(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

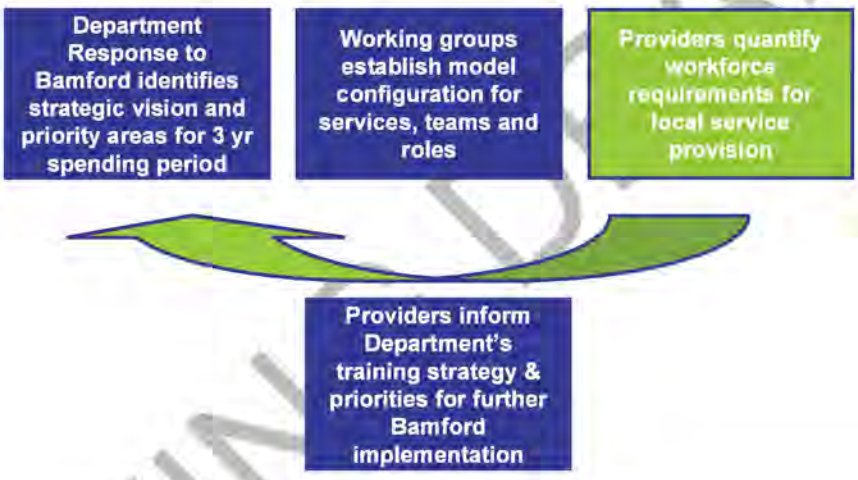
the voluntary and community organisations should be encouraged to build networks to enhance the overall service. Stronger links should be forged between the statutory and community / voluntary sectors in order to improve provision and tackle the issues of self-harm and suicide.

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