workforce planning methodologies at service delivery level for 1- and 3-year workforce plans, in consultation with DPER • In collaboration with DES and HEA, devise protocol for engagement between health, social care and education sectors (including education and training providers), regarding health and social care sector workforce requirements and future supply. Protocol to include approach to determination of annual intakes for certain disciplines • Develop a protocol for engagement with private sector providers at scale in order to facilitate information sharing for effective workforce planning	Steps 3, 4, 5

HSE National Workforce Planning Unit *Report on framework implementation and lead on strategic health workforce planning for health sector*	• Report on framework implementation in the health and social care sector, in line with agreed implementation action plans and programme management arrangements • Identify possible priority areas for sectoral and cross-sectoral strategic workforce planning projects for consideration and approval by Joint DoH/HSE/Tusla Group or Cross Departmental Group, as appropriate • Develop strategic workforce planning reports, on the basis of workforce intelligence, modelling and forecasting activities, and including proposed HRM strategies and solutions, for consideration/approval by Joint DOH/HSE Group or Cross Departmental Group, as appropriate • Develop and implement structured approach for stakeholder consultation and engagement, including all relevant sectoral and cross-sectoral stakeholders (e.g. professional regulators, education and training providers etc.) to be incorporated into the Five Step Approach • Develop and implement a structured approach for consultation and engagement with professional representative bodies, staff associations and unions • Implement approved protocol for engagement between health and education sectors regarding health sector workforce requirements and future supply • Implement approved protocol for engagement with private sector providers at scale for information sharing to support workforce planning • In collaboration with key HSE National HR Units/functions, including NDTP, develop robust modelling arrangements for all categories of health and social care worker to include health and social care professionals, healthcare assistants and other social care support workers, and management/admin grades • Develop proposed methodology for 1- and 3- year workforce plans, in consultation with local level workforce planning, and taking into account relevant models from other jurisdictions, for consideration and approval by DOH/HSE Joint Group • Build system capacity and capability for strategic workforce planning, including through provision of support for local level workforce planners. Supports to include training, coaching and establishment of local workforce planning networks • Monitor workforce plans against actual position and report on current workforce, including identification and escalation of potentially damaging short- to medium-term workforce gaps • Engage with DBEI regarding the Highly Skilled Occupations List (HSOL) and with DBEI/INIS regarding employment and immigration permit regimes to assist with recruitment issues • Liaise with National Recruitment Service to establish appropriate linkages between short- and	Steps 1, 2, 3, 4, 5

	medium-term workforce planning and recruitment activity • Develop HR metrics, for consideration and approval by DOH/HSE/Tusla Joint Group to support measurement of HR outcomes	
Local Level Workforce Planning *Preparation of 1 and 3-year workforce plans and identification of short-term workforce gaps*	• Contribute to design of and implement approved 1- and 3-year workforce planning methodology • Prepare 1 and 3-year workforce plans, on a rolling basis, in collaboration with financial planning and service planning functions • Monitor plans against actual position, reporting on same and identifying any potentially damaging short-term workforce gaps, including skills gaps, for escalation, as appropriate	1, 2, 3, 4, 5

7.4   Implementing the Framework

An 18 Month Action Plan with a Focus on Initial Implementation

The Steering Group recognises that implementing this framework is an ambitious multi-year undertaking, involving actions and activities at various levels of the system – both sectorally and cross-sectorally.

The Group also acknowledges the feedback from stakeholders regarding variable implementation of past workforce planning policies and initiatives in the Irish health system.

Accordingly, the focus of this first action plan is in on initial implementation – i.e. the early actions that we need to take to build workforce planning capacity in the health sector, and enhance engagement between the health and education sectors.

This initial implementation phase will also focus on identification of 2-3 priority workforce planning projects, relating to key national health policy or clinical strategy developments, in order to test, evaluate and refine the Five Step Approach.

This first action plan covers the period from Quarter 4 2017 to Quarter 1 2019.

Keeping Up the Momentum Through Rolling Action Plans

Recognising the absorptive capacity of the health and wider systems to take on board and implement system change, the Group proposes that following completion of the period covered by this first action plan, action plans are prepared on a bi-annual basis taking account of progress in implementing the framework and submitted to the Minister for Health by the Cross Departmental Group for consideration and approval.

The Group recommends that this process should also include periodic strategic reviews of the continued relevance and effectiveness of the strategic framework, taking into account contextual and other changes that may occur.

Taking a Programmatic and Project Management Approach

Recognising the complex nature of system change, as well as the interdependencies between many of the actions, a programmatic and project management approach to implementation is required. This approach will include identification of risks and measures to mitigate against them, in addition to identifying critical dependencies.

Appropriate project management arrangements are currently being scoped out, in collaboration with the Department of Health's Programme Management Office, and will be put in place to support delivery of this action plan.

The Cross Departmental Group will act as programme board to oversee implementation and report on progress.

Communication and Engagement with All Stakeholders

Communications and engagement strategies will be a key component of the implementation approach in order to ensure that partners and stakeholders at all levels of the system – sectorally and cross-sectorally - have an understanding of work planned and/or underway, their roles in leading or supporting implementation, and the opportunities to feed into and inform the work.

Building the Evidence Base

Acknowledging that high quality, complete and timely data, information and analysis are required to inform decision-making and identification of appropriate policies and strategies, the action plan has a particular focus on building the evidence base for workforce planning in Ireland.

This key action area will also take on board the learning from current initiatives including the Taskforce on Staffing and Skill Mix for Nursing and the implementation of the MacCraith reports, and will seek to link up the workforce planning research and policy communities in Ireland appropriately.

Making maximum use of routinely collected data will also be important.

Monitoring and Accountability

Progress on implementing the strategic framework will be monitored by the Cross Departmental Group, with annual progress reports to be submitted to the Minister for Health.

In the course of this work, the Cross Departmental Group will consider the requirement for periodic strategic reviews of the framework, commencing with the preparation of the second annual progress report.

In line with learning from the implementation of the MacCraith reports, the Group recommends that stakeholder perspectives on implementation are sought in the context of the preparation of annual progress reports.

In addition, one of the three goals of DPER's forthcoming Public Service Development and Innovation Framework 2020 is to 'Develop our People and Organisations'. In this context, a key joint action for the Department and the HSE is 'An improved health service arising from better planning, including strategic workforce planning, and leadership development'. Progress in implementing the strategic framework will also be reported through the mechanisms established to track Public Service Development and Innovation Framework 2020.

Connecting Up the Work with Other Key Long-Term Planning Processes

A Health Service Capacity Review is currently underway, following a commitment in the Programme for a Partnership Government. The review is examining capacity requirements across key elements of primary care, acute care and services for older persons for the period 2017 - 2030.

The review is taking account of current activity and unmet demand, demographic projections, epidemiological trends and other factors influencing demand, productivity measures, and possible changes in models of care that are likely to have significant impact on capacity requirements. It is at an advanced stage and is expected to be completed by the end of the year.

Health system capacity and workforce planning are inextricably linked and it is envisaged that the implementation of this framework is a key enabler for future health service capacity reviews.

Key Action Area	Actions	Deliverables	Owner	Sign Off	Target Date
1. Establish governance and framework oversight arrangements	Convene Cross Departmental Group	Cross Departmental Group in place	DOH National HR Unit	-	Dec 2017/ Jan 2018
	Finalise Terms of Reference for Cross Departmental Group	Finalised Terms of Reference	DOH National HR Unit	Cross Departmental Group	Dec 2017/ Jan 2018
	Develop draft Terms of Reference for Joint DOH/HSE/Tusla Strategic Workforce Planning Group	Finalised Terms of Reference	DOH National HR Unit/HSE WFP Unit/Tusla	Cross Departmental Group	Dec 2017/ Jan 2018
	Convene Joint DOH/HSE/Tusla Strategic Workforce Planning Group	Strategic Workforce Planning Group in place	DOH National HR Unit/HSE WFP Unit/Tusla	-	Q1 2018
2. Communicate and engage with stakeholders	Develop purpose, aims, objectives and scope of communications and engagement strategy	Finalised stakeholder communications and engagement strategy	DOH National HR Unit/Department of Education and Skills, HSE WFP Unit/Tusla/HEA	Cross Departmental Group	Dec 2017/ Jan 2018
	Undertake sectoral/cross-sectoral stakeholder mapping exercise	Stakeholder mapping completed	DOH National HR Unit/Department of Education and Skills/HSE WFP Unit/Tusla/HEA	Cross Departmental Group	Q1 2018
3. Operationalise workforce planning in the health sector	Establish and resource HSE National Workforce Planning Unit at national level	HSE National Workforce Planning Unit fully in place	HSE National HR	-	Q3 2018
	Develop an operational workforce planning framework, that includes approaches to enhancing workforce planning capacity and capability at local level	Operational workforce planning framework agreed	HSE WFP Unit	Joint DOH/HSE/Tusla Strategic Workforce Planning Group	Q3 2018 – Q1 2019

4. Develop protocols for engagement between health and education sectors	Undertake consultation with HSE and health and social care representatives, education and training providers, representative bodies, SOLAS and HEA on issues to be covered by the protocol between the health and education sectors (e.g. information-sharing, responsibilities, prioritisation, resource planning, approach to determination of annual intakes for certain disciplines)	Consultation report completed	DOH National HR Unit/Department of Education and Skills/ HSE WFP Unit/HEA/Tusla/SOLAS	Cross Departmental Group	Q1 2018
	Develop and document the protocol in consultation with education and health representatives	Protocol agreed	DOH National HR Unit/Department of Education and Skills/ HSE WFP Unit/HEA/Tusla	Cross Departmental Group	Q2 2018
5. Build the evidence base underpinned by research and evaluation	Establish research team to: (1) build the evidence base to inform and test methodologies for 1- and 3-year workforce planning (2) develop a suite of HR metrics for inclusion in HSE Service Plans	Scoping completed and team established	DOH National HR Unit/HSE WFP Unit/Tusla	Cross Departmental Group	Dec 2017/ Jan 2018
		1- and 3-year workforce planning methodologies developed	DOH National HR Unit/HSE WFP Unit/Tusla and research team	Joint DOH/HSE/Tusla Strategic Workforce Planning Group /PER	Q4 2018
		Suite of HR metrics finalised	HSE WFP Unit/Tusla and research team	Joint DOH/HSE/Tusla Strategic Workforce Planning Group	Q1 2019
	Develop baseline health and social care workforce profile	Baseline developed using available data sources	HSE WFP Unit/Tusla	Joint DOH/HSE/Tusla Strategic Workforce Planning Group	Q2 2018

	Undertake horizon scan of main drivers for change impacting on skills demand/supply	Horizon scan completed	HSE WFP Unit/Tusla	Joint DOH/HSE/Tusla Strategic Workforce Planning Group	Q2 2018
6. Identify and commence implementation of priority workforce planning projects to test, evaluate and refine Five Step Approach	Develop criteria and prioritisation matrix for project selection	Matrix developed and criteria agreed	DOH National HR Unit/HSE WFP Unit/Tusla	Cross Departmental Group	Q1 2018
	Undertake scoping exercise to identify possible priority workforce planning projects across the health and social care system	List of possible projects developed	DOH National HR Unit/HSE WFP Unit/Tusla	Joint DOH/HSE/Tusla Strategic Workforce Planning Group	Q3 2018
	Select priority workforce planning projects	2-3 priority projects selected	Cross-Departmental Group	Cross-Departmental Group	Q4 2018

References

Australian Health Ministers' Conference, 2004. *National Health Workforce Strategic Framework*. Sydney.

Bacon and Associates, 2001. *Current and Future Supply and Demand Conditions in the Labour Market for Certain Professional Therapists*. Dublin: DOH.

Barry, U. and Conlon, C., 2010. *Elderly Care in Ireland - Provisions and Providers.* UCD School of Social Justice Working Papers; 10(1):1-34. Dublin: UCD.

Central Statistics Office, 2016. *Census of Population 2016 – Preliminary Results*. Dublin: CSO.

Chartered Institute of Personnel and Development, 2010. *Workforce Planning: Right People, Right Time, Right Skills.* London: CIPD.

Chartered Institute of Personnel and Development, 2015. *CIPD Profession Roadmap*. London: CIPD.

Commission on Nursing, 1998. *Report of the Commission on Nursing: A Blueprint for the Future*. Dublin: Government of Ireland.

Committee on the Future of Healthcare, 2017. *Houses of the Oireachtas Committee on the Future of Healthcare – Sláintecare Report*. Dublin: Houses of the Oireachtas.

Department of Health and Children, 2001. *Primary Care: A New Direction*. Dublin: DOH.

Department of Health and Children, 2008. *Report of the Commission on Patient Safety and Quality Assurance: Building a Culture of Patient Safety*. Dublin: DOHC.

Department of Health and Children, 2009. *An Integrated Workforce Planning Strategy for the Health Services 2009-2012.* Dublin: DOHC.

Department of Health, 2013. *Healthy Ireland – A Framework for Improved Health and Well-being 2013-2025*. Dublin: DOH.

Department of Health, 2016a. *Health in Ireland. Key Trends 2016.* Dublin: DOH.

Department of Health, 2016b. *Healthy Ireland Survey 2016*. Dublin: DOH.

Department of Health, 2016c. *Department of Health Statement of Strategy 2016 – 2019.* Dublin: DOH.

Expert Group on Various Health Professions, 2000. *Report of the Expert Group on Various Health Professions*. Dublin: HSEA.

EU/OECD, 2016. *Health at a Glance: Europe 2016. State of Health in the EU Cycle*. Paris: OECD Publishing.

FÁS, 2009. *A Quantitative Tool for Workforce Planning in Healthcare: Example Simulations*. Dublin: FÁS/EGFSN.

Forum on Medical Manpower, 2001. *Report of the Forum on Medical Manpower*. Dublin: DOH.

Health Canada, 2005. *A Framework for Collaborative Pan-Canadian Health Human Resources Planning.* Ottawa: Government of Canada.

Health Service Executive, 2014. *Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group.* Dublin: HSE.

Health Service Executive, 2015a. *Health Services People Strategy 2015-2018: Leaders in People Services.* Dublin: HSE.

Health Service Executive, 2015b. *Healthy Ireland in the Health Services – Implementation Plan 2015-2017*. Dublin: HSE.

Health Service Executive 2015c. *Medical Workforce Planning: Future Demand for General Practitioners 2015-2025.* Dublin: HSE.

Health Service Executive, 2016a. *Planning for Health. Trends and Priorities to Inform Health Service Planning 2016.* Dublin: HSE.

Health Service Executive, 2016b. *Medical Workforce Planning Ireland: A Stepwise Approach*. Dublin: HSE.

Health Workforce Advisory Committee, 2005. *Strategic Principles for Workforce Development in New Zealand*. Auckland: Ministry of Health.

Health Workforce Australia, 2011. *National Health Workforce Innovation and Reform Strategic Framework for Action 2011 – 2015.* Canberra: Health Workforce Australia.

Higher Education Authority, 2016. *What Do Graduates Do? The Class of 2015: An Analysis of the First Destination of University Graduates.* Dublin: HEA.

Kinsella, S. and Kiersey, R., 2016. *Health Workforce Planning Models, Tools and Processes in Five Countries: An Evidence Review*. Dublin: HRB.

Kovacs, E., Girasek, E., Kovács, R., Aszalos, Z., Eke, E., Cserháti, Z. and Ragány, K., 2016. *Report on Health Workforce Planning Data WP4*. Hungary: Semmelweis University.

Medical Council, 2016. *Medical Workforce Intelligence Report 2016.* Dublin: Medical Council.

McAleese, S., 2013*. The 'Humanisation' of Medicine? : The Feminisation of Medicine: A Qualitative Study of the Career Experiences of Female Doctors and Implications for HRM in Ireland.* [PhD Thesis]. Dublin: RCSI.

National Joint Steering Group on the Working Hours of NCHDs, 2001. *Report of the National Joint Steering Group on the Working Hours of NCHDs*. Dublin: DOHC.

National Task Force on Medical Staffing, 2003. *Report of the National Task Force on Medical Staffing*. Dublin: DOH.

NHS Wales, 2007. *Design for a New and Integrated Approach to Workforce Planning for NHS Wales*. Cardiff: NHS Wales

OECD, 2016. *Health Workforce Policies in OECD Countries – Right Jobs, Right Skills, Right Places*. Paris: OECD Publishing.

Postgraduate Medical Education and Training Group, 2006. *Preparing Ireland's Doctors to Meet the Health Needs of the 21st Century*. Dublin: DOH.

Review Group of Undergraduate Nursing and Midwifery Degree Programmes, 2012. *Report of the Review of Undergraduate Nursing and Midwifery Degree Programmes*. Dublin: DOHC.

Scottish Government, 2013. *NHS Scotland Everyone Matters: 2020 Workforce Vision*. Edinburgh: NHS Scotland.

Scottish Government, 2017. *NHS Workforce Projections*. Edinburgh: NHS Scotland.

SOLAS, 2016. *National Skills Bulletin 2016.* Dublin: SOLAS/EGFSN.

Sousa, A., Scheffler, R., Nyoni, J. and Boerma, T., 2013. *A Comprehensive Health Labour Market Framework for Universal Health Coverage,* Bulletin of the World Health Organization. Geneva: WHO.

Steering Group on the Nursing and Midwifery Resource, 2002. *The Nursing and Midwifery Resource: Final Report of the Steering Group: Towards Workforce Planning*. Dublin: DOHC.

UK Department of Health, 2013. *Delivering High Quality, Effective, Compassionate Care: Developing the Right People with the Right Skills and the Right Values. A Mandate from Government to Health Education England: April 2015 – March 2015.* Leeds: HEE Sponsor Team.

Working Group on Undergraduate Medical Education and Training, 2003. *Medical Education in Ireland: A New Direction*. Dublin: DOHC.

World Health Organization, 2006. *World Health Report 2006 – Working Together for Health*. Geneva: WHO.

World Health Organization, 2010. *WHO Global Code of Practice on the International Recruitment of Health Personnel*. Geneva: WHO.

World Health Organization, 2016a. *Global Strategy on Human Resources for Health: Workforce 2030.* Geneva: WHO.

World Health Organization, 2016b. *Working for Health and Growth: Investing in the Health Workforce. Report of the High-Level Commission on Health Employment and Economic Growth*. Geneva: WHO.

World Health Organization/Global Health Workforce Alliance, 2013. *A Universal Truth: No Health Without a Workforce.* Geneva: WHO.

Appendices

Appendix One: HSE Workforce Planning, Analytics and Informatics Workshops Summary

In preparation for their contribution to the development of this framework, the HSE's Workforce Planning, Analysis and Informatics Unit ran a series of Benefits Realisation Workforce Planning consultation workshops. The workshops involved introductory presentations outlining the context followed by small group discussions on a number of questions relating to: workforce planning in the context of the Irish health care system; the opportunities and challenges for workforce planning, changes required to implement the process; and the benefits of workforce planning.

The workshops provided the opportunity, for the first time, to identify and present national and local workforce planning projects which stimulated debate and contributed to shared learning around workforce planning. While these projects identified desired health worker levels, the opportunity to positively influence the strength or skill requirements of the future health workforce were not generally in scope for these projects.

An analysis of the 13 projects presented at the 2014 WFP workshop and a further 3 projects in 2016 revealed a multiplicity of drivers for workforce planning activity ranging from restructuring to the implementation of health policy.

The workshop discussions suggested a number of benefits that would emanate from improved workforce planning structures and processes:

- Better planning will lead to better service integration;
- Better resource allocation, equitable distribution of health workers /resources;
- Competent workforce with core and specialist skills to meet service needs;
- Health worker retention and job satisfaction linked to patient satisfaction.

The suggested approach to workforce planning arising from the workshops identified planning activities appropriate to Hospital Groups, CHOs, HSE National Divisions and Government Departments. Workforce planning in Hospital Groups and CHOs is critical in informing near-term, medium- and long-term workforce planning. In addition, the National Divisions play a role in medium- and long-term planning using data generated in the operational units and/or the implications of clinical programmes and policies on models of care. Finally, the Divisions and central workforce planning and development, collectively have both an internal support role and responsibility for engaging externally with Government agencies, educators and regulators on behalf of the services.

The conclusion was that this approach would have the capability to address near-term and medium-term workforce requirements but critically can influence and respond to both the demand and the supply side of the health workforce market place over the longer term.

The key characteristics of the approach are:

- Represents a move from ad-hoc workforce planning to a structured approach based on models of care and service delivery requirements;
- Acknowledges the key role of workforce planning in local services and the linkages with central workforce planning and development units;
- Identifies a supporting role for central services - workforce intelligence, research, analytics, and influencing externally;
- Identifies the need to influence the health workforce supply through structured engagement with relevant Government agencies;
- Acknowledges and facilitates workforce planning for current, medium- and long-term needs;
- Links workforce planning at local and national level.

The consultation process identified the following as necessary to fully develop, implement and manage this approach:

- National workforce planning strategy and frameworks to further develop and implement the model;
- A move from discipline-specific to multi-disciplinary workforce planning based on models of care and clinical programmes;
- Alliances and collaboration with key 'supply side' players, e.g. HEIs, professional associations, regulators, INIS and DJEI;
- An integrated ICT, HR and Finance system based on common methodology, language and framework;
- Nationally agreed criteria to assess, measure and predict workforce requirements;
- Strengthened HR and WFP capability at Hospital Group and CHO level;
- Strengthened workforce planning capability at national level with access to specialist forecasters as required;
- Access to relevant, accurate and usable data;
- More recruitment activity devolved to Hospital Groups and CHOs - local management authorised to make resourcing decisions and to be accountable for resource allocation.

The recommendations arising from the workshops suggested a collaborative cross-sectoral approach is required if the sector is to influence the health labour market and strike a balance between resource allocation, deployment, utilisation and development within budget while maintaining services.

Appendix Two: Overview of Stakeholder Consultation and Engagement Process 2017

Introduction

The Steering Group has endeavoured to ensure that a thorough process of stakeholder consultation has been conducted to inform the development of the framework.

In line with the proposals for stakeholder consultation and engagement agreed by the Steering Group, the purpose of stakeholder engagement has been twofold:

- To communicate and inform stakeholders of the development of the draft framework, with a particular focus on the elements of the framework (IAP2 spectrum – engagement level 1);
- To seek feedback on the approach with a particular focus on identifying any gaps in information flows that should be addressed through the proposed Five Step Approach, and associated structures and governance arrangements (IAP2 spectrum – engagement level 2).

A high-level stakeholder mapping exercise was undertaken by the Secretariat, with input from Steering Group colleagues, to identify stakeholders who were likely to have an interest in the development of the draft framework. This exercise informed the approach to consultation.

About the Consultation and Engagement Process

Communication and engagement on the draft framework commenced in April 2017 with presentations to the Department of Health's Policy Committee and the HSE's Joint Information and Consultation Forum.

Formal public consultation on the draft framework proposals commenced on 26th June 2017. The draft report and framework proposals were published online through the CIVIQ platform and stakeholder views were invited. In particular, to assist with the finalisation of the framework and associated implementation approach, stakeholder feedback was requested on the following questions:

1. Are there any other global, regional or national supply or demand side considerations that should be taken into account?
2. Are there any other key interfaces between the health sector and other sectors nationally that should be taken account of?
3. What gaps in information flows exist – either within the health sector or cross-sectorally – that should be taken into account in finalising the proposed structures and governance arrangements?

The consultation was featured on the Department of Health's public consultations page (http://health.gov.ie/consultations/) and a dedicated email address (workforceplanning@health.gov.ie) was established. Individual email invitations, notifying stakeholders of the consultation and including the link to the online consultation platform, issued to c. 260 colleagues across the health and wider systems. The closing date for receipt of submissions was 21st July 2017.

In parallel with the online consultation process, bi-lateral engagements took place with the following staff associations: Irish Hospital Consultants Association, Psychiatric Nurses Association, Craft Unions and the Irish Dental Association. A further engagement with unions and staff associations took place under the auspices of the HSE's National Joint Council Policies and Procedures Committee during September 2017.

In all, 49 submissions were received via the online platform and/or in writing.

Private individual	14
Internal HSE	8
Education institution / organisation	6
Union	5
Professional body	4
Section 38/39	4
Health institution / organisation	2
Body under the aegis of the Department of Health	1
Advocacy group	2
Other	3

Thematic Analysis of Submissions

A thematic analysis of the submissions received was prepared by the Secretariat for consideration by the Steering Group and these themes have been reflected in the final version of the report, as appropriate. An overview of the themes emerging from the submissions is set out below and it should be noted that discipline-specific and other submissions will be provided to the structures to be established under the framework for information and further consideration.

Theme	Consultation Feedback
Making all health and social care workers visible in the strategic framework	A significant number of submissions drew attention to the balance in the draft report between the various health and social care professions and noted the contribution of particular health and social care professions and disciplines in a variety of settings. Professions cited in particular submissions included: the GP workforce, physiotherapists, clinical measurement scientists, psychologists, speech and language therapists, radiographers, health care assistants, mental health nursing, and community workers. In some instances, respondents requested a discipline-specific strategy, outlining numbers required for an individual profession.
Impact of Brexit	The impact of Brexit is another subject on which many comments were received. The possibility of Ireland retaining common travel rights while restrictions apply to other EU countries was suggested as being a driver for increased recruitment of Irish health staff from the UK. This was supported by other submissions, which were not optimistic about Brexit and its impact on health and social care workforce planning. It was suggested elsewhere that Brexit may create challenges for people living in Northern Ireland but working in the health sector in the Republic of Ireland. Other submissions suggested that 'Brexit could have a potential impact on the sharing of cross border health services, health tourism between the two economies and it could also impact on training and standards, recruitment of doctors and regulatory frameworks as outlined in this document. These issues must also be considered in developing the strategic framework.'

	Taking a more positive view on this matter, another submission suggested that "it could be assumed that a hard BREXIT with regards to working permits could result in a number of Irish HCP's currently working in the UK returning back to the Irish market." The possibility of Brexit impacting on cross border information flows was also raised.
Mental health services	A number of submissions made reference to particular staffing challenges in the mental health sector and the consequent impact on services.
Interface with the education sector	A significant number of submissions emphasised the need for education and health sectors to work together at various levels and through relevant structures including the Apprenticeship Council. While the flow of information between the health and education sectors is well covered in terms of overall workforce planning and ensuring that graduates are available to take up positions required by the Health Service, submissions pointed to other relevant flows between the sectors.
Stakeholder consultation and engagement	A significant number of submissions highlighted the importance of engaging with and involving all relevant stakeholders pertinent to a segment of the health and social care workforce. Examples given included engagement with relevant unions, health and social care professional bodies, patients and service users, and relevant Government Departments not included on a standing basis on the Cross Departmental Group. Submissions suggested that a workforce planning forum could usefully be established to ensure effective collaboration, and to enhance data flows with professional bodies, unions, staff associations and other stakeholders.
Section 38/39 organisations	Two submissions made reference to services provided by Section 38 and 39 organisations and the importance of engaging with them collaboratively on workforce planning, including to improve data and information flows.
Volunteers/informal caregivers	One submission noted that the role of volunteers and informal caregivers constitutes "a key interface that should be recognised and considered in workforce planning." The submission noted that data on current/projected trends for this cohort and was concerned that should the valuable contribution of these groups diminish, this would have an impact on services.
Health and well-being	One submission noted that references to health and wellbeing in the report were limited
Information flows, data and research	In general, existing data limitations were identified as a barrier to effective information flows. There were also specific references to limited information flows between the public and private health sector. The importance of ensuring that all relevant data sources and research evidence is used to inform health and social care workforce planning was noted in a number of submissions, including insights of

	relevance to health workforce policy and practice that arising from current or future health workforce research undertaken in an Irish context.
Implementation issues	A number of submissions raised questions regarding implementation of the framework in the context of the variable implementation of previous workforce planning strategies and processes. The importance of a clear implementation plan was highlighted in this regard, as well as the need for clarity around linkages with existing policies (e.g. the MacCraith reports) and processes such as national and local level service planning.

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Appendix Three: WHO Global Code of Practice on the International Recruitment of Health Personnel

In May 2010, at the 63rd World Health Assembly, the WHO Global Code of Practice on the International Recruitment of Health Personnel was adopted unanimously by the 193 member states of the World Health Organization (WHO), including Ireland. The Code establishes and promotes voluntary practices for the ethical international recruitment of health personnel in a manner that strengthens health systems, including through effective health workforce planning, education and retention strategies.

Emphasising health workforce sustainability and national health worker self-sufficiency, the Code's guiding principles and articles include:

- That Member States should strive to create a sustainable health workforce and work towards establishing effective health workforce planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel (Article 3);
- Ethical international recruitment practices, including ensuring that recruiters and employers observe fair and just recruitment and contractual practices in the employment of migrant health personnel (Article 4);
- That the health systems of both source and destination countries should derive benefits from the international migration of health personnel, with collaboration between destination and source countries to sustain and promote health human resource development and training (Article 5);
- That Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers (Article 5).

The Government of Ireland has committed to implementing the WHO Global Code through a coherent approach involving the Department of Health, the Department of Foreign Affairs, Irish Aid, and their funded programmes and services, including the HSE.

The Department of Health is the designated national authority for reporting on implementation of the Global Code and the Department's National HR Unit leads in this regard.

Appendix Four: Examples of how Workforce Planning is Structured in Other Jurisdictions

New Zealand

Health workforce New Zealand (HWNZ) was established in 2009 within the Ministry of Health. The 2008 financial crisis left New Zealand with an increase in the emigration of health care workers, in particular to Australia, resulting in criticism of an 'unsustainable reliance on immigrant doctors and nurses to meet health care workforce needs'. This led to the establishment of HWNZ. Its aim is 'to work with key organisations to ensure the New Zealand public has a health workforce fit to meet its needs'. This is achieved by collaboration between HWNZ, educational bodies and employers 'to ensure that workforce planning and postgraduate training aligns with the needs of current and future service delivery'.

The modelling work looks at the continuum of the workforce; the qualitative work with clinicians allows for the gaining of intelligence on the workforce for future planning. The quantitative side of the modelling work is based on past trends, statistical knowledge, and contains as many elements as possible.

Workforce service forecasts were developed to suit the system that was being planned for and were initiated by HWNZ to ensure that New Zealand's healthcare workforce was fit for purpose. The workforce service forecast process started with 14 topic-specific areas: aged care, anaesthesia, dermatology, diabetes, youth health, eye health, gastroenterology, Māori workforce, mothers, fathers and babies, mental health, musculoskeletal, Pacific workforce, palliative care and rehabilitation. The approach involves 'scenario building for the effective delivery of service aggregates' in order to both accommodate uncertainty and encourage innovation.

Clinicians lead on what is an inductive process, where in liaison with a forecasting project manager they develop a vision for how they think the workforce should look within the next 5–10 years, including new service configuration and new workforce models. It is quite a qualitative process and, due to the clinician-led process, closely related to practice.

Each of the key workforces that focus on models of care, identified as doctors, nurses, midwives, allied health workers, non-regulated workers (such as HCAs), and those in leadership and managerial roles have had taskforces developed for them by HWNZ. The diagram below from 'The Role of the Health Workforce New Zealand', maps out the orientation of the hierarchy of workforce planning and taskforces in New Zealand.

Each taskforce is comprised of a steering group, 'made up of representatives drawn from across the health sector and a smaller working group, which will, 'implement defined programmes of work to improve professional development, recruitment and retention'. These taskforces are seen as increasingly important, providing very good advice and steerage within and to the Ministry of Health.

Maintaining the model is labour-intensive work; currently, there are 17 FTEs working on workforce planning, which includes three administrative staff. There is one principal technical specialist and the remainder are analysts. There is a reasonable financial investment in the workforce planning sector and in the development of e-Health.

Figure: Developing sustainable workforces and new models of care – New Zealand
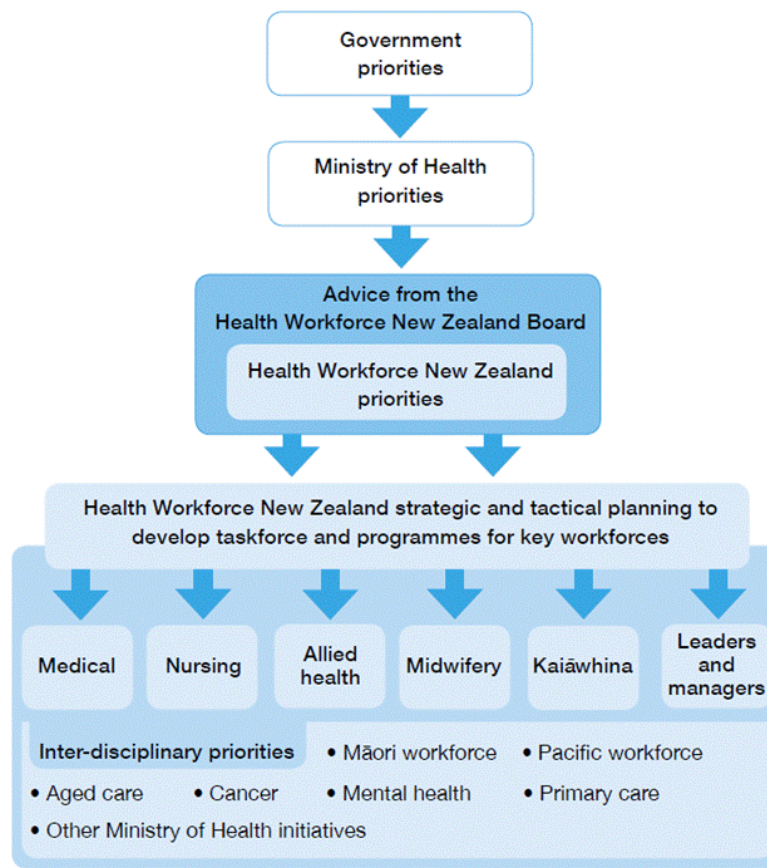
Scotland

NHS Scotland undertakes workforce planning via 14 regional NHS Boards, which are supported by seven special NHS Boards and one public health body that provides further important specialist and national services. Guidance developed in 2005 gave the impetus to NHS Boards to outline markers, develop key methodologies and finalise information requirements for workforce planning. There was investment in workforce planning across NHS Boards and participants received a considerable amount of training. NHS Scotland has a National Workforce Planning Forum, where workforce planners from each NHS Scotland Board are represented; this promotes engagement and qualitative discussions on an on-going basis. The forum has three work streams:

- Information and intelligence;
- Modelling and profiling ;
- Workforce planning education.

The goal of Scottish workforce planning is 'to provide NHS Boards (and their component services) with a consistent framework to support evidence-based workforce planning'. Also to 'ensure the highest quality of care for patients by ensuring NHS Scotland has the right workforce with the right skills and competences deployed in the right place at the right time'.

Around 2007–2008, the Skills for Health Six Step Methodology was adopted, initially informally, by NHS Scotland as a guideline that was suitable for all staff to follow. A revised guidance document, published in 2011, was subsequently issued as a national guide to support workforce planning. It was designed to support and assist those leading the development of workforce plans at service, NHS Board and regional level. The guidance document (CEL 32) seeks to embed the use of the Six Step Methodology as the primary model for workforce planning.

There is a core workforce planning training group which provides initial workforce planning training in order to familiarise each service (group) with what is expected of them locally with regard to planning. The training is carried out over two split, half-day sessions. The core training group also administers the annual skills training template as part of the process of training and completion of plans. This permits each service (group) to analyse its existing data, clean it up and provide accurate data to make the plan, allowing a good local analysis of local data before it is forwarded on to the centre to inform workforce planning. As it stands, most services do not have significant changes from year to year.

At the beginning, the workforce planning process was centralised, but it has since devolved to a more local basis (with an identified planner in each local hub). The centralised component is still important for overseeing the project as a whole and having a single point of contact for workforce planning, which makes it easier to encourage engagement from service-level staff.

Netherlands

The role of the Advisory Committee on Medical Manpower Planning (ACMMP), which oversees health workforce planning in the Netherlands, is to prepare estimates for the training capacity of medical and dental training, based on the expected need for care, in order to adequately control health coverage and university budget management. The ACMMP evaluates supply and demand for medical care presently and forecasted into the future. '

The ACMMP board is comprised of professional representatives from the medical professions, medical schools, health insurers and training hospitals. The board advises the Ministry of Health on the yearly inflow of medical and dental graduates in twenty-six different types of medical and dental specialty training, and also advises the Ministry of Education on the related national numerous clausus for entry to medical and dental school. The professional groups that are considered for the model are: physicians (doctors), dentists, dental hygienists, clinical pharmacologists, clinical chemists and clinical physics. That further breaks down into 35 different medical specialists, eight recognised semi-specialist occupations in the medical field, dentists, dental hygienists, and three technical professions in hospital (clinical pharmacologists, clinical chemists and clinical physics).

The ACMMP itself employs seven staff with backgrounds in healthcare (or healthcare education), research, academic, or advisory expertise; there is also one administrative member of staff. They also utilise a regular pool of experts (approximately 100) working in the field in the appropriate medical specialty, who are consulted on a regular basis. The ACMMP can also consult some research bureaux and other organisations to obtain any additional necessary data.

The ACMMP ascertains the likely influence of each factor involved on demand for medical specialist services through a combination of empirical data and expert opinion; the model also includes undertaking consultation with the medical specialist associations in expert focus group meetings.

Appendix Five: ONMSD Workforce Planning Projects

Service Area	Project
Acute care	Phase 1 of the programme of work of the Taskforce developed a draft Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Adult Hospitals in Ireland'. This is currently being piloted in 3 hospitals (1 Model 4, 1 Model 3 and 1 Model 2 hospital). Phase 2 of this initiative has recently commenced seeking to develop a framework for safe staffing within Emergency Departments and building upon the 'Emergency Department Nursing Workforce Planning Framework' published in February 2016 and the role profiles to support nursing staff. Work undertaken by the ONMSD on behalf of the Emergency Medicine National Clinical Programme.
Children's services	The ONMSD and the Children's Hospital Group are currently undertaking a project to build on the work completed which outlined the staffing requirements of the new National Children's Hospital. The overall aim of this project is to develop an agreed national workforce plan that establishes the future demand and supply of children's nurses to work across the acute sector setting nationally. The Report will aim to understand and prepare for the future needs of children's nursing care in Ireland by critically examining all aspects of the demand and supply of children's nurses.
Maternity services	A national midwifery workforce planning project was undertaken in 2014/2015 using Birthrate Plus® to determine the number of midwives required to provide the current service model within maternity services. Birthrate Plus® measures the clinical workload for midwives emanating from the needs of women commencing from the initial contact in pregnancy and continuing until final discharge from midwifery care in the puerperium. This includes all antenatal, intrapartum and postnatal care in all settings; outpatient clinics, day care and inpatient settings. The report of the project noted that midwifery staffing requirements will change as the new model of care evolves as the Maternity Strategy is implemented.
Older people's residential services	A number of projects using various acuity/dependency tools for example; Criteria for Care, applying the Keith Hurst model, the Augmented IoRN (Scotland) have been applied in a variety of residential settings nationally.
Mental health services	A national nursing workforce plan was completed by HSE Mental Health Division in 2015/2016 which identified a significant supply gap in parts of the country that is expected to continue for the next ten years. The gap is exacerbated by the predicted retirement numbers during this period. The outcome of this project resulted in the increase in the commissioned numbers of undergraduate student places by 60 in 2016 increasing by 130 in 2017 to 420 and continuing at that level thereafter. A one year post registration nursing programme was also commissioned to provide an additional 40 registered psychiatric nurses. This commenced in January 2017.
Intellectual disability services	Recognising the ongoing developments in service models and structures within disability services in response to national policy, the ONMSD in partnership with HSE Social Care Division commissioned a project with Trinity College Dublin to determine the future role of the Registered Nurse Intellectual Disability (RNID). This project used a multi-method approach to collect data to inform their role in the future to support individuals with an intellectual disability in a community based social model of care. Entitled 'Shaping the Future of Intellectual Disability Nursing in Ireland', the report is due to be published in the near future.

Appendix Six: Exemplar HR Metrics to Support Strategic Workforce Planning

Learning and Development

- % L&D spend targeted at priority staff categories
- % L&D spend targeted at critical capabilities

Succession Planning

- Coverage for critical roles
- % of high potential in succession pools

Workforce Commitment

- Absence rate
- Permanent/temporary/contracted ratio
- Flexible working arrangements
- Employee satisfaction survey

Recruitment and Selection

- % of agreed new hires completed
- % of new hires retained after 1 year
- % new hires sourced outside EU
- Offer acceptance rate

Workforce Demographics

- Age distribution / average age
- Diversity distribution

Turnover

- Turnover vs. assumed turnover in the workforce planning scenario
- Promotion rates vs. assumed rates in the workforce planning scenario
- Lateral moves vs. assumed rates

Workforce Gaps

- Current surplus/shortfall by staff category
- Future year predicted surplus / shortfall by staff category
- Key gaps by grade

Appendix Seven: Short-Term Workforce Planning in Other Jurisdictions

England

The NHS Trust Development Authority (NHS TDA) has designed workforce planning forms to capture the workforce information that forms part of NHS Trusts' integrated plans.

The forms collect current year data e.g. 2016/17 (forecast outturn values), and planning data for the following year e.g. 2017/18 profiled for each month of the year. They provide the NHS TDA with information on the workforce aspects of NHS Trusts plans for the following year, as well as providing financial monitoring information against which all monthly submissions for the following year are assessed.

Submissions are prepared in accordance with the guidance prepared the TDA. Some joint working with the Finance Department in the NHS Trust is envisaged to ensure the submission is consistent with the finance plan submission.

The structure of the planning form is as follows:

- Header - contains NHS Trust name, contact details provided to TDA in event of query and summary of progress clearing validations for submission;
- WTE staffing forecast - WTE forecast by staff group category for substantive and under broad medical, non-medical clinical and nonclinical heading for separate bank and agency sections;
- Pay Bill - forecast by staff group category for substantive and under broad medical, non-medical clinical and non-clinical heading for separate bank and agency sections;
- WTE Bridge - substantive WTE Bridge, Bank WTE Bridge and Agency WTE Bridge ;
- Occ Code Tool - provides assistance in categorisation of ESR occupation codes

Scotland

NHS Boards are required to provide baseline data and projections for Year 1, Year 2 and Year 3 for most staff groups. For each staff group there is a narrative section to provide details of data quality issues and assumptions used including general direction of travel, changes resulting from service redesign and reconfiguration, and the likelihood of these occurring.

Workforce projections should have already been discussed with Area Partnership Forums. In the case of the nursing and midwifery workforce, the NHS Board Director of Nursing should have professional oversight of the numbers and have endorsed these as part of the NHS Board Workforce Plan. NHS Boards should reference the National Nursing and Midwifery workforce/workload planning tools (where available) used in deriving the nursing numbers for each clinical area (as appropriate). The tools should be used as part of a triangulated approach incorporating professional judgement with quality measures. The completed returns should also contain a narrative/rationale which describes the changes resulting from service redesign and reconfiguration.

This data is used to inform nationally led processes around student commissioning and other workforce education.