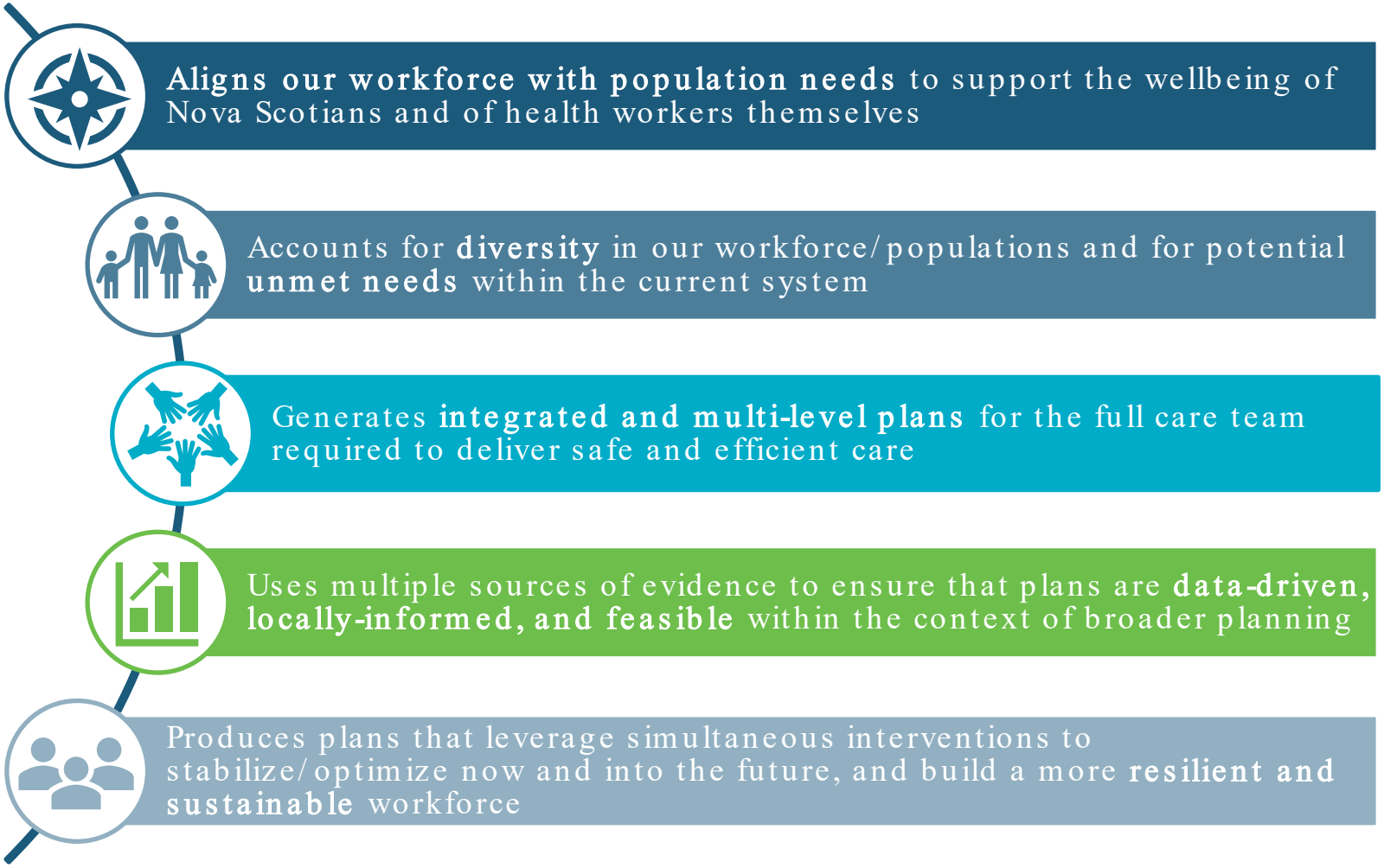
PEOPLE PLANNING PERFORMANCE (P3)

A strategic approach for optimizing workforce capabilities

June 2026

Overview of Integrated Needs-Based Planning at NSH

Why choose Integrated Needs-Based Health Workforce Planning?



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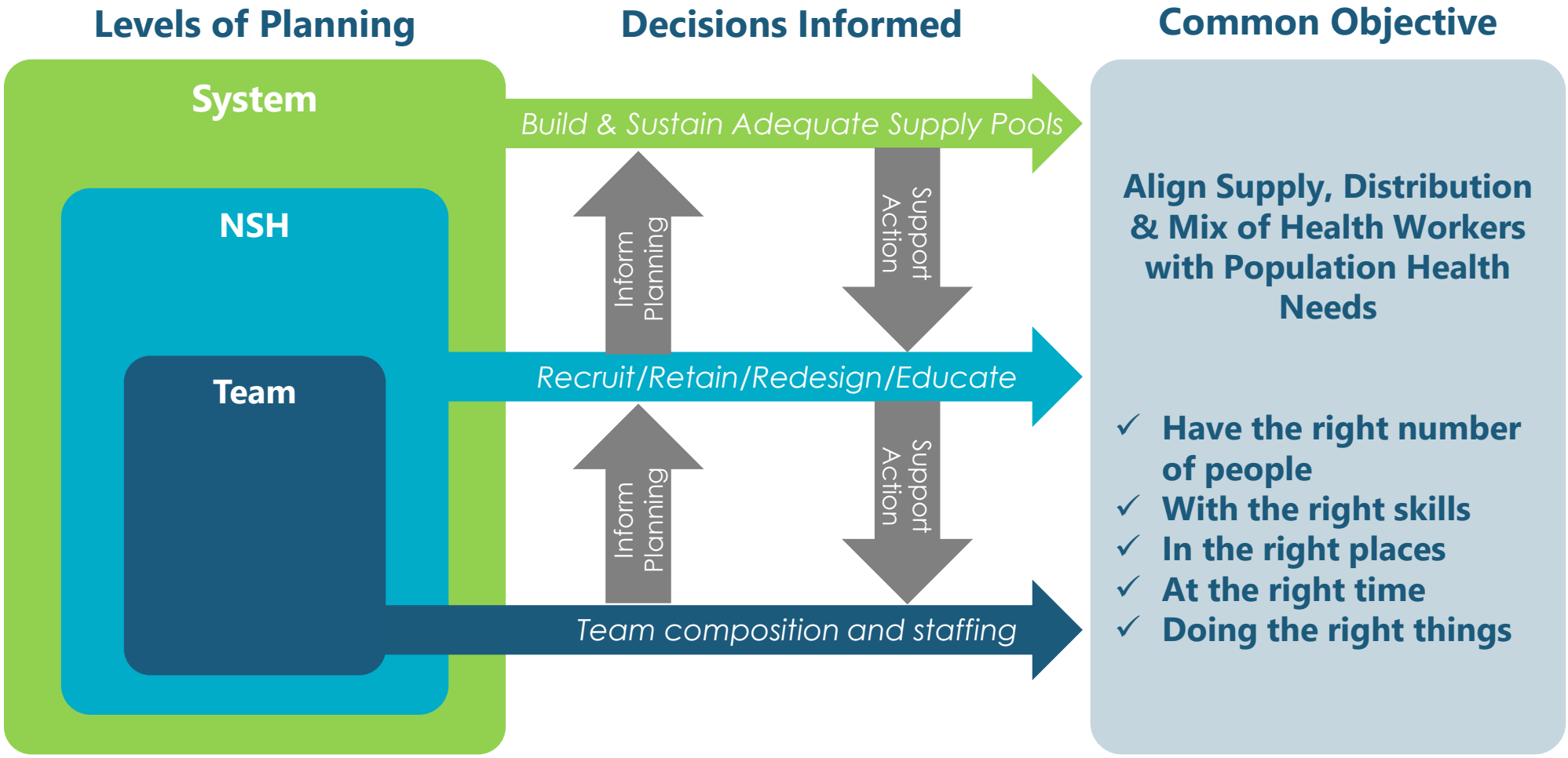
Levels of Needs-Based Health Workforce Planning



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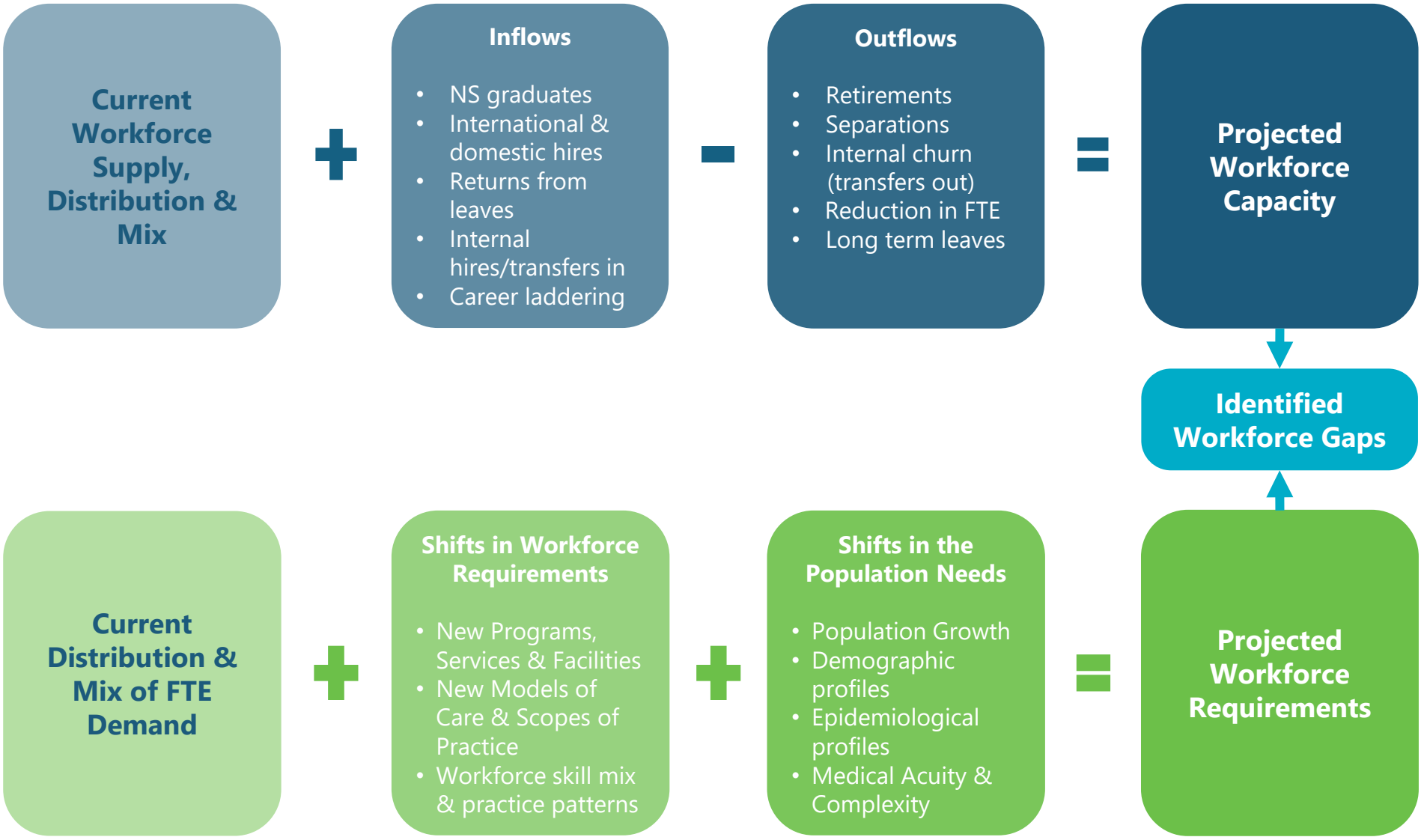
Needs-Based Health Workforce Modeling



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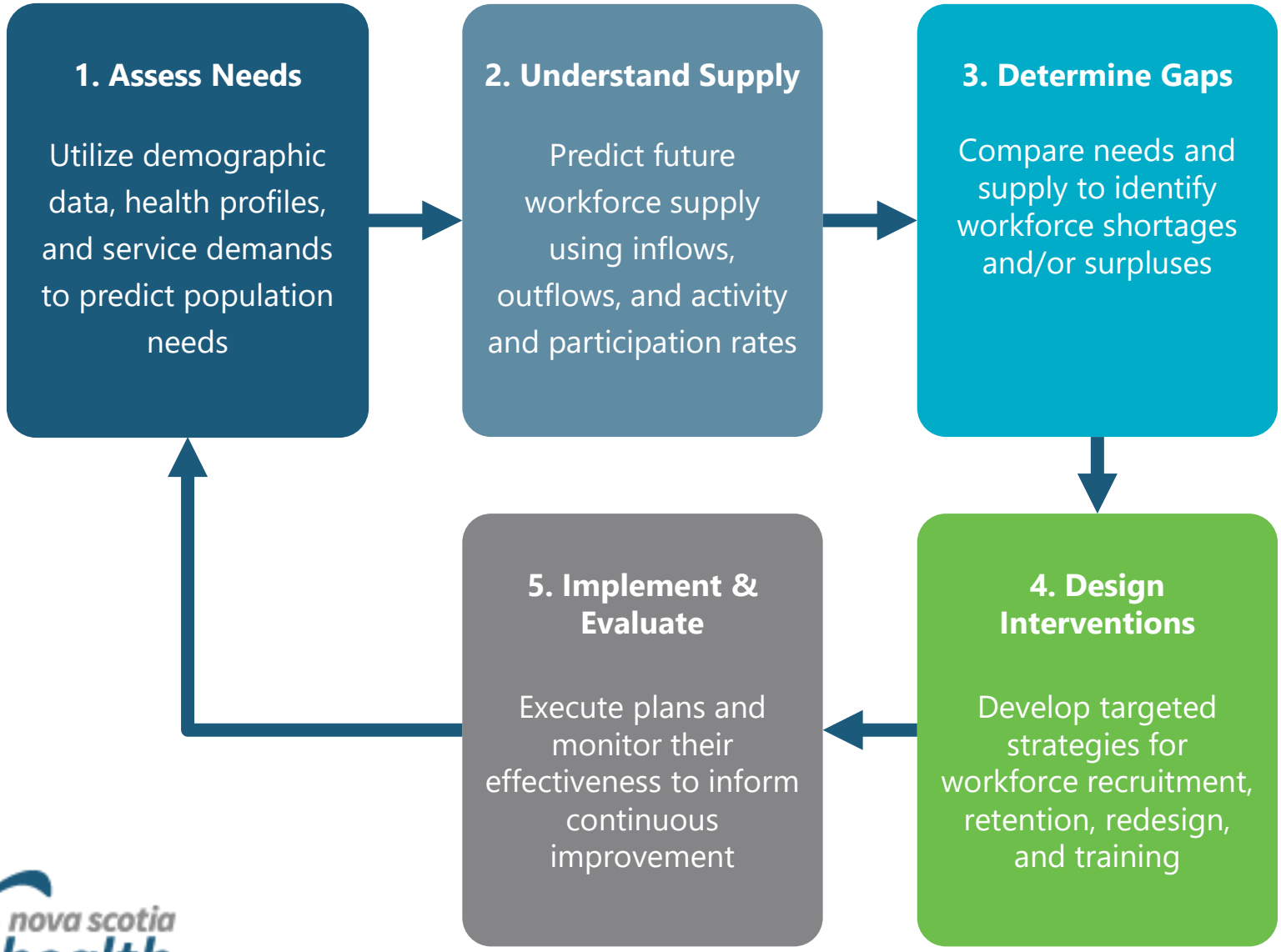
Integrated Needs-Based Workforce Planning Cycle



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P3 - People, Planning & Performance

P3 Mandate

1. Build a Comprehensive Workforce Hub

- Collaborate; Innovate; Co-locate; Apply Best Practices.

2. Leverage Cross-Department Skills and Integration

- Integrated Workforce Planning; Strategy, Performance & Analytics; Implementation Science; Interprofessional Practice & Learning; Medical Affairs; Finance; People Services; IMIT.

3. Close Gaps Using Workforce Intelligence

- Mobilize quantitative and qualitative workforce intelligence to support data-driven planning, implementation, and continuous improvement to close workforce gaps.

4. Support Action for Health & True North Framework Strategies

- Promote the development of workforce plans and strategies that will enable the achievement of these strategic directions

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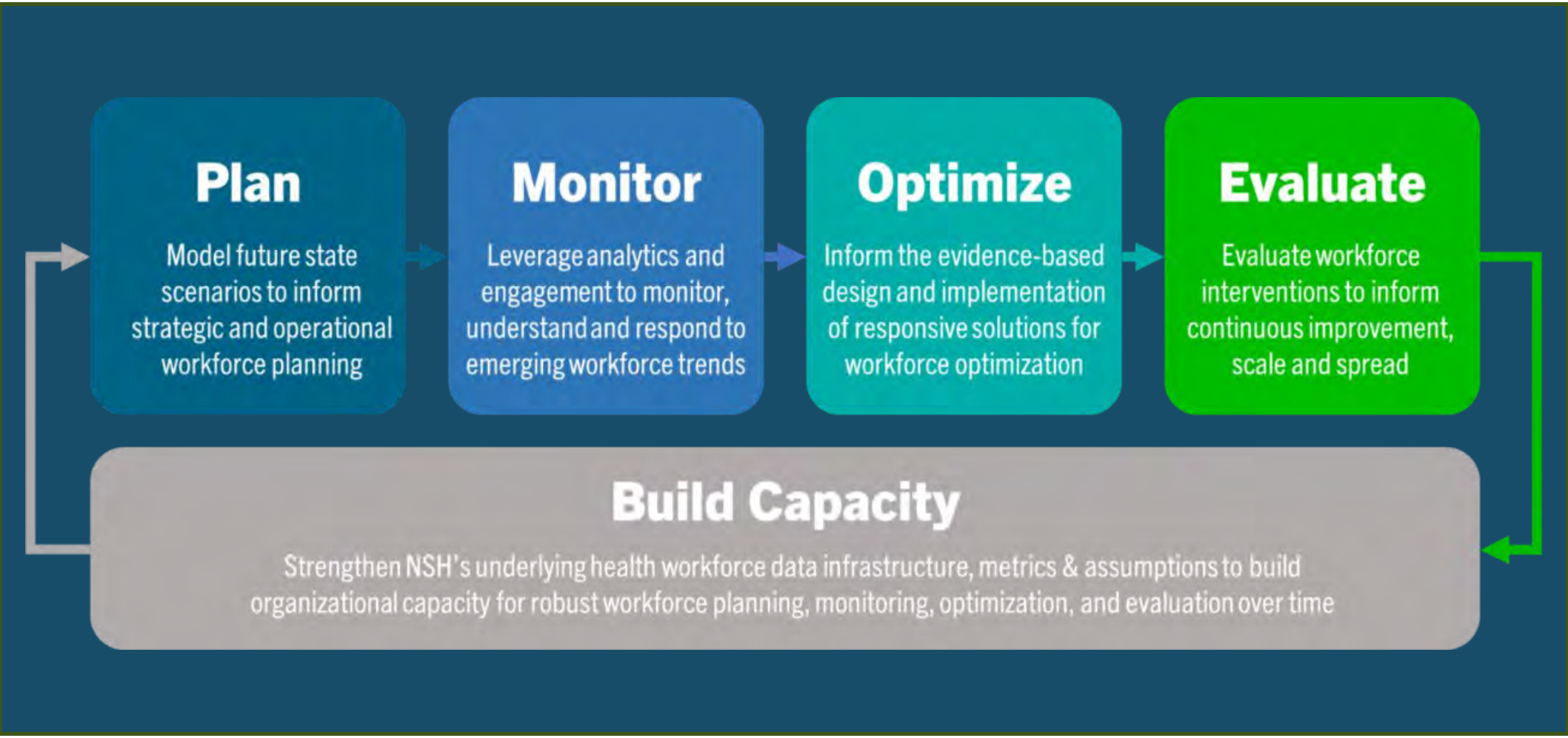
P3 5 CORE OBJECTIVES



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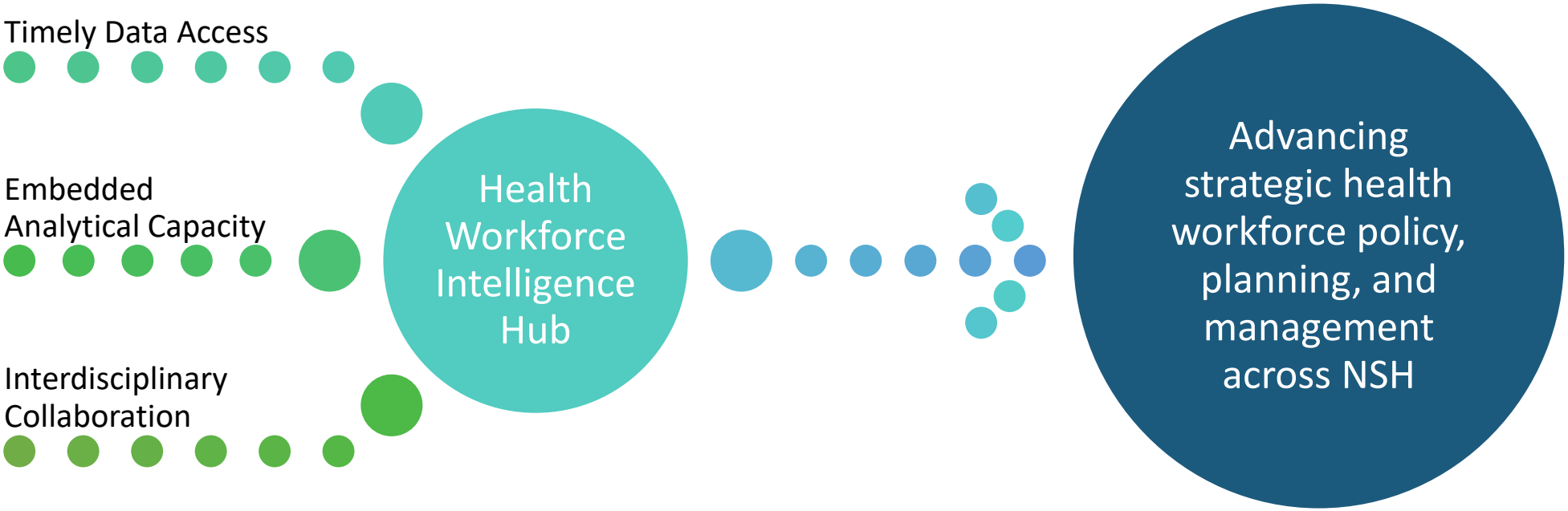
Why does P3 matter?



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P3 Projects

Comprehensive Nursing Report

Background & Objectives

- Nova Scotia Health faces a unique convergence of workforce pressures:
  - A record inflow of new graduate nurses and Internationally Educated Nurses (IENs)
  - Persistent shortages in Emergency and Critical Care specialty areas
  - Overtime and agency spend remaining high in Emergency and Critical Care areas despite overall reductions
  - Limited vacancies and a saturation of novice nurse staff in medical-surgical units

- The distribution of vacancies and experience across units is misaligned with the profile of current supply pools and traditional novice nurse placement pathway.

- To respond, P3 developed evidence-based, multi-factor models that:

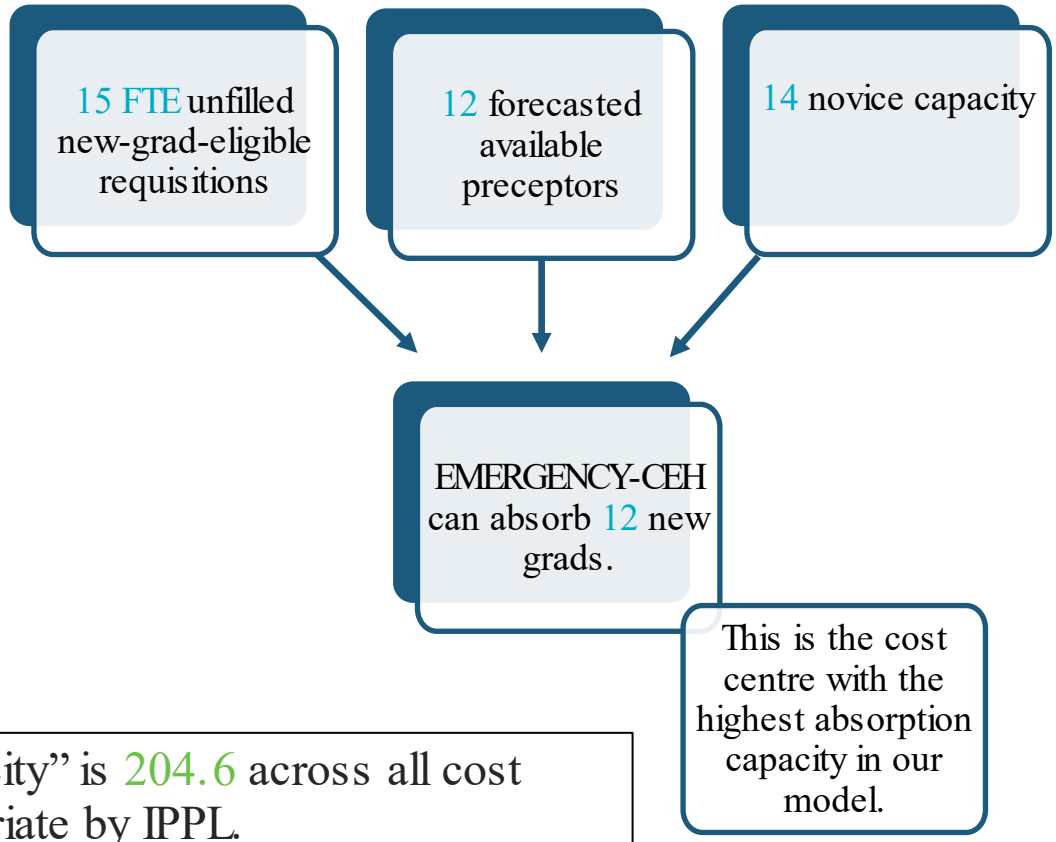
  1. Identify and prioritize cost centres experiencing the most significant hiring and cost pressures to generate new opportunities for new RN placement; and

  2. Identify opportunities for experienced medical-surgical RNs who could take the necessary training and move into specialty areas, freeing up opportunities for new RNs in traditional entry-level role

Estimating Maximum Novice RN hires per unit

- The model looks at the estimated "maximum novice RN hires" for each cost centre equal to the lesser of:
  i. Unfilled new-grad-eligible requisitions,
  ii. Forecasted number of preceptors, or
  iii. The "Novice Capacity" – The number of novice nurses that can be added without exceeding 50% under 2 years of service.

Example: EMERGENCY-CEH



- The estimated total "absorption capacity" is 204.6 across all cost centres deemed to be novice-appropriate by IPPL.
  - For 92% of cost centres, requisitions was the binding constraint.
  - 17% of cost centres were bound by the preceptor constraint
  - 16% of cost centres were bound by the novice constraint

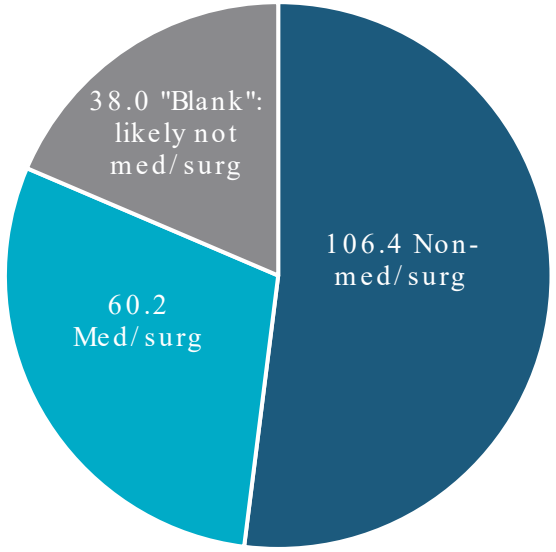
Where can we hire these 204.6 new RNs?

- Emergency and Operations are the Programs of highest capacity.
- The sites with the highest capacity are the QEII (64.4), Colchester (28.0), and Dartmouth (23.4).
- Requisitions are the most common constraint. Sites with relatively few requisitions for their size include the NS Hospital (0.0), Cobequid (0.0), Northside (1.0), Glace Bay (1.0), Valley (8.2), and many community sites.
- One site, Cumberland, stands out for having relatively low capacity (2.0) for its requisitions (11.3).

Capacity by Zone/Program

Program	Central	Eastern	Northern	Western	Total
Emergency	17.1	15.8	17.0	14.0	63.9
Operations	20.0	3.9	8.0	8.6	40.5
Perioperative/Surgical Services	16.6	1.0	4.6	4.8	27.0
Critical Care	13.8	2.7	6.0	3.8	26.3
Community and Rural Health	10.8	3.3	0.0	2.0	16.1
Women and Childrens Health	0.0	2.6	2.0	5.2	9.8
Renal Services	3.6	1.0	0.4	1.5	6.5
Mental Health and Addictions	5.5	0.0	0.0	0.9	6.4
Cancer Care	2.0	0.0	0.0	0.0	2.0
Palliative Care	1.7	0.0	0.0	0.0	1.7
Allied Health	0.8	0.0	0.0	0.0	0.8
Unknown	0.0	2.8	0.0	1.0	3.8
Grand Total	91.8	33.1	38.0	41.8	204.6

Capacity by unit type



Developing a Vacancy & HTF Prioritization Model

- The Hard-to-Fill (HTF) Prioritization Model is an evidence-based tool that identifies and ranks cost centres experiencing the greatest hiring pressure.

- It combines three factors, volume of hard-to-fill positions, difficulty filling vacancies, and overall workforce risk into a single composite score. By weighting these factors, we identify areas with persistent, challenging recruitment needs.

Metrics Measured by the Model:

- The model evaluates three core dimensions of hard-to-fill pressure:

1. Volume: How many Positions are hard to fill?
    - Calculate the average number of HTF cases per month (12 Months) for each unit.
    - This reports long-term demand and workload pressure.

2. Difficulty: How hard is it to fill these positions?
    - Measure the HTF Rate (HTF ÷ Vacancies).
    - This identifies structurally difficult units that tend to go unfilled when vacancies arise.

3. Risk: What is the overall risk profile of the unit?
    - Risk score takes into consideration 10 workforce measures to assess risk at the unit level.
    - The scores is a weighted calculation of the following measures:
      [Agency Spend + Vac. Rate + Turnover Rate + Potential Retirements + Potential Pat. Leave + OT + HTF + Unproductive FTE Rate + Sick Rate + % <2 YOS]

See Appendix E for the data source & methodology

Top 20 Cost Centres Ranked by Highest Need

Nearly half of the top 20 highest-ranking cost centres are emergency departments

Higher composite scores indicate greater hiring need, with a rank of 1 representing the highest level of need.

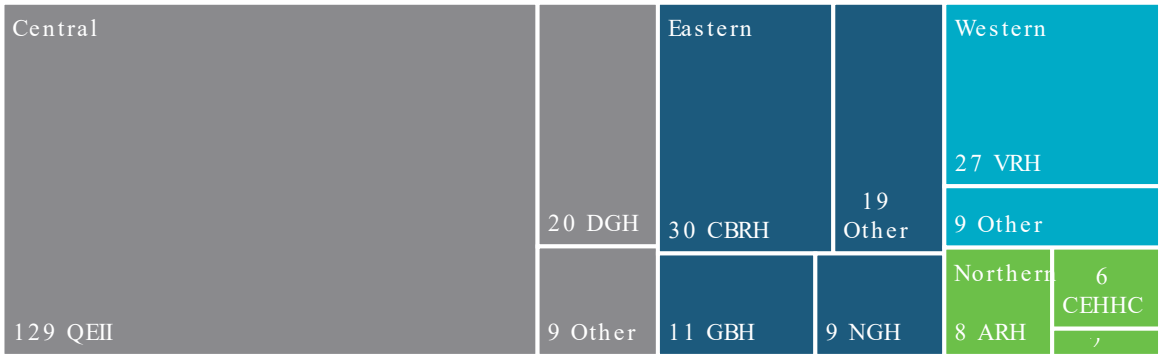
Zone	Program	CostCentre	PersonnelArea	Comp. Score	Rank
Western	Critical Care	INTENSIVE CARE UNIT-YRH	Yarmouth Regional Hospital	1.003	1
Northern	Emergency	EMERGENCY-CEH	Colchester Regional Hospital	0.965	2
Eastern	Community and Rural Health	MEDICAL NURSING UNIT-ICH	Inverness Consol Mem Hospital	0.962	3
Eastern	Emergency	EMERGENCY-ICH	Inverness Consol Mem Hospital	0.961	4
Western	Critical Care	INTENSIVE CARE UNIT-VRH	Valley Regional Hospital	0.938	5
Central	Emergency	EMERGENCY-QE2	QEII	0.902	6
Central	Emergency	EMERGENCY-DGH	Dartmouth General Hospital	0.842	7
Western	Operations WZ	MEDICAL NURSING UNIT-SSR	South Shore Regional Hospital	0.839	8
Western	Perioperative/Surgical Services	W&C ACUTE CARE 2B - YRH	Yarmouth Regional Hospital	0.779	9
Eastern	Emergency	EMERGENCY-CBR	Cape Breton Regional Hospital	0.772	10
Northern	Emergency	EMERGENCY-CRG	Cumberland Regional HC Centre	0.769	11
Eastern	Community and Rural Health	MEDICAL NURSING UNIT-VCM	Victoria County Mem Hospital	0.767	12
Northern	Operations NZ	LONG TERM CARE-BVM	Bayview Memorial HC Centre	0.755	13
Eastern	Community and Rural Health	MEDICAL NURSING UNIT-BMH	Buchanan Mem Comm Hospital	0.752	14
Western	Community and Rural Health	MEDICAL NURSING UNIT-QGH	Queens General Hospital	0.746	15
Central	Perioperative/Surgical Services	OPERATING ROOM THORACIC 11-QE2	QEII	0.737	16
Eastern	Emergency	EMERGENCY-EMH	Eastern Memorial Hospital	0.735	17
Western	Perioperative/Surgical Services	3E-ACUTE CARE B-YRH	Yarmouth Regional Hospital	0.727	18
Western	Emergency	EMERGENCY-DBH	Digby General Hospital	0.725	19
Eastern	Emergency	EMERGENCY-GMH	Guysborough Memorial Hospital	0.724	20

Estimating capacity to increase novice-appropriate opportunities

'career laddering potential' was determined based on experienced RNs that a cost centre could replace with a novice RN without:

1. Bringing the unit experience above 50% novice.
2. Bringing the unit below 1 preceptor for every unfilled new-grad-eligible requisition.

Laddering potential in Med/Surg units by Site/Zone



Laddering potential in Med/Surg units by Program

- Operations, Community and Rural, and Palliative have the strongest laddering potential for their experienced nurse staff.

The "career laddering potential" across in-scope med/surg units in the NFMT was 279 in medical/surgical units.

There are 79 new-grad-ineligible requisition FTE to ladder RNs into

Plus 124.9+ new-grad-eligible position FTE in non-med/surg units (if not filled by new grads)

Create up to 203.9 additional med/surg opportunities for novice nurses

Recommendations
Comprehensive Nursing Report

1. Adopt the Provincial Novice Nurse Placement model
   - Bring consistency, safety, and alignment to workforce strategy.
2. Prioritize placements in Emergency & HTF Units
   - Tie directly with the HTF model results
3. Build transition to practice support capacity for new grads entering directly into specialty areas
   - Work with operational and IPPL leaders to define locally-relevant direct-entry pathways with accompanying transition to practice supports
4. Implement Career Laddering
   - Move tenured RNs out of medical/surgical units to create capacity for novice novice placement.
   - Strengthen experience and close gaps in specialty and HTF units.
   - Align implementation with incentives and training seats.
5. Optimize use of Specialty Training Capacity (ENP/CCNP)
   - Close the gap between seat availability and utilization
   - Address training bottlenecks to stabilize ICUs and EDs
6. Implement Quarterly Analytics Review
   - Adjust targets, uphold safety guardrails and update risk profiles.
   - Measure impact of measures.
7. Analyze potential financial savings of the model
   - Review financial impacts including reduced agency spend, overtime, and incentives as a next step.

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P3 Projects

Recruitment Incentive Prioritization

Background & Objectives

- Recruitment and relocation incentives support attraction and recruitment of new talent and represent a significant cost for the organization
- Over the past four years, many new hires have consistently received recruitment incentives, often provided as blanket amounts of $5,000-$10,000 per hire
- The blanket incentive paid to new health-professional graduates is not adjusted for need and does not align qualified candidates to geographic areas and program areas with the greatest need
- Under current processes, recruitment incentives for the 2026 academic year are projected to cost approximately $6M for all types of health professional roles, of which 5.2M is assigned to nursing roles
- This presents an opportunity to improve value for money by strategically reallocating incentive dollars toward hard-to-fill roles and locations, increase cost-efficiency and sustainability of our recruitment processes, and reduce average incentive costs, while supporting more appropriate distribution of our workforce supply
- To achieve these objectives, a standardized and data-driven Recruitment Incentive Prioritization Approach has been developed to identify areas of greatest workforce need, and assign corresponding recruitment incentive allowances for priority professions

Scoring Methodology

An Incentive Priority Score was developed to identify cost centres eligible for hiring incentives based on indicators of recruitment difficulty, workforce risk, and retention pressure. The model incorporates results across six weighted factors:

Factor	Description	Weight
Average Number of Hard-to-Fill	Requisitions that remain unfilled for three months and enter repost status in SuccessFactors	28%
Average Hard-to-Fill Rate	The percentage of vacancies that are classified as hard to fill	36%
Number of Employees Over 55	The total number of employees over the age of 55 within a cost centre	8%
Percent of Employees Over 55	The proportion of employees aged 55 and older relative to the total workforce	12%
Turnover Volume	The combined count of separations and retirements	4%
Average Turnover Rate	Turnover as a percentage of total employees	8%
Average Vacancy Rate	Vacancies as a percentage of the total employee complement	4%

0.28 * Vol. HTF
+
0.36 * HTF Rate
+
0.08 * Employees > Age 55
+
0.12 * %of Employees > Age 55
+
0.04 * Vol. Turnover
+
0.08 * Turnover Rate
+
0.014 * Vacancy Rate
=
Incentive Priority Score

Results are calculated using rolling 12-month (12MR) data and compiled at the cost centre level. Results are then normalized, and the applicable weight is applied to each.

A higher Incentive Priority Score indicates greater hiring pressure. All profession-cost centre pairings are ranked relative to one another and assigned to tiers based on percentile thresholds.

Proposed Approaches

Two options are proposed to determine levels of financial incentivization.

Both options prioritize the same high-risk cost centres at the top end of the distribution:

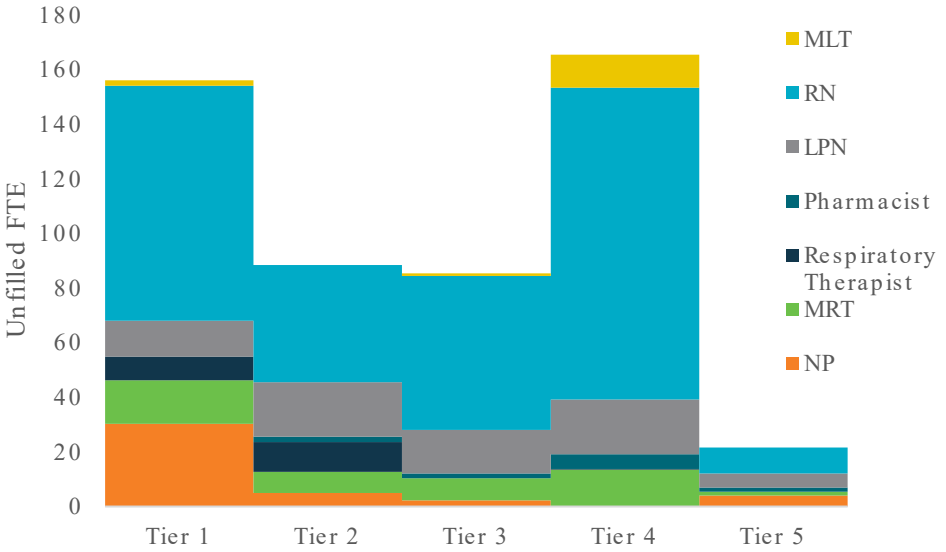
- Option 1 provides greater differentiation across varying levels of risk
- Option 2 simplifies decision-making by collapsing lower tiers and provides a broader incentive strategy

Selection between the two options is a policy and operational choice, not a change in analytical approach.

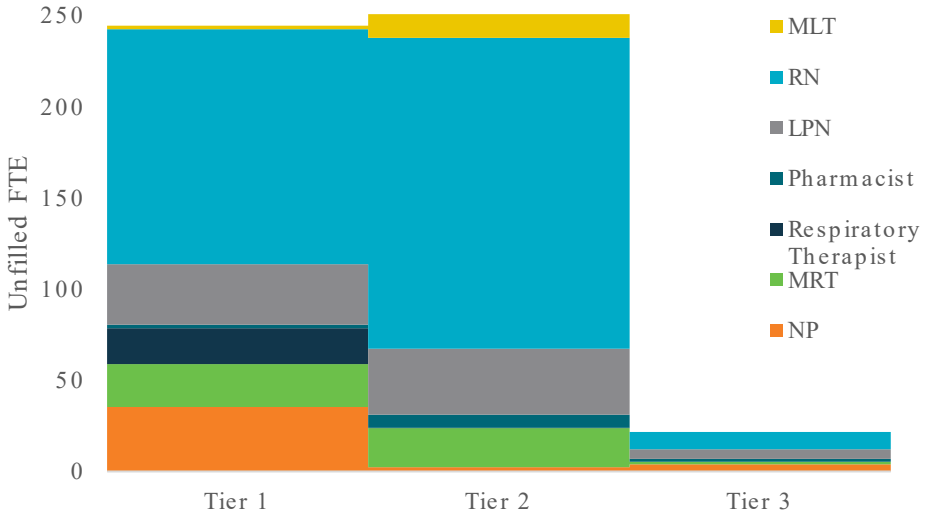
Incentive Priority Score Rank	Per-Candidate Recruitment Incentive Allowance	
	Option 1	Option 2
90th Percentile & above	Tier 1: $10,000	Tier 1: $10,000
80th-90th Percentile	Tier 2: $7,500	
70th-80th Percentile	Tier 3: $5,000	Tier 2: $5,000
Below the 70th Percentile with Some Level of Risk	Tier 4: $2,500	
No Identified Risk	Tier 5 (excluded): $0	Tier 3 (excluded) $0

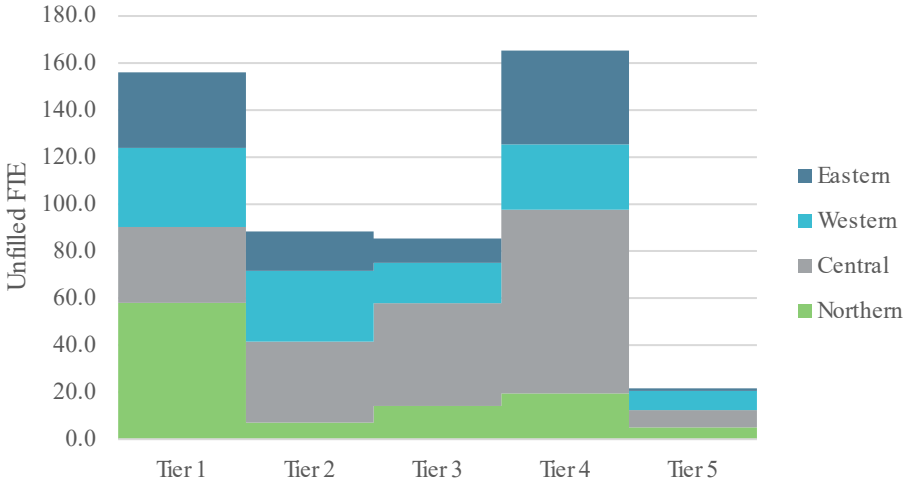
Distribution of Unfilled Positions by Tier, Profession, and Zone

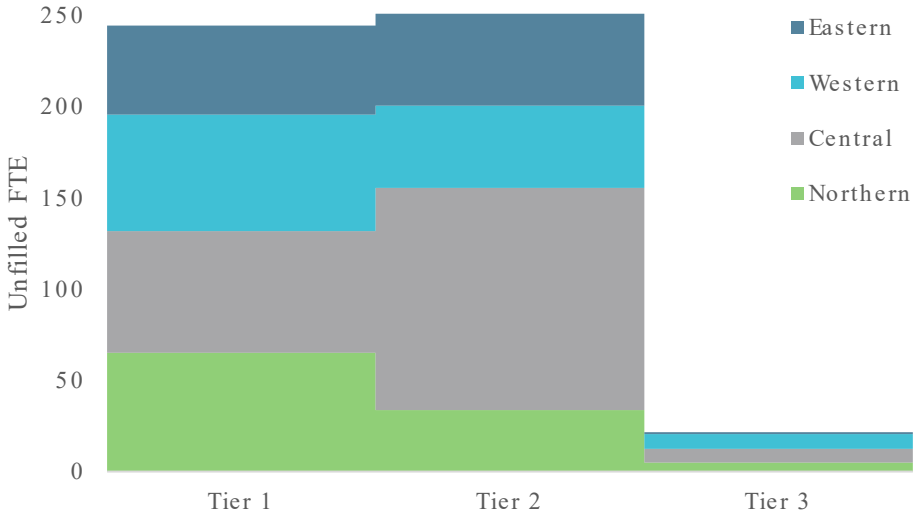
5-Tier model



3-Tier model

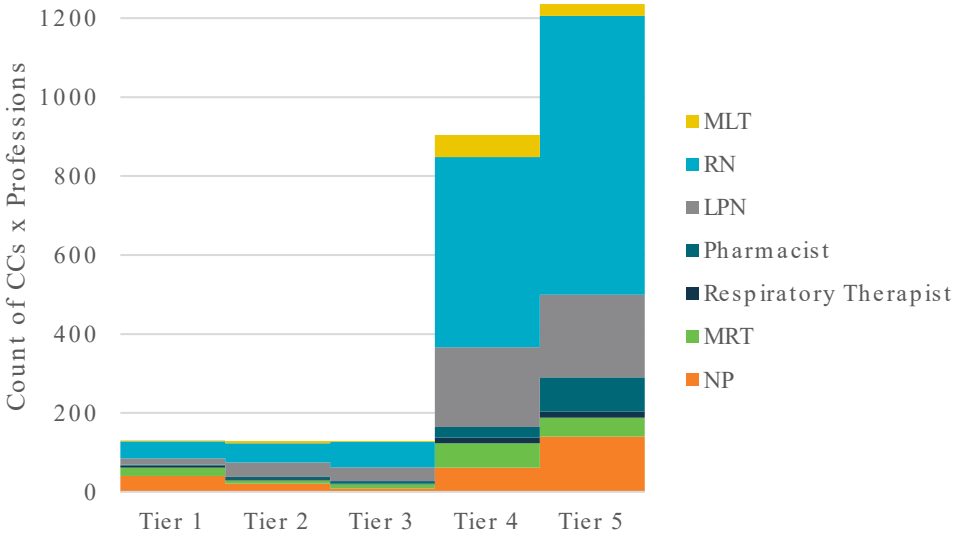


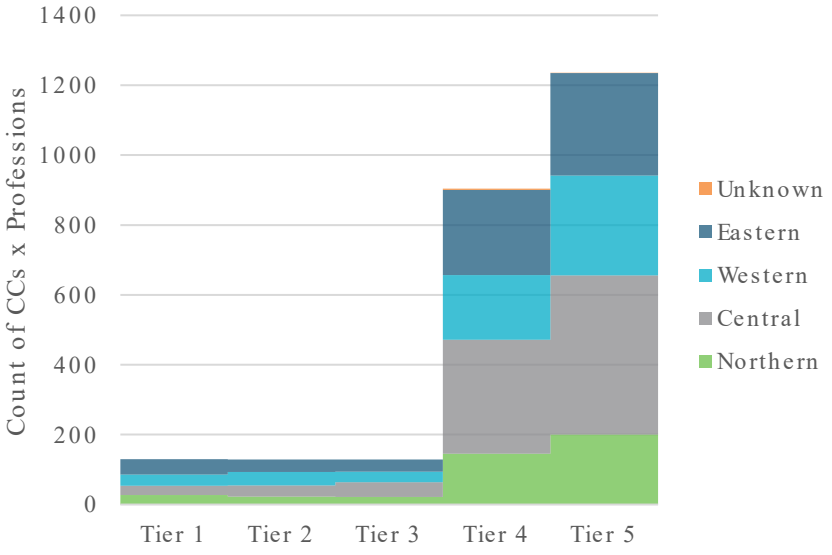




Distribution of Profession-Specific Cost Centres by Tier, Profession, and Zone

5-Tier model





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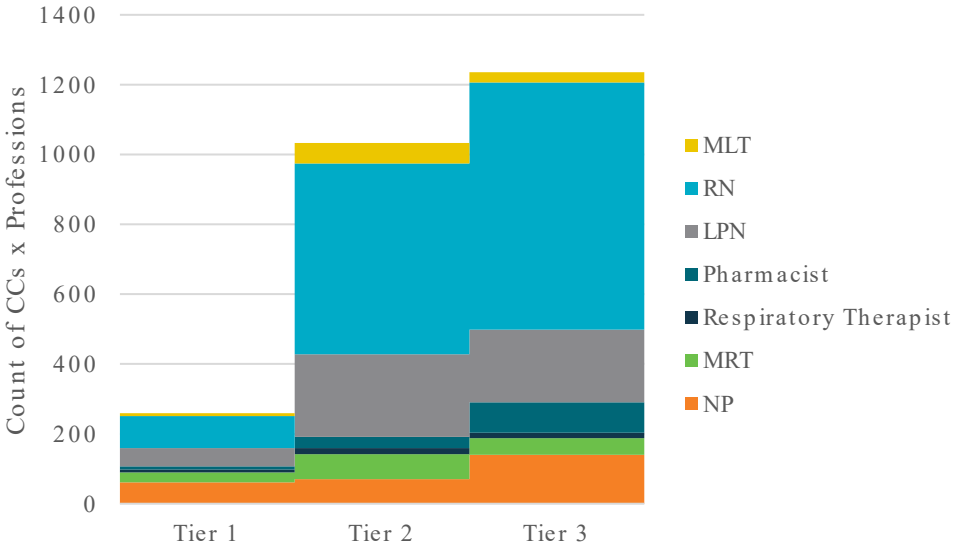

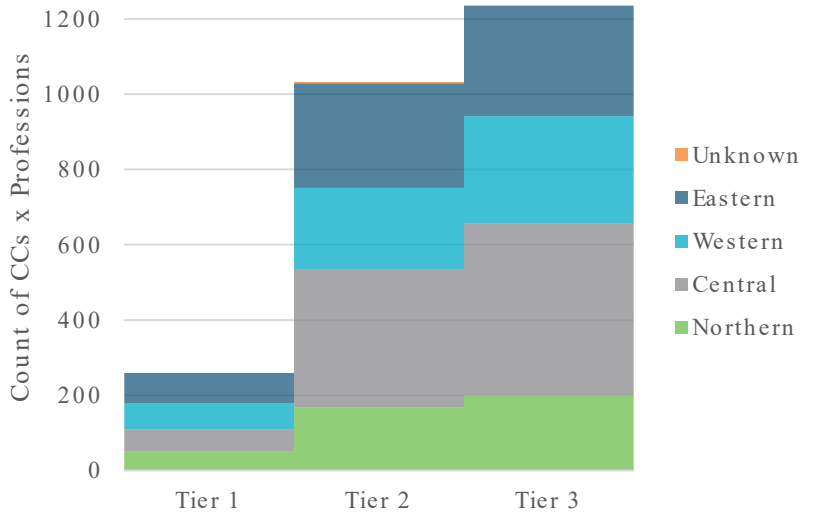

Estimated Cost

We estimated how much the incentive structure would cost, imagining that we paid every current unfilled FTE exactly according to the framework.

The model is flexible; parameters (including the scoring, the cutoff between tiers, and incentive amounts) can be adjusted to meet a given cost target.

	Total cost to fill all 517 current unfilled FTEs		Average incentive per current unfilled FTE	
Profession	5-tier model	3-tier model	5-tier model	3-tier model
RN	$ 1,747,375	$ 2,139,750	$ 1,299	$ 6,931
LPN	$ 411,625	$ 511,750	$ 827	$ 6,878
NP	$ 352,000	$ 364,500	$ 1,299	$ 8,762
MRT	$ 290,000	$ 343,000	$ 1,946	$ 7,384
Respiratory Therapist	$ 169,250	$ 197,000	$ 4,231	$ 9,949
MLT	$ 55,000	$ 85,000	$ 567	$ 5,667
Pharmacist	$ 37,500	$ 56,000	$ 293	$ 5,234
Overall	$ 3,062,750	$ 3,697,000	$ 1,212	$ 7,156

With these parameters:

- Respiratory Therapists would receive the biggest average incentive, and Pharmacists would receive the smallest.
- Programs like Emergency, WZ Operations and NZ Ops; sites like Colchester and most small rural sites would get bigger incentives.
- Programs like Cancer, Population and Public Health, Lab Services, MHA; and most sub-urban sites would have smaller incentives.
- Most of the dollars would go toward RNs.

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Questions & Discussion