Workforce Planning in Mental Health and Learning Disability: Implementation of Bamford Review Recommendations

FINAL REPORT

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1 INTRODUCTION & CONTEXT

1.1 INTRODUCTION

Deloitte MCS Limited was commissioned by the Department of Health Social Services and Public Safety (DHSSPS) to undertake a workforce planning review to support the implementation of the recommendations of the Bamford Review of Mental Health and Learning Disability. There is a commitment at ministerial level to implement the findings of the Bamford Review in an effort to build on mental health and learning disability services in Northern Ireland. This report presents the findings from the review.

1.2 CONTEXT

The Bamford Review of Mental Health and Learning Disability (MHLD) services was the first ever comprehensive investigation of the services, policies and legislation for people with learning disabilities and mental health needs in Northern Ireland. The review was prompted by recent comparable reviews in neighbouring jurisdictions, the need to ensure that law, policy and practice meets human rights and equality laws, and the need to maintain services that meet good practice recommendations. The review was a huge undertaking, involving health and social care professionals, service users and carers, service providers and policy makers from across the MHLD spectrum. Ten reports were published that included examinations of the services available and life opportunities for people with mental health needs (adults, children and young people and older people) and people with learning disabilities. The review highlighted gaps in the current provision of services and the high incidences of mental ill-health experienced in Northern Ireland relative to other parts of the UK. The review envisaged the need for a comprehensive programme of reform and modernisation, and the various reports detail a wide range of recommendations for improving MHLD services and better meeting the needs of their users.

The review concluded formally in 2007 and DHSSPS is now addressing implementation of its recommendations. The successful implementation of the reform of MHLD services will rely on the development of an appropriately sized workforce with the necessary competencies to deliver the services required.

1.3 TERMS OF REFERENCE

The aim of this review was to conduct a workforce planning exercise to provide the Department with a comprehensive assessment of workforce needs to support implementation of the Bamford Review recommendations. The specific terms of reference for this review were as follows:

- To address the main domains in the Bamford review:
  - Adult mental health services;
  - Learning disability services;
  - Child and adolescent mental health services;
  - Dementia and mental health issues in older people;
- To provide detailed analysis of future demand based on provision of services as set out in the Bamford recommendations including:
  - Numbers of each professional group required to meet service demands including areas of new service provision;
  - Skill-mix options in the delivery of services;

- The context within which the skills of various professionals will be delivered and what impact this will have on the workforce;

- Areas of particular difficulty / need and those areas where service development is well underway;

- Provide an analysis of the current multi-disciplinary MHLD workforce in Northern Ireland including:

  - Size, composition, sectoral distribution, age and gender;

  - Working conditions and patterns;

  - Professional area;

  - Specialist service commitments;

- Provide an analysis of current and future recruitment and retention issues including:

  - The different issues applicable to the range of professionals required for the provision of these services;

  - Career development and specialisation issues;

  - Training and professional development issues;

  - Priority areas showing difficulties in recruitment and retention;

  - Geographical issues in supply and demand;

  - Initiatives underway in any professional area or programme of care that specifically relate to MHLD services;

  - Returners; and

  - Working arrangements.

1.4 METHODOLOGY

The approach to the assignment is summarised in the sections below.

Research and Literature Review

Relevant strategic documentation and literature was reviewed to identify the strategic priorities for MHLD and workforce development in health and social services, and current recruitment and retention issues facing the MHLD services / the professional groups that deliver them. This included review and analysis of:

- the reports produced by the Bamford Review;
- recent workforce planning reviews for the staff groups involved;
- the Autistic Spectrum Disorder (ASD) Action Plan;
- information on statutory MHLD workforce available from the Department's Human Resource Management System (HRMS);
- information on the non-statutory MHLD workforce from various sources; and

- documents setting out priorities for MHLD including Priorities for Action, Trust Development Plans and Health and Wellbeing Investment Plans.

Data Collection

A proforma was distributed to key contacts in each of the domain areas as outlined in the Bamford Review across the five Health and Social Care Trusts to gather information on:

- current service model;
- future service model planned;
- the workforce implications of the future service model;
- existing workforce challenges; and
- challenges expected in implementing the future service model.

Workshops

A workshop was undertaken for each of the four main domains of the Bamford review. The primary aim of the workshops was to discuss the recommended models set out in the Bamford reports, explore their workforce implications and gather information about current service development priorities. The workshops involved a range of policy, commissioning and provider representatives from the statutory and non-statutory sectors.

Analysis and Reporting

Information collated through desk research, the data collection exercise and the workshops was analysed to develop recommendations on the priority workforce actions needed to support the implementation of the Bamford recommendations.

1.5 STRUCTURE OF THIS DOCUMENT

This report sets out the findings of the review and is structured as follows:

- Section 2 – baseline analysis of the current MHLD workforce and its existing recruitment and retention challenges;
- Section 3 – description of the Bamford vision for each of the four main domains and analysis of the key workforce implications;
- Section 4 – estimates of the future workforce requirements to inform future resource planning; and
- Section 5 – recommendations for the future workforce actions required to support implementation of the Bamford review.

2 BASELINE WORKFORCE ANALYSIS

2.1 INTRODUCTION

This section presents an analysis of the current MHLD workforce in terms of its size, sectoral distribution, demographic trends and staff group. It also details the key recruitment and retention issues currently facing this workforce.

2.2 DATA SOURCES

The MHLD workforce is made up of a diverse range of staff groups, working across the statutory and independent sectors, in a variety of settings and with a range of client groups. In order to understand this large and diverse workforce, the baseline workforce analysis drew upon the following sources of information:

DHSSPS' Human Resources Management System (HRMS)

All Trusts provide a download of their combined payroll and personnel systems to the Department on a quarterly basis for addition to the HRMS. This download provides a snapshot of all people employed by the Trust at that point in time including information on department / specialty, trust, age, gender and part-time / full-time working.

For the purposes of this review, Departmental statisticians generated a dataset for MHLD staff in the following groups:

- Learning disability nurses and nursing support staff ;
- Learning disability social workers and social work support;
- Mental health nurses and nursing support staff;
- Mental Health social workers and social work support;
- Clinical psychologists and assistant / trainee psychologists;
- Allied health professionals (AHPs) who could be identified as working in MHLD; and
- Medical staff working in MHLD.

It was not possible to identify all of those staff working in MHLD services through HRMS. Where staff groups have been fully transferred over to the new grade titles created under Agenda for Change these codes identify MHLD specialties. This is the case for nursing, social work, clinical psychology and medicine. However where this transfer has not yet happened, specialties must be estimated using department code. For AHPs, only occupational therapy staff could be identified as working within MHLD and for psychologists none were identified on HRMS as working in learning disability. HRMS data did not enable disaggregation of staff into the four Bamford domains. In addition, it is likely that the figures understate the number providing care for older people with dementia and functional mental illness, as this part of the workforce is often managed through the Older People Programme of Care. The statutory dataset compiled from HRMS for this exercise in relation to the MH and LD workforces is described in Section 2.3 below.

Data Returns from Trusts

To support the review, Trusts were asked to complete a proforma for each Bamford domain. The primary objective of the data collection exercise was to inform the review on current service

configuration and planned developments for the future. However, Trusts also provided useful information on their current workforce. This included quantitative data on staff in post across MHLD services and descriptive detail as to the nature of services in place at the Trust and the staff groups involved in providing them. A summary of the information provided is included in Section 2.4.

NICVA Workforce Surveys

The Northern Ireland Council for Voluntary Action (NICVA) conducts annual surveys of the community and voluntary health and social care workforce. The output of the 2007/8 survey has been used as an information source for the current review. The survey is distributed to organisations which define their primary or secondary function as providing mental health or learning disability services. The surveys returned provide an indication of the scale of the voluntary and community sector MHLD workforce. The data is likely to underestimate workforce numbers (not all organisations invited to respond to the survey do so) and cannot be disaggregated into the four main Bamford domains. Workforce estimates from this source are detailed in Section 2.5.

2.3 Statutory Mental Health and Learning Disability Workforce - HRMS

Workforce Composition

Table 2.1 shows the total mental health workforce in the statutory sector based on estimates from HRMS. It indicates that there are approximately 3,461 people working in mental health equating to 3,256.22 Whole Time Equivalents (WTEs). Nursing staff make up the largest proportion of the workforce accounting for just less than three quarters of the mental health staff identified through HRMS. As regards skill-mix, there are large numbers of support staff in the mental health sector:

- in nursing the qualified to unqualified / support ratio is 69:31; and
- In social work the qualified to unqualified / support ratio is 70:30.

Table 2.1
HRMS MH Workforce Figures (Headcount and WTE)

Staff Group	Headcount	WTE
Mental Health Nurse	1,688	1,597.73
Mental Health Nurse Support	771	727.6
Total MH Nurse / Nurse Support	***2,459***	***2325.33***
Clinical Psychologist	214	202.09
Assistant / Trainee Psychologist	47	45.78
Total Psychologist	***261***	***247.87***
Mental Health Social Worker	280	260.89
Mental Health Social Work Support	118	105.1
Total MH Social Worker / Social Worker Support	***398***	***365.99***
Mental Health Occupational Therapist	24	21.5
Mental Health Occupational Therapy Support	16	12.9
Total MH Occupational Therapy	***40***	***34.4***
Consultant	119	106.91
Associate Specialist / Specialist Registrar	117	114.92
Staff Grade	33	28.4
Foundation Doctor	34	32.4
Total MH Medical	***303***	***282.63***
Total Workforce	**3,461**	**3,256.22**

Source: HRMS March 2008 Note: it was not possible to identify all AHPs working in mental health

Table 2.2 shows the total learning disability workforce in the statutory sector based on estimates from HRMS. It indicates that there are approximately 2,139 people working in learning disability or 1,881.71 WTEs. The majority of staff identified on HRMS are in nursing or social work – these groups account for just under 99 per cent of the identified learning disability workforce. The number of nursing and social work support staff outweighs the number of qualified learning disability nurses and social workers:

- in nursing, the qualified to unqualified / support ratio is 50:50; and
- in social work the qualified to unqualified / support ratio is 23:77.

Table 2.2
HRMS LD Workforce Figures (Headcount and WTE)

Staff Group	Headcount	WTE
Learning Disability Nurse	455	416.15
Learning Disability Nurse Support	456	413.41
Total LD Nurse / Nurse Support	***911***	***829.56***
Learning Disability Social Worker	281	250.44
Learning Disability Social Work Support	920	776.72
Total LD Social Worker / Social Worker Support	***1,201***	***1,027.16***
Learning Disability Consultant	10	8.9
Learning Disability Associate Specialist / Specialist Registrar	17	16.09
Total LD Medical	***27***	***24.99***
Total Workforce	**2,139**	**1,881.71**

Source: HRMS March 2008 Note: it was not possible to identify AHPs working in learning disability

Table 2.3 overleaf provides a breakdown of the age, gender and working pattern (i.e. full / part-time) of the staff groups identified as working in statutory MHLD services. Key trends are as follows:

- Gender - across all staff groups, the workforce is predominantly (at least 70 per cent) female, with the exception of the medical workforce which is just under 60 per cent female. The proportion of female staff is particularly high in learning disability, with up to 85 per cent of social workers, social work support staff and nurses being female. In mental health, the assistant / trainee clinical psychology staff are almost entirely female (96 per cent). Of all of the staff groups identified, the medical staff in LD and the clinical psychology group are the youngest. Only 16 per cent of qualified psychologists are aged over 50 and more than half of the assistant / trainee psychology group is aged between 25 and 29;

- Age – many of those working in MHLD services are eligible to retire at age 55 and across all staff groups with exception of clinical psychology and medical staff, more than a fifth of each group is aged over 50. Within learning disability, 28 per cent of social work support staff are aged over 50 and 12 per cent are aged over 55. Within mental health, 22 per cent of social workers are aged over 50 and at least 7 per cent are aged over 55. Only 4 per cent of the medical workforce is aged over 55. Across the workforce, a considerable proportion of staff will become eligible to retire within the next five to ten years and many are already eligible to retire. This presents a significant risk in terms of succession planning and retention of knowledge and experience; and

- Working Pattern - the learning disability social work support staff group is the only group where the proportion of part-time workers (56 per cent) outweighs that of full-time workers (44 per cent). Part-time working is least common in mental health nursing and nursing support and medical staff working within learning disability, with fewer than one in five taking this option. In the other staff groups, between 19 and 32 per cent of staff work on a part-time basis.

Table 2.3
HRMS Workforce – MH and LD Staff Groups by Age, Gender and Working Pattern (Headcount)

		Mental Health (%)							Learning Disability (%)				
		Medical Staff (all grades)	Nurse	Nurse Support	Social Worker	Social Worker Support	Clinical Psychologist	Assistant / Trainee Psychologist	Medical Staff (all grades)	Nurse	Nurse Support	Social Worker	Social Worker Support
Age	25 and under	-	2	10	-	5	-	23	0	2	12	0	7
	25 - 29	28	8	11	8	7	16	51	22	12	9	7	13
	30 - 34	22	10	11	10	11	20	-	-	11	9	11	15
	35 - 39	13	13	15	22	14	21	--	26	14	11	16	16
	40 - 44	11	21	14	20	14	14	0	-	18	13	18	15
	45 - 49	11	22	18	15	8	9	-	-	20	18	19	13
	50 - 54	9	16	13	15	19	10	-	-	14	13	15	11
	55 - 59	4	6	5	7	15	6	-	-	7	9	8	7
	60 - 64	-	1	3	-	7	-	-	0	4	5	5	3
	65+	-	1	-	-	0	-	-	0	-	-	-	1
	Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Gender	Female	58	73	73	74	82	71	96	63	85	77	75	84
	Male	42	27	27	26	18	29	4	37	15	23	25	16
	Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Work Pattern	Part time	18	17	19	22	32	21	6	19	28	27	32	56
	Full time	82	83	81	78	68	79	94	81	72	73	68	44
	Total	**100**	**100**	**100**	**100**	**100**	**100**	**100-**	**100**	**100**	**100**	**100**	**100**
Total Headcount		**303**	**1,688**	**771**	**280**	**118**	**214**	**47**	**27**	**455**	**456**	**281**	**920**

Source HRMS March 2008.

Notes: Figures exclude bank staff and staff with a WTE of less than or equal to 0.03. A dash (-) represents percentages based on fewer than 6 people. Percentages may not sum to 100 due to rounding.

Workforce Distribution by Trust

Table 2.4 outlines the headcount information for those staff groups identified as working in statutory MHLD services across the five HSC Trusts. Information was not available at this level for AHPs working in MHLD. It illustrates that BHSCT has the biggest MHLD workforce and SEHSCT has the smallest. Tables detailing the age and gender breakdown of staff by Trust are included in Appendix I and II. Staff group totals in Table 2.4, and those in Appendices I and II differ due to cell counts of less than six (represented by a dash '-').

Table 2.4
HRMS Workforce – MH and LD Staff Groups by HSC Trust (Headcount)

	HSC Trust	Medical	Nurse	Nurse Support	Social Work	Social Work Support	Psychologist	Assistant Psychologist	Trainee	Total HSC Staff
Mental Health	BHSCT	100	431	223	63	36	76	13		942
	NHSCT	71	338	156	67	67	35	10		744
	WHSCT	47	427	183	56	-	22	7		742
	SHSCT	45	282	133	42	9	20	-		531
	SEHSCT	40	210	76	52	-	27	13		418
	Total	**303**	**1,688**	**771**	**280**	**118**	**180***	**47**		**3,387**
Learning Disability	BHSCT	17	202	243	54	308	*Data not available*			824
	NHSCT	0	20	0	34	298				352
	WHSCT	-	59	77	98	41				275
	SHSCT	6	125	115	38	167				451
	SEHSCT	0	49	21	57	106				233
	Total	**27**	**455**	**456**	**281**	**920**				**2,139**

Source HRMS March 2008

Notes: Figures exclude bank staff and staff with a WTE of less than or equal to 0.03. A dash (-) represents cell counts of fewer than 6 people. *An additional 34 Clinical Psychologists work in Regional Services.

Workforce Turnover

Tables 2.5, 2.6 and 2.7 detail information available from HRMS on MHLD staff who have joined, left or moved within the statutory health and social care system in 2007/8. Overall, the information indicates a relatively stable workforce, with areas of growth. This suggests that despite the aging population within the MHLD workforce, many are choosing not to take up the option of early retirement. Across the Northern Ireland Trusts in the period September 2007 to end of March 2008, turnover averaged 10.4 per cent (calculated on the basis of movers and leavers as a percentage of staff in post) and turnover rates for the various staff groups in MHLD services are considerably below this level based on the information available. It should be noted that this is inconsistent with the views of stakeholders consulting during the review (see Section 2.6) who reported a high degree of turnover in some areas.

The data captured from HMRS in relation to movers only records those individuals who move between trusts, not within, therefore those individuals who move post or are promoted to a new role within a trust are not recorded in HRMS. In addition, the total figures for leavers, movers and joiners are calculated by comparing staff level information from the same time of year, one year apart, and calculating the difference.

Table 2.5
Nursing Staff - Leavers, Movers, Joiners (Headcount)

	Leavers	Movers	Joiners	Staff Turnover (%)
Mental Health				
Nurse	83	17	91	**5.9**
Support Nurse	31	-	57	**4.3**
Learning Disability				
Nurse	25	-	17	**6.2**
Support Nurse	25	-	26	**5.9**

Source: HRMS March 2008

Table 2.5 shows a reasonable degree of movement in the mental health nursing workforce but net differences are small - at year end there were eight more mental health nurses in the system and fifteen more mental health support workers. In learning disability nursing there is also evidence of substantial movement, with an indication of a reduction in the workforce - there were 8 fewer learning disability nurses in the system at the end of the year than at the beginning. The data indicates that staff turnover across the nursing and nurse support workforces is below that of the Trust average of 10.5 per cent.

Table 2.6
Social Work Staff - Leavers, Movers, Joiners (Headcount)

	Leavers	Movers	Joiners	Staff Turnover
Mental Health				
Social Worker	9	0	14	**3.2**
Social Work Support	-	0	15	**-**
Learning Disability				
Social Worker	5	0	6	**1.8**
Social Work Support	12	-	73	**1.5**

Source: HRMS (March 2008)

Table 2.6 indicates there has been more limited movement within social work / social work support parts of the MHLD workforce compared with nursing – there were no recorded movements in three of the staff groups indicating a high degree of workforce stability. Across mental health and learning disability, the large social work support staff groups saw a net growth (by 15 and 61 people respectively). Staff turnover across the social work and social work support workforces is below that of the Trust average of 10.5 per cent.

Table 2.7
Clinical Psychology Staff - Leavers, Movers, Joiners (Headcount)

	Leavers	Movers	Joiners	Staff Turnover
Mental Health				
Clinical Psychologists	8	7	13	**7**
Trainee/Assistant Psychologist	12	22	7	**72.3**

Source: HRMS (March 2008)

Table 2.7 shows that slightly more clinical psychologists working in mental health joined than left in 2007/8 but there was limited movement within the staff group overall. There was greater movement in the trainee / assistant psychology group, probably reflecting movement into qualified posts among trainees and the often temporary nature of assistant posts. This is reflected in the turnover percentage of 72.3, which is significantly higher than that of the Trust average of 10.5 per cent. Staff turnover in relation to the clinical psychology workforce is below that of the Trust average of 10.5 per cent.

2.4 Statutory Mental Health and Learning Disability Workforce - HSC Trust Data Returns

All five Trusts supported this review by providing information on their MHLD service provision. The primary aim of the data collection exercise was to collate information on current service configurations across the different Bamford domains. Trusts provided a variety of quantitative and descriptive information that adds value to the HRMS workforce data by providing information on the

various settings within which these staff work. Tables with full details of the information provided by the Trusts can be found in Appendix III and the sections below provide summaries by domain.

Learning Disability Service Provision

Trust returns indicated that a total of 2,259 WTE staff from across a range of disciplines work in learning disability services with the majority working as support workers in day care service provision. Approximately two-thirds work in hospital settings, with the remainder working in community teams.

Adult Mental Health Service Provision

Approximately 2,640 WTE staff from across a range of disciplines work in adult mental health (AMH) services. More than half of these staff work in hospital services with the remainder in community mental health teams.

Child and Adolescent Mental Health Service Provision

The CAMHS workforce is much smaller, with a total of 299 WTE staff reported by the Trusts. The majority of staff work within supported living services in the community or in hospital services, and a small number within community mental health teams.

Older People's Mental Health and Dementia Services

Three HSC Trusts completed a data return for this domain and in total the returns accounted for 330 WTE. It is possible that the low numbers of staff reported by the Trusts is due to some of the staff residing within the elderly programme of care rather than mental health. Based on this limited information, the majority of staff work in hospital services and residential accommodation.

2.5 THE NON-STATUTORY MHLD WORKFORCE

The 2007/8 NICVA survey of the community and voluntary health and social care workforce provides information on staff groups within the sector and broad service area.

Mental Health

The NICVA research highlights that there is an estimated MH workforce of 26,000 in the community and voluntary sector. In total, 80 organisations responding to the NICVA survey stated their primary or secondary beneficiaries to be people with mental health needs:

- The 80 organisations employ a total headcount of 1,685 staff;
- 78% of these staff are female; and
- 30% of all posts are part-time.

Learning Disability

Of the organisations responding to the NICVA survey, 64 stated their primary or secondary beneficiaries to be people with a learning disability:

- The 64 organisations employ a total headcount of 2,685 staff;
- 74% of these staff are female;
- 36% of all posts are part-time.

The workforce information supplied by NICVA indicates that a total number of 4,370 staff in the community and voluntary sector provide services to individuals with MH and LD needs.

Additional information from NICVA sources indicates that in the voluntary and community sector as a whole, the following professional HSC staff are employed:

- Nurses – 1,100;
- Health care assistants – 577;
- Doctors – 27;
- AHPs – 194; and
- Social workers – 1,500.

2.6 Recruitment and Retention Issues

Recruitment and retention are two of the main issues to be addressed as the transfer of MHLD services from hospitals to community based care is considered.

Key themes Identified by Trusts

- **Competing for Staff**
  - There is significant competition between Trusts to attract new graduates. In relation to nursing in 2008/9, there are 117 funded training places for MH nursing and 30 for LD nursing, and many of the Trusts involved in this review reported that the competition between Trusts to successfully attract these graduates often makes it difficult to ensure continued inflow into the workforce;
  - High average attrition rate for MH and LD pre-registration nursing courses of 25 per cent – this is some nine percentage points higher than the average for adult nursing (16%);
  - Competition with the voluntary, community and private sector for qualified and experienced MHLD staff;
  - Higher than average vacancy rates in MH and LD nursing. A research study completed for DHSSPS (by Moira Davren) compared nursing staff in post to funded establishment for MH and LD services. It found that approximately 13% of funded posts were vacant. The average vacancy rate for general nursing posts is 1.9%, substantially lower than MH and LD nursing; and
  - Competition for potential support staff - other employers offer job opportunities perceived to be less challenging and stressful than MHLD jobs, but with similar terms and conditions e.g. the retail sector.
- **Perception of MHLD Roles**
  - Attrition from pre-registration training and turnover among support staff is attributed to students and staff finding roles much more challenging than expected – there is a need to clearly illustrate to trainees and potential recruits what working in the MHLD sector involves; and
  - Scope for development of new services is also limited by difficulties in recruiting staff.
- **Career Pathways**
  - Lack of clear career pathway and commitment to continuing professional development impacts on recruitment and retention in the sector;

- **Challenging Nature of the Job**

  - Challenge of working with clients with challenging behaviour and working in small community-based units which do not have the same support structures for staff as hospital settings;

  - Professional isolation of staff working in smaller units in disparate locations across Trusts puts a large amount of pressure on these staff members; and

  - Long-term vacancies can pressurise existing staff and impact on retention.

- **Age of the Workforce**

  - A proportion of the workforce is eligible for retirement at 55 – loss of experience could lead to difficulties in service re-design and provision.

3 IMPLEMENTING THE BAMFORD VISION

3.1 INTRODUCTION

This section sets out the separate visions for each of Bamford's four main domains: adult mental health; older people; child and adolescent mental health; and learning disability. A summary of the key changes that will result from the implementation of the Bamford Review is outlined below. The analysis was informed by discussions with stakeholders from each domain through a series of workshops.

3.2 OVERARCHING BAMFORD VISION AND PRINCIPLES

The Bamford vision is for people with a learning disability or mental health need and their carers to have access to responsive services that respect their individual autonomy and that demonstrate justice and fairness. The key principles are set out below.

Key Principles of Bamford Review

Partnership with users and carers in the development, evaluation and monitoring of services;

Partnership with users in the individual assessment process, and in the development of their programme of treatment and care and support;

Delivery of high quality, effective treatment, care and support;

Provision of services which are readily accessible;

Delivery of continuity of care and support for as long as is needed;

Provision of a comprehensive and co-ordinated range of services and accommodation based on individual needs;

Take account of the needs and views of carers, where appropriate, in relation to assessment, treatment, care and support;

Provision of comprehensive and equitable advocacy support, where required or requested;

Promotion of independence, self-esteem and social interaction through choice of services and opportunities for meaningful employment;

Promotion of safety of service users, carers, providers and members of the public;

Staff are provided with the necessary education, training and support; and

Services are subject to quality control, informed by the evidence.

3.3 ADULT MENTAL HEALTH

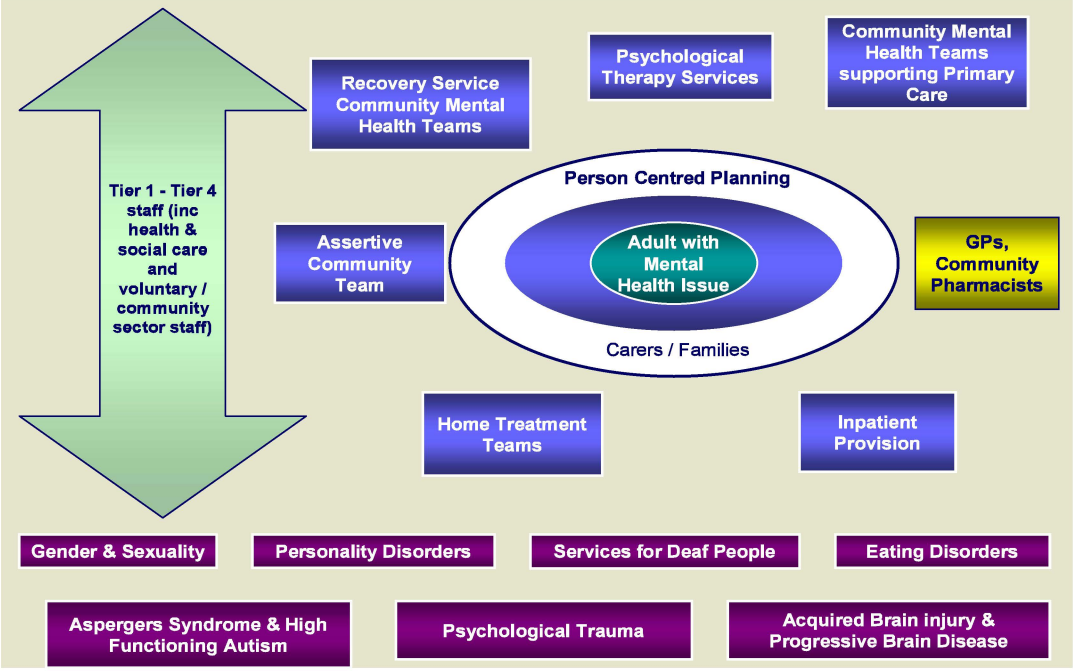
This section describes the vision for adult mental health (AMH) services and discusses the changes required and their workforce implications.

3.3.1 Vision for Adult Mental Health Services

Figure 3.1 illustrates the AMH service model set out in the Bamford Review. Key aspects of the model are:

- A person-centred approach;
- Provision of service in a variety of community and in-patient settings;
- Service provision by multi-disciplinary teams working effectively across tiers of service;
- Provision of service in conjunction with an individual's family and carers; and
- Service provision through the statutory, voluntary and community sectors working together.

Figure 3.1
Bamford's AMH Service Model



3.3.2 Workforce Implications

The workforce implications for AMH services can be separated into the following four areas:

1. New roles;
2. Model service configuration;
3. New / Extended Services; and
4. Specialist services.

1. New Roles

(i) Link Worker

Bamford recommended that all primary care teams should have access to a named mental health professional, a Link Worker. The Link Workers role would be to provide timely, appropriate and accessible assessment and management of people with mental health problems providing a link between primary care and secondary care for adults with mental health issues.

Key Points
Where the Link Worker role has been established it has been filled by a nurse or social worker, however it is apparent that other health care professionals could be appointed to this role. There is lack of consensus in terms of where this role should be located i.e. within primary care or within secondary care.

(ii) Support, Time and Recovery Worker

It is anticipated that the new Support, Time and Recovery Worker (STRW) role will play a key part in recovery services. Developed by the NHS, responsibilities of the role include:

- promoting independent living;
- providing companionship and friendship;
- providing regular and practical support;
- providing support with daily living;
- facilitating people living "ordinary lives";
- helping the service user to gain access to resources;
- providing information on health promotion;
- helping to identify early signs of relapse; and
- supporting service users with involvement/participation with their treatment.

Key Points
The STRW role has mostly been developed in the independent sector in England, and is largely provided by existing and former service users. Clarification of the role, who might fill it, training requirements and career pathway have to be considered for NI. Current and former service users could be recruited into this role, and there is scope for it to be developed and managed within the voluntary and community sectors.

2. Model Service Configuration

(i) Community Mental Health Teams (CMHT) Supporting Primary Care

Bamford recommended that each HSCT should have a CMHT providing services for relatively short term mental health issues such as anxiety or trauma. These teams would require access to a comprehensive range of community resources, both statutory and independent sector. They should have a multidisciplinary mix of staff including nursing, social work, psychology, and medical to enable them to provide a broad range of skills and therapeutic interventions.

The introduction of the stepped care model will result in new ways of working for CMHTs and there will be an increased role for the independent sector and service users to support the delivery of services. CMHTs should operate across the Tiers. The points below summarise the four tiers in the stepped care model:

Tier One: Primary Care - *Services users with mild up to moderate mental health needs*. Services will be provided by local General Practice and or voluntary and community sector. This Tier includes early intervention, mental health promotion and screening for Tier two services.

Tier Two: Screening and Assessment Service – *Service users with moderate mental health needs.* The Gateway team will assess and either treat or signpost and refer to appropriate service.

Tier Three: Secondary Care – *Service users with moderate to severe, acute and chronic mental health needs*. This tier will provide acute services for in-patients, outpatients, day hospitals and home treatment.

Tier Four Specialist Services – *Service users with severe, complex. Atypical and recurrent mental health needs*. It involves referrals to specialist in-patient services, forensic, eating disorder, and addiction services.

A new Psychological Therapist role will be developed within CMHTs and Tier 2 services will be delivered to individuals with specific mental health issues in areas such as: psychological trauma; eating disorder; personality disorder; disorders of gender or sexuality; women with perinatal mental health problems; and deaf people with mental health problems. This will have a significant training implication.

Key Points

CMHTs operate in all Trusts but a consistent service model does not exist and they are each at various stages of developing the teams. CMHT resources are directed towards those with more complex mental health needs (Tier 3-4), as opposed to those with shorter-term mild to moderate needs (Tier 1-2).

In line with the PSA target to reduce hospital admissions, staff are being redeployed from acute to community settings. Stakeholders consider it unlikely that the redeployed staff will be sufficient to fulfil the Bamford vision and highlight the risk of attrition during the redeployment phase.

Key enablers for CMHTs to support Primary Care Services in line with Bamford's recommendation are: having sufficient community infrastructure; having regional direction regarding the CMHT model; reviewing the competencies required by staff to support Primary Care; and developing a learning and development framework to ensure that an effective skill mix is provided by the teams.

(ii) Recovery Service CMHTs

Bamford recommends that Recovery Service CMHTs are required by people with enduring and recurring mental disorder who require care in the longer term. Bamford recommended that these teams should be multidisciplinary and should include nursing, social work, occupational therapy, speech therapy, physiotherapy, medical and user participation. These teams should provide Tier 2 support for the mental health needs of people with brain disease and injury, Autistic Spectrum Disorder (ASD), also services for people with challenging behaviour, dual diagnosis, first episode of psychosis and mild learning disability. The teams should work closely with Home Treatment teams and Assertive Community Treatment teams (both of these teams are discussed at later stages in this section).

Demand for recovery services is increasing from Primary Care Teams and in supported living settings. Recovery should form a significant part of the CMHTs' role and is a key means of preventing admission to hospital. Mental health services are struggling to respond. In practice some but not all of the Trusts have established separate Recovery Service CMHTs, however, recovery services are being supported by Community and Project Workers operating in the voluntary and community sectors. Further development of this service will rely on the appropriate infrastructure being in place.

Key points:
- Separate Recovery Service CMHTs have not been established in all HSCTs but each Trust is delivering recovery services through their CMHT as opposed to a dedicated team;
- Demand for these services is increasing, particularly as a result of the resettlement of inpatients, reducing hospital admissions and the aim of delivering more mental health services in the community;
- Infrastructure will be required to support the delivery of recovery services;
- An increased number of staff from the following disciplines will be required to provide Recovery Services: Nursing, Social Work, Occupational Therapy, Speech Therapy, Physiotherapy, and Medical.

(iii) Home Treatment Teams

Home Treatment teams are designed to provide services on a 24/7 basis as an alternative to inpatient hospital treatment, enabling service users with the greatest vulnerability to be maintained more successfully in community settings. Bamford recommends that these teams have a gate-keeping function to other services, and ensure continuity of care between Recovery CMHTs and inpatient services, enabling a more home-based approach to community service provision.

Investment received by the Trusts to provide an out of hours service has been used in different ways with some having a Crisis Response Team to provide services when CMHTs are not working, and other Trusts having a dedicated Home Treatment Team. There was consensus that out of hours Crisis Response Teams are required but concerns were raised that establishing specific teams could result in staff leaving CMHTs to work in these teams.

Key points:
- The definition of "Home Treatment" and the relationship between Home Treatment, Crisis Response, and CMHTs requires clarification;
- Consistent services should be available within each Trust area appropriate to the population need;
- The service is envisaged to be provided by nurses and more nurses will be required to deliver out of hours services;
- There is potential to utilise the NVQ in "Direct Care" in relation to CMHT and an e-learning package already exists.

(iv) Psychological Therapy Services

Bamford recommended that a range of Psychological Therapy services should be developed in Northern Ireland. It further envisaged development of a single unit from which support, supervision and training can be provided for all CMHT staff.

The provision of a 'basket' of psychological therapy services is a priority for all Trusts as it forms one of their PSA targets.

The Department's draft Strategy for the Development of Psychological Therapy Services recommends

- the implementation of the recommendations set out in the Review of Psychology Workforce (2008);
- a consortium of stakeholders be commissioned to agree a regional approach to undergraduate and post graduate training to meet the needs of a stepped care model for the delivery of psychological therapy services;
- a supervisory framework be developed for the competencies and accreditation required by supervisors at the different level of intervention.

The emphasis is to deliver the majority of services at Primary Care level to provide prevention and early intervention thereby reducing demand for higher level specialist services. Psychological Therapists will also work in new ways and in new settings in support of the move to deliver services in community settings.

Key points:
- There is a need for additional staff to be recruited and trained as psychological therapists and for a supervision and career progression pathway to be defined;
- Roles need to be clearly defined in line with the Stepped Care Model / the regional working group's recommendations; and
- New ways of working will result from the increasing role that will be played by Psychological Therapists in the mental health area and this will impact a range of different mental health professionals working with Psychological Therapists.

3. New / Extended Services

(i) Out of Hours AMH Service

The Review recommended that access to out-of-hours mental health services should be prioritised according to clinical need and should comprise face-to-face contact and telephone advice.

Undoubtedly additional staff will be required to provide these services as flexible working practices are implemented (e.g. new rotas). Trusts are currently introducing out of hours working to some services. It is anticipated that in the future this service may be linked to the Crisis Response Service and Home Treatment Teams and although 24 / 7 cover will be provided it will not be a separate service in itself.

(ii) Liaison Mental Health Service

Bamford recommended development of an enhanced service providing access to mental health services for those people presenting in hospitals. This would be a multi-disciplinary team consisting of a liaison nurse, social worker, clinical psychologist, psychiatric trainee and consultant psychiatrist.

This service is being progressed to different degrees in the Trusts.

(iii) Assertive Community Treatment Teams

Bamford recommended that Assertive Community Treatment Teams should be established to maintain service users with the greatest vulnerability in community settings, as an alternative to inpatient hospital treatment. It was recommended that these teams should be linked closely to the Recovery Service Teams.

These are high cost low volume services and it is not believed to be economical to establish specific teams to deliver the services. Clarification is required on whether separate Assertive Community Treatment Teams will be established or alternatively, how this service could be provided through the Recovery Service, CMHTs or Home Treatment Teams.

(iv) For people with Challenging Behaviour

Within AMH, the term 'challenging behaviour' refers to "people who are suffering from a serious mental illness, for example schizophrenia or sequelae of head injury and who, in addition to severe and often persistent symptomatology, show a range of behavioural problems, such as aggression, violence, repeated self-harm, extreme self-neglect, fire-setting or inappropriate sexual behaviour". Bamford recommends that community mental health services should be equipped to support people with challenging behaviour, and that there should be specialist accommodation with appropriately skilled staff and local intensive care.

This service will require infrastructure within the community including accommodation and also appropriately trained staff to deliver services.

4. Specialist Services

Bamford made several recommendations regarding specialist services in the area of AMH, operating at Tier 3 and in some cases on a regional as opposed to on a local basis.

(i) For People with a Personality Disorder

Bamford recommended that residential and day treatment services for people with personality disorders should be established in Northern Ireland and that specialist multidisciplinary teams should be established to provide assessment, education and support to other services that may come into contact with people with personality disorders. The Review recommended that this service should co-ordinate with other mental health services such as forensic services, substance misuse and with learning disability services, and that awareness training of the needs of those with personality disorders should be provided for such services as primary care, A&E, and perinatal services, and to medical and surgical staff.

A regional group has developed proposals for mental health services for people with a personality disorder and the recommendations of this group will have workforce implications. The proposals, which are currently the subject of stakeholder consultation, are for the development of community-based teams along a hub and spoke model to provide psychotherapeutic care, supervision, liaison, training and support across all Trust areas.

Key Points:
Proposals for personality disorder services will necessitate:

- awareness training for HSC staff;
- further training for more specialist staff;
- approximately 50 additional staff in the short term; and
- development of role descriptions, management structures, and career pathways for the proposed new service.

(ii) For People with an Eating Disorder

Bamford recommended that a regional Tier 3 team should be developed in each Board area to deliver specialist services to people with an eating disorder. These Tier 3 professionals would support Tier 1 and Tier 2 through training, supervision and shared care arrangements. The Review also identified the potential for a Tier 4 service in the longer term at regional level (providing specialist day patient and inpatient services).

A regional strategy for the development of eating disorder services was agreed a few years ago and is broadly in line with Bamford. To date developments have focussed on establishing multidisciplinary (including Medical, Nursing and Psychological Therapy staff) community-based Tier 3 eating disorder services for both adults and younger people. Currently there are 18 WTE staff working in the adult teams, with the Belfast Trust team providing a regional service for more complex cases. Plans are now in place

to designate one medical inpatient bed in each Trust for treatment of those who need to be admitted for refeeding. 'In-reach' to these patients will be provided by the Tier 3 teams.

Key points:
- Recruitment of staff (including Psychotherapists) to provide day support and suitable training provided;
- Specialist training required for staff working in all settings; and
- Career plans and role descriptions developed for all staff in the service.

(iii) For People with Brain Injury

Bamford recommended that there should be development of Community Brain Injury Teams throughout Northern Ireland and identified the need for a specialist regional mental health team to offer expertise in the assessment, diagnosis, treatment and management of mental health problems in acquired brain injury and progressive brain disease.

The main Neurbehavioural Unit is located in BHSCT and provides short-term admissions for assessment, slow stream rehabilitation/recovery and long-term care for those whose behaviour cannot be met in other settings. A multidisciplinary approach is delivered in the Unit. Bamford recommended that this should be developed as a regional specialist service.

Key points
- Although this service does not sit within the mental health programme of care it is likely to require mental health professionals; and
- The workforce implications should be reviewed and addressed following the brain injury service review.

(iv) For Deaf People with Mental Health Needs

Bamford recommended that a new service be established for deaf people with mental health needs i.e. community mental health services linked to other agencies, day services, and out of hours services.

Demand for this service is small and work is being undertaken on an all Ireland basis to consider workforce requirements and delivering a cross border service.

(v) For People with Psychological Trauma

Bamford identified the need for training for primary care staff (and other front line services) in the detection, preliminary intervention and appropriate referral of people with trauma-related needs. The Review also recommended that pre professional training should be given to all HSC professions regarding the conceptualisation, recognition and treatment (including referral) of psychological trauma, with advanced training required for the treatment of Post Traumatic Stress Disorder.

Key points
- The workforce implications resulting from the provision of services to people with psychological trauma should be identified and addressed in line with the Psychological Therapies Strategy.

(vi) For Women with Perinatal Mental Health Problems

The Review recommended that a regional specialist mental health service for women with mental health problems occurring in the perinatal period be established and that all women with a past history of serious non-postpartum mental disorder should be offered assessment by a psychiatrist in the antenatal period.

Work on the development of a specialist regional service is progressing which will potentially identify further new roles to form part of a specialist multidisciplinary team.

The Department has endorsed 2007 NICE clinical guidance on antenatal and postnatal mental health.

Key points
- New dual qualified midwife and mental health nurse role has been developed;
- Career path for the role needs to be developed;
- Any further workforce implications should be identified following the completion of work to develop the regional service. This will include examining required competencies and appropriate training
- Development of a learning and development framework to ensure that an effective skill mix is provided by the team;

(vii) For people with Asperger's Syndrome or High Functioning Autism (AS / HFA)

Bamford recommended the development of multidisciplinary Asperger's Syndrome / High Functioning Autism Teams for each Trust area to deliver:

- specialist assessment services (Tier 3) providing clear pathways and access to services;
- clear referral pathways to mainstream services (Tiers 1 and 2); and
- appropriately trained specialists (Tier 3) to provide specialist interventions.

A review is currently being undertaken to examine where this service should be located. Workforce implications will result from the outputs of a separate ongoing review into the service.

(viii) For People with Disorders of Gender and Sexuality

Bamford recommended that local and community based services are required for People with Disorders of Gender and Sexuality, with appropriate access to regional specialist services, and that the workforce and training requirements should be analysed.

Key points
- It is anticipated that new roles and additional staff will be required to deliver this service; and
- The delivery of the service will have a training implication.

3.4 Older People's Mental Health

This section describes the Bamford vision for older people's MH services and discusses the workforce implications that will result from the implementation of Bamford's recommendations. Note that this covers functional mental illness (FMI) and dementia, and services are variously organised into Elderly and MH Programmes of Care.

3.4.1 Vision for Older People's Mental Health Services

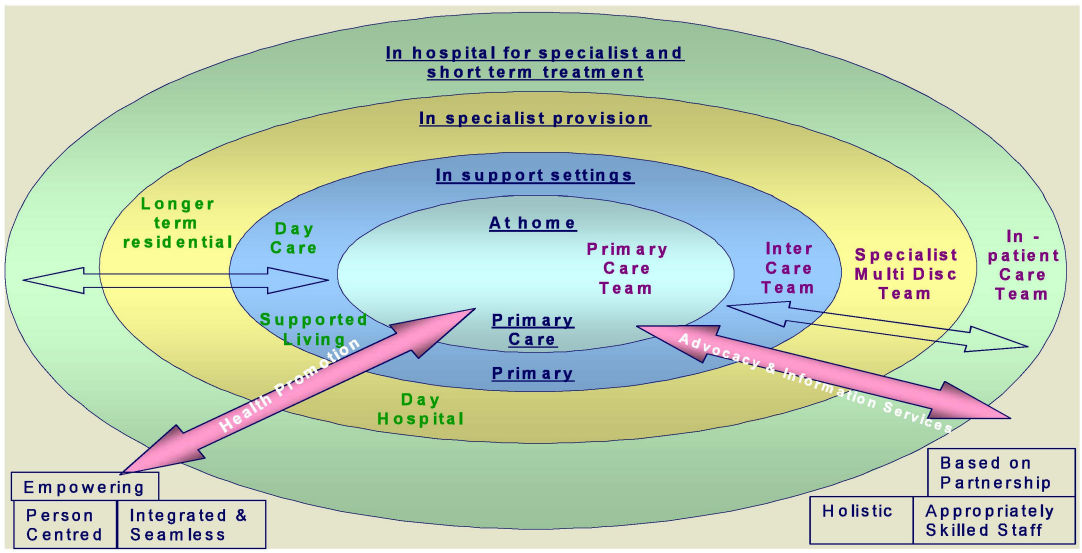
Figure 3.2 illustrates the older people's services model as set out in the Bamford Review. The vision for older people's mental health services depicts a model that operates in various settings and provides a range of services at varying degrees of specialism.

It has been developed based on a number of principles aimed to design services that:

- Respect individual autonomy and are person-centred;
- Demonstrate fairness and justice – transparent allocation and management of resources;
- Involve users and carers in their development, evaluation and monitoring;
- Provide high quality, effective treatment, care and support;
- Are readily accessible;
- Deliver continuity of care and support for as long as is needed;
- Are developed to provide a comprehensive and co-ordinated range of services and accommodation based on individual needs;
- Provide comprehensive and equitable advocacy support, where required or requested;
- Promote independence, self-esteem and social interaction through choice of services and opportunities for meaningful employment;
- Promote safety of service users, carers, providers and members of the public;
- Provide staff with the necessary education, training and support; and
- Are informed by best practice.

Figure 3.2

Bamford's Older People's Services Model



3.4.2 Workforce Implications

The workforce implications for Older People services relate to three main areas:

1. Primary Care and Community Care;
2. Intermediate, Specialist and In-Patient Care; and
3. Special Groups.

1. Primary Care and Community Care

(i) Support for people with acute mental health illness, Crisis Response and Home Treatment

Bamford recommended that support for older people with acute mental illness should be available 24 hours a day, 7 days a week, and that Crisis / Home Treatment Teams should be developed in a similar manner to that for younger people. The Review also recommended that crisis / rapid response services should be developed to include older people with functional mental illness and dementia and be sensitised to their needs.

The manner in which Crisis, Rapid Response, and Home Treatment Services have been configured varies considerably across the Trusts with some having developed a Crisis Response Service for all people with mental health issues, some having a home treatment service for people with FMI but not dementia (dementia cases are signposted elsewhere), some having a Crisis Response and Home Treatment Services combined, another using AMH out of hours service for older people, and another using its Older People Mental Health Team to deliver home treatment.

Key points:

- These services need to be considered on a Northern Ireland wide basis to produce consistencies in approaches and the terminology used. Following this the workforce implications need to be reviewed.

(ii) Specialist domiciliary care services

The Review recommended that Specialist Domiciliary Care Services should be developed for older people with mental health issues and that they should be available over a 24-hour period, assisted by multi-disciplinary Crisis/ Rapid Response.

With the increased focus on supporting people to live at home as opposed to entering residential care facilities an increased number of Domiciliary Care Staff will be required that have been trained in the mental health needs of older people.

(iii) Restraint free / minimal restraint care

Bamford recommended that restraint free / minimal restraint care should be built into organisational structures.

The fulfilment of this recommendation will require training across all grades of staff in the statutory and independent sectors.

(iv) Models of day-time support

Bamford recommended that models of day time support should be developed and particular attention paid to meeting the needs of people in rural settings.

Support may be provided in a variety of settings including day hospitals, day centres, and other community settings. It is anticipated this will require additional nursing and social care staff. Much of this support may be provided by the non-statutory sector and it is anticipated that additional volunteers will also be required.

2. Intermediate, Specialist and In-Patient Care

(i) Respite care

The Review recommended that a range of respite models should be delivered. These services should be provided locally, and be flexible, responsive and of benefit to older people with mental health issues and their carers.

Funding has been committed to develop respite services over the coming years and Trusts have included this within their Development Plans. It is anticipated that progress will be dependent on the availability of appropriate infrastructure. The Department is currently undertaking a piece of work to review respite services and the findings from the review should be taken into consideration before any firm conclusions are drawn on staffing implications.

(ii) Challenging behaviour

Bamford recommended that interim care facilities, that are appropriately staffed and funded, should be developed to provide support for older people with challenging behaviours.

Progress varies across Trusts and some are engaging private sector care homes as a means of providing this support. It is envisaged that this service will require additional specialist challenging behaviour nurses, psychologists, and nursing care staff. The workforce implications should be assessed once plans for service delivery are fully developed.

(iii) Palliative care

The review recommended that an approach for people with advanced dementia should be rolled out to all care settings.

Trusts are currently developing their own specific plans in this regard. One Trust is planning to implement the Liverpool Care Pathway for the Dying Patient (LCP). New approaches will have a training implication for staff working in care homes and palliative care teams. It is also expected that GPs and consultants will need to be educated in this area.

(iv) Intermediate Care

The Review recommended that older people with mental health needs should have access to suitable intermediate care services, and that specialist teams should provide the necessary support to staff working in mainstream intermediate care services.

Plans are at different stages of development across the Trusts but it is envisaged that there will be recruitment and training implications particularly involving dementia nurses, social workers, and AHPs.

(v) Psychotherapeutic services

Bamford identified that older people should have access to Psychotherapeutic Services and all evidence-based treatments according to need.

Currently CBT services treat approximately one older person with FMI each year. This low level of service provision is believed to be due to GPs' reluctance to refer older people with depression to Psychotherapeutic Services. The Advisory Group was however, of the opinion that prescribed medication should be a last resort and older people with mild to moderate depression should be referred to the service.

Development of this service will require GP support and will necessitate additional psychotherapeutic staff. No progress has been reported to date

(vi) Day Treatment Units

Bamford recommended that older people should have access to appropriately staffed Day Treatment Units. The units should have flexible opening hours and people with severe mental illness should be treated in the units as a priority.

Progress is varied across the Trusts but it was reported that additional suitably trained staff would be required in CMHTs to support the fulfilment of this recommendation. Stakeholders suggest that the units should not be restricted to hospital sites but should instead be located in the community. This was deemed to be particularly important in rural areas. This view supports Bamford's recommendation.

(vii) Enhanced Practitioner Roles

Bamford recommended development of the enhanced practitioner role responsible for developing closer links with primary care. These would provide health promotion, education, advice, and therapeutic input.

It is anticipated that additional nurses (including specialist dementia nurses, independent nurse prescribers) and social workers will be required to fulfil the enhanced practitioner role

(viii) Specialist Multi-disciplinary Teams

Bamford recommended that specialist multidisciplinary teams should be introduced for older people with mental health issues where they are not currently in place. These should include: Psychiatry, Nursing, Social Work, Occupational Therapy, Medicine, Occupational Therapy Technicians, Physiotherapy, Nursing Assistants and Mental Health Support Workers.

The skill mix within the teams should include: bereavement counselling, psychotherapeutic expertise or specialist training in management of behavioural problems in dementia. Furthermore, it was recommended that the teams should be further developed to include patient advocacy and input from physiotherapy, speech and language therapy, dietetics, podiatry, and community pharmacy.

Stakeholders reported that it is more important to ensure that the appropriate skills are available as opposed to how a team is structured. Therefore Trusts are reluctant to develop one type of team that is structured in the same way across all Trusts. Guidance from the Department is required to confirm whether Trusts will be required to each establish a specific Specialist Multi-Disciplinary Team.

The skill mix currently available should be reviewed to ensure all of the skills identified by Bamford exist. Ongoing training would be required regarding assessment.

(ix) Key Worker

The Review recommended that anyone with a diagnosis of dementia or long-term severe functional mental illness should be assigned a Key Worker throughout the duration of their illness.

It was reported that there would be no workforce implication resulting from this recommendation as a named contact could be allocated from members of existing Older People's Teams.

(x) Co-ordinating Discharges / Dementia Liaison Nurse

The Review recommended that all discharges for older people with mental health issues should have a dedicated discharge worker.

The majority of Trusts have a Discharge Co-ordinator who could undertake this responsibility would be undertaken by the Co-ordinator.

3. Special Groups

(i) Younger people with dementia

Bamford recommended that a service for younger people with dementia should be located within either the Mental Health Programme or Older People's Programme of Care. The review also recommended that there should be residential respite provision for these younger people for short breaks in a facility linked to an assessment / rehabilitation unit. Furthermore the Review identified potential for joint developments with the Brain Injury service for assessment facilities, respite care and specialist units for those younger people with extreme behavioural problems.

Work is required to establish the configuration of the service needed to support the estimated 450-500 younger people concerned. It is envisaged that additional social workers, community psychiatric nurses, and occupational therapists will be required to staff the service.

(ii) Learning Disability, Dementia and Functional Mental Illness

Bamford recommended that older people with learning disabilities (and who are already known to learning disability services) who develop dementia should remain within the learning disability programme of care for the purposes of continuity of care. The additional support should be delivered via "In-reach" expertise as required. The review also recommended that there should be the ability to care for people with mild learning disability who develop dementia within mainstream services if requested by the patient.

It was reported that learning disability services staff should be equipped with dementia skills via an appropriate dementia training course and that FMI and dementia should be developed as modules of core MH training.

3.5 CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

This section describes the Bamford vision for CAMHS and discusses the reform required and its workforce implications.

3.5.1 Vision for Child and Adolescent Mental Health Services

Figure 3.3 illustrates the Bamford vision for CAMHS. The vision is based on a 4-Tier model that integrates the services of the statutory, voluntary and community services and involves collaborative working between a number of different departments, particularly health and education. The vision was informed by the following principles:

- Comprehensive services: addressing the child's physical, emotional, social and educational needs;
- Individualised services: taking a holistic view of the child including family and community contexts;
- Minimum restriction: least restrictive services & partnership approach;
- Family-focus: the child's family or surrogate family should be a full partner;
- Case management: case management or similar mechanisms used to ensure that the child can avail of multiple services in an effective, co-ordinated manner;
- Early intervention: systems and services to support the early identification and intervention;
- Service transition: smooth transition into the adult service system;
- Cultural competence: staff should respect diversity; and
- Inclusivity: all children who require mental health services should be able to access those services regardless of physical, mental or developmental ability.

Figure 3.3
Bamford's CAMHS Model

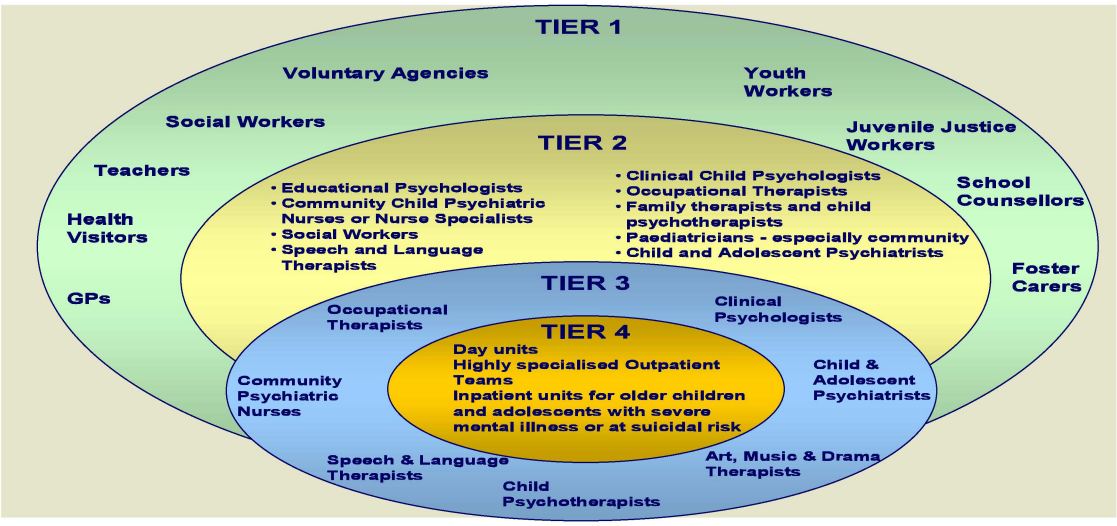


Figure 3.4 summarises how the stepped care model applies to CAMHS including the various staff groups delivering services at each tier.

Figure 3.4
Stepped Care Model for CAHMS

Tier 1	Tier 2
– Offers interventions to children with mild to moderate mental health problems. – many are self limiting but may cause distress in the child or family and disruption to the child's learning. – It is usually the first point of contact between a child and family with primary care, education and/or voluntary and community agencies.	– The first line of specialist services. – Workers need to have completed a dedicated training in the assessment and treatment of a range of mental health disorders. – Workers operate as individual practitioners, offering interventions for mental health problems and mental disorders.
Tier 3	**Tier 4**
– Staffed by specialist CAMHS professionals from Tier 2 who become Tier 3 workers when they function together as teams for particular children and families. – Interventions are offered by professionals working in specialist multidisciplinary teams. – Provision of specialist services for more severe, complex and persistent mental disorders and illness. – Require professional training and specialist training opportunities. – Service should be accessible across NI at a number of centralised sites.	– Delivers very specialised interventions and care for the most complex or uncommon disorders or illnesses. – Includes very specialised clinics that are only supportable on a regional or national basis, inpatient psychiatric services for children and adolescents, residential schools and very specialised residential social care. – Partnership working between education, youth justice, health and social services is essential at this level. – Requires specialist training. – Services will normally have the same profile of professionals as at Tier 3.

3.5.2 Workforce Implications

The workforce implications for CAMHS relate to 3 main areas:

1. New and extended roles;
2. New and extended services; and
3. Specialist services.

1. New / Extended Roles

(i) CAMHS Managers

The Review recommended that managers are recruited to CAMHS services, each covering populations of approximately 250 - 300,000. The Review reported that the skills required for this role would not be found in any one profession.

This is a relatively new role and some of the Trusts have already employed a CAMHS Manager.

Key points
- A small number of posts will need to be recruited into and appropriate training will be required.

(ii) CAMHS Development Co-ordinator

Bamford recommended that a CAMHS Development Co-ordinator should be appointed by the Regional Health and Social Services Board (RHSCB) to facilitate the development of management structures relating to managed networks at local and regional levels across NI.

In England and Wales each region has a CAMHS Development Co-ordinator. The Regional CAMHS Advisory Group (Northern Ireland) is currently developing a job description for this role and there are plans for DE and DHSSPS to jointly fund one of these posts in each Board area. It is expected that these post holders will develop links with those in England and Wales performing a similar job.

(iii) Primary Mental Health (PMH) Workers

Bamford recommends that the role and complement of PMH workers within Northern Ireland should be expanded and that this role could be undertaken by professionals from any discipline with training and expertise in CAMHS. The expanded role should include:

- supporting education regarding CAMH services;
- aiding recognition of CAMH disorders and referral on; and
- assessing and treating some individuals with mental health problems at Tier 1 and Tier 2.

Key points
- The PMH Worker post does not operate consistently across all of the Trusts and is used in different Tiers of services; and
- Expanding the number and role of this post is not an immediate priority for Trusts but one that they may develop in the future.

(iv) Family Therapist and Child Psychotherapist Posts

The Review recommended that Family Therapist and Child Psychotherapist posts and their roles should be enhanced and developed in CAMHS.

The family therapist role is not new and Trusts agreed that more of these posts are required with some estimating that the current number should be doubled. Professionals filling these posts need to be trained in family therapy, family trauma, and psychotherapy. All CAMHS practitioners receive some family therapy training as part of their core training; however, it

takes four years to fully train family therapists whilst they are in service. Ideally family therapists will be in a position to act as consultants to other members of the CAMHS team.

The Family Therapist role does not sit within CAMHS in all Trusts; in some the role sits in the Women and Family Directorate and some stakeholders argued that the role should service more than one Directorate.

The Child Psychotherapist post is not new and is fulfilled by trained nurses or social workers who completed a final specialist year to become a child psychotherapist. This final element of training is not available locally with courses available in Ireland, Scotland and England. In total it takes between four and six years to become a Child Psychotherapist. The Child Psychotherapy Tier 3 service is managed in the EHSSB area by BHSCT, which also manages the regional clinical service. Local service in Northern Ireland does not currently meet demand.

Expansion of the inpatient provision for children is a priority to prevent some children being placed in adult inpatient settings and some being placed in England. Recruitment into posts is difficult and some Trusts are targeting students in their final year at university to help address this.

Key points:
- More family therapists and child psychotherapists need to be trained and recruited;
- Due to the length of time it takes to train personnel in either post plans need to be made now to ensure that appropriate numbers of both posts are developed in the future;
- Additional social workers and nurses will need to be trained to become family therapists and child psychotherapists;
- Clarification is required regarding whether the family therapist role should sit within CAMHS in all Trusts; and
- Tier 4 services are not resourced by the most experienced staff in the service.

2. New / Extended Services

(i) Increased age limit of service

Bamford recommended that CAMHS should be provided to children and young people up to their 18th birthday.

There is a lack of a regional and co-ordinated approach regarding the upper age limit for CAMHS and some Trusts are restricted in terms of delivering the service to children and young people up to their 18th birthday because Clinical Psychologists in the service cannot treat those over the age of 16 due to capacity issues.

Key points:
- There is a lack of a regional and co-ordinated approach regarding the upper age limit for CAMHS; and
- Potentially additional Clinical Psychologists may be required to support service delivery.

(ii) Infants and Early Intervention

The Review recommended that a strategy for infant mental health and early intervention services should be developed.

Key points:
- There is a lack of consistent approach across the trusts regarding the extent to which infant mental health and early intervention services have been developed; and
- Potential that as these services develop further additional health visitors and social services staff will be required.

(iii) Learning Disability

Bamford recommended that severe learning disability inpatient provision should be provided for children and adolescents in a community based specific unit.

A business case for an 8-bed purpose built unit has been approved and the number of beds allocated in the unit to each Board has been split as follows: six for EHSSB, none for WHSSB, one for SHSSB and one for NHSSB. It is planned that the unit will be operational by the end of 2009. The unit will be used to place children and adolescents from Muckamore and concerns have been raised that there will be insufficient beds in it.

It is anticipated that the staff for the unit will be redeployed from Muckamore and will include Psychotherapists, family therapists, nurses trained in psychotherapy and children's LD nurses.

Bamford also recommended that specialist mental health services for children and adolescents with learning disabilities should be commissioned as part of specialist mental health services for all children. The Review also highlighted the need for a small number of key staff to be trained in both learning disability and mental health disciplines to lead development of the service.

This has not to date been taken forward.

Key points:
- It is anticipated that the community based inpatient provision for children and adolescents with a severe learning disability will be delivered by redeployed staff from Muckamore; and
- Potentially a small number of staff will require training in learning disability and mental health disciplines to deliver specialist mental health services for children and adolescents with learning disabilities.

(iv) Autistic Spectrum Disorder

The Review recommended that an ASD assessment service should be established.

Currently each Board / Trust has its developed ASD services and there is no uniformity across Northern Ireland. An ASD Strategy and Action Plan has been developed which aims to introduce a more regional, consistent and streamlined care pathway for those with ASD in Northern Ireland. The Plan also aims to support Trusts' practitioners to share knowledge and working practices. It is anticipated that the finalised Strategy will be published in early 2009.

Key points:
- Full workforce implications should be addressed in support of the finalised Strategy.

(v) Physical and sensory disabilities

The Review recommended that there should be delivery of mental health services to children with physical and sensory disabilities and illnesses.

Currently Clinical Psychologists from England visit Northern Ireland once a month to deliver this service. The National Deaf Children's Society undertook a review which recommended that 2 workers should be employed locally to support the delivery of this service

Key points:
- A small number of additional clinical psychologists are required to deliver this service.

(vi) Occupational therapy

Bamford recommended that Occupational Therapy services should be developed as a core element of CAMH provision.

It was reported that this is a lower priority action for Trusts.

Key points:
- More occupational therapists will need to be trained and recruited for this service but it is anticipated that numbers required will be low and it is not an area that Trusts will develop in the near future.

(vii) European Working Time Directive (EWTD)

Bamford recommended that CAMHS out of hours services should be developed to meet the directive.

This will have a resource implication within CAMHS teams with general agreement that it will not require more medical staff but that Consultants will need to be accessible if required. Fulfilling this recommendation is deemed to be a medium term priority.

Key points:
- As a medium term priority, additional staff will be required to deliver out of hours services in line with the EWTD.

3. Specialist Services

(i) Specialist mental health services for children and adolescents with a learning disability

Bamford recommended that there should be a specialist mental health service for children and adolescents with LD and small number of staff trained in LD and MH to lead this.

Key points:
- There is an aspiration that in the longer term CAMHS would have staff trained in LD and MH;
- This would require an interagency approach with Youth Justice and the voluntary sector;
- In the shorter term there is a need for professional staff to have placements in LD settings during their core training.

(ii) CAMH Community Psychology Service

The Review recommended that there should be a CAMH Community Psychology Service delivered regionally through the CAMHS network. This would result in Psychologists working as part of Community Development Teams in a new way of working.

Key points:
- Identification of appropriate skill-mix and recruitment will be required to support this service.

(iii) Abuse and Sexually Harmful Behaviour

Bamford recommended the development of intervention services for children and young people that have suffered abuse and that display sexually harmful behaviour.

Key points:
- Currently the service delivered across Trusts is inconsistent;
- The voluntary and community sector play a key role in service delivery; and
- Development of the service will require additional Tier 2 and Tier 3 staff (most likely to be social workers).

(iv) Eating Disorders

The development of specialist child and adolescent outpatient services for feeding and eating disorders was recommended in the Bamford Review.

There has been a £1 million investment in these services during the past few years; as a consequence CAMHS teams have been augmented by an additional 11 WTE across the Trusts with working links established with the adult eating disorder teams.

The need to develop an in-patient service has also been identified given the current cost and acceptability of sending patients to the mainland UK for treatment. A Team has been developed to deliver the service which has access to sessions with a consultant psychologist, dietician, nurse and social worker. The outputs of this approach are currently being reviewed

Key points:
- Review of CAMHS eating disorder staffing requirement to take place once both the adult and CAMHS teams have been in operation for a time and in the light of other inpatient developments for eating disorders (as described in the adult eating disorder section).

(v) Psychological trauma

Bamford states that development and expansion of evidence based services to address psychological trauma in children should be taken forward. There is potential to expand core CAMHS teams in order to deliver the service locally.

Key points:
- The Northern Ireland Centre for Trauma and Transformation (NICTT) is currently being evaluated. It is likely that Psychiatrists, Psychologists, and Psychological Therapists would be involved in any local service delivery;
- It is considered that the voluntary and community sector could play a key role;
- Workforce implications to be further considered following the evaluation of the NICTT

(vi) Challenging behaviours

Bamford recommended that community based teams focusing on outreach, service flexibility and community development should be developed for young people with perceived challenging behaviours.

Key points:
- Currently this service is delivered through social work teams. There is a need for these teams and CAMHS to develop their Tier 2 and Tier 3 services which will require new ways of working;
- No additional workforce implication identified.

(vii) Complex Needs

Bamford recommended that models for assertive outreach / intensive treatment / day unit treatment for complex needs should be developed.

Funding of approximately £1 million was invested in the development of such services in recent years and each Trust has developed its own service.

Key points:
- there is not a consistent approach across all trusts;
- the highest priority development is the provision of day care services;
- the biggest pressures the service faces are from waiting lists (the waiting list agenda came after Bamford and therefore the Review did not account for the agenda's waiting list targets), delayed discharges, and inappropriate inpatient facilities;
- it is anticipated that independent providers will enter the Northern Ireland market and that this will automatically change the shape of service provision, although it is impossible to predict this in the absence of any firm plans;
- need for additional appropriately trained nursing staff and social workers to deliver day care services.

3.6 LEARNING DISABILITY SERVICES

This section describes the vision for LD services and discusses the changes required and their workforce implications.

3.6.1 Vision for Learning Disability Services

The vision for LD services depicts a multi-agency and multi-sector model that operates across various settings, and provides a comprehensive range of services for people with a learning disability that aim to maximise social inclusion and improve quality of life. The service model includes a range of ongoing supports to maintain people with a learning disability in the community and specialist diagnostic, assessment and treatment services (community and hospital based) when required. It is underpinned by the following principles:

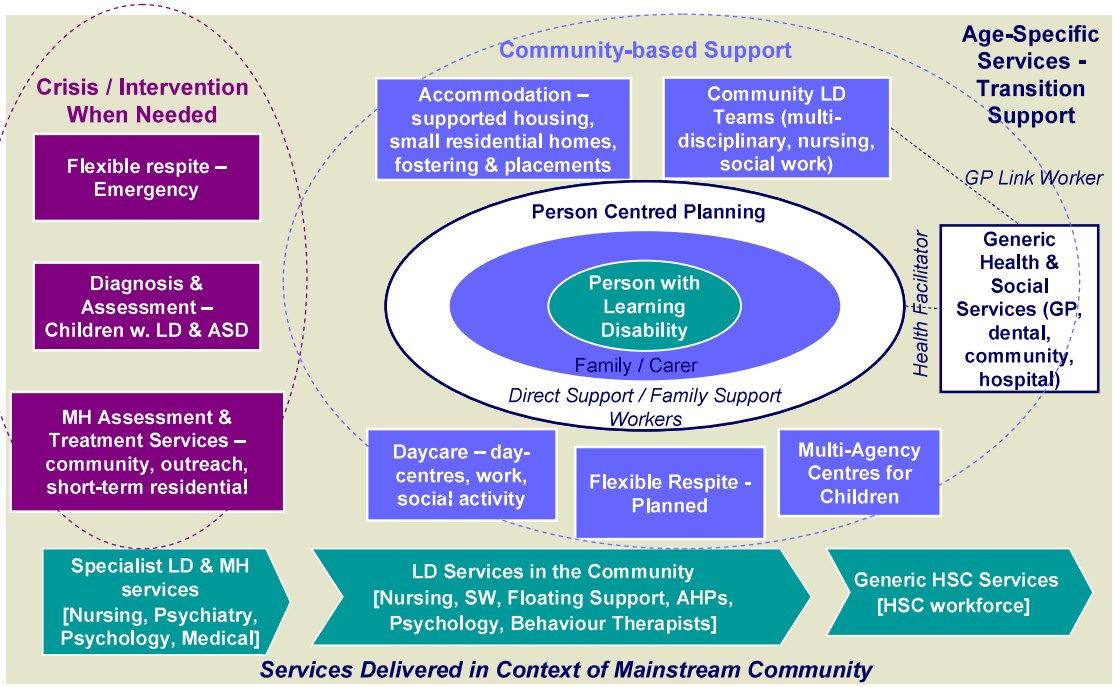
- ensuring that people with a learning disability:
  - have access to mainstream services;
  - participate in decisions affecting their lives;
  - have equal access to opportunities as they move into adulthood;
  - be supported to age well in their neighbourhoods;
  - be supported to enable them to live in the community;
- supporting families and carers of people with a learning disability;
- accessibility of high quality, locally based, health services;
- ensuring that health and social care staff are confident and competent in working with people with a learning disability; and
- joint working across sectors and settings to improve the quality of life of people with a learning disability.

The support model should operate in the context of mainstream services rather than as a discrete, segregated system. Services should be age-specific, reflecting the different needs of a person with a learning disability over the course of their lives and providing particular support at transition points, e.g. at first diagnosis, starting and finishing school, entering employment and vocational training, and moving between children's, adults and older people's services. The model involves co-ordination of services across several interfaces:

- the statutory and independent sectors;
- other Bamford domains, for example, in respect of people with a learning disability who also have mental health problems as children, adults or older people;
- mainstream health and social care services, for example, GP, dental, primary care and hospital services; and
- non-health and social care services, for example, education, employment and training, housing and community development.

Figure 3.3 illustrates the model for LD services described in the Bamford Review.

Figure 3.3
Bamford's Learning Disability Model



3.6.2 Workforce Implications

The workforce implications for LD services relate to 3 main areas:

1. New and extended roles;
2. New and extended services; and
3. Specialist services.

1. New / Extended Roles

(i) Key Worker

Bamford recommended that Key Workers should be available for all people with a learning disability using services. They would assume the primary responsibility for co-ordinating service intervention and delivery and lead on the production of Family Support Plans.

Key points:
- A Key Worker role is already provided by professionals in multi-disciplinary Community Learning Disability Teams (CLDTs);
- Nurses and social workers perform this role but it could be carried out by other appropriately trained professionals;
- Current CLDT resources do not support the level of Key Worker contact envisaged by Bamford;
- Services are not currently age-differentiated and specific needs exist for early years and transitions;
- Additional staff resource is required to fulfil this role fully.

(ii) Family Support Worker

The Review recommended that a Family Support Worker role be introduced to provide practical support to families of people with learning disability.

Key points:
- The Family Support Worker role does not currently exist in any of the Trusts, although all have plans to provide a family support model and the WHSCT will be introducing a Family Support Worker role;
- Role description, career pathway and appropriate training needs to be identified.

(iii) Health Facilitator

Bamford recommended that a Health Facilitator role be introduced to assist a person with a learning disability to achieve and maintain good physical and mental health by facilitating access to primary care and acute hospital services. It was recommended that one facilitator is available for every 110-120,000 population (i.e. 15-16 for the region).

Key points:
- Several of the Trusts are developing health promotion services for LD including role similar to the Health Facilitator role but a common approach does not exist across the region;
- The health facilitator role is anticipated to be taken up by LD nurses.

(iv) GP Link Worker

A further new role in the health promotion field was identified by Bamford. The GP Link Worker would act as a link between CLDTs and GP practices, provide staff training in health centres on learning disability and physical/mental illness, develop effective partnership work between primary care and LD services, and assist in health promotion for people with a learning disability.

Key points:
- The GP Link Worker role is a new role and not currently being developed in any of the Trusts
- The role should be planned in the context of a range of roles, training and other services to promote good physical health among people with a learning disability

(v) Direct Support Workers

The Bamford Review recommended that work continue to make people with a learning disability aware of the availability of Direct Payments as an alternative to support packages provided directly by Trusts. An increase in the uptake of Direct Payments would result in an increase in the number of Direct Support Workers employed by people with a learning disability, and expansion of the range of roles they undertake. Bamford recommended that that Direct Support Workers complete standard induction and foundation training (as per NISCC requirements) and that support is provided for their employers (i.e. people with a learning disability in receipt of Direct Payments).

Key points:
- Direct Support Worker roles are seen as an important element of a tailored service for people with a learning disability;
- Induction training is required for Direct Support Workers as well as promotion of Direct Payments uptake.

2. New and Extended Services

(i) Community based mental health assessment and treatment services

The Review recommended that services should be developed to support people with a learning disability who have specific mental health needs and / or challenging behaviours. They should include outreach to individuals, families and community services and short-term intensive treatment for those within a residential facility which may be approved to treat people under mental health legislation. Services should also target those with severe mental health problems including children and young people (with appropriate interface with CAMHS).

Key points:
- community based assessment and treatment services have been or are due to be developed in each of the Trusts;
- additional behaviour support and forensic services are required to support resettlement in the community;
- there is some opportunity for redeployment of hospital staff into these services but additional staff will also be required (professional and support staff specialists in nursing, social work, psychology and psychiatry);
- significant training needs have been identified for new / redeployed staff providing these services in challenging behaviours, forensics, therapies and community treatment, and community based practice.

(ii) Flexible respite – emergency and planned support and accommodation

The Review recommended that a much improved range of respite options be developed for people with a learning disability to provide home based support, community based activities, family placements, and residential respite.

PfA sets outs a target for the provision of an additional 200 respite places by 2011. In order to meet this target, all Trusts are expanding their respite care through development of community based respite facilities.

These will require experienced LD nursing, social work, and support staff who can provide respite care for people with complex physical and psychological needs. They will be required to operate at weekends and out of hours. Both these factors may make these positions difficult to recruit into.

The development of family based respite options is also a priority for those people with less complex needs. Recruitment of families who would provide these services is proving difficult and stakeholders suggested the need for regional coordination of recruitment and training.

Key points:
- Additional staff will be required to provide services in community based respite facilities being developed in each Trust;
- Regional coordination is required to develop family based respite care.

(iii) Community-based accommodation (for adults)

The Review recommended that accommodation for people with a learning disability be in community based supported housing and residential settings. PfA targets have been set to support the resettlement of people from hospitals into community accommodation.

Key points:
- All Trusts are increasing the number of supported living places available;
- New statutory provision is being developed but most supported living is provided by the independent sector;
- Domiciliary care support is also provided to maintain people with a learning disability at home with their families;
- Additional professional nursing and social work staff will be required as well as a range of support staff (Band 3 and 4) to provide these services;
- Increasingly complex needs will be supported in supported living facilities and at home as the resettlement programme progresses – this will challenge efforts to recruit, particularly into support roles;
- New roles were also identified for brokers, managers and team leaders.

(iv) Permanent placements for children and young people with a learning disability

Bamford identified a need for permanent placements (specialist fostering or intensive care provision as appropriate) for children and young people with a learning disability.

Key points:
- All Trusts are seeking to increase permanent placements for children and young people to support the resettlement programme;
- Increasingly complex needs will be supported in these facilities as the resettlement programme progresses and this presents a recruitment and retention challenge;
- Staff available from redeployment of hospital services will be insufficient to meet the demand - additional professional nursing and social work staff will be required as well as a range of support staff (Band 3 and 4) to provide these services;
- New roles were also identified for brokers, managers and team leaders

(v) Multi-agency centres (for children)

Multi-agency centres for children were recommended in Bamford to provide generic and specific services for children including those with LD. It was envisaged that these centres would be developed and operated in partnership with Education and Library Boards, the health service and a wide range of statutory and non-statutory organisations that provide support for young people.

Key points:
- No progress was reported to date and this is not a current priority for Trusts
- Regional leadership and co-ordination would be required to progress this initiative

(vi) Diagnosis, assessment and individual support for ASD

The Review recommended that diagnosis and assessment, and individual supports be provided for children with both an Autistic Spectrum Disorder and learning disability.

Key points:
- New posts will be required for this service – the ASD strategy will define the service model to be made available

(vii) Flexible modernised day services

Bamford recommended reform and modernisation of day care services for people with a learning disability. A greater variety of day opportunities was recommended including supported voluntary work and leisure opportunities as well as 'traditional' day centre provision for people with complex needs.

Key points:
- Differentiated day services are being developed by each Trust to provide more individualised options;
- Staffing in day centres will need to be experienced and specialist in managing challenging behaviours and complex needs;
- Significant multi-agency and multi-sector working is required to provide options that meet a range of needs and non-day centre based options;
- Additional staff roles will be needed to co-ordinate alternative day options including brokering, direct support and mentoring / guidance;
- There is significant opportunity for skill mix – many new roles will be support roles.

(viii) Learning disability nurse input in day centres and special schools

The Review recommended that LD nurses be employed to work in day centres and special schools, and that they could be employed directly by schools or employed by the Trusts. The Department of Education (DE) is currently conducting a review of the LD services it provides to day centres and special schools. DE employs nurses to work in day centres and special schools, so a link-up is needed to ascertain the outcome of the DE review and the likely numbers of nurses it will provide.

Key points:
- One Trust is progressing this new role but no other progress was identified;
- This role would require additional LD nurses but numbers and the approach (i.e. who would employ the role) have not been identified.

3. Training

(i) For the LD workforce generally

The Review recommended that a learning and development pathway be developed for all of the professional and support staff in LD careers. Stakeholders highlighted the following in relation to learning and development within the LD workforce:

- strong leadership and managerial capacity is required to support LD services through significant reform;
- extensive re-training will be required for LD staff being redeployed from reducing areas of service (e.g. long stay hospitals) into new services (e.g. community based accommodation) to ensure they have the skills and confidence to provide effective services in their new roles;
- new skills are needed to support new ways of working i.e. more multi-disciplinary teams and working across sectors and services to provide integrated, holistic services;
- to reflect this, learning and development opportunities should be designed to be cross professional;
- the statutory and independent sectors should identify and meet training needs collaboratively for the good of the LD service as a whole; and
- a common foundation and development programme for LD would help attract young people into LD careers and support retention by providing clear career development pathways.

Key points:
- Significant training needs are identified for the LD workforce including a common foundation and development programme, retraining for new /redeployed staff, and training for all LD staff in new ways of working;
- Where possible training should be developed and delivered on a multi-disciplinary and multi-agency/sector basis

(ii) For family, carers, volunteers and service users

In light of the Bamford principles of self-determination and independence for people with a learning disability, it was recommended that LD service users and their families and carers also have access to training support from statutory and other service providers.

Key points:
- Regional work is recommended to identify good practice approaches to service user involvement in service development

(iii) For the generic health and social care workforce

The Review recommended that all generically trained health and social services professionals (medicine, AHPs, nursing, social work etc) should receive at a minimum awareness raising training on learning disability.

Key points:
- Stakeholders agreed on the need for better awareness of the needs of people with a learning disability among generic health and social care workers
- Efficient approaches were recommended (inclusion in induction training, basic training etc.)

4. Collaborative Working Structures

(i) Embedding new ways of working

The Bamford vision for LD is underpinned by a more collaborative approach to developing and delivering services, providing much better integration of LD services with other specialist and mainstream services. Key aspects of this approach are:

- Engaging service users and carers in determining services;
- Co-ordination of services across programmes of care – older people & mental health; and
- Multi-Sectoral and multi-agency services.

Key points:
- Strong regional and local leadership is required to embed the new ways of working required to fully implement the Bamford model for LD services.

3.7 Summary of Workforce Implications across the Four Domains

Table 3.5 summarises the overarching workforce implications that are common across each of the four Bamford domains as identified Sections 3.3 to 3.6. Tables 3.6 to 3.9 summarise the workforce implications that are specific to the AMH, Older People, CAMHS, and LD domains.

It is apparent from these summaries that the challenge for the workforce is wide ranging and includes recruitment, retention, training, redeployment, career development, and skill mix implications.

Table 3.5
Summary of Bamford Workforce Implications: Overarching Implications affecting all Domains

	Recruitment	Retention & Redeployment	Training	Redeployment	Career Development Paths
All Domains	Mental Health Nurses Learning Disability Nurses Social Workers specialising in Mental Health and Learning Disability Clinical Psychologists Psychological Therapists Psychiatrists AHPs specialising in Mental Health and Learning Disability Mental Health and Learning Disability Support workers including: • STRW • Expert Users • Nursing support workers • Social care support workers	Retaining staff being redeployed from acute to community settings Reducing turnover across MHLD services	Attracting required numbers into pre-registration training for nursing, social work, AHP and psychology Embedding pre-registration training placements in Mental Health and Learning Disability settings (including community settings) Ensuring adequate pre-registration training places are available for the increased number of MHLD professionals needed Ensuring adequate provision of vocational training for the increased number of support workers needed	Redeployment of staff to community settings from acute settings	For all new roles and across extended services

Table 3.6
Summary of Bamford Workforce Implications: AMH

	Recruitment	Training	New & Extended Roles (including role description, competency identification, development framework)	Career Development Paths
AMH	CMHTs: • Nurses, Social workers, Psychologists, and Psychological Therapists Recovery Services • Nurses, Social Workers, OTs, Speech Therapists, Physiotherapy Home Treatment • Nurses Psychological Therapies • Psychological Therapists, Psychologists and Assistant Psychologists Liaison Service • Nurses, Social Workers, Clinical Psychologist, Psychiatric Trainees, and Consultant Psychiatrists Eating Disorder • Medical, Nurses, Psychological Therapists	Develop learning and development framework for CMHT roles Develop training for new roles Develop training for new ways of working for CMHTs Explore potential for NVQ in Direct Care and existing e-learning package for Home Treatment services For CMH service staff regarding Challenging Behaviour Awareness training for all HSC staff regarding Personality Disorders Specialist training for Eating Disorder staff working in acute settings Training for Dual qualified Midwife and Mental Health Nurse	Link Worker Support, Time and Recovery Worker (STRW) Psychological Therapists Eating Disorder specialists Personality Disorder specialists Dual qualified Midwife and Mental Health Nurse	For CMHTs For new roles For Psychological Therapists For Liaison Service For Personality Disorder Service

Table 3.7
Summary of Bamford Workforce Implications: Older People

	Recruitment	Training	New & Extended Roles (including role description, competency identification, development framework)	Career Development Paths
Older People	Domiciliary Care • Domiciliary staff Day Support • Nurses, social care support staff and volunteers Respite care • Nurses, social care support staff and volunteers Intermediate Care • Dementia Nurses, Social Workers, and AHPs Day Treatment Units • Additional staff recruited to CMHTs Crisis /Home Treatment / Out of Hours • Additional staff recruited to CMHTs Challenging Behaviours • Nurses, psychologists and nursing support staff	For Domiciliary Staff All grades of staff (including in voluntary and community sector) working with older people with mental health issues regarding minimal restraint / restraint free care Training for Statutory, voluntary and community, and private sector staff regarding respite care Training for Palliative Care Teams, care home staff (statutory and independent), GPs and Consultants regarding palliative care approaches for older people with advanced dementia Training for Intermediate Care staff Dementia Nurses, Social Workers, and AHPs For additional staff recruited to CMHTs regarding older people with mental health issues	Liaison Nurse Key Worker Challenging Behaviour Roles	For all new roles and across extended services

Table 3.8
Summary of Bamford Workforce Implications: CAMHS

	Recruitment	Training	New & Extended Roles (including role description, competency identification, development framework)	Career Development Paths
CAMHS	CAMHS Development Co-ordinators (following completion of job description being developed by CAMHS Advisory Group) Expansion of CAMHS teams Primary Mental Health (PMH) Workers Family Therapists Child Psychotherapists Occupational Therapists Community Development Teams • Psychologists Abuse and Sexually Harmful Behaviour • Social Workers Complex Needs • Nurses and social workers	Family Therapists Social Workers and Nurses trained to become Child Psychotherapists Occupational Therapists trained in CAMHS Training for HSC staff in CAMHS regarding LD (longer term priority) Psychologists for Community Development Teams	Enhanced Practitioner Dementia Liaison Nurse (role expansion) Key worker (role expansion)	For all new roles and across extended services

Table 3.9
Summary of Bamford Workforce Implications: Learning Disability

	Recruitment	Training	New & Extended Roles (including role description, competency identification, development framework)	Career Development Paths
LD	Community based assessment and treatment: • LD nurses & support, behaviour support (clinical psychologists, specialist nurses, social workers and vocationally qualified behaviour support staff), specialist forensic staff (nurses, psychology, psychiatry) and social workers Respite Services: • LD nursing, social work, and support staff Supported Accommodation for Adults & Permanent Placements for Children: • LD nurses, social workers and support staff, new roles for brokers, managers and team leaders, foster families for children Day Care: • LD nurses, social workers, new roles for brokering, direct support and mentoring / guidance ASD posts (Regional Strategy)	Learning and development pathway for all LD careers Family, carers, volunteers and service users Direct Support Workers Generically trained health and social services professionals	Key Worker Family Support Worker Health Facilitator GP Link Worker Direct Support Worker Respite & Supported Accommodation Brokers, Managers & Team Leaders Day care Brokers & Mentors	Learning and development pathway for all LD careers For new and extended

3.8 Summary of Key Messages

The following points summarise the key findings from this section:

- The workforce implications of the Bamford reports are wide ranging and will present a challenge for Trusts in terms of putting in place the appropriate number of staff with the necessary skill mix;
- The Bamford reports are giving the opportunity to provide more consistent services across the region;
- Progress has been made in some areas to implement a number of the Bamford recommendations, particularly those that relate to PFA targets;
- Despite this progress, Trusts are implementing the recommendations to varying degrees and therefore there is inconsistent provision of services across Northern Ireland presently;
- A number of Bamford's recommendations are being reviewed by specific working groups that are considering how a new service will be rolled out regionally / locally. The workforce implications for these services will not be fully apparent until the conclusion of the work of the groups, and this type of approach is needed for many other elements of the Bamford vision;
- The Trusts will have an increasing role in leading workforce development activity and identifying how Bamford's implications will impact them over time as they reconfigure their services as a result of RPA; and
- The voluntary and community sector will play an increasing role in the delivery of MH and LD services, in addition to service users and carers.

4 ESTIMATES

4.1 INTRODUCTION

This section analyses currently available information on the number of staff required to provide the services envisaged in the Bamford Review. It focuses on:

- the future workforce requirements to fully implement the long term vision set out in the Bamford reports;
- Trusts' estimates of their additional staffing requirements in the current spending review period 2008-2011; and
- the implications of increased workforce demand for the provision of training places for MHLD professionals.

4.2 FUTURE SERVICE PROVISION

The following sections outline the information detailed in the various Bamford reports on the estimated number of staff required to support the implementation of reformed MHLD services. The projected workforce requirements identified by the Trusts are also detailed for each domain. An analysis of the implications of the future workforce requirements for each domain is then considered.

4.2.1 Adult Mental Health

Bamford AMH Workforce Projections

The Bamford report on AMH sets out the number of staff required to provide community mental health services; the estimates are shown in Table 4.1.

Table 4.1
Adult Mental Health Future Service Provision

Recommendation	Total Staff Numbers*
• 5 Community Mental Health Teams (CMHT) each of 11 staff, serving a population of 50,000 each	375
• 3 CMHTs of 23 each underpinning Recovery Services for populations of 85,000	475
• 3 Home Treatment Teams of 8 staff each per 250,000 of population, each linked team linked to a CMHT	165
• 15 staff, made up of 3 teams of 5, working in Assertive Community Treatment linked to one of 3 Recovery CMHTs	100
• Staff at a ratio of 1.3 per bed, to man 20 acute mental health beds and 10 challenging behaviour beds for populations of 100,000	663
* Assumed to be WTEs	**1,778**

Note: Bed ratio based on advice from a Trust and Departmental consultation with nursing advisors

As shown in Table 4.1 a total estimated workforce of 1,778 is required to fully implement the Bamford vision for community-based AMH services and acute hospital services over the next 10-15 years. The exact profile of the staff groups which should be involved in this workforce is not detailed in the Bamford reports; it is envisaged that services would be provided by multi-disciplinary teams with many roles being available to professionals from a range of

backgrounds. Additional workforce numbers would be required to provide other specialist services including those for personality disorder, eating disorder and psychological trauma.

HSC Trust Workforce Projections

Data returns received from the five Trusts indicate that there are 2,640 AMH staff currently in post, of which around 1,421 are currently in the hospital setting and 1,220 are in a non-hospital setting. Two Trusts quantified their estimated demand for additional staff to deliver AMH services. They indicated that a total of 92 additional AMH posts will be required by beginning of 2011. This equates to a total number of staff in post by 2011 of 2,732. This figure underestimates demand as it does not account for the additional staff required in the three remaining Trusts.

Key Observations

- The current statutory AMH workforce is estimated as 2,640 (based on Trust returns)
- The Bamford Review of AMH services recommends that for community AMH services only, the required workforce should have 1,115 staff (in the next 10-15 years), plus approximately 663 staff based in the hospital setting, equating to a total number of 1,778 staff
- Additional staff would be required to deliver the full range of specialist AMH services
- Based on these figures, the additional AMH workforce needed in the immediate future is at least 92 and it would appear that the current community mental health staff numbers would be adequate to meet Bamford recommendations. However, the recommendations pose a significant requirement for redeployment and movement of staff within the system – notably a reduction of more than half in the number of AMH staff in the hospital setting. This creates significant risk of destabilising the workforce and losing skilled, experienced staff.

4.2.2 Children and Adolescent Mental Health Services

Bamford Workforce Projections

Table 4.2 outlines the total number of staff required in the CAMHS workforce to support the full implementation of the Bamford vision for the service.

Table 4.2
Child and Adolescent Mental Health Services Future Service Provision (WTE)

• Generic Specialist multi-disciplinary CAMH service per 100,000 of population with teaching responsibilities	425
• Generic Specialist multi-disciplinary CAMH service per 100,000 of population without teaching responsibilities	340
• 6 full-time CAMHs managers to cover populations of 250,000 – 300,000	6
• Staff at a ratio of 1.3 per bed, to man 33 CAMHS beds	**43**
	Min 389 / Max 474

Table 4.2 highlights that an estimated total CAMHS workforce of between 389 and 474 is needed to fulfill Bamford recommendations in the longer term (depending on teaching responsibilities of those staff). The exact profile of the staff groups which should be involved in this total staff number is not detailed, and it should be noted that the Bamford report into

CAMHS services made only a quantitative projection in relation to the teams above. Additional workforce numbers would be required to provide other specialist services including those for challenging behaviours, eating disorders and psychological trauma.

HSC Trust Workforce Projections

Trust data returns indicated that there are 299 CAMHS staff currently in post. Four HSC Trusts provided information on additional staff required to deliver new and extended services. This number totalled 62, and these additional staff are projected to be phased between 2008/09 and 2010/11.

Key Observations

- The Bamford Review of CAMHS recommends that in the longer term, the workforce should have at least 389-474 staff (depending on teaching responsibilities)
- Additional staff would be required to deliver the full range of CAMHS services
- Trusts identified plans to increase the number of staff in post to an estimated 361 by 2011 (i.e. an additional 62 staff)
- Based on these figures, the additional CAMHS workforce needed to meet Trust requirements in the immediate future is at least 62, and in the longer term a workforce with up to 175 additional staff is needed to fully implement the Bamford vision.

4.2.3 Older People's Mental Health and Dementia Services

Bamford Workforce Projections

Table 4.3 outlines the total number of additional staff required to support the implementation of the Bamford vision for the Older People's service.

Table 4.3
Older People's Mental Health and Dementia Services Future Service Provision – Additional Staff Requirement

Professionally Trained Staff	
• 76.5 WTE nurses Bands 5-8 • 138 WTE staff Bands 2-4 (for acute and assessment services) • 10 WTE CPNs • 10 advocacy workers (may be from a variety of professions • 5 WTE Trainers • 14 WTE social workers • 16 WTE Occupational therapists • 7.5 WTE Consultant Psychiatrists of Old Age	• 2 WTE SHOs • 1.5 WTE staff grades • 22 WTE crisis workers (may be from a range of professional groups) • 8 HCOs • 2 WTE Pharmacists • 15 WTE Psychologists • 13 WTE Physiotherapists • 2.5 WTE dieticians • 4 WTE podiatrists • 15 WTE speech and language therapists
Non-Professionally Trained Staff	
• Majority of social care workforce is employed in older people's services • Domiciliary workforce to expand by 20% to meet projected demand based on current service provision	

Table 4.3 highlights that in the longer-term a total additional professional workforce of 362 WTE staff will be required across the different staff groups to fully implement Bamford recommendations. In addition, the review recommends that the domiciliary workforce will need to increase by 20 per cent. Baseline workforce numbers for domiciliary staff working in

Older People's mental health services were not available, so it has not been possible to quantify this percentage increase.

HSC Trust Workforce Projections

Three Trusts completed Older People information requests for this review regarding the current workforce baseline. These indicate that there are currently 330 staff (a combination of professional and non-professional staff) in post within this domain (not accounting for the Trusts that did not submit information).

Four Trusts provided information on the estimated number of additional staff that would be required to deliver Older People's mental health and dementia services to 2011. These projections indicated an additional 89 staff being required in the immediate future.

Key Observations

- The Bamford Review of Older People's mental health and dementia services recommends that the workforce should have an additional 362 professionally trained staff to deliver the vision for the service in the longer term.
- It was also recommended that the domiciliary workforce in older people's mental health and dementia care should increase by 20 per cent.
- Based on the Trust returns, an estimated additional 89 staff will be required by 2011.
- There will be a need for staff to remain within the hospital setting to staff the dementia beds which will exist. The number of beds needed has not yet been defined.
- Based on this incomplete information, it is estimated that at least 89 additional staff will be needed for Older People's mental health and dementia services in the next three years, and in the longer term, an increase of 362 professional staff and a 20 per cent uplift in domiciliary care staff will be required to fully implement Bamford.

4.2.4 Learning Disability Services

Bamford Workforce Projections

The Bamford review did not detail the specific staff numbers needed to deliver the vision for the LD service. Therefore it is not possible to map the differences between current service provision and the Bamford vision. We have outlined below some of the main points which the Bamford review detailed in relation to the demands on the service and the possible types of teams needed to deliver services. Further work is required to estimate the staffing ratios and profiles to deliver these places:

- In addition to those currently living in hospital it is estimated that approximately 1,600 persons may require alternative accommodation and/or support arrangements in the coming 5 to 10 years. Around 170 places are likely to be required in the next 2 years;
- In order to meet the emerging needs identified an additional 100 supported living places per annum for the next 15 years should be developed to enable people to move from family care without having to be placed in inappropriate settings;
- An additional 75 places are required for young people who need to live away from the family home in settings appropriate to their needs;
- A transitions service should be developed for each population of 100,000 – 120,000 which will work with approximately 60 young people;
- An independent advocacy service should be in place each serving a population of 100,000 – 120,000; and
- A Health Facilitator should be appointed to drive and champion implementation of the framework. This totals a minimum of 14 staff.

It is important to note that there is a large volume of staff sitting outside of the health and social care sector who provide integral care and support services to people with a learning disability, for example those working in education, vocational training and employment, and community development. It is anticipated that the number of staff working in other sectors will also be affected by the implementation of Bamford's vision.

HSC Trust Workforce Projections

All five HSC Trusts provided data relating to their current staffing levels for LD services. The total number of LD staff in post is reported to be 2,259. All five Trusts provided data on the additional staff needed in the next three years to support service reform. An estimated 247 additional staff are reported to be needed, equating to a total workforce of 2,506 by 2011.

Key Observations

- The Bamford review for LD services did not provide specific workforce projections to support the implementation of the vision for the service.
- Trust returns indicated that an estimated 247 additional posts will be created in the next three years for LD services;
- An estimated minimum of 247 additional LD staff will be required in the next three years, and more analysis is required to determine additional workforce demands in the longer term.

4.2.5 Alternative sources of Staffing Estimates

A report commissioned by the Sainsbury Centre for Mental Health in 2007, entitled "Delivering the Government's Mental Health Policies: Services, staffing and costs" was a substantial research paper which aimed to produce estimates of staffing requirements for various adult mental health services in England. As with the Bamford report, the Sainsbury Centre research used population size as a basis for producing the staffing levels needed to deliver services, and therefore can be used as a comparator for the staffing estimates produced by the Bamford report. In the main, the staffing estimates produced by the Sainsbury Centre report are similar to those produced by Bamford. Table 4.4 below illustrates how the staffing estimates for the main mental health teams of staff compare.

Table 4.4
Bamford Review and Sainsbury Adult Mental Health Staffing Estimates

Adult Mental Health Service	Bamford Staffing Estimate	Sainsbury Centre Staffing Estimate
Community Mental Health Teams	125	119
Assertive Community Treatment	15	24
Home Treatment	24	23
Early Intervention in Psychosis	No estimate, although the report does mention the need for these services	21
Total	**164**	**187** **(166 excluding the Early Intervention staffing estimate)**

The Sainsbury Centre staffing estimates are based on populations of 250,000, in line with the Bamford estimates. It should be noted that the Sainsbury Centre staffing estimates above exclude support workers, and it was highlighted that a total of 50 support workers would be required for population totals of 250,000, working across all of the teams outlined in Table 4.4 above. The Bamford report does not specify the staff mix which make up the above named mental health teams, therefore further clarification is needed before a complete staffing estimate can be given, inclusive of support staff numbers.

Furthermore, the below points should also be noted:

- The staffing ratios highlighted in the Sainsbury Centre report for acute/intensive care beds range from 1.6 for acute care to 3.2 for intensive care unit beds. This compares to the average figure of 1.3 used in the estimates in Table 4.1 above (based on advice from DHSSPS nursing advisors and a Trust). The difference between staffing ratios would have a significant impact on the numbers of staff required for the acute hospital setting; and

- The staffing estimates within the Bamford report cover only community mental health teams, and Bamford highlighted that staff would be needed to provide, for example, eating disorder, psychological trauma and challenging behaviour specialist services. The Sainsbury Centre report provides staffing estimates for a number of specialist services. These are based on populations of 250,000 and include; Eating Disorder services (38.5 staff), Local Personality Disorder services (16 staff) and Perinatal services (55.5 staff). These figures add to the overall staffing levels needed to deliver the full range of adult mental health services in England. Further scoping work is required in Northern Ireland to ascertain the staff levels needed to deliver these specialist services.

4.2.6 Summary

Table 4.4 provides an overall summary of:

- Current workforce estimates based on:
    - Baseline workforce information from HRMS; and
    - HSC Trust returns (mapping of current service provision);
- Future workforce projections based on;
    - Bamford's recommendations for implementing recommendations within each domain (in the longer term); and
    - HSC Trust returns indicating the additional staff required to deliver reformed services in the next three years.

The following limitations in this analysis should be noted:

- quantitative estimates of the future workforce required to fully implement the long term vision set out in the Bamford reports are not yet available for every element of service – further analysis is required;

- not all Trusts were able to provide quantitative data in relation to the additional staff needed to deliver on service developments for 2009-2011. Trust demand figures in the table below do not comprehensively illustrate the demand for staff in the next three years but should be considered the likely minimum required. (The number of Trusts providing demand estimates is shown in brackets in the 'Demand' column.);

- the analysis does not take account of the number of posts that will reduce in MHLD services i.e. in hospital services. There will be staff available for redeployment into new and extended services from existing MHLD hospital services. However hospital and community services will be required to run in parallel for some time during the transition, and workshop participants noted the potential loss of economies of scale with community-based provision;

- the analysis does not allow for disaggregation between different staff groups. It is envisaged that many of the services will be provided by multi-disciplinary teams and that many new roles will be designed to be suitable for staff from a variety of professional backgrounds. In addition, meeting the efficiency requirements over the next three years will necessitate improved productivity, including skill-mix efficiency. New service models are likely to involve a greater proportion of support staff;

- the analysis focuses on the statutory element of the MHLD workforce. Available information indicates that within the voluntary and community sector there are an estimated 1,685 MH and 2,685 LD staff. There will be additional demand for MHLD services from the independent sector, particularly in relation to support services tailored to meet the specific needs of individuals with a learning disability or mental illness. However, the Bamford estimates in the Table below largely relate to statutory provision; and

- further work needs to be undertaken to scope both the size and composition of those teams designed to provide specialist services for those adults with, for example, a personality or eating disorder. The Sainsbury Centre report includes this information, allowing a staffing estimate which is more representative of the demand for services.

Table 4.4
Current Statutory MHLD Workforce Compared to Estimated Additional Workforce Demand

	Domain	Current Workforce (WTE)		Estimated Future Demand (WTE)*		
		HRMS	Trust Returns	Bamford Estimates (10-15 yrs): Workforce Estimate	Bamford Estimates (10-15 yrs): Additional Posts**	Trusts (2-3 yrs) Additional Posts
LD	LD Total	1,882	2,259	Not Quantified		+247 (5 Trusts)
MH	Older People	-	330	+362 and Domiciliary Care	+362 and 20% increase	+89 (4 Trusts)
	CAMHS	-	299	389-474	+175	+62 (4 Trusts)
	AMH	-	2,640	1,778	-862	+92 (2 Trusts)
	MH Total	3,256	3,269	A reduction in MH staff of 325 + 20% increase in Domiciliary Care		Additional 243 Staff

Notes: * Estimates do not account for all staff groups, specialist services are not included

** Additional Posts show difference between Current Workforce from Trust Returns and Bamford Workforce Estimate

Key Observations

- Based on the available information, estimates suggest that in the longer term the MH staff complement should reduce by some 325 staff (to a figure of 2,944). However, this reduction does not include the full range of specialist MH services and does not account for a substantial increase to domiciliary care workers in older people's MH services. In addition, the figure does not reflect the significant level of redeployment that will be required within the system;

- Further analysis is required to determine the full workforce implications of implementing the recommendations for LD services, but a similarly significant impact on the workforce would be expected given the scale of reform set out;

- Information currently available from the Trusts indicates that in the short term, there is significant demand for staff - at least an additional 243 MH and 247 LD staff by 2011;

- Joint service development and workforce planning between providers will help to determine the impact on staffing within the independent sector. There is a need for a co-ordinated approach to ascertain the scope of services currently provided by the independent sector and the demand for services which is placed upon the sector by service users. It is critical that models of service provision need to be created and piloted to test their suitability, as the demand for services, including a range of specialist services, from the independent sector grows.

4.3 Impact on MHLD Training Places

Despite the incomplete nature of the demand estimates available, it is clear that additional MHLD professionals will be required if service provision is to move towards the vision set out in the Bamford Review. There will be a need for significant redeployment of staff to support the transition programme and maintain service delivery in a period of significant upheaval. In order to increase the inflow of professional staff into the MH and LD domains the number of training places available for the range of disciplines which form part of the MHLD workforce will need to be increased. This section provides worked examples of the impact that increasing the numbers of training places for the various MHLD professional staff groups would have on meeting the estimated short-term workforce demands provided by the Trusts and the longer-term workforce requirements of Bamford.

Table 4.5 shows the number of professional training places available per year that would help meet the additional demand for the MHLD workforce. The table shows the current number of places and an increase of 10 per cent, 20 per cent, 30 per cent and 50 per cent. Key points to note are as follows:

- The scenarios in Table 4.5 assume that current attrition rates remain constant. Given the currently high attrition rates in MH and LD nursing (16 per cent) there is further scope to increase output within the figures shown. It is noted that there have been increases to MH and LD training places in recent years;

- The proportion of Social Work and AHP professionals qualifying who choose to enter MHLD careers was not available, Table 4.5 shows the total number of places. Increasing the proportion of these groups entering MHLD posts would make further contribution to meeting the additional workforce demand; and

- Table 4.5 only shows the potential increase to professional training places and does not account for support staff demand which is likely to be a substantial element of the workforce going forward, reflecting new ways of working and required productivity improvements.

Table 4.5

Professional Training Places – Potential Increases

		10% increase		20% increase		30% increase		50% increase	
Training Course	**Current Inflow (minus attrition)**	**Current inflow +10%**	**Additional places**	**Current inflow +20%**	**Additional places**	**Current inflow +30%**	**Additional places**	**Current inflow +50%**	**Additional places**
Mental Health Nursing	*124	136.4	**12.4**	148.8	**24.8**	161.2	**37.2**	186	**62**
Learning Disability Nursing	22	24.2	**2.2**	26.4	**4.4**	28.6	**6.6**	33	**11**
Social Work*	**281.5	309.7	**28.2**	337.8	**56.3**	366	**84.5**	422.3	**140.8**
Social Work Post-Reg	23	25.3	**2.3**	27.6	**4.6**	29.9	**7.9**	34.5	**11.5**
Clinical Psychology	10.7	11.7	**1**	12.8	**2.1**	13.9	**3.2**	16.1	**5.4**
AHP*	**196.7	216.3	**19.6**	236	**39.3**	255.7	**59**	295.1	**98.4**
Total	**659.7**	**723.6**	**65.7**	**789.5**	**131.5**	**855.3**	**198.4**	**987**	**329.1**

* Social Work and AHP training places are not specific to MHLD

Key Observations

- In the short term (to 2011), Trusts have estimated a need for at least an additional 243 MH and 247 LD staff. There will be a continuing need for staff based in the hospital setting during the transition period, although this will reduce as reforms are implemented;
- Applying existing attrition rates, there are currently up to 659 professionals *available* per year to enter the MHLD workforce, including all qualifying social workers and AHPs. However, only 146 of this supply of professionals are on specific MHLD training courses (i.e. MHLD nursing);
- A 10 per cent increase to these numbers would provide an additional 65.7 qualifying professionals per year or 657 over the next 10 years;
- A 20 per cent increase to these numbers would provide an additional 131.5 qualifying professionals per year or 1,315 over the next 10 years;
- A 30 per cent increase to these numbers would provide an additional 198.4 qualifying professionals per year or 1,984 over the next 10 years;
- A 50 per cent increase to these numbers would provide an additional 329.1 qualifying professional per year or 3291 over the next 10 years;
- Given the lead in time required for professional training and the considerable additional demand for MHLD staff in the short-term it would appear that additional training places are required and these should be linked to actions that aim to reduce attrition.
- An effort needs to be made to direct the additional pre-qualification social work and AHP trainees into MHLD careers. Possible approaches include increasing the availability of placements in MHLD settings during training and aligning pre-qualification trainees to roles which they would undertake post-qualification e.g. through bridging contracts.

5 ACHIEVING THE VISION: RECOMMENDATIONS

5.1 INTRODUCTION

The purpose of this section is to set out a series of recommendations regarding the way forward for the development of the MHLD workforce in Northern Ireland. These recommendations are based on the analysis of all information and data collected throughout this assignment. These are proposals for consideration and although these are presented as separate recommendations, there are a range of interdependencies between them that must be considered when making decisions about the implementation of recommendations.

5.2 THE WAY FORWARD

The Bamford Review recommends large scale and long term change regarding the provision of mental health and learning disability services in Northern Ireland. Although the Department, Boards and Trusts are making progress, it is clear that the full implications of the Review on service configuration, both at regional and local levels (and including the role of the voluntary and community sector), has not been fully identified.

Although it is appreciated that the implementation of the Bamford recommendations comes at a challenging time for Trusts as they work to comply with the CSR and fully implement the new Trust arrangements put in place under RPA, further clarity is required in terms of how the Review's recommendations will be rolled out. This will be informed by the budget for MHLD services 2008-11 allocation of an additional £44 million to Mental Health and Learning Disability services (£27 million for Mental Health, £17 million for Learning Disability Services and an additional £3 million for Mental Health promotion over three years).

To enable the development of MHLD services as envisioned by Bamford it will be necessary to strengthen the partnership working between the statutory, voluntary and community and independent sectors. This will enable the sector to address interface issues across and within sectors.

5.3 RECOMMENDATIONS

5.3.1 Development Plan

It is recommended that Trusts work together to compile a development plan, which identifies a common model for the future delivery of the Bamford vision. The purpose of this plan is to build on the existing work and service delivery targets to:

- Standardise the quality of the provision of services
- Improve access to services
- Reduce waiting times
- Ensure timely discharge
- Resettle people from hospital to community settings

The plan should identify current service provision, what the provision should deliver beyond 2011 into the period of the next Comprehensive Spending Review, and how the investment over the next two years takes it towards this vision.

Given the economic climate and the restraints and challenges of budgets a considerable proportion of the change within MHLD workforce will be through reform and modernisation of the current workforce. Trusts must actively consider redesign in the wider context of their service delivery alongside CSR proposals. It is recommended that this time of change should be used as an opportunity to implement service improvements aligned to the Bamford vision.

5.3.2 Regional Strategies and Reviews

It is recommended that Trusts workforce plans to delivering the Bamford vision should be aligned to the New Service Frameworks, the Mental Health Service Framework and the Learning Disability Framework. Building on Bamfords vision of multi-disciplinary teams.

It is recommended Bamford workforce plans should recognise and reflect other relevant current regional strategies alongside strategies under development such as:

- New Strategic Direction for Alcohol & Drugs
- Autism Spectrum Disorder (ASD) Strategy
- Mental Health and Well-Being Strategy
- Tackling Domestic Violence at Home Strategy
- NI Suicide Prevention Strategy Northern Ireland – Protect Life
- The Response of the NI Executive to the Bamford Review of Mental Health and Learning Disability (July 2009)
- NI Carers Strategy

It is recommended that the MHLD workforce plans take cognisance of the independent inquiry reports in the context of resultant changes in the delivery of services such as:

- The strengthening of the Child-Care and Mental Health Interface (Madeline O'Neill Independent Inquiry Report)
- Introduction of Family Group Conferencing to Mental Health Services (Madeline O'Neill Independent Inquiry Report)
- Child protection changes (Madeline O'Neill Independent Inquiry Report)
- Pro-active implementation of the 2004 Discharge Guidelines (McCleery Report)
- Effective interfacing of CAMHS, Addiction Services and Adult Mental Health Services for the benefit of individuals and families (McCartan Review)
- Ensuring the full implementation of Looked After Children (LAC) Policy and Procedures, the implementation of Understanding the Needs of Children in Northern Ireland (UNOCINI) and the provision of training for the staff in the field of disability with regard to the protection of children and vulnerable adults (Cherry Lodge Independent Review).

5.3.3 Psychological Therapies

It is recommended that workforce plans and training enhancements should align developments within the workforce to reflect the outcomes of the Strategy for Improving Access to Psychological Therapies.

5.3.4 Suicide Prevention within MH Services

Within the statutory sector it is recommended that HSCB and PHA consider current models of good practice highlighted within the Review of the Northern Ireland Suicide Prevention Strategy "Protect Life" with the aim of standardising access and improving service provision regionally. Trusts in support of this should develop a change management plan to develop and establish these models of good practice for their local population and embed these within their workforce plans.

It is recommended that cognisance be taken of the valuable and important contribution made by the voluntary and community sectors in delivering services to those who self-harm and / or are affected by suicide. In the development of workforce plans for MH and LD services

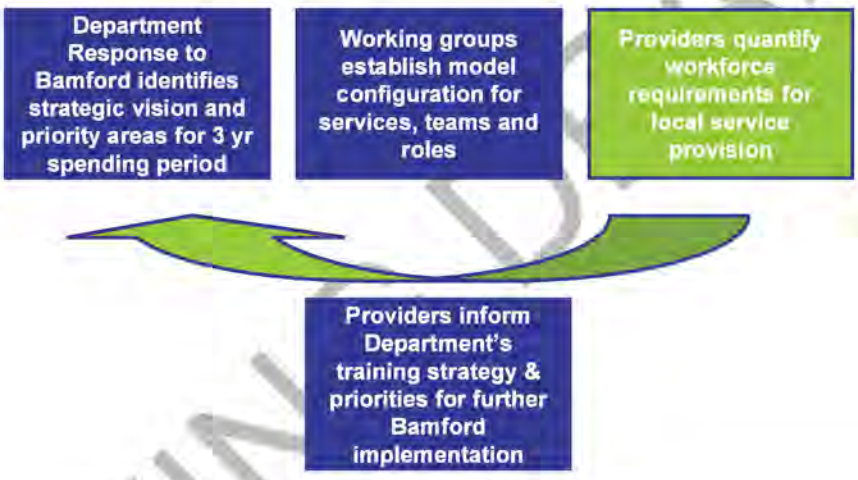
the voluntary and community organisations should be encouraged to build networks to enhance the overall service. Stronger links should be forged between the statutory and community / voluntary sectors in order to improve provision and tackle the issues of self-harm and suicide.

5.3.5 Increasing Role of Trusts in Workforce Planning

It is recommended Trusts in partnership with the independent, voluntary and community sectors continue to build and plan the workforce together recognising the vital contribution from all sectors towards the sustainability of service delivery into the future.

As illustrated in Figure 5.1 this should be a continuous and ongoing process in line with the evolution and development of services.

Table 5.1
Ongoing Definition and Implementation of Bamford Recommendations – 3 Year Workforce Planning Cycle



5.3.6 Workforce Planning Leadership Skills

The ongoing process of translating the strategic vision for MHLD services into detailed workforce plans at provider level will need to be led by a dedicated and appropriately skilled leadership. It is recommended that there is access to adequate multi-professional workforce planning training at all appropriate levels from leadership to management posts should help strengthen and build capacity of workforce planning within Trusts.

5.3.7 Promoting MHLD Careers

It is evident that the MDLD workforce will require strengthening in coming years both by reform of current services and investment in additional staff with new roles. This presents a challenge for both employers and training providers as recruitment to these areas of work have traditionally been subject to recruitment problems. Previously successful campaigns have increased interest in Mental Health Learning Disability training places.

It is recommended that the Department invest in a further promotional campaign with input from statutory, voluntary and community sectors, education, service users and carers. The campaign should:

- showcase developments within the service such as new community based services which are going to become the predominant work setting under Bamford;
- illustrate the multi-disciplinary / multi-agency team working structure; and

- demonstrate career pathways in MHLD.

It is recommended that the Department lead the campaign with input from providers in statutory, voluntary and community sectors. The campaign should also be developed with input / linkages from schools, FE colleges, university, service users and carers.

The campaign should also be developed with input / linkages from schools, FE Colleges, university and service users and carers and should be timed to align with the University and schools' academic timetable and commissioning cycle. The full range of MHLD roles should be included in the scope of the campaign i.e. professional and support roles.

5.3.8 Training Provision

The following training requirements (Table 5.1) have been identified as a result of the Bamford Review and it is recommended that these become part of a training action plan.

Table 5.1
Training Related Recommendations

Target Group	Nature of Training
Generic HSC workforce	Immediate plans should be put in place for all HSC staff (existing workforce & those in initial training) to receive awareness training in aspects of MHLD e.g. recognising mental health issues, meeting the needs of patients with a learning disability etc. This should also help to promote MHLD as a career path and should become part of core training.
MHLD workforce	The Bamford Principles should be embedded into all MHLD training from 2009 onwards.
	All MHLD staff (regardless of their discipline) should receive induction training focusing on new ways of working under the reconfigured services when they assume a post within a MHLD team (including redeployed staff)
	Awareness training for all MHLD staff in relation to cognitive behaviour / psychological therapies and practitioner training for those who will provide these services to patients displaying low levels of need. The possibility of including this training in core professional training should be explored as a means of developing a critical mass of skills in talking therapies.
	Training for the users of LD services and their families/ carers to support greater self-determination in service uptake
	Induction training for Direct Support Workers employed by people with a learning disability
	Training for families providing respite and fostering placements for people with a learning disability
MHLD Team Specific	Specific MHLD team / staff training should be developed and made available to staff delivering new and extended services including: – an e-learning package for Home Treatment staff; – challenging behaviour training for staff in community MH and LD services; – specialist training for Eating Disorder staff in acute settings; – training for Palliative Care Teams regarding palliative care approaches for older people with advanced dementia; – specialist training to support ASD services; – training in managing challenging behaviours for LD staff in respite, supported accommodation and day centre services; – training in therapeutic services, forensics and challenging behaviours for LD staff in assessment and treatment services. Where the independent sector is involved in the delivery of any MHLD services their staff should have the opportunity to avail of necessary training along with Trust staff.

It is recommended that the following activities are undertaken:

- Removal of structural barriers that delay entry into the MHLD workforce
- The time taken for a qualified health professional, i.e. Nurse or Social Worker, to train to enter the MHLD area is lengthy and presents a barrier to those wishing to enter the workforce.
- The Department explores options to reduce the conversion time. This could include the introduction of a programme similar to that in operation in Scotland (the Flying Start programme), which enables nurses to be more quickly deployed into community settings. Any such programmes should be available to staff seeking entry to MH and LD.
- The Department liaises with QUB and UU in order to explore aspects of initial professional training (e.g. for AHPs and Social Workers) that could be amended to support any staff wishing to specialise in MH or LD to do so in a timelier manner.
- MHLD has lower appeal to health and social services staff than other areas of work, and this in turn has a negative impact on the numbers of staff who want to work in the area. In order to help reverse this perception it is recommended that core training for different professional groups including AHPs and Social Workers includes more placements in MHLD settings. The Department should liaise with QUB and UU with a view to enabling these placements to be available during the 2010/2011 training year.
- The Trusts work with the Department and education and training providers to develop training / employment programmes that provide job offers to HSC professionals upon completion of their training (e.g. bridging contracts that guarantee placement students employment upon completion of training).

5.3.9 Professional Training Places

Implementing the Bamford vision will require a considerable increase in the MHLD workforce over the coming years, with an estimated demand of at least 104 LD staff and 243 MH staff in the next three years, and a further significant growth in the longer term to fully implement the Bamford recommendations.

It is recommended that DHSSPS commissions additional training places for all professional programmes that will support the expansion of the MHLD workforce:

- There is particular demand for LD and MH nurses in the short term and an existing shortage of these staff. The training places for MH and LD nursing should be increased by 50 per cent with effect from 2010/11. The promotional campaign noted above should specifically focus on attracting people into LD and MH nursing courses and action should also be taken to reduce the attrition rates on these courses; and
- We recommend that the number of social work, psychology, and AHPs training places should be increased by at least 10 per cent in 2010/11, with additional action taken to tie these additional places to MHLD careers.

5.3.10 Engaging and Building Capacity within the Voluntary & Community Sector in Workforce Planning and Development

The voluntary and community sector will play an increasing role with regard to the provision of MHLD services particularly as more services are delivered in the community as recommended by Bamford. Therefore this sector will form a critical element of the MHLD workforce and demands from the sector for additional resources are likely to increase as Bamford's vision for the service is implemented.

It is recommended that the Trusts establish and maintain workforce partnerships with voluntary and community sector service providers in order to facilitate workforce planning

actions as they are identified and that processes are developed that facilitate voluntary and community sector staff working in MHLD to train with Trust staff. This would increase access to training for the voluntary and community sector and should help to facilitate cross-sectoral working and embed this into reconfigured services.

5.3.11 Defining Roles

Implementation of Bamford's recommendations will result in a number of new roles and teams being introduced into the MHLD workforce over the coming years. Work has commenced to articulate the exact nature of the psychological therapies and support, time and recovery worker roles. It will be important that the Department, with input from providers, fully determines the following aspects of each role:

- Scope and responsibility;
- Necessary qualifications / experience / background;
- Competencies;
- Skills;
- Training requirement;
- Recruitment activity; and
- Career pathway.

It is recommended that the Department works closely with Commissioners and Trusts in order to confirm, prioritise and develop each of these on a timely basis.

The full scale of the roles requiring this attention will be realised over time but it is anticipated that the following will be included:

- Link Worker between CMHTs and primary care;
- Support, Time and Recovery Worker;
- Dual qualified Midwife and Mental Health Nurse;
- Eating Disorder roles;
- Psychological Therapists;
- Personality Disorder roles;
- CAMHS Manager;
- Primary Mental Health Worker for CAMHS;
- Key Worker for LD;
- Family Support Worker for LD;
- Health Facilitator and GP Link Worker for LD;
- Direct Support Worker for LD;
- Respite & Supported Accommodation Brokers, Managers & Team Leaders for LD; and
- Day care Brokers and Mentors for LD.

The following priorities are recommended:

- Within MH the Link Worker role should be clarified, developed and recruited in the short-term; and
- Within LD priority should be given to defining the Key Worker, Health Facilitator and GP Link Worker roles.

5.3.12 Retention Strategy

The implementation of Bamford's vision, particularly the shift in focus of service provision from acute settings to community settings, will require a significant staff redeployment exercise. This has already commenced as Trusts work towards achieving their PfA targets. Retaining the extensive skills and experience that many acute MHLD staff possess will be of critical importance to the future of service delivery, however as with any change the redeployment risks the loss of some of these staff.

It is recommended that the Trusts develop and implement redeployment strategies for MHLD that aim to:

- Ensure that the transition of professional and support staff from one setting to another is as smooth and undisruptive as possible (for staff and patients);
- Retain skilled and experienced professional and support staff through redeployment maintaining skills during the harmonisation and reconfiguration of services; and
- Identify any specific training that professional and support staff will require to support them to work in their new roles / settings.

It is recommended that Trusts should assign a senior member of staff with responsibility for monitoring progress with regard to the implementation of the retention strategy to identify and address any issues that may arise.

It is recommended that the Trusts explore ways in which they can increase retention rates for those members of the workforce who are aged over 55 years and include these in the overall strategy.

5.3.13 Reviewing Trust Recruitment Strategies

In light of clarification of the agreed vision and strategic direction for MHLD, and taking on board the ongoing reform and modernisation of services, it is recommended that Trusts should undertake a review of their own recruitment strategies.

The purpose of this review would be to ensure that Trusts are prepared in advance to progress the actions necessary to facilitate uplift in recruitment activity. The review should seek to identify creative but workable methods of recruitment including undertaking joint recruitment activities with the voluntary and community sector, and developing links into potential workforce pools including Further Education, former service users and carers.

It is recommended that partnership working between the statutory, voluntary and community and independent sector is strengthened in order that together they can address interface issues across sector and within sectors. All workforce plans should have multi-agency, multi-sectoral, users and carers input to identify ways of improving overall service provision and the patient/client experience.

5.3.14 Conclusion

The conclusions and recommendations presented in this report have been developed through the work of the Bamford Workforce Planning Steering Group. These should form a foundation from which multi-disciplinary workforce planning for MH & LD can be developed. The new organisational arrangements across the HSC provide an opportunity to develop a new approach to multi-disciplinary workforce planning.

A group of key stakeholders should be established to take this work forward. This group should develop a regional action plan based on the recommendations set out in this report. The modelling at organisational level will inform workforce numbers required to take the MH&LD services into the future.

Appendix I

Age Breakdown by MHLD staff groups

Table 1
Age profile of MHLD nursing staff

5 year age bands	< 25				
	Belfast	Northern	Western	Southern	South Eastern
	Headcount	Headcount	Headcount	Headcount	Headcount
Mental Health Nurse	19	-	-	-	-
Mental Health Nurse Support	21	20	10	15	8
Learning Disability Nurse	-	0	0	-	-
Learning Disability Nurse Support	42	0	8	-	0
Total	**82**	**20**	**18**	**15**	**8**
			25 - 29		
Mental Health Nurse	39	36	29	25	11
Mental Health Nurse Support	31	21	15	9	-
Learning Disability Nurse	25	-	6	20	-
Learning Disability Nurse Support	20	0	9	12	0
Total	**115**	**57**	**59**	**66**	**11**
			30 - 34		
Mental Health Nurse	47	46	27	32	22
Mental Health Nurse Support	29	15	21	7	11
Learning Disability Nurse	18	-	9	12	9
Learning Disability Nurse Support	19	0	10	8	-
Total	**113**	**61**	**67**	**59**	**42**
			35 - 39		
Mental Health Nurse	58	46	61	40	21
Mental Health Nurse Support	31	22	37	17	10
Learning Disability Nurse	30	-	8	8	11
Learning Disability Nurse Support	31	0	10	8	-
Total	**150**	**68**	**116**	**73**	**42**
			40 - 44		
Mental Health Nurse	109	76	81	54	42
Mental Health Nurse Support	32	12	31	30	10
Learning Disability Nurse	36	-	-	26	9
Learning Disability Nurse Support	38	0	11	8	-
Total	**215**	**88**	**123**	**118**	**61**
			45 - 49		
Mental Health Nurse	76	58	115	66	50
Mental Health Nurse Support	35	23	35	22	15
Learning Disability Nurse	38	6	9	33	-
Learning Disability Nurse Support	26	0	12	40	-
Total	**175**	**87**	**171**	**161**	**65**
			50 - 54		
Mental Health Nurse	57	44	85	39	38
Mental Health Nurse Support	24	20	25	23	10
Learning Disability Nurse	27	0	15	12	8
Learning Disability Nurse Support	26	0	9	24	-
Total	**134**	**64**	**134**	**98**	**56**
			55 - 59		
Mental Health Nurse	17	22	21	15	20
Mental Health Nurse Support	14	14	-	6	-
Learning Disability Nurse	12	-	-	8	-
Learning Disability Nurse Support	26	0	7	7	-
Total	**69**	**36**	**28**	**36**	**20**
			60 - 64		
Mental Health Nurse	7	-	-	6	-
Mental Health Nurse Support	6	6	-	-	-
Learning Disability Nurse	11	0	-	-	-
Learning Disability Nurse Support	14	0	-	-	-
Total	**38**	**6**	**0**	**6**	**0**
			65+		
Mental Health Nurse	-	-	0	-	0
Mental Health Nurse Support	0	-	0	0	0
Learning Disability Nurse	-	0	0	0	0
Learning Disability Nurse Support	-	0	0	0	-
Total	**0**	**0**	**0**	**0**	**0**
Overall Total	**1091**	**487**	**716**	**632**	**305**

Note: A dash (-) represents cell counts of fewer than 6 people

Table 2
Age profile of MHLD social work staff*

		Belfast	Northern	Western	Southern	South Eastern
		Headcount	Headcount	Headcount	Headcount	Headcount
< 25	Mental Health Social Workers	-			-	
	Mental Health Social Worker Support	-	-			
	Learning Disability Social Worker	0	0	0	0	0
	Learning Disability Social Worker Support	22	32	-	-	-
25 - 29	Mental Health Social Workers	6	10	-	-	0
	Mental Health Social Worker Support	-	-	0	-	0
	Learning Disability Social Workers	0	-	11	-	-
	Learning Disability Social Worker Support	40	37	9	25	-
30 - 34	Mental Health Social Workers	-	9	-	-	7
	Mental Health Social Worker Support	-	8	0	0	0
	Learning Disability Social Workers	6	-	14	-	-
	Learning Disability Social Worker Support	58	41	7	21	13
35 - 39	Mental Health Social Workers	16	14	11	9	12
	Mental Health Social Worker Support	8	6	0	-	-
	Learning Disability Social Workers	6	-	14	7	14
	Learning Disability Social Worker Support	47	49	6	18	25
40 - 44	Mental Health Social Workers	10	16	11	9	10
	Mental Health Social Worker Support	6	9	0	0	-
	Learning Disability Social Workers	12	6	16	6	11
	Learning Disability Social Worker Support	49	39	-	27	17
45 - 49	Mental Health Social Workers	12	-	10	8	9
	Mental Health Social Worker Support	-	6	0	-	0
	Learning Disability Social Workers	18	6	10	9	10
	Learning Disability Social Worker Support	40	33	-	27	18
50 - 54	Mental Health Social Workers	8	6	13	-	11
	Mental Health Social Worker Support	-	13	-	-	-
	Learning Disability Social Workers	-	6	18	7	10
	Learning Disability Social Worker Support	25	34	-	25	12
55 - 59	Mental Health Social Workers	-	-	-	-	-
	Mental Health Social Worker Support	-	12	-	-	-
	Learning Disability Social Workers	-	-	10	-	-
	Learning Disability Social Worker Support	16	20	-	14	11
60 - 64	Mental Health Social Workers	0	-	-	0	-
	Mental Health Social Worker Support	-	-	0	0	0
	Learning Disability Social Workers	-	0	-	-	-
	Learning Disability Social Worker Support	9	11	-	-	-
65+	Mental Health Social Workers	0	-	0	0	0
	Mental Health Social Worker Support	0	0	0	0	0
	Learning Disability Social Workers		-			
	Learning Disability Social Worker Support	-	-		-	
Overall Total		**416**	**423**	**160**	**233**	**190**

Note: A dash (-) represents cell counts of fewer than 6 people

Table 3
Age profile of clinical psychology staff

		Clinical Psychologists	Trainee/Assistant Psychologists
5 year age bands		**Headcount**	**Headcount**
< 25	**Belfast**	0	-
	Northern	-	-
	Western	0	-
	Southern	0	0
	South Eastern	0	-
	Regional Services	-	0
25 - 29	**Belfast**	-	6
	Northern	-	-
	Western	-	-
	Southern	-	-
	South Eastern	-	-
	Regional Services	19	0
30 - 34	**Belfast**	15	-
	Northern	-	-
	Western	6	0
	Southern	-	0
	South Eastern	7	-
	Regional Services	8	0
35 - 39	**Belfast**	18	-
	Northern	12	0
	Western	-	0
	Southern	-	0
	South Eastern	7	-
	Regional Services	-	0
40 - 44	**Belfast**	13	0
	Northern	-	0
	Western	-	0
	Southern	-	0
	South Eastern	-	0
	Regional Services	-	0
45 - 49	**Belfast**	11	0
	Northern	-	0
	Western	-	0
	Southern	-	-
	South Eastern	-	0
	Regional Services	0	0
50 - 54	**Belfast**	8	0
	Northern	-	0
	Western	-	0
	Southern	-	0
	South Eastern	-	-
	Regional Services	0	0
55 - 59	**Belfast**	-	0
	Northern	-	0
	Western	-	0
	Southern	-	0
	South Eastern	0	-
	Regional Services	0	0
60 - 64	**Belfast**	-	0
	Northern	0	0
	Western	0	0
	Southern	0	0
	Regional Services		
65+	**Belfast**	-	0
	Northern	-	0
	Western	0	0
	Southern	0	0
	South Eastern	0	0
	Regional Services	0	0

Note: A dash (-) represents cell counts of fewer than 6 people

Table 4
Age profile of clinical MH medical staff

		Belfast	Northern	Western	Southern	South Eastern
		Headcount	Headcount	Headcount	Headcount	Headcount
< 25	Mental Health Medical Staff	0	-	0	0	0
25 - 29	Mental Health Medical Staff	22	21	16	11	14
30 - 34	Mental Health Medical Staff	22	14	10	9	12
35 - 39	Mental Health Medical Staff	15	12	-	-	-
40 - 44	Mental Health Medical Staff	13	-	-	8	-
45 - 49	Mental Health Medical Staff	9	11	-	-	-
50 - 54	Mental Health Medical Staff	10	-	-	7	-
55 - 59	Mental Health Medical Staff	6	-	-	-	-
60 - 64	Mental Health Medical Staff	-	-	-	0	0
65+	Mental Health Medical Staff	-	0	0	0	0
Overall Total		**97**	**58**	**26**	**35**	**26**

Note: A dash (-) represents cell counts of fewer than 6 people

Table 5
Age profile of clinical LD medical staff

		Belfast	Northern	Western	Southern	South Eastern
		Headcount	Headcount	Headcount	Headcount	Headcount
25 - 34	Learning Disability Medical Staff	7	0	0	-	0
35 - 44	Learning Disability Medical Staff	8	0	-	-	0
45 - 59	Learning Disability Medical Staff	-	0	-	-	0
Overall Total		**15**	**0**	**-**	**-**	**0**

Note: A dash (-) represents cell counts of fewer than 6 people

Appendix II

Gender Breakdown by MHLD staff groups

Table 6
Gender profile of MHLD nursing staff*

	BHSCT		NHSCT		WHSCT		SHSCT		SEHSCT	
	F	M	F	M	F	M	F	M	F	M
Mental Health Nurse	300	131	239	99	306	121	228	54	153	57
Learning Disability Nurse	162	40	17	-	47	12	117	8	44	-
Mental Health Support Nurse	154	69	126	30	129	54	102	31	54	22
Learning Disability Support Nurse	193	50	0	0	54	23	86	29	19	-

Note: A dash (-) represents cell counts of fewer than 6 people

Table 7
Gender profile of MHLD social work staff

	BHSCT		NHSCT		WHSCT		SHSCT		SEHSCT	
	F	M	F	M	F	M	F	M	F	M
Mental Health Social Worker	44	19	53	14	40	16	35	7	34	18
Mental Health Support	21	15	64	-	-	-	8	-	-	-
Learning Disability Social Worker	36	18	25	9	71	27	33	-	47	10
Learning Disability Social Work Support	246	62	260	38	31	10	146	21	93	13

Note: A dash (-) represents cell counts of fewer than 6 people

Table 8
Gender profile of clinical psychology workforce*

		Clinical Psychologists**	Trainee/Assistant Psychologists
HSC Trust		**Headcount**	**Headcount**
Belfast	F	57	13
	M	19	0
Northern	F	22	9
	M	13	-
Western	F	13	6
	M	9	-
Southern	F	12	-
	M	8	0
South Eastern	F	22	13
	M	-	0

** 34 Clinical Psychology staff work in Regional Services. A dash (-) represents cell counts of fewer than 6 people

Table 9
Gender profile of MHLD medical workforce

		MH Medical	LD Medical
HSC Trust		**Headcount**	**Headcount**
Belfast	F	58	12
	M	42	-
Northern	F	40	0
	M	31	0
Western	F	26	-
	M	21	-
Southern	F	26	-
	M	19	-
South Eastern	F	25	0
	M	15	0

Note: A dash (-) represents cell counts of fewer than 6 people

Appendix III

HSC Trust Data Returns

Note:

The returns received back from the Trusts in relation to Learning Disability, Adult Mental Health, Older People's Mental Health and Dementia Services and Children and Adolescent Mental Health service provision contained data in different formats ranging from WTE estimates per staff grade, to organisation charts with summary grade titles and no specification of numbers involve. Full returns were not received for all settings within all domains.

Table 7
HSC Trust returns – LD services

Service	HSC Trust	WTE
Hospital Services	SEHSCT	0
	WHSCT	59.5
	NHSCT	0
	SHSCT	139.16
	BHSCT	432.5
Total		**631.16**
Respite Services	SEHSCT	0
	WHSCT	26
	NHSCT	39.86
	SHSCT - part of Hospital Services	0
	BHSCT - part of Supported Living	0
Total		**65.86**
Community Teams	SEHSCT	44
	WHSCT	42.9
	NHSCT	73
	SHSCT	95.25
	BHSCT	41.8
Total		**296.95**
Daycare	SEHSCT	135.52
	WHSCT	160.7
	NHSCT	237.53
	SHSCT	12.06
	BHSCT	231
Total		**776.81**
Supported Living	SEHSCT	37.93
	WHSCT	45.9
	NHSCT	75.21
	SHSCT	87.13
	BHSCT	144
Total		**390.17**
Psychology Services	SEHSCT	4.8
	WHSCT	2.8
	NHSCT	0
	SHSCT	0
	BHSCT	9
Total		**16.6**
Other	SEHSCT	0
	WHSCT	63.98
	NHSCT	
	SHSCT	0
	BHSCT	18.1
Total		**82.08**
		2259.6

Table 8
HSC Trust returns – AMH services

Service	HSC Trust	WTE
Hospital Services	SEHSCT	168.84
	WHSCT	90
	NHSCT	397.78
	SHSCT	224.95
	BHSCT	539.39
Total		**1420.96**
Community Mental Health Teams	SEHSCT	64.39
	WHSCT	50
	NHSCT	89
	SHSCT	80.8
	BHSCT	165.21
Total		**449.4**
Daycare	SEHSCT	16.1
	WHSCT	15
	NHSCT	0
	SHSCT	6
	BHSCT	27.04
Total		**64.14**
Supported Accommodation in the Community	SEHSCT	8.5
	WHSCT	72
	NHSCT	28
	SHSCT	80
	BHSCT	43.63
Total		**232.13**
Respite Services	SEHSCT	0
	WHSCT	45.9
	NHSCT	28
	SHSCT	87.13
	BHSCT	0
Total		**161.03**
Psychology / Psychotherapy Services	SEHSCT	18.4
	WHSCT	16
	NHSCT	No data
	SHSCT	8.6
	BHSCT	7.38
Total		**50.38**
Specialist AMH Services	SEHSCT	17
	WHSCT	No data
	NHSCT	40
	SHSCT	15.6
	BHSCT	41.77
Total		**97.37**
Support Services for Carers	SEHSCT	1
	WHSCT	No data
	NHSCT	2
	SHSCT	6
	BHSCT	18.1
Total		**26.1**
Other	SEHSCT	30
	WHSCT	69.98
	NHSCT	0
	SHSCT	46.15
	BHSCT	22.57
Total		**138.7**
		2640.21

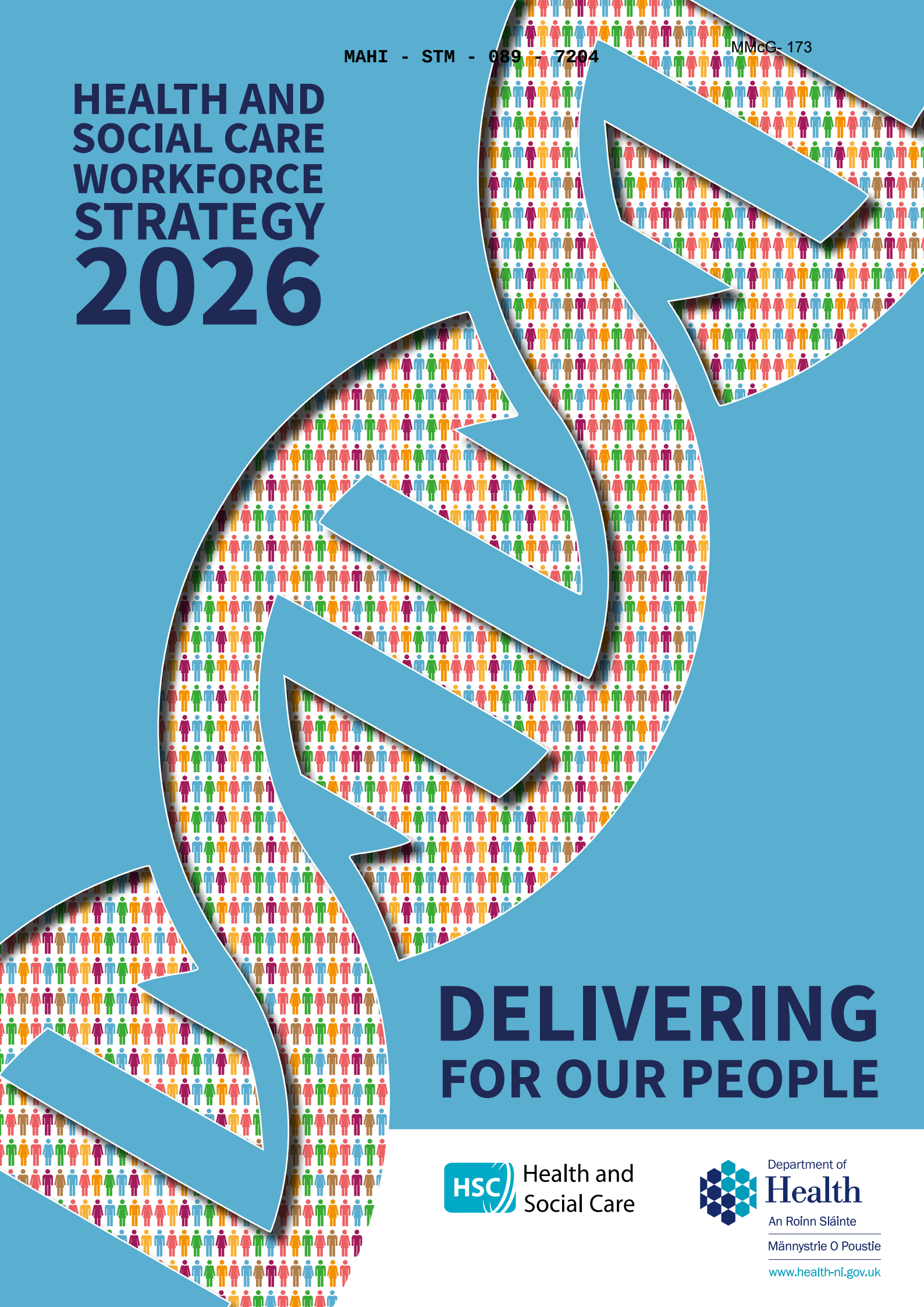
Table 9
HSC Trust returns – CAMH services

Service	HSC Trust	WTE
Hospital Services	SEHSCT - part of BHSCT for CAHMS	
	WHSCT	N/A
	NHSCT	0
	SHSCT	N/A
	BHSCT	53.8
Total		**53.8**
Community Mental Health Teams	SEHSCT	13.75
	WHSCT	30.29
	NHSCT	17.4
	SHSCT	N/A
	BHSCT	21
Total		**82.44**
Daycare	SEHSCT - part of BHSCT for CAHMS	
	WHSCT	N/A
	NHSCT	0
	SHSCT	N/A
	BHSCT	N/A
Total		**0**
Supported Accommodation in the Community	SEHSCT - part of BHSCT for CAHMS	
	WHSCT	N/A
	NHSCT	0
	SHSCT	80
	BHSCT	N/A
Total		**80**
Respite Services	SEHSCT - part of BHSCT for CAHMS	
	WHSCT	N/A
	NHSCT	0
	SHSCT	N/A
	BHSCT	N/A
Total		**0**
Community Psychology / Psychotherapy Services	SEHSCT - part of BHSCT for CAHMS	
	WHSCT	N/A
	NHSCT	1
	SHSCT	N/A
	BHSCT	N/A
Total		**1**
Specialist CAMH Services	SEHSCT - part of BHSCT for CAHMS	
	WHSCT	N/A
	NHSCT	17.4
	SHSCT	2.9
	BHSCT	24.55
Total		**44.85**
Support Services for Carers	SEHSCT - part of BHSCT for CAHMS	
	WHSCT	N/A
	NHSCT	0
	SHSCT	17
	BHSCT	N/A
Total		**17**
Other	SEHSCT - part of BHSCT for CAHMS	
	WHSCT	N/A
	NHSCT	7.5
	SHSCT	12.4
	BHSCT	N/A
Total		**19.9**
		298.99

Table10
HSC Trust returns – OPD services

Community Mental Health Services for Older People	HSC Trust	WTE
Hospital Services	SEHSCT	N/A
	WHSCT*	147.65
	NHSCT	No return
	SHSCT	No data
	BHSCT	No return
Total		**147.65**
Community Mental Health Services for Older People	SEHSCT	N/A
	WHSCT	38.5
	NHSCT	No return
	SHSCT	No data
	BHSCT	No return
Total		**38.5**
Daycare	SEHSCT	N/A
	WHSCT	11.9
	NHSCT	No return
	SHSCT	No data
	BHSCT	No return
Total		**11.9**
Residential Accommodation	SEHSCT	N/A
	WHSCT	63.46
	NHSCT	No return
	SHSCT	No data
	BHSCT	No return
Total		**63.46**
Respite Services	SEHSCT	N/A
	WHSCT	7
	NHSCT	No return
	SHSCT	No data
	BHSCT	No return
Total		**7**
Psychology / Psychotherapy Services	SEHSCT	N/A
	WHSCT	2
	NHSCT	No return
	SHSCT	No data
	BHSCT	No return
Total		**2**
Domicillary Care for Older People	SEHSCT	N/A
	WHSCT	N/A
	NHSCT	No return
	SHSCT	2.9
	BHSCT	No return
Total		**2.9**
Support Services for Carers	SEHSCT	1.5
	WHSCT	6
	NHSCT	No return
	SHSCT	No data
	BHSCT	No return
Total		**7.5**
Other	SEHSCT	N/A
	WHSCT	16.5
	NHSCT	No return
	SHSCT	33
	BHSCT	No return
Total		**49.5**
		330.41

HEALTH AND SOCIAL CARE WORKFORCE STRATEGY 2026



DELIVERING FOR OUR PEOPLE

HSC Health and Social Care

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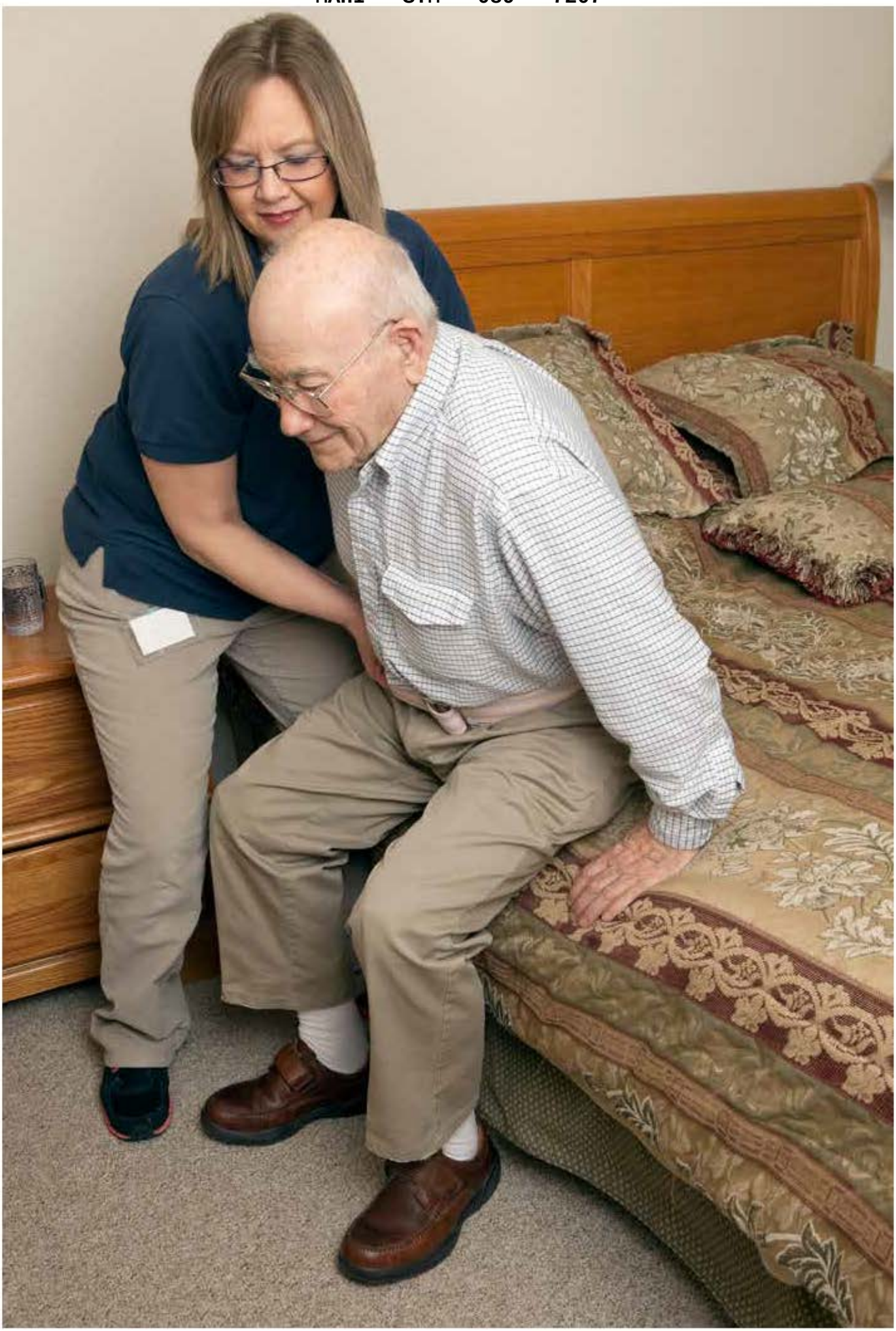


FOREWORD

Health and Wellbeing 2026 – Delivering Together, was the outworking of the recommendations of the Expert Panel on transforming health and social care, chaired by Professor Rafael Bengoa. It acknowledged that our health and social care services were designed to meet the needs of the 20th century population, and therefore transformation of health and social care services is essential if we are to meet the challenges of the future.

The people who work in health and social care – whether employed by the statutory Health and Social Care (HSC) organisations, independent contractors, or as our partners in the voluntary and community sector – are the system's greatest strength, working ever harder to provide the care needed by patients and service users. The system could not run without the skill, dedication and commitment of our talented, hard-working colleagues, across all disciplines, professions and levels.

We therefore owe it to them, and to the people of Northern Ireland, to address the workforce issues that need to be fixed, in order to transform health and social care. These issues place additional pressure on an already hard-working workforce, which has resulted in an increasing use of unsustainably expensive locums and agency workers. But recruiting additional people alone to prop up outdated service models is not the answer.

Instead, we need to resolve fundamental problems with supply, recruitment and retention of the health and social care workforce. We need to recognise that our highly-trained, skilled people are much sought-after across the world. We need to up our game as employers, to attract and retain the best talent.

Colleagues across health and social care need the opportunity to develop skills and expertise, whilst maintaining the provision of personalised, compassionate care. We need more investment in people, and effective workforce engagement and planning. We need to support our people.

This strategy has been developed through detailed engagement with colleagues across health and social care sectors. It reflects their views on how to create an environment in which excellent, high-quality care can continue to be provided. Skills development, career pathways, increased numbers of trainees, the development of new roles, investment in the wellbeing of the workforce and empowering and supporting the workforce to do what they do best, were all identified as necessary if we are to make employers within the local health and social care system the first choice for the best people.

This workforce strategy outlines a number of actions which, when implemented, will support our people to deliver world class health and social care.

The Transformation Implementation Group

There is no option but to transform how we deliver health and social care in Northern Ireland.

Demand for services has never been so high, and will only increase. Our population is growing. Thanks to healthier lifestyles, and advances in medical science and technology, people are living longer. Increasing numbers of people are living with more than one health condition.

As the system is currently structured, funding levels cannot keep pace. If we accept a conservative estimate of inflation at 1%, new medical developments at 1% and demand rising at 4%, then the health and social care system as currently configured would require at least a 6% budget increase each year simply to stand still.

This workforce strategy is just one of the components required for successful transformation; central to it will be how services are reconfigured. Other workstreams within the transformation process will play their role in moving towards a sustainable health and social care system for the 21st century.

This strategy needs the commitment and engagement of workers and management across all health and social care providers to implement change successfully.

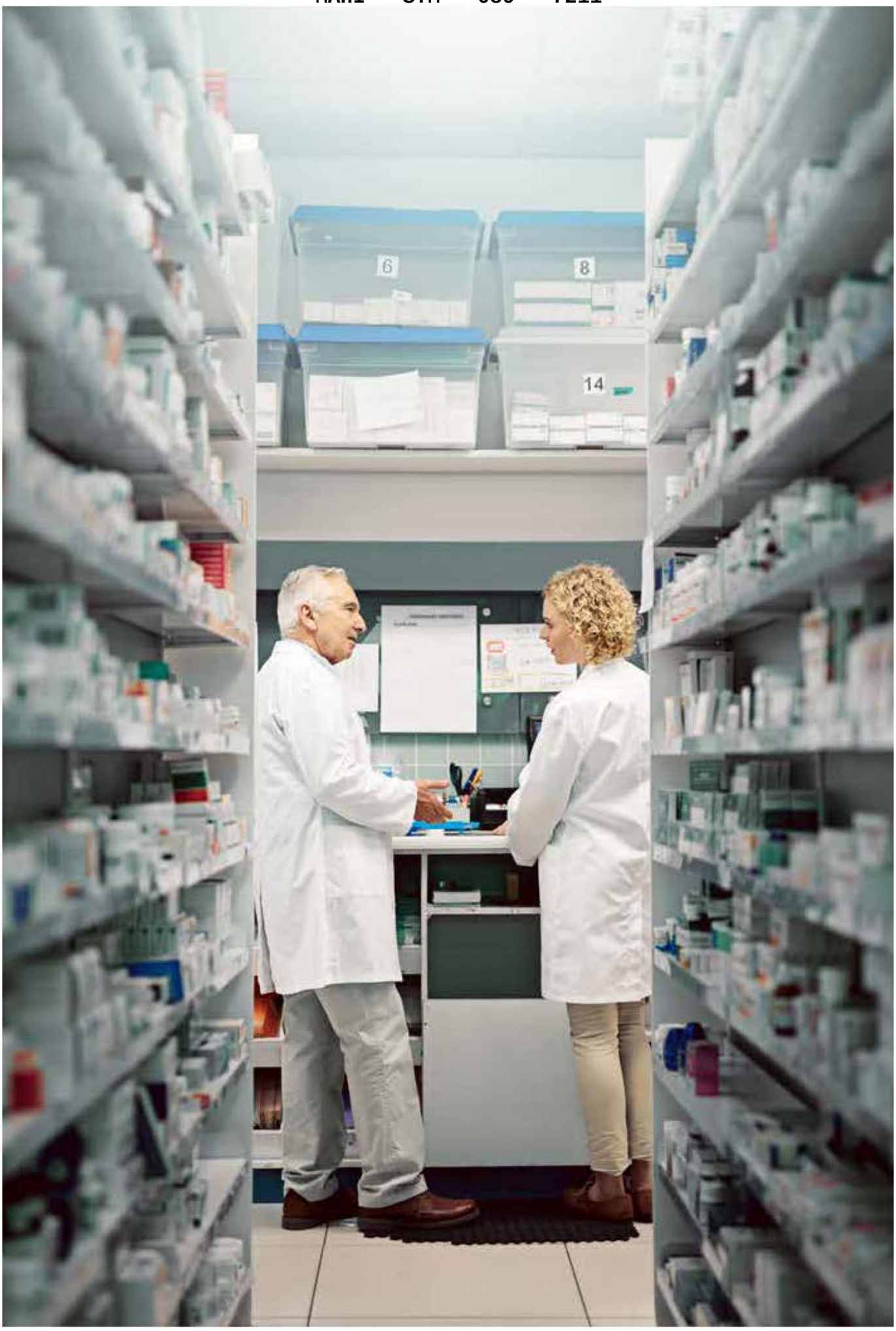
Ultimately, our aim is, by 2026, to meet our workforce needs – and the needs of our workforce.

In this document, we set out details about:

- our current workforce;
- the aim and objectives of the strategy;
- achieving our objectives and meeting our aim;
- the first of three action plans 'Action plan 2018-20';
- conclusion and;
- appendix: Current problems and future challenges.

We are also publishing alongside this document:

- an analysis of the workforce (https://www.health-ni.gov.uk/publications/workforce-strategy-workforce-information); and
- a report of the engagement process leading to this strategy (https://www.health-ni.gov.uk/publications/workforce-strategy-initial-engagement-findings).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The Department of Health is required by law to provide, or secure the provision of, health and social care in Northern Ireland. This strategy therefore includes those who are directly employed by HSC organisations, and those employed as and by independent contractors such as general practitioners (GPs), dentists, pharmacists and ophthalmic practitioners. It also recognises the contribution, challenges and future needs of the independent and voluntary health and social care sectors which support the HSC, and without which, it could not function.

As at March 2017, the Northern Ireland Statistics and Research Agency estimated the total size of the 'human, health and social work activities' sector at 122,560 jobs, covering public and private sectors (includes those known as independent and voluntary sectors).[1]

The public sector covers those directly employed by the 16 HSC bodies, namely the:

- Health and Social Care Trusts – Belfast, Northern, Southern, South Eastern, Western and Ambulance Service; and

- the Public Health Agency, Health and Social Care Board, Business Services Organisation, Regulation and Quality Improvement Authority, Patient and Client Council, Social Care Council, Medical and Dental Training Agency, Blood Transfusion Service, Guardian Ad Litem Agency, and Practice and Education Council for Nursing and Midwifery.

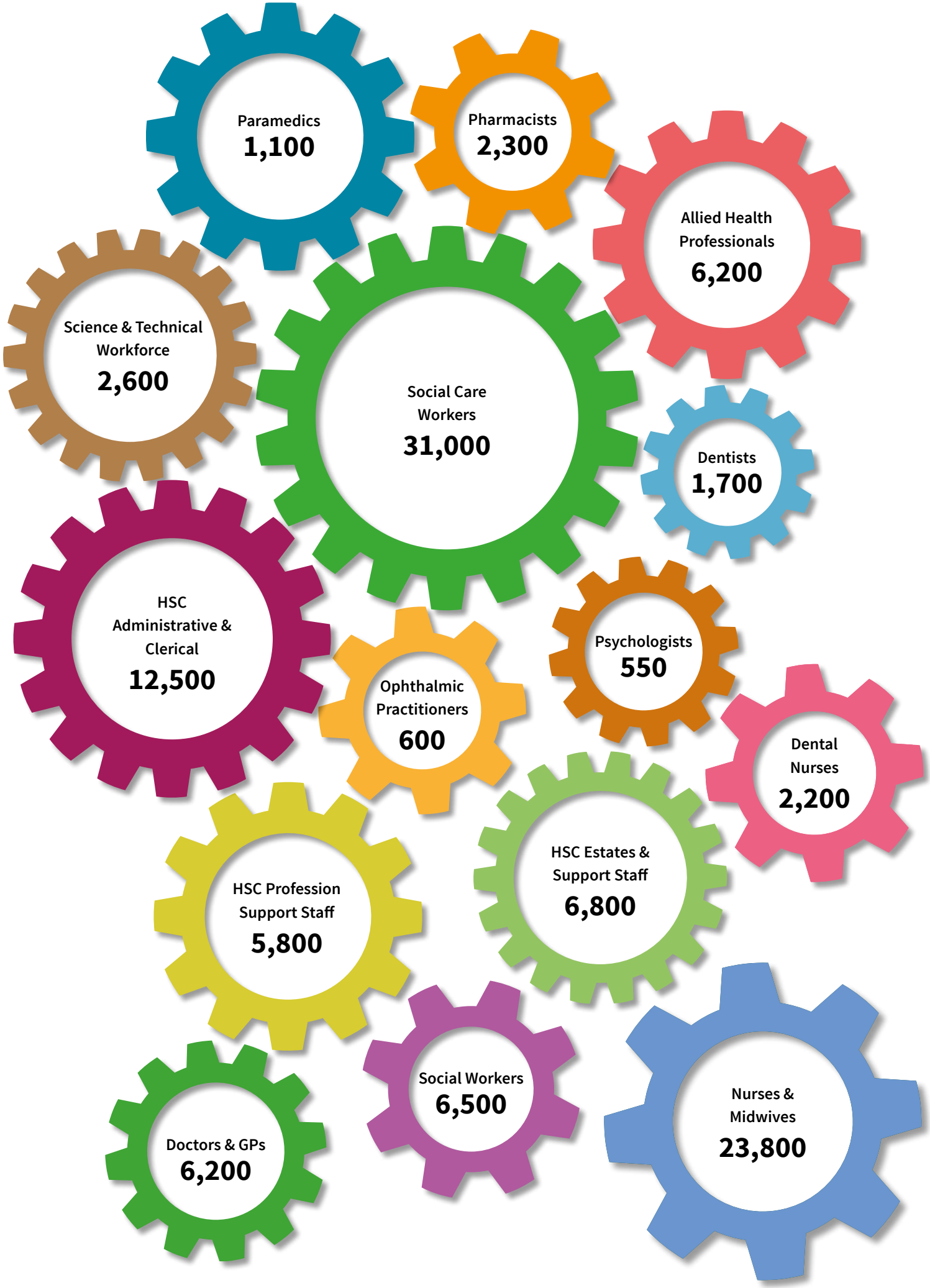
Further information about each organisation can be found at https://www.health-ni.gov.uk/

The Department also secures the provision of health and social care services from independent contractors, including GPs, dentists, pharmacists and ophthalmic practitioners, which are collectively known as Family Health Services or Primary Care Services.

Social care and health care have been integrated in Northern Ireland for decades. A large proportion of social care is delivered by independent and voluntary sector organisations.

The workforce that the Department knows most about is the one directly employed by the HSC organisations. Combining this information with other sources, such as professional regulation registers, gives an overview of the majority of the whole health and social care sector.

1. Quarterly Employment Survey March 2017.


Paramedics
1,100
Pharmacists
2,300
Allied Health Professionals
6,200
Science & Technical Workforce
2,600
Social Care Workers
31,000
Dentists
1,700
HSC Administrative & Clerical
12,500
Psychologists
550
Ophthalmic Practitioners
600
Dental Nurses
2,200
HSC Estates & Support Staff
6,800
HSC Profession Support Staff
5,800
Social Workers
6,500
Nurses & Midwives
23,800
Doctors & GPs
6,200

- We know there are over 31,000 social care workers registered in Northern Ireland, with the majority working in the independent sector (adult residential care, day care and domiciliary care for example) in the areas of older people's services, children's services, learning disability services, physical disability services and mental health services. Social care services are therefore reliant on the independent sector for the delivery of effective and efficient social care. In addition, there are 6,500 registered social workers, around two thirds of which work for HSC organisations. *Source: NI Social Care Council*

- There are over 23,800 nurses and midwives registered, mostly employed by the HSC Trusts but also in the independent sector in the likes of nursing homes, hospices and GP practices. *Source: Nursing & Midwifery Council*

- The number of doctors licensed to practice is over 6,200. The majority are employed by the HSC Trusts, but around 1,700 are GPs (with most working as independent contractors). *Source: General Medical Council*

- There are 1,700 dentists registered, with around two thirds providing at least some HSC general dental services and there are 2,200 dental nurses. *Source: General Dental Council*

- We have over 2,300 pharmacists registered in Northern Ireland, with a majority working in local pharmacies, around 580 working in HSC Trusts, but now also a growing number employed in general practices. *Source: Pharmaceutical Society of NI*

- There are 600 ophthalmic practitioners (optometrists and dispensing opticians) working as or for independent practitioners and providing HSC services. Around 6,200 people are registered as allied health professionals (AHP), with around 70% working for HSC Trusts. *Source: General Optical Council and Health & Care Professions Council (HCPC)*

- Almost 2,600 people are registered clinical scientists and biomedical scientists or HSC-employed medical technical officers, assistant technical officers or science support staff. *Source: General Optical Council and Health & Care Professions Council (HCPC)*

- There are around 550 registered practitioner psychologists with over 60% working for HSC Trusts. In HSC organisations, the administrative and clerical workforce is over 12,500 and the estates and support services workforce is almost 6,800. *Source: HCPC and HRPTS*

- There are many other support staff, with HSC-employed nursing/midwifery support numbering just under 5,000 people and over 800 HSC-employed AHP/psychology support staff. *Source: HRPTS*

- The total number of paramedics plus other NI Ambulance Service roles (e.g. emergency medical technician, control staff and ambulance officers) is over 1,100 workers. *Source: HRPTS*

Brief profile of the workforce

- Overall, the health and social care workforce is predominately female, though some staff groups have a majority of male employees.
- The average age of directly employed HSC staff has increased slightly in the last 10 years from 40 years to 43 years.
- Some of the HSC staff groups with younger and majority female profiles also show high levels of maternity leave.
- There are also HSC staff groups with older age profiles who therefore experience higher leaving rates.
- Around 40% of the HSC workforce are part-time staff.

Apart from age and gender profiles, workforce intelligence on the working patterns, leave and absence profiles of all of the independent sector workforce are not centrally available. Workforce diversity across all dimensions should be encouraged and understood, not only for the purposes of understanding the needs of staff and workforce planning, but also to ensure that the benefits associated with having a diverse workforce in place are realised.

Expenditure

Information on workforce expenditure is most readily available for HSC organisations, which spent over £2.3 billion on directly employed staff in 2015/16 and an additional £92 million on agency workers to fill HSC posts.

Areas of pressure

Sickness absence remains a priority area of focus, with mental health and musculo-skeletal issues being the largest contributing factors.

Addressing the HSC's increasing use of agency workers/locums is also a priority area. HSC expenditure on agency workers has doubled in the last five years. The largest proportion of agency worker expenditure is on doctors.

Whilst overall workforce numbers have been increasing in recent years, there is still a need for additional people. The March 2017 HSC vacancy rate (of posts being actively filled) was around 5% for posts currently in the system. Drilling down into this figure highlights key areas of concern, including within nursing, midwifery and medical staffing.

A more detailed workforce profile is available at:
https://www.health-ni.gov.uk/publications/workforce-strategy-workforce-information


O2 MASKS
AMBULANCE

The World Health Organisation[2] highlights the importance of developing workforce strategies:

> ***"Health systems can only function with health workers; improving health service coverage and realising the right to the enjoyment of the highest attainable standard of health is dependent on their availability, accessibility, acceptability and quality. Mere availability of health workers is not sufficient: only when they are equitably distributed and accessible by the population, when they possess the required competency, and are motivated and empowered to deliver quality care that is appropriate and acceptable to the sociocultural expectations of the population, and when they are adequately supported by the health system, can theoretical coverage translate into effective service coverage."***

The workforce is also the most valuable asset in social care, and can, at its best, be at the forefront of empowering people's independence and choice and improving their social inclusion, participation and social wellbeing. Delivering this vision requires a confident, capable and well-trained workforce.

This strategy sets the objectives and actions to ensure that in Northern Ireland, we **meet our workforce needs – and the needs of our workforce.**

First, however, it is worth setting the workforce challenges in context.

Strategic issues in Northern Ireland

Inevitably, any discussion on reform of health and social care begins with the amount of money invested in the system. At present, over £5 billion is spent on commissioned health and social care services in Northern Ireland, with £2.3 billion of this on directly employed HSC staffing. Whilst total cash spending continues to increase every year, significant unmet need remains.

We must ensure that the resource we spend on the workforce is spent in the best way possible, not only with an emphasis on value for money, but also on improving services and achieving better outcomes for patients and service users. This strategy does not automatically assume that a certain amount of new money will be needed for it to succeed, although a number of proposals are being taken forward under Transformation funding. In addition, we will make the best use of the money we already have, and when new needs are identified over the course of implementing the strategy, we will make the best case possible for these to be funded, in line with other strategic reforms.

The future

We must also take into account the future shape of health and social care provision. Delivering Together set out a number of actions to stabilise, reconfigure, change services in, and transform the HSC. These include actions to address waiting lists, make significant investment in primary care, carry out a number of service configuration reviews, and bring forward proposals for Elective Care Centres. We do not yet know how

2. Global Strategy on Human Resources for Health: Workforce 2030

the system will be configured by 2026 in terms of sites and models of care; nor can we fully anticipate the technological advances that will happen by 2026.

Future e-Health solutions will both improve patient and client experience and make life easier for our workforce. This will include significant investment in mobile working solutions which will allow those on the frontline to work more effectively, spending more time working directly with patients and clients.

As we consolidate the different IT solutions used across the wider health and social care sector it should be easier for staff to view a joined-up care record, to move between different sites and different providers, and to draw out information to help improve the services we provide. The Encompass programme, which will be replacing the core patient administration systems and a number of other key systems, will be central to driving this consolidation.

Technology

The support that technology can provide to people who work in health and social care will continue to grow. In the best health and care systems, health analytics are shaping and improving the way services are delivered, while those working on the frontline are using IT systems which provide decision support tools, helping to improve the quality of clinical and professional decision making. In time, artificial intelligence is likely to make a significant impact in health and social care. Technology can provide a rich source of information to health and social care professionals – for instance with telemonitoring solutions supporting early intervention and prevention and allowing for more refined diagnoses.

Technology can also form part of the solution where individuals need treatment or support to live independently in their own homes – with apps and wearable technology helping individuals to understand and monitor their health. All of these developments will have an impact on the way that health and social care professionals do their jobs in the future.

We have taken care in this strategy to ensure that we are not trying to solve the problems of 2006 or 2016. Instead, the strategy identifies the objectives which need to be achieved to ensure that we have the optimum number of the workforce, with the best mix of skills, for the issues that will exist in 2026. The objectives therefore allow for flexibility in how they will be implemented over the next nine years.

Policy and planning

In line with the draft Northern Ireland Programme for Government, this strategy focuses on outcomes which set a clear direction of travel, enable continuous improvement, and depend on collaborative working between organisations and groups, whether in the public, voluntary, or private sectors.

The outcomes-based approach of the draft Programme for Government 2016 -2021, recognises that health and social care services do not operate in isolation. Workers regularly operate across a variety of settings that require collaboration, with a wide-range of bodies, spanning sectors such as education, housing, the emergency services and the criminal justice system. As such, the development of the performance indicators for each of the actions within this strategy will give due regard to the need for cross-sectoral and cross-government working.

Policy decisions and planning exercises must be based on robust evidence. Improving and acting upon the workforce intelligence gathered is therefore a key area of focus within this strategy. For example, previous nursing and midwifery workforce planning exercises have identified the need for baseline information on the independent nursing sector. The same could be said for all private, voluntary and community sectors, on which we rely to provide health and social care services. The final stage of the rollout of registration of social care workers with the Social Care Council will help provide more accurate information about the profile of the social care workforce across all sectors.

Other reports and strategies

The outcomes in the strategy will ultimately be focused on the health and wellbeing of our population, and these have obvious workforce implications. The King's Fund report, Population health systems – going beyond integrated care (February 2015) states that: "population health means different things to different people, but can be broadly defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group[3]".

"While access to traditional health and care services plays an important part in determining the health of a population, evidence suggests that this is not as important as lifestyle, the influence of the local environment, and the wider determinants of health – that is, the conditions in which people are born, live and work[4]. This means that improving population health requires efforts to change behaviours and living conditions across communities. It also means that accountability for population health is spread widely across these communities, not concentrated in single organisations or within the boundaries of traditional health and care services."

There is also a series of other Departmental strategies, for example, the Quality Strategy 2020 (a 10-year strategy designed to protect and improve quality in health and social care in Northern Ireland), Making Life Better 2012–2023 (a 10-year public health strategic framework), and Improving and Safeguarding Social Wellbeing 2012–2022 (a 10-year strategy for social work), which run concurrently with this workforce strategy, the purposes and aims of which must be taken into account throughout the transformation process.

Early intervention

The workforce strategy also needs to take account of the continuing drive for early intervention and prevention. It needs to enhance ongoing multidisciplinary efforts to

3. Kindig and Stoddart 2003

4. Canadian Institute for Advanced Research et al, cited in Kuznetsova 2012; Booske et al 2010; Marmot et al 2010; McGinnis et al 2002; Bunker et al 1995

ensure that a flexible workforce specialising in public health is trained, developed and strengthened to meet the health needs of employers and the population of Northern Ireland in the future, and ensure that core public health competencies are embedded in undergraduate and postgraduate training.

Mental health

We must also continue to recognise that we are not simply talking about physical health care. The Department is committed to moving towards parity of esteem for mental health. This is not a call for 50/50 funding between the two; rather, that mental health should receive its fair share of health education, attention and resource, including staffing.

Achieving parity of esteem for mental health will require sustained investment in care and the development of a flexible, fit-for-purpose mental health workforce to deliver modern effective care. The establishment and integration of multi-disciplinary teams and the development of integrated practice models for all condition-specific and high-intensity teams will be important.

Social care

In December 2017, the report of the Expert Advisory Panel on Adult Care and Support was published, 'Power to People: proposals to reboot adult care and support in NI'. It outlines a broad programme of reform, with specific proposals relating to the terms, conditions and status of the social care workforce. Implementing these proposals will have significant workforce impacts.

Approximately 31,000 people in Northern Ireland are registered social care workers, including 12,000 domiciliary care workers. An estimated 75% of the workforce is employed by the independent sector, with 25% employed by HSC Trusts. The Northern Ireland Social Care Council estimates that an additional 1,400 care workers are needed every year to meet growing demand.

However, recruitment and retention are major challenges. We will need to ensure that there is a sense that social care is a profession with clearly developed and recognised career pathways so that we have the workforce to match the very challenging nature of demand in that sector and the increasing levels of complex need in the community.

Brexit

Finally, we need to be aware that the potential effects from the UK's exit from the European Union, scheduled for March 2019, are still being defined, and are subject to the provisions of any exit agreement to be negotiated by the UK and the EU. However, we know that there are potential impacts on workforce supply from EU countries into Northern Ireland, particularly health and social care workers who live and work

around the Irish border and with the mutual recognition of professional healthcare qualifications. The workforce strategy will need to be flexible to take account of the emerging picture.

What the workforce thinks

To understand the concerns and issues facing the health and social care workforce in Northern Ireland, we gathered feedback from across the HSC, independent practitioners, the independent, voluntary and community sectors, trade unions and employer organisations.

Full details of the engagement process are available at https://www.health-ni.gov.uk/publications/workforce-strategy-initial-engagement-findings, but in summary, the consistent messages we heard were:

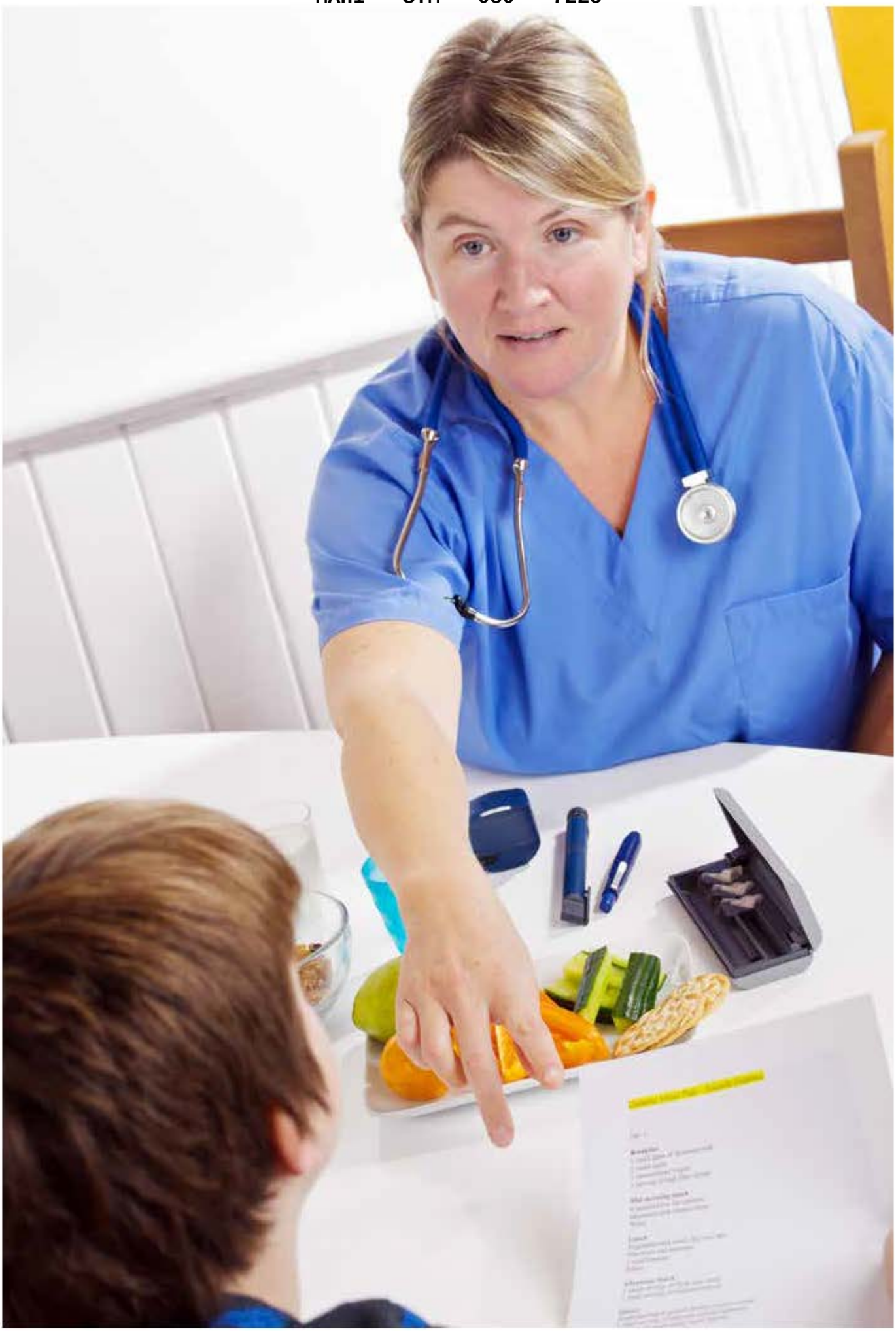
- **Recruitment challenges**, in terms of the numbers of training places available, planning for retirements, and the processes by which vacancies are managed.
- **Increasing workloads**, and in particular administrative tasks being transferred to frontline workers.
- The need for job plans and roles which reflect an **ageing workforce**, in response to increases in State Pension Age and the desire of individuals to work longer.
- The need to consider different **skills mixes and different roles** for the workforce of the future, taking changes in the complexity of conditions and patient outcomes into account.
- A workforce increasingly seeking **flexible working patterns**, for a variety of generational and practical reasons.
- The importance of having clearly defined **career pathways** for all workforce groups.
- The increasing attractiveness of **agency work** de-stabilises teams, and can have a demoralising impact upon the directly employed permanent workforce.

Other issues raised

Those who deliver health and social care also raised the following issues:

- Innovation should be actively encouraged more, or recognised, for example by sharing the learning from positive changes across organisations.

- Frustration with the differences in pay across the UK, and that this contributed to the appeal of agency work to augment pay and provide more flexible terms and conditions.
- Frustration at a perceived lack of communication about ongoing reform.
- A desire for more upskilling opportunities, and the ability to use newly acquired skills after training.
- There is a perceived lack of information gathered from those leaving the system, and suggested that an independent third party carrying out exit interviews would encourage open and honest discussions.
- There are potential opportunities to advertise health and social care services more effectively, and raise awareness amongst young people in particular, for example by offering more volunteering and work experience placements to those at GCSE level.
- A frustration at perceived lack of opportunities for people living in rural locations to gain employment in local HSC organisations, and also with the perception that rural services were struggling to continue to provide the depth of training and work required to sustain services.
- Frustration about being expected to navigate several software packages at once to access one set of patient records, and staff felt that they were not properly engaged during development.
- A desire for a more long-term, consistent view of HSC transformation taken by decision-makers, with a balance struck between political/public expectation and what was realistically deliverable in the context of resourcing pressures.
- It was questioned whether the guidelines issued by royal colleges on staff-patient ratios were relevant for the system of today, and some suggested that these ratios might have frustrated innovation and multi-disciplinary working.
- Concern was expressed that the health and well-being of the workforce was not properly addressed and supported by existing occupational health policies, which could be more person-centred and less focussed on managing attendance.
- It was suggested that health and social care workforce could receive ‘fast-track’ health and social care to help them to recover more quickly from illness or injury, which may result in them being able to return to work as soon as possible, thereby cutting sickness leave rates and agency and locum costs.



AIM AND OBJECTIVES OF THE STRATEGY

The **aim** of this strategy is that **by 2026, we meet our workforce needs – and the needs of our workforce.**

To achieve this aim, we need to meet three **objectives:**

1. **By 2026, the reconfigured health and social care system has the optimum number of people in place to deliver treatment and care, and promote health and wellbeing to everyone in Northern Ireland, with the best possible combination of skills and expertise.**

2. **By 2021, health and social care is a fulfilling and rewarding place to work and train, and our people feel valued and supported.**

3. **By 2019, the Department and health and social care providers are able to monitor workforce trends and issues effectively, and be able to take proactive action to address these before problems become acute.**

Thanks to the involvement of colleagues working across health and social care, we have a good understanding of the main themes that the workforce strategy needs to tackle. They are outlined below.

1. **Attracting, recruiting and retaining**
   - Attracting people from an early age to want to pursue a career in health and social care.
   - Recruiting enough of the right people, with the right skills, into health and social care.
   - Ensuring that they want to keep working in health and social care.
   - Provide opportunities to return to work for experienced colleagues who have left service.

2. **Sufficient availability of high-quality training and development**
   - Development opportunities are properly planned and sustainably provided.
   - Training needs are recognised as dynamic and constantly need to be reviewed at a strategic level.

3. **Effective workforce planning**
   - Have an optimum workforce model developed, agreed and in place.
   - Have optimum numbers of appropriately skilled people working in every setting and in every specialty, now and in the future to populate the model.
   - All necessary posts and vacancies are filled quickly.

4. **Multidisciplinary and inter-professional working and training**
   - Health and social care teams have the right skills mix to provide the right care and support efficiently, effectively and with compassion.
   - Successful multidisciplinary working can be promoted by effective multidisciplinary training.
   - Each profession recognises the value and contribution of other professions to health and wellbeing.
   - Postgraduate healthcare education forum.

5. **Building on, consolidating and promoting health and wellbeing**
   - Promoting support.
   - Developing occupational health services for health and social care workers, which can be used as a model for the rest of the Northern Ireland workforce.

6. **Improved workforce communication and engagement**
   - Between strategic bodies and delivery partners.
   - Between management, the workforce and workforce representatives.
   - Between the HSC, independent and voluntary sectors.

7. **Recognising the contribution of the workforce**
   - Valuing the contribution that all make to delivering excellent, compassionate care and to improving the health, quality of life and wellbeing of the people of Northern Ireland.
   - Protecting and developing terms and conditions in a time of reform.
   - Devolving decision-making to the appropriate levels, including locally where possible.

8. **Work-life balance**
   - Recognising that people have different needs and obligations outside of work, whilst balancing service needs.
   - Responding to the changing needs and expectations of the workforce over time.

9. **Making it easier for the workforce to do their jobs**
   - Simplifying the employment relationship.
   - Eradicating unnecessary duplication and bureaucracy.
   - Improving IT infrastructure and staff capacity.

10. **Improving workforce business intelligence**
    - Identifying and addressing gaps in workforce data/intelligence/statistical information, thereby improving the ability to take proactive action using business intelligence findings

These ten themes fit within one or more of the three objectives.

Action Plans

2018 - 2020 | **2021 - 2023** | **2024 - 2026**

1 AIM

The **aim** of this Strategy is that **by 2026, we meet our workforce needs – and the needs of our workforce.**

3 OBJECTIVES

1. By 2026, the reconfigured health and social care system has the optimum number of people in place to deliver treatment and care, and promote health and wellbeing to everyone in Northern Ireland, with the best possible combination of skills and expertise.
2. By 2021, health and social care is a fulfilling and rewarding place to work and train, and our people feel valued and supported.
3. By 2019, the Department and health and social care providers are able to monitor workforce trends and issues effectively, and be able to take proactive action to address these before problems become acute.

10 THEMES

1. Attracting, recruiting and retaining
2. Sufficient availability of high-quality training and development
3. Effective workforce planning
4. Multidisciplinary and inter-professional working and training
5. Building on, consolidating and promoting health and wellbeing
6. Improved workforce communication and engagement
7. Recognising the contribution of the workforce
8. Work-life balance
9. Making it easier for the workforce to do their jobs
10. Improving workforce business intelligence

Action plans

This is a long-term strategy, to be implemented over a nine-year period. The eventual configuration of health and social care in Northern Ireland is not yet known. It is impossible in 2018 to be definitive about the impact of technological advances in 2026. The shape of the UK's exit agreement from the EU has, at this point, to be determined.

This strategy therefore needs to be flexible. That is why we propose **three** consecutive action plans over the life of the strategy, for:

- **2018-2020;**
- **2021-2023; and**
- **2024-2026.**

This will allow for formal review of progress every three years, to take account of global, national and local developments - political, economic, social and technological - and chart a path of cumulative action to achieving our objectives.

The draft action plan for 2018-2020, which is subject to further co-production and Departmental approval, is included in this document.

Oversight and accountability

- A programme board will be established by the Department of Health to plan and formally monitor and manage implementation. Progress will be informally reviewed periodically.

- A reference group, with representation from relevant employers, trade unions and others will provide advice and assurance to the programme board on progress, and act as the key body for resolution of any issues.

- Individual project teams and/or task and finish groups will be commissioned by the programme board, with input from the reference group, to take forward certain tasks.

Measuring success

Achieving the actions in each action plan will be a good indicator of success in meeting our aim and objectives. But we must also take an evidence-based approach. The first task and finish group to be set up will therefore produce and agree the performance indicators for the strategy.

This work will be completed by the end of June 2018. The performance indicators may include a mix of quantitative evidence, such as reductions in job/training vacancy rates and agency/locum spend, and qualitative measures such as those in staff surveys, etc.

AMBULANCE

OBJECTIVE 1

By 2026, the reconfigured health and social care system has the optimum number of people in place to deliver treatment and care, and promote health and wellbeing to everyone in Northern Ireland, with the best possible combination of skills and expertise.

THEME 1

Attracting, recruiting and retaining

ACTION 1

Set up and roll out a regional health and social care careers service targeted at the existing workforce, young people from the age of 14, and possible returners to service.

WHY?

- To help ensure a good supply of people in the future.
- To inform and excite people on the range of jobs and professions.
- To publicise health and social care as a career option, with properly mapped career pathways, developed in partnership with existing members of the workforce.
- Focus on the skills developed within areas and locations which have recruitment difficulties.
- To provide volunteering and work experience opportunities.
- Will act as a single point of contact for new recruits and experienced returners.

OUTPUT
By 31/12/2020

Regional Health and Social Care careers service established.

ACTION 2

Explore and establish non-salary incentive programmes as a means of recruiting and/or retaining people and/or dealing with pressures in less popular specialties and locations.

WHY?

- We are experiencing difficulties in filling certain posts.
- Need new innovative ways to recruit and retain.
- Addressing supply and location issues should ultimately reduce reliance on agency and locum workers.
- Such a policy can be linked to return of service obligations – establishing a new two-way commitment between HSC employers and trainees.

OUTPUT
By 31/12/2020

Non-salary incentive programmes finalised for various professions in health and social care.

THEME 2

Sufficient availability of high-quality training and development

ACTION 3

Commissioning of sustainable training programmes that are aligned to meet current and future health and social care requirements for multidisciplinary service delivery.

ACTION 4

Commissioning of time-protected, appropriately located, sustainable post-registration training programmes, and development opportunities for more experienced people, including consideration of preceptorship arrangements to smooth the transition from training into practice.

WHY?

- Values the needs of students and workers.
- We need a sustainable approach to planning for, and funding, training for pre-registration students, to ensure that health and social care is fit for purpose by 2026.
- This will take account of revisions to the various curriculums – for example, resulting from findings of the Nursing and Midwifery Task Group in relation to mental health nursing.
- Smooth the transition from education environment to the realities of delivering health and social care, and the characteristics/skills required to do so.
- Reduce reliance on agency and locum workers.
- We need a sustainable and transparent approach to planning for, and funding, training for post-registration students, to ensure that health and social care is fit for purpose by 2026.

OUTPUT

By 31/12/2020

Rolling, prioritised programme of workforce plans aligned to health and social care service delivery requirements.

Policy on departmental commissioning of training and development for health and social care.

Multidisciplinary working and training to be a key principle.

Align to Leadership Strategy.

THEME 3

Effective workforce planning

ACTION 5

Develop and, by 2026, sustainably fund, an optimum workforce model for reconfigured health and social care services.

WHY?

- We need a strategic, coherent, dynamic workforce model that clearly outlines the people and skills required to meet service and population needs across the region in 2026. This should take account of population needs and demographic trends.
- We need a product that collates and coordinates the findings from the various prioritised workforce reviews that are regularly carried out for every profession and discipline. The optimum workforce model will be this product.
- We can also take account of, for example, the findings of the Nursing and Midwifery Task Group which is due to report in 2018.
- The optimum workforce model will adopt a number of key principles, including the need for multidisciplinary and inter-professional working.

OUTPUT
By 31/12/2020

Review of required medical training places completed by June 2018.

Progression of all recommendations arising from workforce planning reviews.

Optimum Workforce Model framework in place, co-designed with clinical leads, which will take account of reconfiguration plans, current and future drivers and pressures.

ACTION 6

By fully implementing and embedding the Regional HSC Workforce Planning Framework (six-step methodology), ensure that this is supported by necessary resources and underpinned by a multidisciplinary ethos across all providers.

WHY?

- Consistent, evidence-based regional approach to workforce planning.
- Need to review adequacy of training across all HSC providers.

OUTPUT
By 31/12/2020

By re-establishing a group to take forward regional workforce planning to ensure that the six-step methodology is fully embedded into workforce planning practices, including use of population health, disease profile data etc.

THEME 3

Effective workforce planning

ACTION 7

We take account of, and plan for, the workforce implications arising from the UK's exit from the EU and the subsequent implications for the EU/EEA and non-EU/EEA workforce

WHY?

- Need to take account of the implications for workforce supply, frontier workers, mutual recognition of professional qualifications, international recruitment, borders agency, immigration quotas and shortage occupation lists.

OUTPUT
By 31/12/2020

Terms of reference for EU exit workforce group, comprising (among others) worker and management representation to be agreed.

Regular meetings in 2018-19.

THEME 4

Multidisciplinary and inter-professional working and training

ACTION 8

Planning for and introducing new roles.

WHY?

- Need to develop and integrate new ways of working and jobs across health and social care.
- Need to ensure that the appropriate skills mix is in place.
- New roles need to be evidence-based, with clarity on outcomes of what new roles will contribute and achieve.

OUTPUT
By 31/12/2020

Needs analysis of new roles required.

Pilot and evaluation of physician associate (PA) students trained at Ulster University.

Recruitment of PAs into newly created posts.
Ongoing training programme in Northern Ireland to provide a supply of PAs into HSC.

Assess actions for other potential new roles.

THEME 4

Multidisciplinary and inter-professional working and training

ACTION 9

Develop multi-disciplinary, cross-sector working that will characterise the delivery of collective, compassionate care in the future

WHY?

- Effectively utilising skills and resources.
- Streamlining care pathways across locations and teams.
- Addressing increasing incidence of co-morbidities in an ageing population.
- Need to ensure that role of multidisciplinary teams in transformation of delivery of health and social care services is clear and embedded in all undergraduate health and social care courses.

OUTPUT

By 31/12/2020

Cross reference the work of and seek input from (among others):

- **Postgraduate Health and Social Care Education Forum**
- **Nursing Strategic Workforce Development Group**
- **Primary Care Multi-disciplinary Working Group**
- **Paramedic Steering Group**
- **Imaging Review**
- **Adult Social Care Review**
- **Assistive technology commitments, learning and development programmes.**

OBJECTIVE 2

By 2021, health and social care is a fulfilling and rewarding place to work, and our people feel valued and supported.

THEME 5

Building on, consolidating and promoting health and wellbeing

ACTION 10

Working with employers, and all those who work in the health and social care sector and trainee representatives, the Department and commissioners will produce an HSC staff health and wellbeing framework, with the aim of assisting staff to remain resilient, and physically and mentally well at work.

WHY?

- Investment in health and wellbeing services for the workforce reduces sickness absence, improves ability to recruit and retain staff (with corresponding savings on agency and locum expenditure).

OUTPUT
By 31/12/2020

Audit of existing services and procedures.

Adopt and roll out new regional staff health and wellbeing policy.

ACTION 11

Commissioning and establishment of sustainable occupational health services.

WHY?

- Investment in occupational health services for the workforce reduces sickness absence, improves ability to recruit and retain staff (with corresponding savings on agency and locum expenditure).
- This will also act as a model for new occupational health services for use by the wider public and private sectors.

OUTPUT
By 31/12/2020

Audit of existing services.

Completion and implementation of multidisciplinary occupational health workforce plan.

Establish group to appraise options for the more effective delivery of occupational health services to the wider health and social care sector, and subsequently other Northern Ireland industry sectors.

THEME 6

Improved workforce communication and engagement

ACTION 12

Establish processes and procedures to ensure that information flows freely across organisations/systems and that employees are kept abreast of developments.

WHY?

- Addresses concerns raised in previous staff surveys and in the fieldwork for this strategy.
- Allows for staff networks/forums to discuss such matters which are common across all sectors and bands.
- Allows for coherent messages on health and social care developments, including transformation and industrial relations.

OUTPUT
By 31/12/2020

Audit of existing services.

Processes and procedures co-produced and fully embedded.

ACTION 13

Co-produced staff appraisal and engagement project, and rollout of recommendations.

WHY?

- Allows for coherent action to address staff concerns in relation to:
  - Team working
  - Appraisal
  - Personal development
  - Knowledge and Skills Framework
  - Organisational / leadership culture (address high pressure cultures and how these can create high stress cultures and ultimately low morale).

OUTPUT
By 31/12/2020

Audit of existing services.

Completion and rollout of project and recommendations.

THEME 6

Improved workforce communication and engagement

ACTION 14

Design and implementation of co-produced policy on recognition initiatives.

WHY?

- Supporting the workforce to achieve success, and to feel valued and supported.
- Allows for coherent action on possible introduction/use of:
  - Advanced Information and Communication Technology
  - Co-production leading to greater staff involvement in decision-making.
  - Sufficient freedom to display initiative and make decisions.
  - Proper supervision.
  - Opportunities for training and development at all grades, and not just tied to promotion.
  - Agreed job rotation.
  - Opportunities for educational leave, etc.

OUTPUT
By 31/12/2020

Audit of existing services.

Completion and rollout of agreed co-produced policy.

ACTION 15

Working with employers, and the workforce and trainee representatives, the Department and commissioners will produce a set of standards that all HSC staff can expect in terms of facilities.

WHY?

- Addresses staff concerns in relation to food/drink/rest break facilities.

OUTPUT
By 31/12/2020

Agreed and updated HSC staff facility policy.

Recognising the contribution of staff

THEME 7

ACTION 16

Recognising the contribution of the workforce

Develop a regional system of workforce recognition, based on the policy developed under action 14 and existing areas of best practice.

WHY?

- Valuing the contribution that all make to delivering excellent, compassionate care.
- Devolving decision-making to the appropriate levels, including locally where possible.

OUTPUT
By 31/12/2020

Policy published by 31 December 2018.

THEME 8

ACTION 17

Work-life balance

Co-produce a regional work-life balance policy for health and social care workers.

WHY?

- Recognises the needs of the workforce such as those with dependent relatives and/or caring responsibilities, whilst balancing the requirements of the service.
- Support the workforce to access their work remotely where appropriate.
- Also will provide clarity around working time regulation/sleepover duties/working hours in 24-hour service.

OUTPUT
By 31/12/2020

Regional policy design group established and work under way.

THEME 9

Making it easier for the workforce to do their jobs

ACTION 18

Simplification of employment arrangements, for example, explore whether a single employer for all HSC staff is feasible and will produce benefits for staff/patients/clients.

WHY?

- To provide clarity and remove duplication and possibility for error/confusion in relation to payroll, generic training, etc.

OUTPUT
By 31/12/2020

Completion of lead employer project for doctors in training.

Learning from doctors in training, lead employer project applied to planning for possible single HSC employer.

ACTION 19

Continue to develop workforce engagement projects for the introduction of new technologies and systems, including e-health initiatives, Encompass, etc. , which are designed to support the workforce in doing their jobs.

WHY?

- Some parts of the workforce do not feel sufficiently involved in design and roll-out of new technology and systems.

OUTPUT
By 31/12/2020

Comprehensive workforce engagement plans to be developed as part of design and implementation of new technologies and systems.

ACTION 20

Develop a policy which more effectively outlines a process for devolving the selection of 'new team members' to line management/team members (with support of central HR function) who have knowledge of the skills/attributes and individual qualities required for the post.

WHY?

- Eradicate unnecessary delays in filling vacancies

OUTPUT
By 31/12/2020

Policy in place by 31 Dec 2018, with first two-year evaluation about to begin in January 2021.

OBJECTIVE 3

By 2019, the Department and health and social care providers are able to monitor workforce trends and issues effectively, and be able to take proactive action to address these before problems become acute.

THEME 10

Improving workforce business intelligence

ACTION 21

Department to oversee and monitor exercise to examine where current gaps exist. This will involve collaboration with the relevant bodies to introduce data collections that we know to be missing e.g. gather more primary care workforce data, independent sector, etc.

WHY?

- We have a number of gaps in our business intelligence, which if closed will allow us to monitor workforce trends and issues effectively, and be able to take proactive action in the future.

OUTPUT
By 31/12/2020

This objective to be achieved by 31 Dec 2019.

ACTION 22

Align staff survey with workforce strategy to ensure information is available to measure progress against intended outcomes

WHY?

- We need better business intelligence from this source.
- Need to maximise response rate.

OUTPUT
By 31/12/2020

This objective to be achieved by 31 Dec 2019.

THEME 10

Improving workforce business intelligence

ACTION 23

Roll-out of exit interviews for all staff leaving the HSC.

WHY?

- Results of detailed and meaningful exit surveys can be monitored and fed into workforce planning processes and decision-making.

OUTPUT
By 31/12/2020

This objective to be achieved by 31 Dec 2019.

ACTION 24

Explore workforce data systems and analytics software to inform more evidence-based decision making and solve problems.

WHY?

- We need better business intelligence.

OUTPUT
By 31/12/2020

This objective to be achieved by 31 Dec 2019.


CAUTION
WET FLOOR

This is a deliberately ambitious strategy. We do not underestimate the task at hand. In the first half of this strategy we set out the significant challenges facing health and social care in Northern Ireland. These combine to create a complex environment in which to transform.

However, there are already very positive examples of the fantastic work carried out by the health and social care workforce on a daily basis to transform and improve services, which showcase the dedication, innovation and caring approach so evident to anyone in Northern Ireland.

Perhaps more fundamentally, they offer evidence that the wide-ranging transformation envisaged by this strategy can be achieved. A selection of these examples can be found at: https://www.health-ni.gov.uk/topics/health-policy/transformation-programme#toc-0.

The strategy seeks to contribute to deep and wide transformation of health and social care in Northern Ireland by establishing a long-term, sustainable and sensible approach to meeting our workforce needs, and the needs of our workforce. The success of the strategy will rely on cooperation between employers and workers, professions and disciplines, and across all sectors.

The consequences of failure to achieve the aims and objectives of this strategy are grave. The already unsustainable rate of agency and locum expenditure will continue to increase. Waiting lists for treatment will continue to rise. Health and social care services will become unsustainable, and the longer this continues, the more difficult it will be to transform these services.

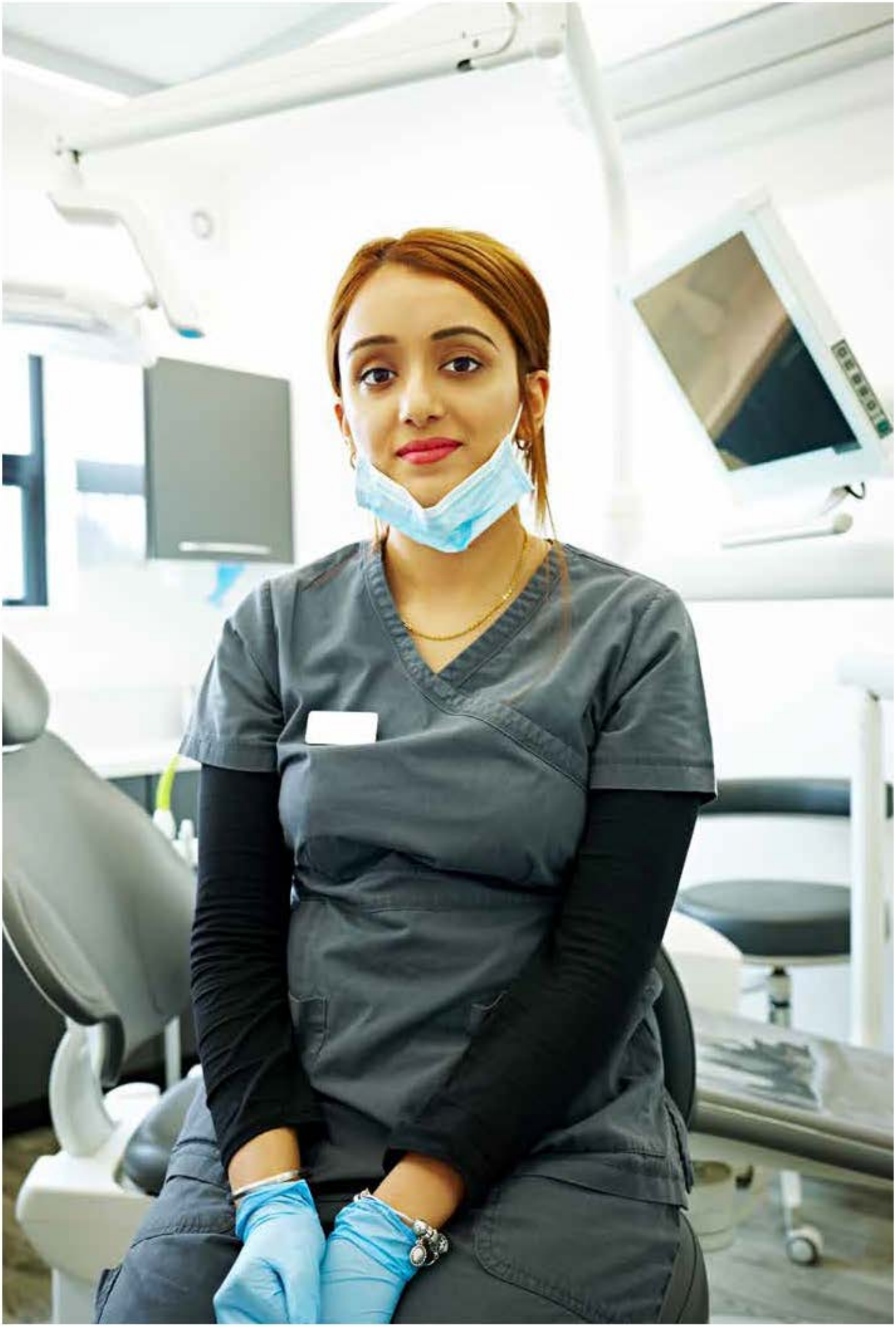
This strategy not only seeks to tackle issues in the present, but looks forward to health and social care as it will be in 2026. It is designed to be flexible enough to respond to issues that will arise in the future.

To make sure the strategy achieves its objectives, the Department will develop three consecutive action plans, with oversight mechanisms (programme board, reference group and project teams) designed to hold the Department accountable for their success. Annual progress updates will be published on the Departmental website, along with regular highlight reports showing the progress of each action.

The first task and finish group to be set up under the strategy will determine and agree the performance indicators to measure success. This work will be completed by the end of June 2018.

This strategy is not an isolated document. Many of the actions contained in the plan will be dependent on a number of other enablers and actions on the health and social care transformation agenda.

Throughout the development and co-production of this strategy, the most important focus has been to ensure that everyone has the opportunity to have their say, and shape policy for the next decade. We look forward to working together to ensure that we meet our workforce needs, and the needs of our workforce.



APPENDIX

CURRENT PROBLEMS AND FUTURE CHALLENGES

SOCIAL CARE

There can be considerable differences between the terms and conditions of employment for social care workers in statutory organisations and those employed within the independent sector. Lower pay, less favourable conditions, temporary or zero-hours contracts and a perceived lack of recognition of their value to society, have all contributed to low morale and a high turnover of the workforce.

Investment in learning and improvement for social care workers tends to be more limited in the independent sector. There are also fewer promotion opportunities in some areas of social care such as domiciliary care which may also discourage people from choosing social care as a long-term employment option.

The domiciliary care workforce needs should be an early priority in recognition of the particular vulnerabilities we face in social care. The Department is finalising a domiciliary care workforce review which has demonstrated that services at present are stretched, with the result that there is already a gap in the supply and demand chain, with unmet need already existing.

There is a need to build in robust and cohesive systems of communication, analysis and joint workforce planning between social care and nursing for example, and between the HSC and independent social care sectors. Analysis needs to look not only at spend, but also output and efficiency.

For the first time, anywhere in the UK, Northern Ireland social care workers are now required to register with the Northern Ireland Social Care Council, which is responsible for the regulation of the social work and social care workforces. Regulation requires social workers and social care workers to maintain the skills they need to perform their tasks effectively with the support of their employers.

Alongside this, a code of practice and code of conduct has been introduced for all social care workers, together with common induction standards and a regional framework for the delegation of tasks to social care workers. A continuous learning and development framework is also under development.

SOCIAL WORK

At present, there are significant pressures on social workers in several areas within HSC, including adult mental health, child protection and services for looked-after children. Other factors which will increase the demands on social work services in the coming years include the Northern Ireland Executive's target to improve social wellbeing through person-centred care, community development, self-directed support and co-production.

New legislation such as the Mental Capacity Act and the Adoption and Children's Bill will also mean additional statutory roles and responsibilities for social workers in the future. In the next five to 10 years, social workers will be expected to have more specialist knowledge and skills.

MEDICAL WORKFORCE

Upon graduation, provisionally registered doctors enter a two-year foundation programme, becoming fully registered at the end of year one. Effectively, all local graduates enter the UK programme and all but a small number complete it, making them eligible for the next stage of medical training.

The next stage of training is specialty training (core training, higher specialty training or run through training). A number of vacancies exist at this level, particularly in core medical training and emergency medicine. There are multiple factors that impact on trainee medics' career choices, including location of posts, work-life balance and career prospects.

This is compounded by the fact that posts are sometimes designated as training posts when they should more appropriately be service posts. Medical trainees also have concerns[5] about:

- staff shortages and resultant pressure on the workforce;
- high workloads and emotional demands;
- lack of autonomy and appreciation of their role;
- emphasis on service provision at the expense of training;
- too frequent job rotation;
- unsustainable and expensive locum positions;
- irregular working hours impacting on work-life balance;
- lack of social and supervisory support;
- disconnect between trainees and management; and
- uncertainty over the junior doctor contract.

Medical vacancies

In addition to the existing vacancies in the NI training programmes, the HSC has been experiencing a growing number of medical vacancies at consultant and specialty doctor/associate specialist level. Whilst a small number of specialties feature on the UK shortage occupation list, a growing number of grades and specialties not on this list are being reported as 'hard to fill'. This not only has an impact on waiting lists, but also on the overall cost of elective care.

Postgraduate training

There is also a differential pattern of recruitment at specialty training level. Ideally all recruitment into specialty training should be into programmes (i.e. a series of postings leading to the completion of specialty training). However, approximately a fifth of training posts are of one year duration and these are continually difficult to recruit into.

Some training programmes are becoming more difficult to recruit into, most notably in the medical specialties. This impacts on the availability of consultant applicants, both now and in future years, in areas such as general and acute medicine, cardiology, diabetes, gastroenterology, rheumatology and oncology.

5. HSC/NIMDTA Valued Strategy 2016

Specialty and associate specialty (SAS)

Specialty and associate specialist (SAS) doctors can play a key role in delivering the aspirations of Health and Wellbeing 2026 – Delivering Together, through leadership and developing innovative solutions, if the right support is put in place. Motivated SAS doctors, with the requisite planned training will continue to be able to work at a consistently high level, contributing clinically, educationally, in management, clinical governance, appraisal and innovation.

An infrastructure is required with accountability and support to ensure that a SAS doctor role is an attractive role and one which makes a significant contribution to the delivery of high-quality patient care. The Department continues to work with the BMA and HSC employers to support and develop the role of SAS doctors as a valued and vital part of the medical workforce.

Consultants

There remain significant consultant vacancies in some specialties, notably radiology; not as a result of recruitment issues to the training programme but rather the output from the programmes does not meet the current and future service demand for consultants.

The inability to recruit to postgraduate training programmes in NI, as outlined above, will result in increasing levels of locum cover being required to meet the service demands of a consultant led service.

Medical workforce representatives state that a combination of lower remuneration, workload, lack of autonomy and underinvestment in services has made working as a consultant a less attractive role in Northern Ireland than in other parts of the UK and Ireland.

General Practice

Demand for services led by GPs has increased significantly recently – with a 76% rise between 2004 and 2014 in consultations and a 217% rise in test results being dealt with over the same period.

At the moment, 39% of the GP workforce in general practice is aged 50 and over. There is anecdotal evidence of a shift towards more part-time working in the general practice workforce and of a preference for portfolio careers mixing a range of roles with an increasing emphasis placed on work-life balance.

Anecdotally we have heard of an increasing preference for salaried GPs, though surveys by BMA in recent years have indicated that younger GPs are more likely (73%) to say they envisage looking for a GP partnership in the future.

Premises infrastructure limitations are a real barrier to the utilisation of skills mix opportunities (the funding schemes for premises are no longer attractive to some).

For some GPs, they consider that the role is at 'tipping point' – the job has become undoable; expectations are too high, with too much to do in too little time.

Work is ongoing to deliver multidisciplinary primary and community care teams.

PHARMACY

The pharmacy workforce is expanding, with a range of careers for pharmacists, pharmacy technicians and other pharmacy staff. This reflects the increasing need for pharmaceutical expertise within multi-professional teams in all settings, helping to optimise the benefits of medicines and transform services.

Medicines

Medicines are the most commonly used healthcare intervention within health and social care. Increasing demands present challenges in terms of affordability and complexity of care. The current cost of medicines within HSC is £600 million however, despite this significant expenditure, medicines are over used, under used and misused to the extent where outcomes are sub-optimal.

There is therefore a need to secure the important contribution that pharmacy professionals bring to the transformation of health and social care in the areas of improved quality in (a) patients' outcomes, (b) valued interventions and (c) effective integration.

Challenges

By 2026, we need to deal with the following workforce challenges:

- the professional development of the clinical prescribing role of pharmacists in general practice. While all general practice pharmacists train as prescribers, it is important that they are supported in their ongoing professional development. For example, they should have the opportunity to develop in line with the advanced practice framework;
- embedding clinical leadership in the profession through the recruitment of consultant and specialist pharmacists in hospital and federation leads in primary care. However, it is recognised that leadership applies at all levels and this should be embedded in career development frameworks;
- the continued development of clinical pharmacy services and consultant roles in secondary care;
- the integration of prescribing skills into the roles of clinical pharmacists in all settings;
- the regulation of pharmacy technicians and development of the workforce to provide a better skill mix, particularly in community pharmacy. This is an important factor to increase capacity, if pharmacists are to deliver more clinical service;
- the expansion of the role of pharmacy workforce in all settings, and
- embedding of seven-day working.

Future developments

Enhanced deployment of pharmacists' clinical skills and collaborative working with other health and social care professionals should support patients' appropriate, safe and efficient use of medicines, improve economic health gain and reduce pressures on health care systems.

Emerging new models of care and new technologies will support people to manage their own health and gain the optimal benefit from treatment with medicines. Such system redesign and scale up should be underpinned by foundation and advanced postgraduate training to support inter-professional working and professional leadership. These are standard training pathways for secondary care pharmacists, which should be replicated in the primary care and community pharmacy sectors.

DENTAL WORKFORCE

General dental practitioners, as independent contractors, spend almost three quarters of their time on health service dentistry. However this has been decreasing in recent years, leading to a corresponding increase in private dentistry.

Dental nurses

Turnover of dental nurses can be high and there is little or no career progression currently available. There is a reliance on the availability of relevant courses through the network of Further Education colleges. The current experience within the dental workforce is that the courses necessary to train dental nurses are becoming difficult to access due to lack of availability.

Community dental service

The Community Dental Service, which is the main provider for special needs groups, has reported challenges in filling posts, particularly in the western region. Also, significant numbers of the most experienced community dentists are approaching retirement, with up to 40% reported to be potentially retiring by 2025.

Dental hospital/school

The Dental Hospital/School has reported some challenges in filling posts for particular dental specialties and it is understood that this is a problem in other parts of the UK too as the market is competitive for the relatively small numbers who have completed training.

Providing work experience for young people is much harder to do nowadays, with increased insurance costs, complex administration and onerous patient permission processes. Access NI checks for new staff can take up to 10 weeks (although this time period is quite variable). Practice owners are finding that there are additional costs associated with dental nurses due to indemnity and General Dental Council registration fees.

There is a recognised tendency for new graduates to remain close to the city in which they trained. This makes it harder to recruit to rural practices.

The dental technician workforce is ageing and unless new workers are attracted we will soon run out of skilled technicians, particularly those who are able to make dentures.

The ongoing Dental Services Workforce Review is considering these issues.

CLINICAL PSYCHOLOGY

There has been an unprecedented increase in recognition of the relevance and need for psychological interventions in health and social care. This is reflected in NICE guidance for physical, as well as mental, health presentations and in numerous regional and national strategies in relation to particular population and service needs.

Psychological interventions have been recognised as not only relevant to improved health and well-being, but as beneficial from a healthcare economics point of view in reducing costs associated with disability, healthcare dependence and social exclusion. Future legislative and associated policy changes, such as the implementation of the Mental Capacity Act, will also impact on demand for clinical psychologists within the health and social care workforce.

Clinical Psychologists are employed in a range of specialisms including adult mental health, adult physical health, neurology services, learning disability, children's mental health, paediatrics and child disability, autism services for adults and children, services for looked after children, older adult, forensic and addiction services.

Over recent years, consistent with NICE guidelines, there has been an increased diversification of the areas of employment and especially within staff wellbeing, Autistic Spectrum Disorder services, health, disability and early intervention services. Northern Ireland has the lowest rate of clinical psychologists per head of population across the four nations of the UK and in comparison with the Republic of Ireland.

Clinical Psychologists are trained through a doctoral clinical psychology training programme and contribute to the HSC workforce throughout training. NI has the lowest number of training commissions per head of population across the UK and Ireland. There is a 100% employment rate for graduates of the regional training programme currently delivered at Queen's University Belfast with approximately 19% of the workforce being recruited from outside Northern Ireland.

The British Psychological Society 2015 Workforce Review identified a 19% vacancy rate across Trusts with supply of clinical psychology graduates not keeping pace with need and demand. Regional priorities for new psychological services and the increased role of clinical psychology in governance and training of others, means that demand for clinical psychologists continues to grow.

Moreover, the profession is a female dominated profession (77%) and part-time working has increased from 25% in 2008 to 39% in 2015. This demography and pattern of working has created significant workforce pressures especially in the absence of any viable locum pool to cover maternity leave and family friendly work policies. 17% of the Clinical Psychology HSC workforce are over 50 years of age with early retirements available through mental health officer status for this cohort.

Following on from the DHSSPS Strategy for the Development of Psychological Therapy Service (June 2010) there have been very significant developments in recruitment of other professions, across a skill mix, into psychological services. These include psychological therapists, behaviour support workers, autism workers and rehabilitation assistants.

Effective governance arrangements are required for these other professionals delivering psychological or psychology informed interventions. Clinical Psychologists are well placed to contribute to the transformation agenda by supporting the development of psychological mindedness across the workforce and delivering a safe, effective and well governed stepped care approach to the provision of psychologically informed health and social care.

NURSING AND MIDWIFERY

Nurses and midwives are critical to health service delivery, accounting for 35% of the HSC workforce. They have the most contact time with patients and service users, and provide a diverse range of services across all settings. As members and coordinators of inter-professional teams, they help promote and maintain health and wellness, bringing person-centred care closer to communities, and improving outcomes.

Challenges and opportunities

The professions have embraced the challenges and opportunities placed on their practice by growing demands and changing service needs with a corresponding increase in workforce knowledge, skills and expertise. There is significant evidence that the development of innovative new roles such as advanced nurse practitioners and consultant nurses and midwives have advanced autonomous practice and embedded strong clinical leadership.

The potential of these roles needs to be maximised. Family nurse partnerships are an example of early intervention models that deliver positive outcomes.

The development of clinical specialisms, and treatment advances, have increased demands on the specialist nursing workforce, in particular cancer specialists. Further examples of nurse-led initiatives include nurse endoscopists and models involving minor surgery (such as dermatology).

Rising demands on community and primary care services, and the prevalence of long-term conditions, have placed a significant burden on community nursing services. Alongside the focus on advanced and specialist practice, is the need for adequate investment in post-registration education and development of the generalist nursing workforce.

In response to ‘Delivering Together’ and the increasing demands on the workforce, a Nursing and Midwifery Task Group was established to identify how the contribution of nurses and midwives can be maximised to improve population health outcomes. The task group’s work is underpinned by a public health approach that promotes health and wellbeing.

It will identify best practice, evidence-based innovations which build on work already undertaken here. Indications emerging from extensive engagement with the workforce include a concerning picture of a pressurised, under-resourced service, curtailing the capacity to deliver safe, effective care.

Recruitment and growth in demand

The nursing and midwifery workforce has risen by 8% since 2008 but this has not kept pace with demand, and there is a significant shortfall in the number of nurses available to take up vacant posts in both the statutory and independent sectors. The same picture is emerging for midwifery, and the independent sector.

The impact of vacancies is compounded by high levels of maternity leave and sick absence in some areas. Maintaining service delivery incurs high bank and agency costs. Continued growth in demand has impacted on Trusts' ability to recruit at entry level.

There is a global shortage of registered nurses and midwives, and this impacts on Northern Ireland. Contributory factors include demographic changes with rising healthcare needs, changing service requirements, growth in nursing and midwifery-led services, and the expanding scope of practice with new roles emerging.

A further significant local factor is that investment in pre-registration nurse training between 2010 and 2015 did not keep pace with demand, resulting in a significant shortfall of nurses and midwives to fill vacancies. The Department has increased investment in undergraduate nurse training, commissioning an additional 100 places each year from 2016/17 and a further 100 new places for 2017/18. To help maintain safe staffing levels, an international nurse recruitment campaign commenced in 2016 as a short-term measure.

The implementation and progression of Delivering Care: Nurse Staffing in NI has highlighted the disparity that exists between current staffing levels across a range of specialities and those needed for optimum delivery of safe, effective care. Phase 1 investment has strengthened the workforce in acute medical/surgical areas.

Children's nursing

Advances in care and technology mean that many more children are living better, or more comfortably, with complex health care needs. Children's nurses have the expertise to care for and support children and their families in a variety of settings, both community and hospital based.

The intention with A Strategy for Children's Palliative and End of Life Care 2016–26 is to improve children's lives in real terms. The children's nursing workforce has to reflect changing population health needs, increasing complexities of conditions, the opportunities of innovation in healthcare alongside similar demographic workforce issues to the other fields of nursing.

Mental Health nursing

A mental health nursing review is underway, to enhance the contribution of mental health nurse to population outcomes. As the largest mental health workforce, mental health nurses are a core asset in the delivery of services and are central to workforce development.

There is a need to revise the mental health nursing undergraduate curriculum, strengthen the provision of psychological therapies and promote the development of advanced practice roles. All nurses and advanced nurse practitioners will have a critical role to play with the implementation of the Mental Capacity Act.

Learning Disability nursing

'Strengthening the Commitment' sets the strategic direction for learning disability nursing and recognises the important contribution learning disability nurses make in providing effective person and family centred care.

Recruitment, retention and replacing vacant posts are challenges, and it is within this context that a new career framework is being developed to further enhance the roles of learning disability nurses.

The aim is that they will be able to make a more significant contribution in improving physical, psychological, behavioural and social outcomes across primary care, community care, and acute and specialist learning disability services. This will also include the development of advanced and nurse consultant roles including specialist practice roles in Forensic Care Services.

Nursing Assistants

The current HSC nursing workforce model, where a Band 2 and 3 nursing assistant works under the delegated supervision of a registered nurse, is optimal in delivering safe, effective nursing care across all clinical settings. This skill mix model provides clarity and distinction between the role of a registered graduate nurse and that of a nursing support worker/assistant.

Development of the Band 3 role, with a wider skillset, has proved invaluable in supporting the graduate workforce to deliver effective care.

The Department has launched mandatory Standards for Nursing Assistants and other linked resources, including an Induction and Development Pathway, to endorse and strengthen the vital role undertaken by this cohort of staff.

The resources recognise and value the important contribution to nursing care made by Nursing Assistants and further enhance governance, oversight and patient safety.

New legislation such as the Mental Capacity Act will also mean additional statutory roles and responsibilities for nurses and midwives in the future.

Midwifery

The scope of practice of the midwife is clearly described and demarcated. The role has developed to meet changing population needs and the changing context of healthcare delivery. The birth rate in Northern Ireland has stabilised at approximately 24,500 births per year, however the complexities surrounding women giving birth has increased.

Evidence shows that it is in the interests of women to receive the majority of their care from a small group of midwives they know and trust, and the principle of "right care for the right woman in the right place by the right professional" is key.

Current service developments are in line with the 2012 Maternity Strategy, and include the development of midwifery-led care services, the acquisition of enhanced skills and competencies and development of maternity support workers.

Midwives have increasingly taken a major role as the lead professional for straightforward pregnancies, whilst developing roles as the key coordinator of care within the multidisciplinary team for complex cases. There is increasing recognition of the impact on the workforce of increasing midwife-led care, the shift to community based services and the development of freestanding birth centres.

The wide-ranging scope of midwifery practice to include increased safeguarding measures and public health responsibilities, and the impact of new initiatives such as the Early Intervention Transformation Programme adds strain to the service.

Changes to superannuation schemes and the potential impact of revalidation mean it is likely that a significant proportion of those eligible will chose to leave the service over the next five to 10 years. Current data indicates that in 2017, 21% of midwives in Northern Ireland are over 55 and eligible to retire.

The loss of more experienced midwives will potentially result in a skill mix imbalance in some areas. As younger midwives enter the profession, the challenges will relate to part-time working and maternity leave needs.

ALLIED HEALTH PROFESSIONALS[6]

Key to successful innovation and modernisation will be capitalising on the knowledge, expertise and professional experience of the AHP workforce, and communicating and sharing good practice, particularly in areas such as public health, diagnostics and re-ablement. Demand for AHP services continues to rise and this requires a review of the current workforce including supply and demand pressures.

There are several significant challenges for AHP recruitment and these vary across the professional groups. Regional recruitment for HSC Band 5 posts is coordinated through BSO for several of the professions. This requires further development to ensure a responsive recruitment process.

Further work is required to support the development of advanced practice across the AHP professions, as some professionals have highlighted issues with succession planning for the future at higher bands. An advanced practitioner framework is being developed to support this practice.

The services of all AHP professions are under pressure with capacity and high levels of maternity leave. This impacts on services and reduces the ability to respond to waiting lists in a timely way.

Temporary staffing is difficult to address through regional recruitment or agency working as there are not the clinical skills available for specific roles.

Due to the very diverse nature of clinical areas there is not the ability to use a bank system to backfill some posts.

There are many opportunities for the skills of AHPs to contribute to the transformation agenda, but this requires specific specialist training and competences. In respect of upskilling, for example, AHP staff have received training to allow them to act as independent prescribers.

However, issues exist with executing this role after training as operational matters need to be addressed to maximise the new skills into clinical practice.

6. The AHP (allied health professional) workforce group encompasses a variety of roles under the umbrella term. Seven of the AHP professions (speech and language therapists, physiotherapists, radiographers – diagnostic and therapeutic dieticians, occupational therapy, podiatrists and orthoptists – are directly employed through HSC and the five other professions (art drama and music therapists, orthotists and prosthetists) are subcontracted into Trusts through various local arrangements.

SCIENTIFIC SPECIALISMS

Scientists work across health and social care in life sciences, physical sciences, physiological sciences and clinical bioinformatics. They deliver care directly to patients and also provide essential supporting and diagnostic services. Over 50 separate scientific specialisms are recognised nationally.

Increasing demand for healthcare science work has led to challenges in managing workloads in many areas. There is almost no area of clinical care which does not rely on scientific support for the delivery of services.

Scientific advances are a key driver of innovation in health and social care, leading to improved patient outcomes. It is essential to have a fully trained and sufficient scientific workforce in all areas to ensure that these benefits can be delivered in a timely way, particularly in the face of continued growth in demand.

Genomics will impact on a number of disciplines in the future. There will be a need for highly trained biomedical scientists and clinical scientists to implement and run the technology, and for bioinformaticians to interpret the results.

Best practice elsewhere points to the need for the development of regional subspecialist teams supported by effective technology, such as digital imaging. However, separate consideration will need to be given to the evolving roles of each specialism when developing a future workforce plan.

Pathology is one of the key areas in need of reform, as the current pathology service model does not lend itself to effective regional workforce planning. The lack of medical and scientific staffing in some Trusts, disparity in resource across the HSC pathology service and variable distribution of workload across the region, all present a risk to provision of equitable health services across the region including delays in the provision of cancer pathology diagnostics.

New technology, for example digital pathology can help alleviate problems with consultant shortage as part of a wider strategy and should be adopted by the HSC.

There is a need for new expert, advanced and consultant-level scientific roles for clinical and biomedical scientists to alleviate the pressure caused by consultant shortages and to maximise new technology; new training programmes are required to facilitate this. Northern Ireland currently has no funded training programme for clinical scientists, advanced biomedical scientists, or epidemiologists in public health.

OPHTHALMIC SERVICES

Throughout the UK, ophthalmic hospital departments are struggling to provide the service required by their population. Around a half of the units have unfilled consultant and/or SAS positions.

Over 90% are undertaking waiting list initiative surgery or clinics, with a similar proportion estimating that they require between one and five additional consultant ophthalmologists over the next two years.

The Royal College of Ophthalmologists predicts a 20–30% increase in workload over the next 10 years for the common ophthalmic conditions of the elderly. Ophthalmology is a high demand specialty, typically accounting for 10% of all outpatient and 5% of all inpatient/day case activity.

This demand is particularly susceptible to demographic pressures, new and emerging treatments and technologies, and a historical reliance on additional in-house and independent sector activity.

The Health and Social Care Board and Public Health Agency have undertaken exploratory discussions around ophthalmology workforce planning, intended to reflect significant developments in service provision, including the expansion of capacity and capability in primary care (optometry), already evidenced in community-based acute eye and glaucoma referral refinement schemes, and the expanded use of multi-disciplinary teams in secondary care.

AMBULANCE SERVICE

Annual turnover of Emergency Medical Technicians (EMTs) and trainees, and ambulance care attendants and trainees has traditionally been low, but is beginning to rise. External application rates for non-registered trainee posts are healthy, with no associated recruitment difficulties.

However, external application rates for registered posts (i.e. HCPC qualified paramedics) are relatively low. While the majority percentage of staff in paramedic and rapid response vehicle paramedic posts are currently below the age of 55, a significant percentage of paramedic line managers are 55 or over.

The Northern Ireland Ambulance Service HSC Trust (NIAS) has partnered with the Ulster University to develop a paramedic education programme of a level 5 Foundation degree in Paramedic Practice, with an anticipated commencement for the first cohort of October 2018. Initially, this programme will draw on existing NIAS EMTs as candidates. The Trust will continue to work with DoH in respect of the further developments in Paramedic Education which may potentially include a BSc qualification.

Consideration is also being given to the impact of the publication of a new Agenda for Change national profile for the role of Paramedic which reflects developments in the role in recent years.

Paramedics

There has been significant development in the Paramedic role including in terms of additional clinical skills and decision making. Paramedics make a valuable contribution to the wider health and social care system including through the introduction of Alternative Care Pathways, where patients may be referred to a more appropriate alternative path to transportation to Emergency Departments.

In continuing to transform and modernise its service, NIAS has also introduced new Paramedic services and roles including:

- The creation of a Clinical Support Desk, staffed by Paramedics, within Emergency Ambulance Control to triage lower acuity calls in order to consider suitability for emergency ambulance response or an appropriate alternative.
- The creation of HEMS (Helicopter Emergency Service) Paramedic roles for Paramedics who operate alongside clinicians on the new Northern Ireland Air Ambulance.
- The piloting of a new Community Paramedic role.

There are also potential opportunities for further benefits to be derived from Paramedics working in other settings such as emergency departments, out of hours centres, GP surgeries, in minor injury/illness centres, in remote medicine and a varied range of other environments.

Workforce Review

Workforce considerations for Paramedics and other ambulance roles will be considered in the DoH, newly initiated Workforce Review for the service, established in partnership with trade unions.

Ambulance response times

A demand and capacity review has been undertaken to determine the underlying capacity required to deliver ambulance response time performance for Northern Ireland, designed to meet Ministerial targets and the Trust's own performance objectives.

The review was structured to include the identification of internal efficiencies designed to optimise performance using existing resources against an accurate demand analysis projected forward to 2020. The review also considered detail on the optimal rostering and deployment of that additional resource.

The modelling assessed the best performance that can be achieved with existing resource against current and projected response targets. After the consideration of all efficiencies, the remaining gap was identified and a detailed examination given of the resource required to bridge that gap.

This identified a requirement to significantly increase the numbers of Paramedics and EMTs, which in turn will have a significant impact on recruitment and training needs in the short term. The results of the demand and capacity analysis are now being considered by NIAS in partnership with Department of Health and Commissioners.

HSC ADMINISTRATIVE AND CLERICAL WORKFORCE

Administrative and clerical staff occupy roles both in direct and indirect frontline services, for example reception services, patient records and business support functions such as finance, HR and IT. Within HSC organisations this group of staff is often targeted with regard to efficiency savings and therefore, despite increases in most other HSC staff groups to meet increased demand for services, staff numbers had changed little in recent years.

As with many other staff groups, administrative and clerical staff report not being able to meet the conflicting demands of their work. A high portion of administrative and clerical staff also report working additional unpaid hours. At March 2017 HSC organisations had around a 4% vacancy rate in the administrative and clerical workforce and, as such, agency workers are being utilised.

HSC ESTATES AND SUPPORT SERVICES

Estates services staff (e.g. electricians, plumbers, engineers etc.) are a mostly male (97%) workforce, with little part-time working currently and over half aged 50+. The staff survey responses highlight issues with lack of appraisals and feedback from managers, not feeling valued, conflicting demands of work, issues of having inadequate materials and supplies to do their jobs and not having enough staff in teams. This staff group also report a high proportion working additional paid and unpaid hours.

The Support Services staff (e.g. catering, cleaning, drivers, porters etc.) are comprised of around 60% females and 40% males, with almost half aged 50+. Two thirds work part-time. This workforce also experiences high levels of sickness absence with injury, fracture and musculoskeletal issues being prevalent reasons for absence. Staff survey results also highlight low levels of appraisals, management feedback and engagement with staff about decision-making.

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Health and Social Care Workforce Strategy 2026 - Delivering for our People

Second Action Plan (2022-23 to 2024-25)

The 'Health and Social Care Workforce Strategy 2026 – Delivering for our People' was published in May 2018. It acknowledged that the people who work in Northern Ireland's health and social care system – whether employed by the statutory Health and Social Care (HSC) organisations, independent contractors, or as our partners in the voluntary and community sector – are the system's greatest strength, working ever harder to provide the care needed by patients and service users.

The experiences of the last two years has demonstrated to me that the system simply could not function without the skill, dedication and commitment of our talented, hard-working colleagues, across all disciplines, professions and levels.

The aim of the Workforce Strategy is that by 2026 "we meet our workforce needs, and the needs of our workforce". In practice, this means ensuring that a transformed health and social care system has the right numbers of appropriately-trained staff, with the right skills mix; and that the Department and employers create the conditions so that health and social care becomes an employer, and a trainer, of choice.

The Strategy's first action plan, while impacted by the pandemic, has delivered significant progress in a range of areas. However many of the challenges previously identified remain and further challenges have emerged as a result of the pandemic's effects. This second action plan, covering the three year period from 2022/23, has been developed in partnership with colleagues and stakeholders from across the health and social care system. It seeks to address our workforce challenges through an ambitious series of actions that will be taken forward over the next three years.

I have often said that an increased and sustained investment is necessary to support our ambitions for the health and social care workforce and to ensure full implementation of this second action plan. The Department of Health currently faces a very challenging financial position and I am on record as warning that funding pressures in health may be significant by the second half of 2022/23 with the

financial situation undoubtedly being constrained whatever the final budget settlement.

My ability to plan strategically is being significantly impaired by the ongoing budgetary uncertainty and my Department does not currently have the funding necessary to deliver all of the actions which have been identified as necessary by stakeholders. My Department will continue to do the best it can to deliver on these actions with the resources available, however, in the absence of significant additional funding a further process to identify actions of the highest priority for progression will be required.

Health Minister Robin Swann

Introduction

The 'Health and Social Care Workforce Strategy 2026: Delivering for Our People' was published in May 2018. The aim of the Strategy is that '**by 2026, we meet our workforce needs and the needs of our workforce'.**

To achieve this aim, we need to meet three objectives:

1. The reconfigured health and social care system has the optimum number of people in place to deliver treatment and care, and promote health and wellbeing to everyone in Northern Ireland, with the best possible combination of skills and expertise;
2. Health and social care is a fulfilling and rewarding place to work and train, and our people feel valued and supported; and
3. The Department and health and social care providers are able to monitor workforce trends and issues effectively, and be able to take proactive action to address these before problems become acute.

The Strategy was developed by the Department of Health through detailed engagement with colleagues from across the HSC and independent, voluntary and community sector healthcare providers and trade unions, and covers the period 2018 to 2026.

To enable flexibility in delivery over the life of the Strategy, three consecutive action plans will be developed. The first action plan which covered the period 2018 to 2020, despite being impacted by the pandemic, delivered progress in a number of significant areas. These included:

- commissioning by the Department of the highest ever number of pre-registration nursing and midwifery places at 1,325;
- delivery of an international nurse recruitment process which by December 2020 had recruited a total of 647 nurses, of which 593 remain in post;

- the delivery of an ongoing programme of workforce reviews, each utilising the Regional HSC Workforce Planning Framework six step methodology;
- the move to a Programme of Care approach to workforce planning in these reviews;
- the introduction of the Physician Associate role across the HSC;
- delivery of measures by each HSC Trust to support health and wellbeing of staff;
- movement of doctors in training to a single employer arrangement;
- introduction of processes that have reduced the time taken during recruitment from point of receipt into the HSC Recruitment Centre until final offer; and
- alignment of the HSC staff survey with the Workforce Strategy to ensure information is available to better measure progress against intended outcomes.

Our response to the pandemic has delayed the formal development of the second action plan with the Department completing an internal review of progress in the autumn of 2020 which identified a series of actions for progression from the beginning of 2021 with a view to them being incorporated into the formal second action plan.

The Department has worked collaboratively with colleagues from across the health and social care sector in recent months in the development of this second action plan with a particular focus on:

(i) building on the first action plan, continuing to address issues contained in the first action plan that remain relevant while ensuring these are refreshed where necessary to accurately address the current situation;
(ii) considering new actions specifically arising from the experiences of the pandemic; and
(iii) assessing additional actions relevant to an ever evolving health and social care system.

The result of this collaborative engagement is the second action plan outlined below which identifies actions for delivery over the next three years (2022/23 to 2024/25).

The second action plan identifies an ambitious range of strategic actions for progression over the next three years which is reflective of the breadth and content of feedback received from stakeholders, providing the mechanisms, strategic context and flexibility within which the objectives of the Strategy can be progressed.

It is recognised that the full implementation of this second action plan will require additional funding over the next three years at a time when we face a very challenging financial position. Securing this funding will not be easy or straightforward but the Department is committed to exploring every opportunity going forward to secure additional funding as the costs of implementation become clearer.

Health and Social Care Workforce Strategy: Delivering for Our People – Second Action Plan (2022-23 to 2024-25)

Timescales for delivery	2022/23	2023/24	2024/25
	Ongoing actions to be delivered across the period to 31/03/25		

Objective 1 - The reconfigured health and social care system has the optimum number of people in place to deliver treatment and care, and promote health and wellbeing to everyone in Northern Ireland, with the best possible combination of skills and expertise			
Theme/Action	**Outputs**	**Lead organisation**	**Funding position**
Theme 1 – Attracting, recruiting and training Action 2.1 - Invest and establish a robust infrastructure within the HSC which promotes health and social care careers and supports future workforce planning <u>WHY?</u> • To help ensure a good supply of people in the future. • To inform and excite people on the range of jobs and professions. • To publicise health and social care as a career option, with properly mapped career pathways, developed in partnership with existing members of the workforce. • Focus on the skills developed within areas and locations which have recruitment difficulties. • To provide volunteering and work experience opportunities. • Will act as a single point of contact for new recruits and experienced returners.	HSC organisations will work collaboratively with schools and the further education sector with a prime aim to actively promote and encourage students to join the HSC family and become our workforce for the future. This will be achieved by:	HSC Employers	
	(i) using a blended approach including showcasing HSC at targeted career related events/conferences and campaigns including the use of virtual platforms (ongoing to 31/03/25)		can be partially implemented but will also require additional funding to ensure full implementation
	(ii) development and roll out of an agile marketing campaign with consistent HSC wide branding [Approximately 6 months from funding being identified to development of campaign]		requires additional funding
	(iii) developing links with other interested partners and stakeholders in the use of their digital space and develop profession specific materials and resources to increase awareness		can be partially implemented but will also require additional funding to ensure full implementation

	and promotion of the wide range of HSC roles (ongoing to 31/03/25)		
	(iv) investing further in the development of jobs.hscni.net to enhance its presence and improve the impact [Approximately 12 months from funding being identified to implementation of this output]		requires additional funding
Theme 1 – Attracting, recruiting and training Action 2.2 - Development and rollout of specific campaigns to showcase particular professions and support recruitment	Focussed campaigns to showcase and support recruitment into a career in social care including healthcare support workers [Approximately 9 months from funding being identified to implementation of this output]	Social Care Directorate (DoH) / NI Social Care Council	requires additional funding
<u>WHY?</u> • To promote opportunities within specific professions that require focussed recruitment initiatives.	Focussed campaign to support recruitment into Children and Family social work as a way of addressing the increasing challenges of recruiting and retaining social workers within this sector [Approximately 12 months from funding being identified to implementation of this output]	Social Care Directorate (DoH) / NI Social Care Council	requires additional funding
	Identify other professions suitable for similar focussed campaigns through recommendations arising from workforce reviews (ongoing to 31/03/25)	Workforce Policy Directorate (DoH) and Chief Professional Officers (DoH)	can be partially implemented but will also require additional funding to ensure full implementation

Theme 1 – Attracting, recruiting and training Action 2.3 – Explore new and alternative opportunities that may provide a recruitment and training pathway to a career in the health and social care system <u>WHY?</u> • To broaden the potential supply of people. • To provide career progression and development pathways to both new recruits and also existing HSC staff.	Convene cross HSC apprenticeship working group to scope health and social care and business support professions and roles that may be suitable for (i) Level 2/3 and (ii) Higher Level Apprenticeship programmes with view to also establishing career development pathways (by 30/06/22)	HSC Employers	can be fully implemented without additional funding
	Liaise with relevant stakeholders to explore most appropriate funding models for HSC apprenticeship programmes (by 31/03/23)	Workforce Policy Directorate (DoH)	can be fully implemented without additional funding
	Scope potential application of existing apprenticeship frameworks i.e. pharmacy services, dental nursing and social care (by 31/03/23)	HSC Employers	can be fully implemented without additional funding
	HSC apprenticeship working group to engage with Healthcare Sectoral Partnership established by DfE to develop new (i) apprenticeship frameworks and (ii) apprenticeship programmes for identified professions, subject to appropriate funding models being established [Ongoing development once funding secured]		requires additional funding
	Develop proposals to harness the supply of psychology graduates to support the Clinical Psychology workforce (by 31/03/23)		can be partially implemented but will also require additional funding to ensure full implementation
	Examine opportunities to support and utilise employability academies		can be fully implemented without additional funding

	designed to facilitate the recruitment of staff i.e. social care (by 31/03/23)		
	Examine opportunities to develop and utilise existing trainee schemes to provide Level 1 entry into healthcare and business support professions with view to establishing career development pathways (by 31/03/23)		can be fully implemented without additional funding
	Develop a social work trainee scheme [Approximately 24 months from funding being identified to implementation of this output]	Social Care Directorate (DoH)	requires additional funding
Theme 1 – Attracting, recruiting and training Action 2.4 – Develop innovative approaches to support the recruitment and retention of social workers to address the workforce challenges within this sector WHY? • We need to deliver sufficient numbers of social workers to meet identified demand and ensure compliance with statutory functions. • Recruitment pressures within Children and Family social work services remain acute, impacting upon the delivery of delegated statutory functions. • There is a need to create adequate capacity within front line teams to meet increasing demands for services.	Establish a Social Work Workforce Implementation Board to progress initiatives to support the recruitment and retention of social workers (ongoing to 31/03/25)	Social Care Directorate (DoH)	can be partially implemented but will also require additional funding to ensure full implementation
	Develop a strategy to secure and retain a stable, skilled and motivated Children and Family social work workforce to ensure the appropriate mix of staff with the appropriate skills to deliver safe and high quality social work services (ongoing to 31/03/25)	Social Care Directorate (DoH)	can be partially implemented but will also require additional funding to ensure full implementation

Theme 1 – Attracting, recruiting and training Action 2.5 – Establish structures to oversee the implementation of recommendations arising from workforce reviews WHY? • Ensures focus is retained on recommendations arising from workforce reviews with view to developing implementation frameworks for delivery.	Oversee implementation of the recommendations of the 2020 Pharmacy Workforce Review (ongoing to 31/03/25)	Pharmaceutical Advice and Services Directorate (DoH)	can be partially implemented but will also require additional funding to ensure full implementation
	Establish structures to oversee recommendations arising from rolling programme of workforce reviews (ongoing to 31/03/25)	Chief Professional Officers (DoH)	can be partially implemented but will also require additional funding to ensure full implementation
Theme 1 – Attracting, recruiting and training Action 2.6 – Explore opportunities to recruit health and social care professionals from other jurisdictions <u>WHY?</u> •Provides an additional source of registered health and social care professionals.	Undertake international nurse recruitment programme to complement workforce (ongoing by 31/03/25)	Business Services Organisation	can be partially implemented but will also require additional funding to ensure full implementation
	A project to scope potential for international recruitment in other health and social care and social work professions including Pharmacy, Allied Health Professionals and Children and Family social workers [Project will complete within 12 months once funding is identified]		requires additional funding
	Develop initiatives to attract NI domiciles trained in GB to pursue a career in the HSC [Project will complete within 12 months once funding is identified]	Workforce Policy Directorate (DoH)	requires additional funding
	Scope feasibility of a streamlined	Strategic Planning and	can be fully implemented

	process for recently trained GPs from ROI obtaining entry onto the NI Primary Medical Performers List (ongoing to 31/03/25)	Performance Group (DoH)	without additional funding
	Developing an agreed regional process, including guidance documentation, to facilitate the creation of an approved employer to enable retention of recently qualified international GP graduates (ongoing to 31/03/25)	Strategic Planning and Performance Group (DoH)	can be partially implemented but will also require additional funding to ensure full implementation
Theme 1 – Attracting, recruiting and training Action 2.7 – Provide opportunities for former staff to return to the HSC <u>WHY?</u> •Provides an additional source of registered health and social care professionals.	Establish focussed process to facilitate recruitment of staff returning to the HSC (by 31/12/23)	Chief Professional Officers (DoH) / Strategic Planning and Performance Group (DoH) / HSC Employers	can be partially implemented but will also require additional funding to ensure full implementation
Theme 1 – Attracting, recruiting and training Action 2.8 – Explore and establish non-salary incentive programmes as a means of recruiting and/or retaining and/or dealing with pressures in less popular specialties and locations <u>WHY?</u> • We are experiencing difficulties in filling certain posts. • Need new innovative ways to recruit and retain. • Addressing supply and location issues should ultimately reduce reliance on agency	Undertake focussed consultation with HSC staff to establish non-salary incentives attractive to specific professions and locations (by 31/03/23)	Workforce Policy Directorate (DoH) / HSC Employers	can be partially implemented but will also require additional funding to ensure full implementation
	Utilise the findings of the above consultation to explore feasibility of implementing identified non-salary incentive programmes [Project will complete within 9 months once funding is identified]		requires additional funding
	Development of Return on Service obligation initially for BSc paramedics course with extension to other professions (commencing with an		can be fully implemented without additional funding

and locum workers. • Such a policy can be linked to return of service obligations – establishing a new two way commitment between HSC employers and trainees.	assessment of the feasibility of a Return on Service commitment for doctors) (by 31/03/23)		
	Cross HSC working group to develop agile, flexible and hybrid working people strategies (by 31/12/23)		can be fully implemented without additional funding
	Continued engagement on Agenda for Change terms and conditions (ongoing to 31/03/24)		can be partially implemented but will also require additional funding to ensure full implementation
Theme 1 – Attracting, recruiting and training Action 2.9 – Explore and establish incentive programmes as a means of recruiting and retaining across health and social care with a particular emphasis on less popular specialties and locations <u>WHY?</u> • We are experiencing difficulties in filling certain posts. • Need new innovative ways to recruit and retain. • We need to provide a particular focus on our existing staff with view to creating the conditions that maximise retention.	Establishment of a Fair Work Forum for Social Care which will consider how pay and conditions of the social care workforce can be improved across all sectors (by 31/12/22)	Social Services Policy Group (DoH)	can be partially implemented but will also require additional funding to ensure full implementation
	Develop & deliver initiatives to support the specific retention of experienced health and social care professionals [Project will complete within 12 months once funding is identified]	Workforce Policy Directorate (DoH) / HSC Employers	requires additional funding
	Develop initiatives to support retention within all health and social care professional groups [Ongoing initiatives once funding is identified]	Workforce Policy Directorate(DoH) / Chief Professional Officers (DoH) / HSC Employers	requires additional funding
Theme 2 – Sufficient availability of high-quality training and development Action 2.10 - Commissioning of sustainable training programmes that are aligned to meet current and future health and social	Undertake a review of funding arrangements required to support workforce reviews undertaken to inform the process of strategic workforce planning (by 31/12/22)	Workforce Policy Directorate (DoH)	can be fully implemented without additional funding
	Undertake review of Supplement for		can be fully implemented

care requirements for multidisciplinary service delivery; and Action 2.11 - Commissioning of time-protected, appropriately located, sustainable post-registration training programmes, and development opportunities for more experienced people, including consideration of preceptorship arrangements to smooth the transition from training to practice <u>WHY?</u> • Values the needs of students and workers. • We need a sustainable approach to planning for, and funding, training for pre-registration students, to ensure that health and social care is fit for purpose by 2026. • This will take account of revisions to the various curriculums. • Smooth the transition from education environment to the realities of delivering health and social care, and the characteristics/skills required to do so. • Reduce reliance on agency and locum workers. • We need a sustainable and transparent approach to planning for, and funding, training for post-registration students, to ensure that health and social care is fit for purpose by 2026.	Undergraduate Medical and Dental Education (31/12/23)		without additional funding
	Ongoing development and delivery of a rolling, prioritised programme of workforce reviews to inform the process of strategic workforce planning with an increased focus on planning by Programme of Care and integrated care pathways aligned to the health and social care Transformation Programme. This should address multidisciplinary and inter-professional aspects of service delivery and training, including paramedics, with costed implementation plans for recommendations (ongoing to 31/03/25)		can be partially implemented but will also require additional funding to ensure full implementation
	Produce a policy on departmental commissioning of training and development for health and social care (i) with emphasis on the requirement for multi-disciplinary service delivery and (ii) within a three year training budget plan (by 31/03/24)		can be fully implemented without additional funding
	Undertake review of medical training places (by 31/12/23)		can be fully implemented without additional funding
	The Department will undertake a review of post registration education and training arrangements to include Medical, Pharmacy, Social Work, Nursing and Midwifery and Allied Health Professionals (by 31/03/23)		can be fully implemented without additional funding
	Produce a costed implementation plan		can be partially

	for recommendations contained within existing workforce reviews with view to commissioning (i) additional pre-registration training programmes and (ii) additional post-registration and Medical Specialty Training within a three year training budget plan (by 31/03/23)		implemented but will also require additional funding to ensure full implementation
	Working with employers, the Department will review the potential of maximising the contribution of vocational learning, commencing with the existing nursing and social care workforce, to ensure the workforce develop and retain necessary skills (ongoing to 30/06/24)		can be partially implemented but will also require additional funding to ensure full implementation
	Examine the feasibility of developing preceptorship arrangements within professions (ongoing to 31/03/24)	Chief Professional Officers (DoH)	can be partially implemented but will also require additional funding to ensure full implementation
	Continue to align and support a collective leadership culture within the HSC through the full implementation of the HSC Collective Leadership Strategy (ongoing to 31/03/25)	HSC Employers	can be fully implemented without additional funding
Theme 2 –Sufficient availability of high–quality training and development	Undertake assessment of attrition rates from medical foundation training to medical specialty training in Northern Ireland (by 31/12/23)	Workforce Policy Directorate (DoH)	can be fully implemented without additional funding
Action 2.12 – Develop a system-wide innovative approach to enhance the attractiveness of the HSC medical education programmes as a way of addressing the increasing challenges of	Working with employers and medical training partners, the Department will develop innovations to make the HSC an attractive place to train and remain		requires additional funding

attracting doctors into specialty training programmes after completion of their foundation training <u>WHY?</u> •We need to ensure there are sufficient doctors available to meet identified demand across all specialties and services.	[Ongoing initiatives once funding is identified]		
	Develop focussed initiatives to attract Northern Ireland domiciled students who have completed undergraduate training elsewhere to return for post graduate training [Ongoing initiatives once funding is identified]		requires additional funding
	Undertake review of GP training programme with view to enhancing retention of trainees in Northern Ireland (by 31/12/23)		can be fully implemented without additional funding

Theme 3 – Effective Workforce Planning Action 2.13 – Develop, and by 2026 sustainably fund, an optimum workforce model for reconfigured health and social care services that utilises the findings of our strategic workforce planning to provide a system wide view of workforce requirements <u>WHY?</u> •We need a strategic, coherent, dynamic workforce framework that clearly outlines the people and skills required to meet service and population needs across the region in 2026. This should take account of population needs and demographic trends. • We need a product that collates and coordinates the findings from the various prioritised workforce reviews that are regularly carried out for every profession and discipline and as part of transformation initiatives that are ongoing. The optimum workforce model will be this product. • The optimum workforce model will adopt a number of key principles, including the need for multidisciplinary and inter-professional working.	Working with clinical leads and other relevant stakeholders, the Department will design a robust methodology for an Optimum Workforce Model. This will utilise outputs from the workforce reviews undertaken for the purposes of strategic workforce planning to provide a system wide view of workforce requirements across the reconfigured health and social care system (ongoing to 31/12/23)	Workforce Policy Directorate (DoH)	can be fully implemented without additional funding
	Utilise outputs from the prioritised workforce reviews undertaken for the purposes of strategic workforce planning on an ongoing basis to populate the agreed Optimum Workforce Model with view to developing a system wide view of workforce requirements (ongoing to 31/03/25)	Workforce Policy Directorate (DoH)	can be partially implemented but will also require additional funding to ensure full implementation
Theme 3 – Effective workforce planning Action 2.14 - By fully implementing and embedding the Regional HSC Workforce	Continue to ensure that the six-step methodology is fully embedded into workforce planning practices, including use of population health, disease profile	Workforce Policy Directorate (DoH)	can be fully implemented without additional funding

Planning Framework (six-step methodology), ensure that this is supported by necessary resources and underpinned by a multidisciplinary ethos across all providers WHY? • Consistent, evidence-based regional approach to workforce planning. • Need to review adequacy of training across all HSC providers.	data etc. (ongoing to 31/03/25)		
Theme 3 – Effective workforce planning Action 2.15 – Development of proposals to reduce agency dependency across the HSC WHY? •Reduce reliance on agency/locum workers leading to reduced agency/locum expenditure. •Redirect resources to the delivery of permanent HSC staff.	Implement a new procurement framework for agency staff (by 30/9/2022)	Business Services Organisation (BSO)	can be fully implemented without additional funding
	Working with HSC employers and stakeholders, the Department will identify a range of additional mechanisms to support a significant reduction in 'off contract' agency expenditure (by 30/9/2022)	Workforce Policy Directorate (DoH)	can be fully implemented without additional funding
	Implement agreed mechanisms with a view to these activities contributing to a commencement of savings (from October 2022)	Organisations across HSC	can be partially implemented but will also require additional funding to ensure full implementation
Theme 3 – Effective workforce planning Action 2.16 – Development of legislation and consider the resource required to ensure safe staffing within health and social care settings	The Department in partnership with Trade Unions and Key Stakeholders to discuss and agree appropriate legislative options including appropriate primary legislation for safe staffing across all Health and Social Care settings (by 31/12/22)	Workforce Policy Directorate (DoH)	can be fully implemented without additional funding

WHY? •Ensure safe staffing levels are maintained across all health and social care settings including paramedics. •Provide increased assurance for patient safety.	Develop a safe staffing policy that is inclusive for those working in Health & Social Care settings including the NI Ambulance Service (by 30/06/23)	Workforce Policy Directorate (DoH) / Chief Professional Officers	can be fully implemented without additional funding
	Develop appropriate secondary legislation including staff calculation methods that can be implemented in specific Health & Social Care settings (by 30/06/24)		can be partially implemented but will also require additional funding to ensure full implementation
Theme 3 – Effective workforce planning Action 2.17 - We take account of, and plan for, the workforce implications arising from the UK's exit from the EU and the subsequent implications for the EU/EEA and non-EU/EEA WHY? •Need to take account of the implications for workforce supply, frontier workers, mutual recognition of professional qualifications, international recruitment, borders agency, immigration quotas and shortage occupation lists.	Consider appropriate arrangements for the regulation of healthcare professions delivering services or undertaking training on the island of Ireland (by 31/12/23)	Workforce Policy Directorate (DoH)	can be partially implemented but will also require additional funding to ensure full implementation
Theme 4 – Multi- disciplinary and inter-professional working and training Action 2.18 - Planning for and introducing new roles WHY?	Support UK wide work to secure statutory regulation and prescribing rights for Physician Associates (by 31/03/24)	Workforce Policy Directorate (DoH)	can be partially implemented but will also require additional funding to ensure full implementation
	Complete full review of the Physician Associate pilot programme (by 31/12/23)		can be fully implemented without additional funding

• Need to develop and integrate new ways of working and jobs across health and social care. • Need to ensure that the appropriate skills mix is in place. • New roles need to be evidence-based, with clarity on outcomes of what new roles will contribute and achieve. • Strategic development of new roles facilitates transfer of best practice across professions.	Develop of a NI-wide strategy for utilisation of Physician Associates, along with the associated funding stream (by 31/12/24)		can be fully implemented without additional funding
	Support UK wide work to secure statutory regulation and prescribing rights for Pharmacy Technicians (by 31/03/24)		can be partially implemented but will also require additional funding to ensure full implementation
	Cross HSC working group to develop a formal process and criteria for the identification and development of new roles (by 31/12/22)	Workforce Policy Directorate (DoH) and Chief Professional Officers (DoH)	can be fully implemented without additional funding
	Undertake a needs analysis of new roles required across all health and social care professions commencing with Advanced Practitioner (Paramedic), Assistant Practitioner (Radiography) and Social Work Assistant (by 31/12/23)		can be fully implemented without additional funding
	Development of appropriate models for delivery of recruitment, training and practice frameworks for identified new roles, including identification of associated funding [Ongoing development once funding secured]		requires additional funding
Theme 4 – Multi- disciplinary and inter-professional working and training Action 2.19 - Develop multi-disciplinary, cross-sector working that will characterise the delivery of collective, compassionate	Cross reference the work of and seek input from relevant forums, working groups and reviews being undertaken in this area across health and social care to ensure alignment with the Workforce Strategy (among others):	Workforce Policy Directorate (DoH)	can be fully implemented without additional funding

care in the future WHY? • Effectively utilising skills and resources to deliver collective compassionate care. • Streamlining care pathways across locations and teams. • Addressing increasing incidence of co-morbidities in an ageing population. • Need to ensure that role of multidisciplinary teams in transformation of delivery of health and social care services is clear and embedded in all undergraduate health and social care courses.	- Reshaping Stroke Care - Review of Neurology Services - Review of Urgent and Emergency Care - Regional Medical Imaging Board - Mental Health Strategy - Future Planning Model - Cancer Strategy for NI - Children Services Review (ongoing to 31/03/25)		
Objective 2 - Health and social care is a fulfilling and rewarding place to work, and our people feel valued and supported			
Theme 5 - Building on, consolidating and promoting health and wellbeing Action 2.20 - Working with employers and all those who work in the health and social care sector and trainee representatives, the Department and commissioners will produce an HSC staff health and wellbeing framework, with the aim of assisting staff to remain physically and mentally well at work	Complete audit of existing health and wellbeing services and procedures (by 31/09/22)	Workforce Policy Directorate (DoH)	can be fully implemented without additional funding
	Establish working group, aligned to the Regional Health and Wellbeing Network to produce a HSC staff health and wellbeing framework that will support employers in planning and implementing effective processes and resources for improving staff health, wellbeing and safety at work (by	HSC Employers / Workforce Policy Directorate (DoH)	can be fully implemented without additional funding

WHY? • Investment in health and wellbeing services for the workforce reduces sick absence, improves ability to recruit and retain staff (with corresponding savings on agency and locum expenditure).	31/12/22)		
	Ongoing development and implementation of initiatives to proactively support staff across health and social care to remain physically and mentally well at work (ongoing to 31/03/25)	HSC Employers	can be partially implemented but will also require additional funding to ensure full implementation
	HSC Employers will work to develop and support sustainable initiatives to build a diverse and inclusive workforce where all colleagues are valued, listened to and through active involvement can contribute to decision making (by 31/12/23)		can be partially implemented but will also require additional funding to ensure full implementation
	HSC employers will work with Trade Unions to co-produce a regional policy for dealing with disciplinary matters in accordance with a just culture approach (by 31/12/22)		can be fully implemented without additional funding
Theme 5 - Building on, consolidating and promoting health and wellbeing Action 2.21 - Commissioning and establishment of sustainable occupational health services WHY? • Investment in occupational health services for the workforce reduces sickness absence, improves ability to recruit and retain staff (with corresponding savings on agency and locum expenditure). • This will also act as a model for new occupational health services for use by the	Complete audit of existing occupational health services (by 30/09/22)	Workforce Policy Directorate (DoH) / Chief Nursing Officer	can be fully implemented without additional funding
	Complete an occupational health workforce review with view to the creation and implementation of a multidisciplinary occupational health workforce plan across the HSC that addresses the impact and learning from the Covid 19 pandemic (by 31/03/23)		can be partially implemented but will also require additional funding to ensure full implementation
	Re-instate the occupational medicine speciality training programme [Project will complete within 12 months once funding is identified]		requires additional funding
	Scope the requirements for an occupational nurse training programme		requires additional funding

wider public and private sectors.	[Project will complete within 12 months once funding is identified]		
	Establish working group to appraise options for the more effective delivery of occupational health services to the wider health and social care sector, and subsequently other Northern Ireland industry sectors (by 31/12/24)		can be fully implemented without additional funding
Theme 6 – Improved workforce communication and engagement Action 2.22 - Establish processes and procedures to ensure that information flows freely across organisations/systems and that employees are kept abreast of developments <u>WHY?</u> • Addresses concerns raised in previous staff surveys and in the fieldwork for this strategy. • Allows for staff networks/forums to discuss such matters which are common across all sectors and bands. • Allows for coherent messages on health and social care developments, including transformation and industrial relations.	Complete audit of existing processes for communication with staff across the HSC (by 31/12/22)	HSC Employers	can be fully implemented without additional funding
	Processes and procedures co-produced and fully embedded (by 31/12/24)		can be partially implemented but will also require additional funding to ensure full implementation
	HSC organisations will co-produce formal mechanisms with staff and Trade Unions to ensure consistent communication and engagement mechanisms embedded across the HSC (by 30/06/24)		can be fully implemented without additional funding
Theme 6 – Improved workforce communication and engagement Action 2.23 - Co-produced staff appraisal and engagement project and rollout of recommendations	Complete audit of existing staff appraisal and engagement processes (by 31/12/22)	HSC Employers	can be fully implemented without additional funding
	Working with staff and Trade Unions, HSC organisations will undertake a review of staff appraisal and engagement practices with view to		can be fully implemented without additional funding

WHY? • Allows for coherent action to address staff concerns in relation to: -Team working -Appraisal -Personal development -Knowledge and Skills Framework -Organisational / leadership culture (address high pressure cultures and how these can create high stress cultures and ultimately low morale).	developing and implementing a regional staff appraisal and engagement framework that formally incorporates health and wellbeing within the appraisal process (by 31/12/23)		
Theme 6 – Improved workforce communication and engagement Action 2.24 - Working with employers and the workforce and trainee representatives, the Department and commissioners will produce a set of standards that all HSC staff can expect in terms of facilities WHY? • Addresses staff concerns in relation to food/drink/rest break facilities.	Develop and implement an updated HSC staff facility policy [Policy will be developed within 12 months once funding is identified. Implementation of policy will be dependent on funding being available]	Infrastructure and Investment Directorate (DoH) and HSC Employers	requires additional funding
Theme 7 – Recognising the contribution of the workforce Action 2.25 - Design and implementation of	Complete audit of existing recognition initiatives (31/12/22) Working with staff and Trade Unions, HSC organisations will develop and	HSC Employers	can be fully implemented without additional funding requires additional funding

co-produced policy on recognition initiatives WHY? • Valuing the contribution that all make to delivering excellent, compassionate care. • Devolving decision-making to the appropriate levels, including locally where possible. • Supporting the workforce to achieve success, and to feel valued and supported. • Allows for coherent action on possible introduction/use of: -Advanced Information and Communication Technology. -Co-production leading to greater staff involvement in decision-making. -Sufficient freedom to display initiative and make decisions. -Proper supervision. -Opportunities for training and development at all grades, and not just tied to promotion. -Agreed job rotation. -Opportunities for educational leave, etc.	implement a regional framework on recognition initiatives [Development will complete within 12 months of funding being identified; implementation of framework will be dependent on funding]		
Theme 8 – Work-life balance Action 2.26 – As part of a four nations approach, HSC organisations will carry out a HSC wide review of flexible working practices in Northern Ireland, in partnership with staff and Trade Unions WHY?	Adopt Section 33 Agenda for Change Handbook arrangements within HSC (from 01/04/22)	Workforce Policy Directorate (DoH) / HSC Employers / Trade Unions	can be fully implemented without additional funding

• Recognises the needs of the workforce such as those with dependent relatives and/ or caring responsibilities, whilst balancing the requirements of the service. • Support the workforce to access their work remotely where appropriate. • Also will provide clarity around working time regulation/sleepover duties/working hours in 24-hour service. • There is a need to develop working patterns which are reflective of the demographics of the workforce.			
Theme 9 – Making it easier for the workplace to do their jobs Action 2.27 - Simplification of employment arrangements, for example, explore whether a single employer for all HSC staff is feasible and will produce benefits for staff/patients/clients <u>WHY?</u> • To provide clarity and remove duplication and possibility for error/confusion in relation to payroll, generic training, etc.	Completion of lead employer project for doctors in training (by 31/03/23)	Workforce Policy Directorate (DoH)	can be fully implemented without additional funding
	The Department and relevant stakeholders will complete a formal evaluation of the lead employer project for doctors in training and produce recommendations on the feasibility of creating a single HSC employer for doctors (by 31/12/23)		can be fully implemented without additional funding
	Produce a costed implementation plan for recommendations contained within evaluation [Plan will be developed within 3 months once funding is identified]		requires additional funding
	Scope feasibility of a possible single HSC employer [Project will complete within 12 months once funding is identified]		requires additional funding
Theme 9 – Making it easier for the	Comprehensive workforce engagement	Business Services	can be fully implemented

workplace to do their jobs Action 2.28 - Continue to develop workforce engagement projects for the introduction of new technologies and systems, including e-health initiatives, Encompass etc., which are designed to support the workforce in doing their jobs <u>WHY?</u> • Some parts of the workforce do not feel sufficiently involved in design and roll-out of new technology and systems.	plans to be developed as part of design and implementation of new technologies and systems (ongoing to 31/03/25)	Organisation / Project Leads	without additional funding
Theme 9 – Making it easier for the workplace to do their jobs Action 2.29 – Establish processes and procedures to ensure the design and delivery of learning, development and training in a comprehensive, accessible and timely manner <u>WHY?</u> • Ensure modern technologies are utilised in the delivery of comprehensive and accessible learning, development and training to staff across all HSC settings.	Establish a cross HSC working group to scope the feasibility of developing a new Learning Management System, utilising learning from the pandemic and modern learning technologies, to deliver modern and responsive learning and training needs across the HSC (by 31/03/23)	HSC Employers	can be fully implemented without additional funding
	Produce a costed implementation plan for recommendations [Plan will be developed within 9 months of resources being identified]		requires additional funding
Theme 9 – Making it easier for the workplace to do their jobs Action 2.30 – Establish processes and procedures to ensure safe recruitment practice is managed in as short a time as possible engaging the candidate throughout	Cross HSC working group to develop and design a replacement for the HRPTS system (EQUIP programme) ensuring the HSC adopts best practice and fully utilises modern technology opportunities (ongoing to 31/03/25)	Business Services Organisation (EQUIP)	can be partially implemented but will also require additional funding to ensure full implementation
	HSC Employers and BSO Shared	HSC Employers /	can be fully implemented

the journey WHY? Eradicate unnecessary delays in filling vacancies.	Services will complete a full review of the HSC recruitment model and process to scope the opportunities for improvement and inform the subsequent implementation programme. This review will align and support the business change required to support implementation of the EQUIP Programme (by 31/12/22)	Business Services Organisation	without additional funding
	Develop and progress the implementation plan for improvement of the HSC recruitment model and process to achieve an improved experience for candidates and recruiting managers (by 31/12/24)		can be partially implemented but will also require additional funding to ensure full implementation
	Scope and procure necessary adaptions required to enhance existing HRPTS system in line with identified actions to improve timeliness and maximise candidate experience of the recruitment journey [Ongoing development once funding secured]	HSC Employers	requires additional funding
	Continue to develop streamlined approaches to recruitment of Health and Social Work students on the basis of learning acquired from pilot exercises completed during 2021 (ongoing to 31/03/25)	HSC Employers	can be partially implemented but will also require additional funding to ensure full implementation

Objective 3 – The Department and health and social care providers are able to monitor workforce trends and issues effectively, and be able to take proactive action to address these before problems become acute.			
Theme 10 – Improving workforce business intelligence Action 2.31 - Department to oversee and monitor exercise to examine where current gaps exist. This will involve collaboration with the relevant bodies to introduce data collections that we know to be missing e.g. gather more primary care workforce data, independent sector, etc. <u>WHY?</u> • We have a number of gaps in our business intelligence, which if closed would enhance workforce planning, allowing us to monitor workforce trends and issues effectively, and be able to take proactive action in the future.	Establish cross HSC working group to undertake audit of existing workforce data provision necessary for effective workforce planning across the health and social system (by 31/12/22)	HSC Employers	can be fully implemented without additional funding
	Where data gaps are identified, scope the feasibility of introducing the recording and reporting of data (by 31/12/23)	HSC Employers / IAD (DoH)	can be partially implemented but will also require additional funding to ensure full implementation
Theme 10 – Improving workforce business intelligence Action 2.32 - Explore workforce data systems and analytics software to inform more evidence-based decision making and solve problems <u>WHY?</u> • We need better business intelligence.	Utilise opportunities arising from the EQUIP programme to deliver enhanced, regionally consistent and interactive workforce analyses to stakeholder audiences enabling effective benchmarking and evidence based decision making with regard to workforce planning (ongoing to 31/03/25)	HSC Employers / Business Services Organisation (EQUIP)	can be partially implemented but will also require additional funding to ensure full implementation
	Explore opportunities arising from data systems and software across other health and social care areas to enhance workforce planning capabilities (ongoing to 31/03/25)	HSC Employers / IAD (DoH)	can be partially implemented but will also require additional funding to ensure full implementation

Theme 10 – Improving workforce business intelligence Action 2.33 - Align staff survey with workforce strategy to ensure information is available to measure progress against intended outcomes <u>WHY?</u> • We need better business intelligence from this source. • Need to maximise response rate.	HSC staff survey management group will meet regularly to develop and evaluate regular HSC staff surveys (ongoing to 31/03/25)	HSC Employers	can be fully implemented without additional funding
	Deliver HSC staff surveys aligned with the workforce strategy to provide data necessary to monitor intended outcomes [Surveys developed and delivered within 9 months of resources being identified]		requires additional funding
Theme 10 – Improving workforce business intelligence Action 2.34 - Roll-out of exit interviews for all staff leaving the HSC <u>WHY?</u> • Results of detailed and meaningful exit surveys can be monitored and fed into workforce planning processes and decision-making.	Establish cross HSC working group to develop a regional process and reporting mechanism for exit interview for staff leaving the HSC (by 31/12/22)	HSC Employers	can be fully implemented without additional funding
	Develop implementation plan for the roll-out of exit interviews for all staff leaving the HSC including processes for utilising feedback to inform service design and retention initiatives [Plan can be developed within 9 months of resources being identified; implementation will follow]		requires additional funding

Oversight and Accountability

Oversight and accountability of the Workforce Strategy continues to be provided by a Programme Board which was established in 2018. The Workforce Strategy Programme Board is supported in this function by the Workforce Strategy Reference Group, with representation from relevant employers, trade unions and others, which provides advice and assurance to the Programme Board on progress.

During 2021 a new Workforce Strategy Unit was created within Workforce Policy Directorate in the Department. This Unit will be responsible for co-ordinating the Strategy with additional arrangements for the management and monitoring of implementation incorporated into the second action plan.

This will focus on the Workforce Strategy Unit working closely with stakeholders to identify and allocate leads for each action contained within the second action plan. Dedicated working groups, with appropriate representation from across the health and social system, will be convened with delivery plans and timeframes for implementation agreed for each output.

There is also a need for a consistent focus on the implementation of this action plan. A process of regular monitoring and reporting of progress against each identified output will also be undertaken by a focussed implementation group.

Together with continued input from the Reference Group, this process will enhance the Programme Board's ongoing management of the Strategy.

Funding

This second action plan has identified an ambitious and challenging range of actions and outputs for progression over the next three years. Many of the commitments can be taken forward without additional funding. Indeed, as a first step, many of the identified actions and outputs are to undertake scoping work to identify the most appropriate mechanisms for delivery, including costed implementation plans.

For other actions such as the commissioning of pre-registration and post-graduate training, the Department will continue to provide ongoing funding though it is recognised significant additional funding will also be required to grow our workforce to the required levels identified by our strategic workforce planning.

However, it is recognised that significant, additional, multi-year funding will be required to deliver the full challenging series of actions and outputs identified and the Department is committed to exploring all options to fund this second action plan, including the release of resources through service efficiencies and through seeking additional funding from the Executive. While this may have an impact on the pace of delivery, the Department believes it is right to be ambitious and, working with colleagues from across health and social care, we are committed to the implementation of this second action plan at the earliest opportunity.

Measuring Success

Achieving the actions in this action plan will be a good indicator of success in meeting our aim and objectives. But we must also take an evidence-based approach. A dedicated working group will be set up to produce and agree the performance indicators for the strategy, with this work to be completed by the end of September 2022. The performance indicators may include a mix of quantitative evidence, such as reductions in job/training vacancy rates and agency/locum spend, and qualitative measures such as those in staff surveys etc.