Muckamore Abbey Hospital Inquiry

Organisational Module 7 – MAH Operational Management

WITNESS STATEMENT OF JOAN PEDEN

I, Joan Peden, Retired Co-Director of Human Resources and Organisational Development in the Belfast Health and Social Care Trust, make the following statement for the purposes of the Muckamore Abbey Hospital Inquiry (the MAH Inquiry):

1. This statement is made on my own behalf in response to a request for evidence from the MAH Inquiry Panel dated 28 March 2024. The statement addresses a set of questions posed to me relating to Muckamore Abbey Hospital Operational Management.

2. This is my first witness statement to the MAH Inquiry.

3. The documents that I refer to in this statement can be found in the exhibit bundle attached to this statement marked “JP1”.

Qualification, Experience and Position of the Statement Maker

4. I am professionally qualified in personnel management from 1989. I have been a Fellow of the Chartered Institute in Personnel Development from 2005 to date. I hold a Batchelor of Arts degree in History and Politics (1984). I hold a Master of Science degree with distinction in Executive Leadership (2018).

5. Over my career, I have held the following positions:

    - From 1985 to 1998 I held positions at levels from clerical officer to Senior Manager, in Human Resource management at the Royals Hospitals, Eastern Health and Social Care Board and Mater Hospital.

    - From 1998 to 2007 I held the position of Director of Corporate Development at the Mater Hospital Trust with lead responsibility for the strategic and policy development of the full range of Human Resource services.

    - From 2007 to 2022 I held the position of Co-Director Human Resources/ Organisational Development in the Belfast Health and Social Care Trust (the Belfast Trust), with responsibility for a range of Human Resource functions, with the inclusion of Occupational Health Services from 2016.

Module

6. I have been asked to provide a statement for the purpose of Module 7: Muckamore Abbey Hospital (MAH) Operational Management.

7. I have been asked to address a number of questions for witnesses working in a senior HR position at MAH. The 28 March 2024 MAH Inquiry request for evidence, with the accompanying questions, can be found behind Tab 1 in the exhibit bundle. I will address these questions in turn.

<u>Questions for witnesses working in a senior HR position at MAH</u>

Question 1

Please explain your role and the responsibilities which you held in respect of MAH (including details of when you held such role/ responsibilities).

8. The first and only role in which I held responsibilities which related to MAH was in my role as Co Director in Human Resources for the Belfast Trust.

9. In this position, I was responsible for supporting the Director of Human Resources on setting direction and taking the lead on a range of Human Resource functions. These areas of responsibility changed over the years. From 2007-2009 they included Governance Equality and Improving Working Lives and from 2009 the additional responsibility of Modernisation. From 2011 they changed to Modernisation, Learning and Organisational Development, Equality, and from 2013 Workforce Planning. In 2016, the additional responsibility of Occupational Health Services was added to my remit. The responsibilities of the role were Trust wide and not specific to an area or location.

10. The position involved attending a number of set meetings at Trust, Human Resource Departmental and Regional Level. At Belfast Trust Level this involved the Chief Executive Briefing originally held monthly and later weekly, at which Directors, Co-Directors and Clinical Leaders attended for briefings and updates. In addition, there was a series of set meetings with the Trade Unions, weekly with the Chief Executive to deal timely with any current issues.

11. As part of the Belfast Trust's facilities arrangements with the Trade Unions, I jointly Chaired two meetings with a Trade Union Lead. The first was the monthly Workforce Governance Policy Sub–Committee, which formed part of the approval process for policies with staffing implications. The second was the Learning and Development Sub-Committee at which some general staff training was discussed and agreed.

12. At Human Resource Directorate Level there were:
    a. Monthly Senior Team meetings.
    b. Fortnightly meetings with the HR Co-Directors and HR Senior Managers / Business Partners to brief on Trust level issues and service level issues; and
    c. Regular one to one meetings with my direct reports including Senior Managers for Organisational and Learning and Development, Modernisation and Workforce Planning and Occupational Health Manager.

13. I also represented the Belfast Trust at Regional meetings and groups relevant to my areas of responsibility.

14. My position also involved taking the lead on the Belfast Trust's workforce priorities within my respective areas of responsibility. For example, I would lead as the HR Advisor on the workforce issues associated with Strategic Reform and Modernisation programmes. This involved advising and putting in place the appropriate Management of Change Framework to ensure the workforce and equality implications of service change were managed in accordance with the legal obligations and to assess and mitigate the impacts on staff. This required participating in Senior Level Project Groups, associated with significant service change programmes, including centralisation of services, temporary closures and service modernisation programmes such as the introduction of the Human Resource and Payroll Travel System.

15. My role also involved leading on the development and planning of the Trust Leadership and Management Development Strategies and Plans which involved working with both external and internal training providers in design and delivery. I was also the Trust Co-Director Lead for Investors In People, (IIP), an internationally recognised standard in people management at which the Belfast Trust gained recognition in 2010, successful review in 2013, Bronze status in 2016 and Silver level under the sixth generation standard in 2019.

16. As a Co-Director I also participated as a Panel member in Grievance and Disciplinary Appeals Panels.

HR Business Partnering.

17. Between 2007/8 and 2016, a business partnering model was employed in Human Resources. This model saw each Co-Director being aligned to some of the Clinical or Service Directorates as a Strategic HR advisor at the Senior Management Team Level.

18. During this time period, (2007/8-2016) in addition to my roles and responsibilities as outlined above, I was aligned to the Adult Social and Primary Care Directorate. As part of this role, I attended the monthly Directorate Senior Management Team meetings and advised the Director and Senior Team within the Directorate on HR issues associated with the Clinical/ Service Directorate Strategy/ Plans and HR Strategies and plans. I also acted as a conduit for workforce issues to be addressed by the wider HR teams and functions. In 2016, a new model of HR Business Partnering was put in place which saw the transition from Business Partners being Co-Directors to being 8B Senior Managers undertaking the role alongside a responsibility for a range of HR functions**.**

Question 2

What training was provided for new line managers at MAH on staff management processes.

19. As I have explained above, in my role I was involved in ensuring the development, design and delivery of a range of general staff training and management and leadership development programmes. This training was available to all managers and not specific to new line managers at MAH.

20. However, it is important to set out the context on the appointment process of new line managers and the induction arrangements, both of which are relevant to new line managers' awareness on staff management processes.

21. In the first instance as part of the recruitment and selection process for new line managers, the job description sets out the roles and responsibilities of the position. The personnel specification then sets out the essential requirements in terms of qualifications, knowledge, skills, and experience required. For line managers with staff management responsibilities this normally includes the requirement of having experience in managing people and or the ability/skills to effectively manage staff/teams. The personnel specification is used to assess the candidate's suitability for the position. The seniority of the position is reflected in the specification requirements for the post.

22. The Belfast Trust provides an induction at a Corporate and Local level as set out within its comprehensive Induction Policy and Management Guidelines. These Guidelines apply to all newly appointed staff to the Belfast Trust as well as to those who are new to post (with the exception of Medical and Dental Staff in training who have separate arrangements) . This is designed to welcome new employees to the Belfast Trust and familiarise them with the essential information about the Belfast Trust and their roles within it. It sets out the roles and responsibilities of the Belfast Trust, managers and individuals to ensure staff are supported to deal with the transition to the new post. As such managers of new line managers have specific responsibilities to ensure the effective induction to carry out the duties of their new position along with ongoing supervision and development of new members of staff.

23. The Belfast Trust had in place an inhouse range of training available for new and existing managers on staff management. Some examples included appraisal skills, performance management, communication skills, managing change, handling difficult conversations, provided by the Human Resource Learning and Development Team. Other specialist teams within Human Resources also provided training on recruitment and selection of staff, managing absence and disciplinaries. The full range of training provided by the Human Resource function on staff management processes is set out in the annual Belfast Trust Training Portfolios. The various Leadership and Management Development Strategies and programmes, over this period set out the provisions for management and leadership development, succession planning, coaching and mentoring.

24. In addition, some staff groupings, including Nursing, Midwifery and Social Care had Co Directors with lead responsibility for workforce and had profession specific training providers providing specialised training for their staff grouping.

Question 3

Please explain the performance management arrangements for all staff, including managers, at MAH.

Performance Management Arrangements for Staff

25. All staff performance was managed by way of Staff Appraisal.

26. The staff appraisal process developed and changed over the years. When the Belfast Trust first began, staff appraisal for all staff within the Belfast Trust, with the exception of Medical and Dental staff, was conducted by way of a Personal Contribution Framework. This framework was designed to engage staff in the conversation which aligns individual contribution with the development and achievement of team/ service/ directorate objectives as well as working to identify the individual development needs to meet agreed contributions.

27. The Belfast Trust later transitioned to a Staff Development Review Guidance document, incorporating the Staff Development Review (SDR) process and the Knowledge and Skills Framework (KSF). This guidance was designed to support staff in understanding what is expected of them in their role, how they contribute to meeting the objectives of the Belfast Trust and how they develop themselves within their role and future career progression reflected in their personal development plan (PDP).

28. Broadly there are four components to the discussion between the reviewer and the member of staff. Review of the past year, on individual objectives and contributions, including how the Belfast Trust values have been demonstrated. The Knowledge and Skills Framework review, discussing the knowledge and skills required for the post as set out in the Knowledge and Skills profile for the position (not all jobs had KSF profiles completed). Individual objectives and contributions, involving joint discussion on the individual contribution for the year for the team/ service. Finally, the Personal Development Plan (PDP) discussion and agreement on the personal development plan, based on their objectives and contributions, KSF profile for the post and career progression.

29. Medical and Dental Staff had a separate Appraisal and Revalidation process.

30. For those staff members where it was identified that there was a genuine lack of capability, the Belfast Trust also had in place a Capability Procedure. I understand that the Capability Procedure was first formalised within the Belfast Trust as a policy in April 2015. The purpose of this procedure, which applied to all staff (excluding Medical and Dental Staff), was to deal with a staff member with a genuine lack of capability, rather than a deliberate failure on the part of the employee to perform to the required standard.

31. In the event of a deliberate failure by an employee to perform to the required standard, the matter would be dealt with as a conduct matter under the Belfast Trust Disciplinary Procedure. The Capability Procedure included a process to support staff who were not performing to the required standards, offering support, guidance and (if necessary) training to improve their work performance. It set out the stages in addressing capability concerns including the informal, formal and appeal mechanisms.

Performance management arrangements for Managers

32. Managers were subject to the same performance management arrangements as all staff, which I have outlined above.

33. In addition, Senior Managers within each Directorate would participate in the Belfast Trust's Performance Management Accountability Framework. This involved Directorates being held to account on their performance against Belfast Trust Objectives and Directorate Plans at Accountability Review meetings. These were held on at least an annual basis with the Chief Executive and other Executive Directors. It also provided the opportunity to discuss successes and challenges. The Performance Management and Accountability Review process was led and managed by the Director of Planning.

Question 4

Were line managers required to seek HR advice and/or inform HR if they undertook performance management meetings?

34. Line managers were not required to seek HR advice and/or inform HR when undertaking a staff appraisal meeting with their member of staff. This was normally conducted in a one-to-one basis. However, HR advice was available should the line manager seek or require it.

35. Training was available for line managers on undertaking staff appraisal and training on managing people-performance and communication skills had been included in the annual Training Portfolio.

36. The process for capability related issues is slightly more nuanced. The first step in the capability procedure is to deal with capability related performance issues on an informal basis, such as an informal discussion, between the line manager and relevant member of staff. The line manager is not required to seek HR advice at that stage nor to inform HR. However, HR advice is available to the line manager, if requested.

37. Where the capability issue has not been resolved through the informal process, line managers must discuss the issue with a representative from HR before initiating the formal process. A member of HR staff may be present at a Formal Hearing stage.

Question 5

What processes were in place to provide career development opportunities to staff at MAH, to ensure that staff had the required specialist skills to deliver care in a learning disability facility?

38. My role as Co-Director in Human Resources involved the development of Belfast Trust wide generalist learning, development and training, including career development opportunities for staff. It did not involve the provision of the required specialist skills to deliver care in a learning disability facility. The respective Co Directors within Nursing and Social Care with lead responsibility for workforce and learning and development are better placed to respond to the specific career

development opportunities to staff at MAH, to ensure that staff had the required specialist skills to deliver care in a learning disability facility.

39. The Trust-wide generalist development and career development opportunities for staff extended to staff at MAH and are outlined below for information.

40. Staff were supported to study by the Assistance to Study Policy, which was designed to support staff in the acquisition of knowledge and skills and competence to provide efficient and safe health and social care. The policy was used in relation to any learning and development activity to be undertaken outside of the Belfast Trust, which had a direct financial cost to the Belfast Trust or required time away from the workplace. The types of learning activity supported included learning and development activity “off the job”, formal education, training related to the staff member’s personal development review, training linked to staff appraisal, professional development including continuous professional development and personal development, including long term career progression and personal growth. It applied to all staff with the exception of Medical and Dental Staff who had separate arrangements for Study Leave.

41. The Belfast Trust also had a range of strategies and frameworks over the period I was in post which set out its approach to leadership, leadership and management behaviours and its development and support programmes for leaders and managers. These included:

    a) The Leadership and Management Development Strategy 2009, including the Leadership and Management Charter 2009.

    b) Developing Our People Today for Tomorrow, a formalised succession planning programme for Managers interested in progressing to the next level.

    c) Leadership Development Programmes for Senior Managers at level three (Co Director level), level four (Senior Service Manager level) and

level five (Assistant Service Manager level), namely Living Leadership and Leading for Success.

d) Coaching Framework and Mentoring programme, providing staff with the opportunity for one-to-one coaching and mentoring, supporting them in their career development.

42. There have been subsequent strategies, including the Learning and Development Strategy 2013- 16, “Growing Our People Today for Tomorrow”, providing further learning and development opportunities for staff.

43. The Belfast Trust also had Annual Learning and Development Portfolios in place which set out the range of skills, personal development training, leadership and management development training, team building and development training, induction training, and statutory and mandatory training development arrangements available to staff. This is also relevant to the career development opportunities for staff discussed earlier in my statement.

44. The Belfast Trust is an accredited learning centre for the delivery of the Institute of Leadership and Management (ILM) levels 3 and 5. This programme enabled staff at front line level to develop and progress their skills for the purposes of career development, such as managerial skills, personal effectiveness, and the skills, knowledge and attributes to build personal and team effectiveness. As an accredited learning centre, it has regular independent assessment and reviews by the ILM regulator.

45. Staff were also able to apply to undertake regional development programmes provided by the HSC Leadership Centre.

Question 6

Please describe the role of Human Resources in workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix (and

thereby to ensure safe care) at MAH? Please also explain how any concerns about such matters escalated.

46. The Directors of the Belfast Trust had lead responsibility for reviewing their organisation plans and establishment levels to ensure each were consistent with achieving the objectives of the Belfast Trust and recommending change where appropriate.

47. There were also Executive Directors who had professional responsibility for specific staff groupings such as Nursing and Midwifery, Social Care, Allied Health Professionals and Medical and Dental. Where this was the case, these Directors had responsibility for the establishment and review of the appropriate staffing levels, skill mix and grade mix to ensure safe staffing levels. My understanding is that general workforce planning issues were escalated up the line of management. However, issues within professional staff groupings, such as those referred to above, were escalated up the professional lines of management to the Executive Director with professional responsibility and onwards to the Trust Board, if requested. Such matters could also be escalated to the Commissioners and relevant sections of the Department of Health as well as and when required.

48. The role of Human Resources was to provide workforce monitoring information which included staffing levels, turnover, absence, leavers and vacancies. This information was provided as Quarterly Workforce Information reports to the Directorates and then, from what I can recall, to Workforce dashboards.

49. In addition, the workforce planning team within the Human Resource Service provided awareness training on workforce planning, including the regionally adopted Skills for Health Six Step Workforce Planning methodology. Support was also provided to a few specialities to support them in the development of their local workforce plans. This included the Adult Social and Primary Care Directorate as set in response to question 1 above.

Question 7

Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panels conclusions of the Terms of Reference?

Adult and Social Primary Care Directorate Integrated Workforce Plan

50. In 2013, the Director of Adult and Social Primary Care (Ms Catherine McNicholl) established a Modernisation Board to provide a strategic overview to all reform and modernisation projects within the Directorate. In June 2013, as HR Business Partner and as part of my substantive role within HR, I tabled a draft proposal for discussion on "Adult Social and Primary Care, Modernisation (Continuous Improvement) Board, Workforce Development and Equality". I have enclosed this paper behind Tab 2 of the exhibit bundle.

51. This paper included a proposal for the development of a workforce development plan to provide a strategic overview on workforce issues and development required from an overall Directorate perspective. This included the proposal for the development of an integrated workforce plan, applying the six-step model which was the regionally agreed approach to workforce planning. This was agreed and an Adult Social and Primary Care Directorate Steering Group was established. I have enclosed the Terms of Reference of the Adult Social and Primary Care Workforce Planning Steering Group behind Tab 3 of the exhibit bundle.

52. I chaired this group and to the best of my recollection it met a couple of times. The service areas to be included were, Older People Services, Learning Disability, Mental Health, Physical and Sensory Disability and the Administrative and Clerical Support Service. Project leads were to be identified in each area because, to be effective, it needed to be service led. The HR Senior Manager with lead responsibility for workforce planning (Mrs Stephanie Read) was the HR Project Lead to complete the development of the Adult Social and Primary Care Directorate Integrated Workforce Plan, supported by the HR Workforce Planning/ Modernisation Manager (Mr Neil Mc Dade) and the HR workforce planning team.

53. The development of the plan took from May 2014 to February 2016 due to the size, scale, complexity and availability of service leads and input. A presentation of the plan was presented by Mrs Stephanie Read and myself at the Modernisation Board meeting in February 2016 and a final copy of the plan dated 22 March 2016 was issued by the HR project lead to the Director and members of the modernisation Board. A copy of this presentation is enclosed behind Tab 4 of the exhibit bundle. A copy of the final plan is enclosed behind Tab 5 of the exhibit bundle.

54. I consider that it is important the Panel knows about the ASPC Workforce Planning Steering Group and the work that it produced.

Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have either exhibited or referred to the documents which I believe are necessary to address the matters on which the MAH Inquiry Panel has requested me to give evidence.

Signed: **Joan Peden**

Dated: **13 June 2024**

Joan Peden Organisational Module 7 Exhibit Bundle “JP1”		
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MAHI Muckamore Abbey Hospital Inquiry

MAHI Team
1st Floor
The Corn Exchange
31 Gordon Street
Belfast
BT1 2LG

28 March 2024

By Email Only
Ms Joan Peden

Dear Ms Peden

Re MAHI Organisational Modules 2024: Request for Witness Statement

The Inquiry is currently preparing for the final phase of evidence. Please see enclosed a document summarising the ten organisational modules to be heard in this phase: Organisational Modules 2024.pdf (mahinquiry.org.uk).

It is anticipated that the Inquiry will hear evidence in respect of these modules in September and October 2024.

The purpose of this correspondence is to issue a request, in the first instance, for a statement from you that will assist the Inquiry in this phase of evidence. It should be regarded as a request by the Inquiry Panel for the purposes of Rule 9 of the Inquiry Rules 2006.

The Inquiry understands that you were aligned to the Adult Social and Primary Care Directorate of the Belfast Health and Social Care Trust (BHSCT) as Business Partner in the role of Co-Director from 2007 to 2022, and in the role of Co-Director/ HR Business Partner up until 2016.

You are asked to make a statement for the following module:

M7: MAH Operational Management

I have also enclosed for your attention a copy of the Inquiry's Terms of Reference. You will note that the module in respect of which you are asked to make a statement, spans across the Terms of Reference.

Please find enclosed a set of questions that the Panel wish to be addressed in your statement ("Questions for witnesses working in a senior HR position at MAH"). It would be helpful if you could address those questions in sequence in your statement. If you

do not feel that you are in a position to assist with a particular question, you should indicate accordingly and explain why that is so.

Please note that, while the Inquiry has received and heard a considerable body of evidence about the relevant systems and processes that were in place during the timeframe of the Terms of Reference, the Inquiry will now be focusing primarily on the *adequacy and effectiveness* of those systems and processes.

Please see enclosed a Statement Format Guide that will assist with the presentation of your statement. It is important that statements made for Inquiry purposes should be consistent in format. It is appreciated that the number of required sections will depend on the range and breadth of issues to be covered and that some flexibility will be needed to ensure the most effective presentation, but you are asked to adhere to the Guide to the extent that is possible.

You are requested to furnish the Inquiry with your completed statement by 10 May 2024. Your statement should be uploaded to the Inquiry's document management platform BOX via the following link:

https://mahinquiry.box.com/s/o1c1hyrds3dnkrqqvmwg6vm7wynh4urk

Should you have any issues accessing BOX please email info@mahinquiry.org.uk and a member of the team will assist you.

Statements made for the purpose of the organisational modules will be published on the Inquiry's website.

As noted above, it is anticipated that evidence in these modules will be heard by the Inquiry in September and October 2024. If there are any dates in those months on which you will be unavailable to attend the Inquiry to give evidence, please inform the Inquiry as soon as possible by emailing the Inquiry Secretary jaclyn.richardson@mahinquiry.org.uk.

If you have any queries about this correspondence, please do not hesitate to contact me.

Yours faithfully,

Lorraine Keown
Solicitor to the Inquiry

Encs:

1. Outline of Organisational Modules April – June 2024. Organisational Modules 2024.pdf (mahinquiry.org.uk)
2. MAHI Terms of Reference.
3. OM2024 Statement Format Guide.
4. Questions for witnesses working in a senior HR position at MAH.

Module 7: MAH Operational Management
Questions to be Addressed in Witness Statement

Questions for witnesses working in a senior HR position at MAH

1. Please explain your role and the responsibilities which you held in respect of MAH (including details of when you held such role/ responsibilities).

2. What training was provided for new line managers at MAH on staff management processes?

3. Please explain the performance management arrangements for all staff, including managers, at MAH.

4. Were line managers required to seek HR advice and/or inform HR if they undertook performance management meetings?

5. What processes were in place to provide career development opportunities to staff at MAH, to ensure that staff had the required specialist skills to deliver care in a learning disability facility?

6. Please describe the role of Human Resources in workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix (and thereby to ensure safe care) at MAH? Please also explain how any concerns about such matters were escalated.

7. Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of the Terms of Reference?

Belfast Health and Social Care Trust

Draft for Discussion

Adult Social and Primary Care

Modernisation (Continuous Improvement) Board

Workforce Development and Equality

Joan Peden
4th June 2013

① Introduction

The Adult Social and Primary Care (ASPC) Directorate has one of the largest workforces within the Trust with 4,822 headcount and 3,591.46 wte.

The ASPC Directorate, as set out within the Trust Vision and Corporate Plan, has underway significant transformational service change programmes within its broad range of services.

The establishment of the ASPC Modernisation (Continuous Improvement) Board is to provide for a strategic overview of the following broad areas of work :-

- Adult Social Care Reform
- Community Service Improvement
- Community Integration and Resettlement
- Hospital Modernisation
- Integrated Urgent Care Pathway (Integrated Care Partnerships)
- Proactive Management of Long-term Conditions
- Workforce Development
- Service User and Staff Involvement
- Equality

within

- Older People Services
- Learning Disability
- Mental Health
- Physical and Sensory Disability
- Administrative and Clerical Support Service

② Workforce and Equality Issues Integrated within Programmes of Work

Within the ASPC Directorate service change and modernisation is well established and underway within Older People Services, Learning Disability, Mental Health and the other services.

The Trust has in place a number of underpinning procedures, policies and practices that are key enablers to the service and workforce change and modernisation. These are being applied (mostly need to be applied in all) within the workstreams in place. In summary these include :-

- Good Practice Guide on Communication and Consultation
- Trust Consultation Scheme
- Trust Equality Scheme
- Organisational Framework on the Management of Staff Affected by Organisational Change and Staff Redeployment Scheme

It is important that the workforce and equality issues are integrated and dealt with within the workstreams that are in place or to be established.

The Continuous Improvement Plans (CIPs) provide for the identification of workforce and equality issues.

It is recommended the CIPs are reviewed to identify and prioritise the workforce and equality issues.

It is further recommended where the projects have significant workforce or equality issues associated with them a Senior HR Manager / Business Partner is also a member of the workstream.

③ Workforce Development / Plan

A strategic overview on workforce issues and development is required from an overall Directorate perspective. A methodology that will enable the identification of the workforce implications of service change in regard to 'Right People with the Right Skills and Competencies in the Right Plan at the Right Time to Ensure the Right Outcome for the Service User' is an integrated workforce planning model.

The model applied within the Belfast Trust on Workforce Planning has been the six step approach to Workforce Planning as detailed below :-

The Integrated Service Centred Six Step Methodology

Step 1 : Defining the Plan
Step 2 : Visioning the Future / Mapping Service Change
Step 3 : Assessing the Required Workforce
Step 4 : Identifying Workforce Availability
Step 5 : Developing an Action Plan
Step 6 : Implement, Monitor and Refresh

This integrated six step model has been agreed as the Regional approach to workforce planning on TYC. If agreed it would probably be detailed as over-leaf :-

Project Monitoring Template

Project Name	The development of an integrated Workforce Plan for the Adult and Social Primary Care Directorate. This will be determine and undertaken on a service area basis, eg. Older People, Learning Disability, Mental Health in order to determine the overall Workforce Plan incorporating development and the full range of workforce issues, resources, skills, roles and numbers to meet the vision
Project Lead	To be effective this needs to be service lead. A Project lead within each area supported by other service representatives. A Senior HR Manager will be appointed as support lead supported by Workforce Planning and Information staff
Project Aim and Description	To ensure all the workforce issues associated with continuous improvement within the Directorate are identified in order to inform the resources, skills, roles and development issues to meet and deliver the future service needs of the Adult and Social Primary Care Directorate
Project Product and Outputs	➢ ASPC Directorate Workforce Plan ➢ Service based workstreams Workforce Plans ➢ A description of the numbers, skills, roles, development issues of the workforce required to deliver the…..
Key Actions and Timescales	➢ Development of Project Plans ➢ Identification of Leads ➢ Awareness Training on six-step model ➢ Service X Service Approach ➢ Decisions
Risk and Constraints	Competing Priorities
Project Completion Date	To be determined

Belfast Health and Social Care Trust

Terms of Reference

Adult Social and Primary Care Directorate Steering Group on the Development of an Integrated Workforce Plan

1) Project Aim

To determine an overall Directorate Workforce Plan for which describes, identifies and sets out the key workforce issues, associated with the service plans within the Directorate, including future service needs of the Directorate

- WTE's
- Skill mix
- Grade mix
- Changing roles and responsibilities
- New roles
- Workforce trends and requirements, turnover, recruitment
- Training requirements

Project Description

A broad description of the Integrated Workforce Plan is as follows :-

- Overview of Directorate
  - Vision
  - Values
  - Priorities and Plans
  - Description of Workforce and Workforce Trends and Issues 2013

- Service by Service Review
  - Define the Plan / Purpose / Scope
  - Visioning the Future / Mapping the Service Change

- Application of the Six Step Model
  - Assessing the required workforce
  - Identifying Workforce availability
  - Development an Action Plan
  - Implementation Plan
  - Overview for Directorate
  - Conclusion and Implementation and Monitoring Plan and Arrangements

2) Role and Responsibilities

- To oversee the development of the Workforce Plan in accordance with the Project Plan

- To report to and update the Modernisation Board on Progress

3) Membership

3.1 Chair
The Chair of the Steering Group will be Joan Peden : Co-Director, Human Resources and Adult Social and Primary Care HR Business Partner

3.2 Members

4) Timescale
As set out with the Project Plan

5) Frequency of Meeting

ADULT SOCIAL & PRIMARY CARE
DIRECTORATE INTEGRATED WORKFORCE PLAN
APRIL 2015 – MARCH 2020



Belfast Health and Social Care Trust
caring supporting improving together

respect & dignity | openness & trust | leading edge | learning & development | accountability

Contents

- Terms of Reference
- Directorate strategic context
- Methodology
- Key findings
- Action Plan
- Conclusions
- Next steps

Terms of Reference

To determine an overall Directorate integrated workforce plan that sets out the key workforce issues associated with the service plans within the directorate, including the future needs of the Directorate in terms of:-

- WTE's
- Skill mix
- Grade mix
- Changing roles and responsibilities
- Workforce trends
- Training requirements

Vision statement

" We will work together to promote health, wellbeing, independence and hope, supporting people to enjoy fulfilling lives in their community"

Belfast Health and Social Care Trust
caring supporting improving together

respect & dignity openness & trust leading edge learning & development accountability

Strategic Context

Departmental, Regional & Local Policy Direction	> Quality 20/20 > Savings Plans > Nursing Normative Staffing > TYC > Social Work Strategy > Regional Workforce Reviews > New Directions 2
Performance & accountability	➢ Directorate Balance Scorecard ➢ > Management Plan & scorecard
Strategic Reform & Modernisation Programme	> Service change > 19 modernisation projects > 2 workforce service reviews
Workforce / Development	> Second largest Directorate 4639 headcount, 3906.10 wte > Nurse Revalidation > NISCC Registration > Recruitment & Retention
Funding	> Effective and Efficient > £150 million pay > £142 million non pay > £7,522,000 savings

HSC Belfast Health and Social Care Trust
caring supporting improving together

respect & dignity openness & trust leading edge learning & development accountability

Range of Service Areas

Mental Health

- CAMHS including Home Treatment, Early Intervention Team, Acute MH Hospital
- Recovery including Community MH Teams, Eating Disorder Service, MH & Deafness Early Intervention
- Primary Mental Health Care including Psychological therapies, Self-harm Team, addictions & trauma support.
- Acute including Home Treatment, Acute MH Hospital and day treatment services

Learning Disability

"Social Inclusion & Independence"

- Supported Living & Day Opportunities
- Community Treatment & Support Services
- Muckamore Abbey Hospital
- Iveagh Children's Unit

Range of Service Areas

Older People Services & Physical & Sensory Disability

"Supporting people to maintain independence, inclusion within family and community, protection for vulnerable people"

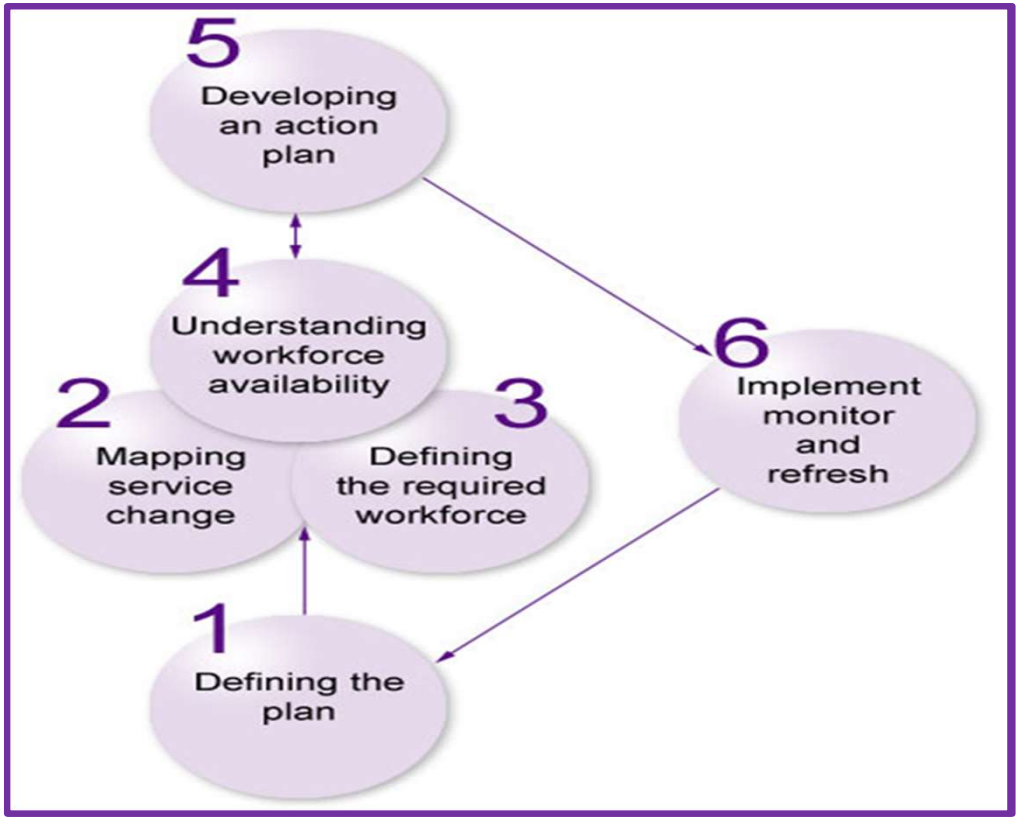
- **South & East Belfast Locality & Older People wards, BCH**
- **Intermediate Care, Mental Health and Dementia Inpatient and Outreach Services.**
- **North & West Belfast Locality and Stroke Services, RVH/ Mater**

Psychology Services

"Enhancing and enabling psychological health and wellbeing"

- **Adult Psychologoical Services including physical health and mental health problems**
- **Neuro-Disability Psychological Services including adults with learning disability, acquired brain injury and neuropsychological problems**
- **Children's Psychological Services including children's disability services, paediatric psychology & therapeutic services for looked after children**

Methodology



Caveats and Considerations

- Document is fluid and subject to change
- Projections are indicative and will change over time
- HRPTS
- Framework for monitoring & review

1 Defining the plan

DRIVERS For Change

- Bamford, Cavendish, Berwick, Donaldson, Keogh
- Transforming Your Care
- Quality 2020
- Excellence & Choice Strategic Reform & Modernisation
- Regional Social Work Strategy
- RQIA Reviews
- Adult Safeguarding
- Mental Health Capacity Bill
- Delivering Care: Nurse Staffing in Northern Ireland
- Recruitment & Retention
- Regional & Local Workforce Reviews
- Succession Planning : Growing our People Today for Tomorrow
- Agency Expenditure
- Pension Reforms

2 Mapping service change

Mental Health Services

- Reprovision of services in community settings
- Rehabilitation & Recovery Services
- CAMHS Review
- Day Opportunities Review
- New Mental Health Hospital

Learning Disability Services

- Muckamore Abbey Resettlement
- Community Treatment & Support Services
- Day Opportunities Review

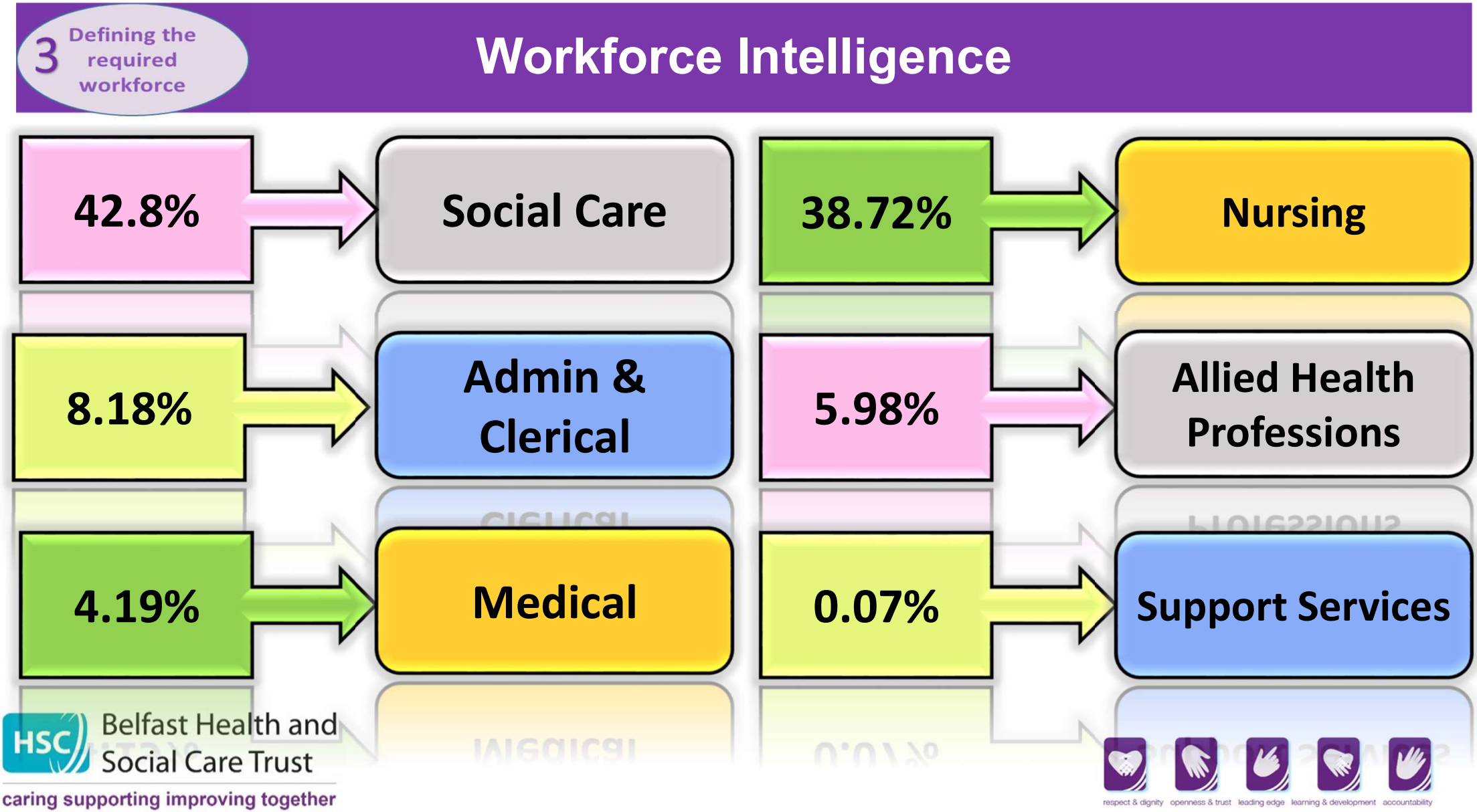
2 Mapping service change

Older People Services

- Statutory Residential Care
- Supported Living
- Reablement
- Acute Care At Home
- BCH Direct
- District Nursing Review
- Social Care Review
- Social Care Rapid Response
- Physical & Sensory disability services
- Sleep-Ins
- Admin review

Psychology Services

- Provision of Trust wide life-span autism diagnostic and intervention services
- Increase access to Psychological services across the Trust
- New model of service delivery for children's emotional, behavioural and mental health services


3 Defining the required workforce
Workforce Intelligence
42.8%
Social Care
38.72%
Nursing
8.18%
Admin & Clerical
5.98%
Allied Health Professions
4.19%
Medical
0.07%
Support Services
HSC
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learning & development
accountability

3 Defining the required workforce

Workforce Intelligence

Grade Mix Set to change to improve agency spend	Skill Mix set to change to meet nursing normative staffing levels	Social Care Workforce Review	District Nursing Workforce Review
Succession Planning : Growing our People Today for Tomorrow	Systems and new ways of working	NISCC Registration for domiciliary and day care workforce	Recruitment & Retention Strategy
Supporting the Shift Left	Savings Target £7,522,000	Workforce Budget year ending March 2015 £150 million	Nurse Revalidation
Impact of new technology	New skills	Highest Admin & clerical agency expenditure	Agency Expenditure £5.5 million

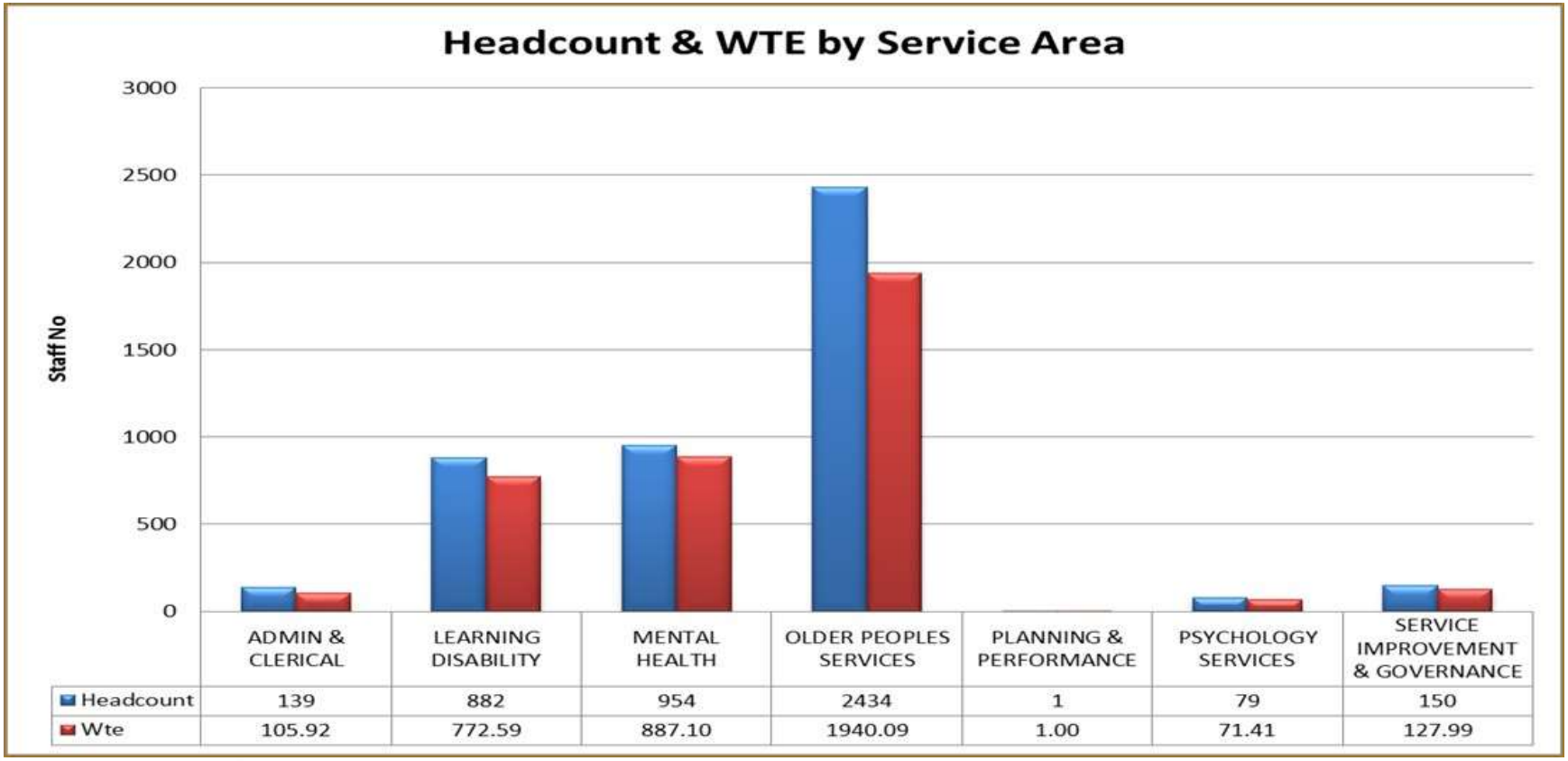
Workforce Projections

WTE is projected to reduce by an indicative 24.4 wte

	2015/16	2016/17	2017/18	2018/19	2019/20
Staff in post 31st March	4639	4647.21	4622.81	4566.41	4546.01
Average No. of Leavers	-321.4	-321.4	-321.4	-321.4	-321.4
Average No. of Starters	+299	+299	+299	+299	+299
Learning Disability Reviews	-46				
Mental Health Reviews	-28	-2	-34	-2	-2
Older People Reviews	+24				
Admin & Clerical Reviews	+80.61				
Total **Indicative** Projected staff in post 1st April	4647.21	4622.81	4566.41	4546.01	4521.61
Net Variance	+8.21	-24.4	-56.4	-20.4	-24.4

4 Understanding workforce availability

Key Workforce Findings



	ADMIN & CLERICAL	LEARNING DISABILITY	MENTAL HEALTH	OLDER PEOPLES SERVICES	PLANNING & PERFORMANCE	PSYCHOLOGY SERVICES	SERVICE IMPROVEMENT & GOVERNANCE
Headcount	139	882	954	2434	1	79	150
Wte	105.92	772.59	887.10	1940.09	1.00	71.41	127.99

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Key Workforce Findings

50% of staff employed in Older People Services

20% of staff employed in Learning Disability Services

23% of staff employed in Mental Health Services

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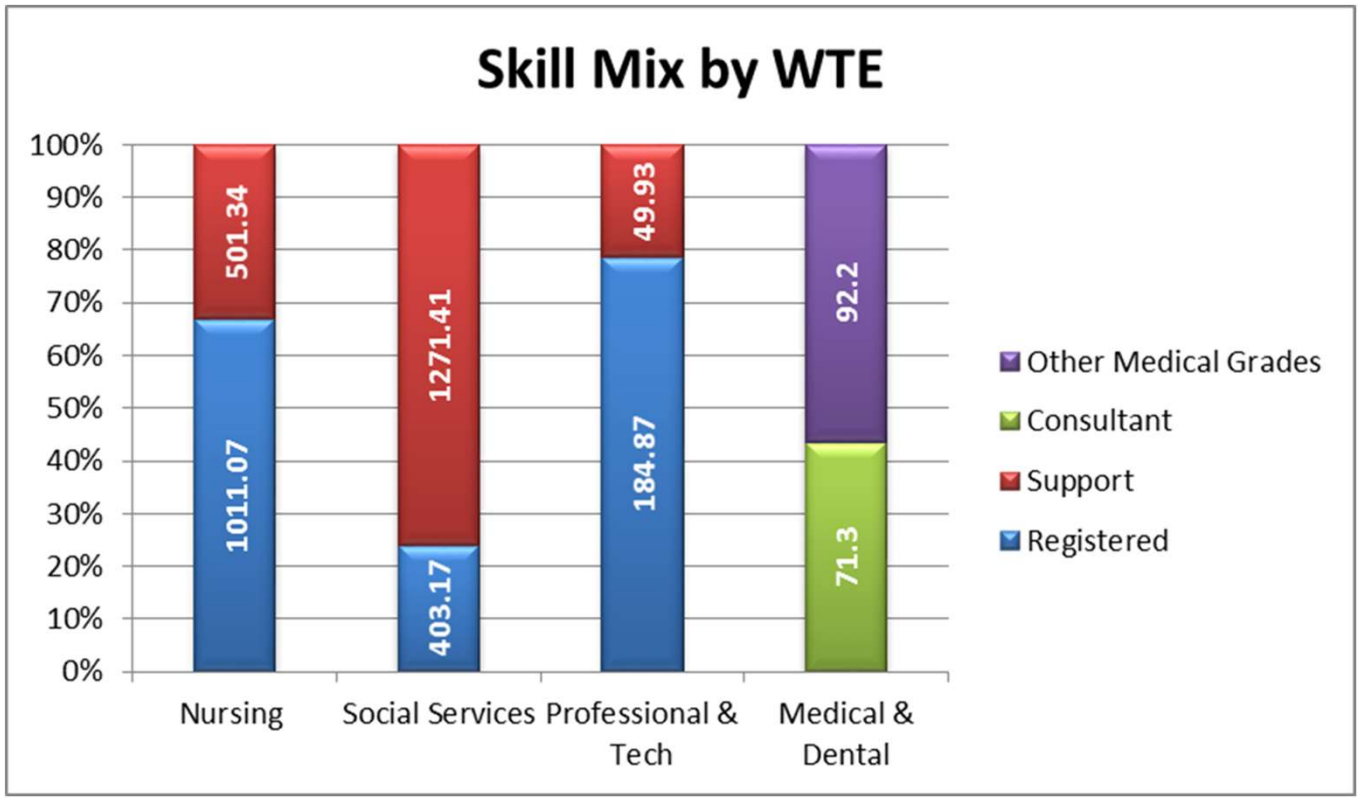
Key Workforce Findings – Skill Mix



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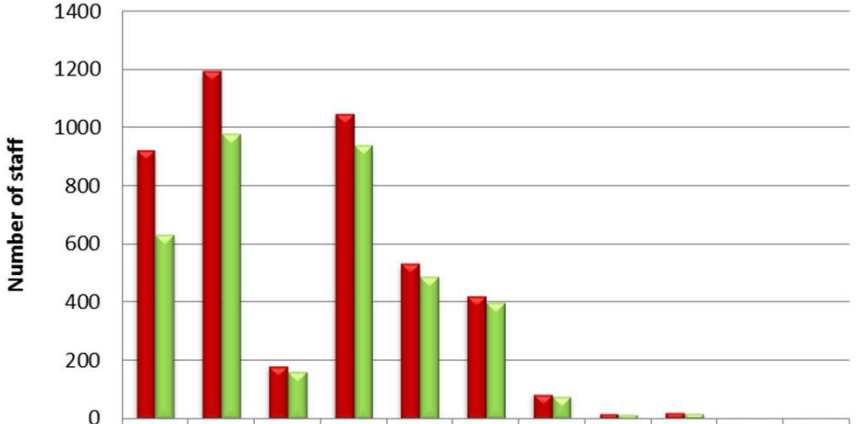
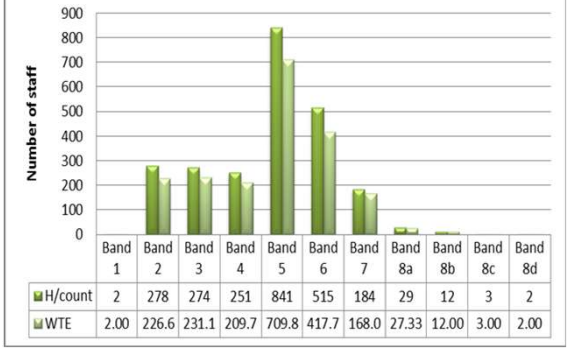
Key Workforce Findings – Grade Mix

Adult Social & Primary Care Directorate



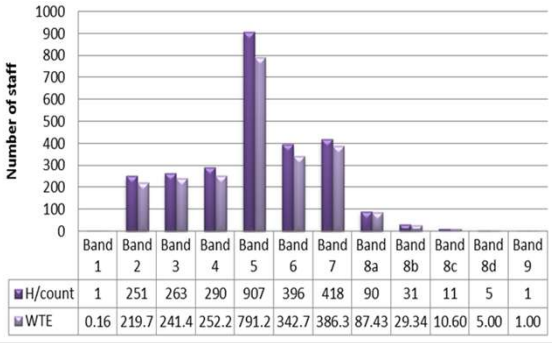
	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9
H/count	924	1193	184	1048	535	423	87	20	25	6	1
WTE	634.4	979.8	166.5	940.5	489.7	401.9	81.19	18.20	22.59	5.60	1.00

Specialist Hospitals and Womens Health Directorate



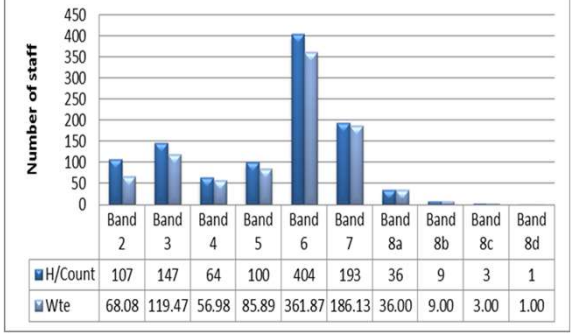
	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d
H/count	2	278	274	251	841	515	184	29	12	3	2
WTE	2.00	226.6	231.1	209.7	709.8	417.7	168.0	27.33	12.00	3.00	2.00

Surgery and Specialists Services Directorate



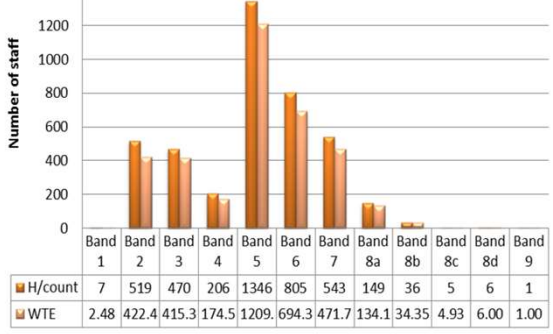
	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9
H/count	1	251	263	290	907	396	418	90	31	11	5	1
WTE	0.16	219.7	241.4	252.2	791.2	342.7	386.3	87.43	29.34	10.60	5.00	1.00

Children's Community Services Directorate Band Profile



	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d
H/Count	107	147	64	100	404	193	36	9	3	1
Wte	68.08	119.47	56.98	85.89	361.87	186.13	36.00	9.00	3.00	1.00

Acute & Unscheduled Care Directorate



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9
H/count	7	519	470	206	1346	805	543	149	36	5	6	1
WTE	2.48	422.4	415.3	174.5	1209.	694.3	471.7	134.1	34.35	4.93	6.00	1.00

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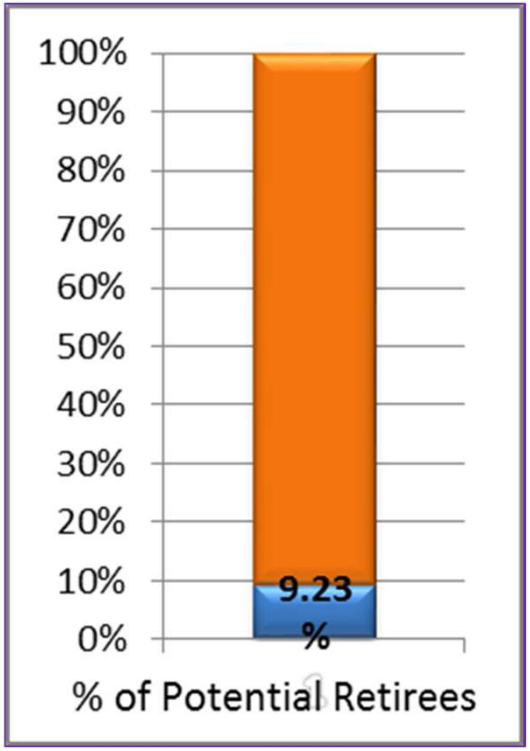
Key Workforce Findings – Turnover & Potential Retirement Profile



Pension changes
State pension
HSC pension

People working longer

Trust turnover at Sept 14 was 4.88%

Directorate turnover was 5.84%

Mental health service area turnover rate at 31 March 15 was 9.67%

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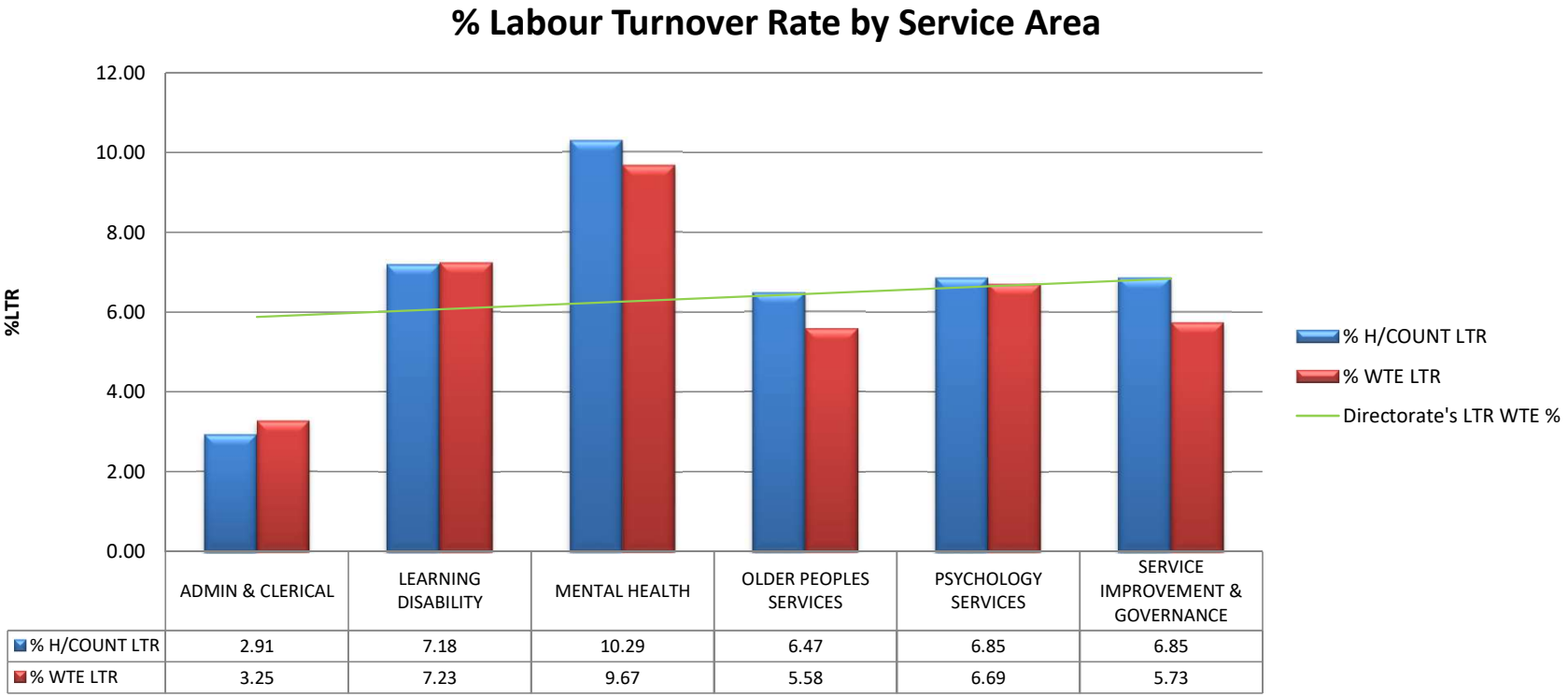
Key Workforce Findings – Turnover



	ADMIN & CLERICAL	LEARNING DISABILITY	MENTAL HEALTH	OLDER PEOPLES SERVICES	PSYCHOLOGY SERVICES	SERVICE IMPROVEMENT & GOVERNANCE
% H/COUNT LTR	2.91	7.18	10.29	6.47	6.85	6.85
% WTE LTR	3.25	7.23	9.67	5.58	6.69	5.73

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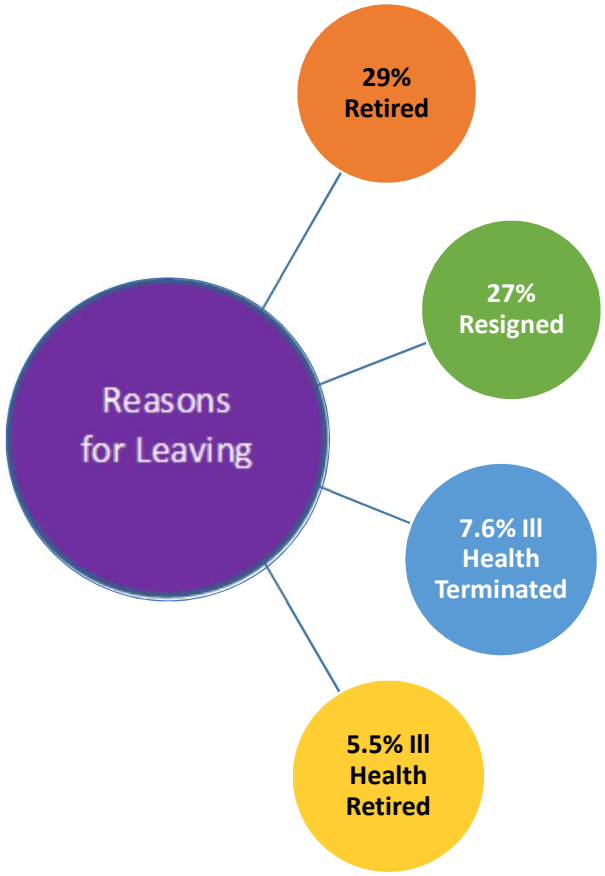
Workforce Findings – Reasons for Leaving

REASON FOR LEAVING	2014-2015 H/C	2014-2015 WTE
Death	4	3.34
Disciplinary action	4	3.25
End fixed term contract	15	12.35
External Secondee Out	1	0.8
Ill Health Retirement	17	14.76
Ill Health Termination	34	20.37
Medical Rotation	41	39.2
Resignation	104	72.32
Retirement	96	76.83
Transfer to other HSC Org	17	15.8
VER - Actuarilly Reduced	10	8.82
GRAND TOTAL	**343**	**267.84**



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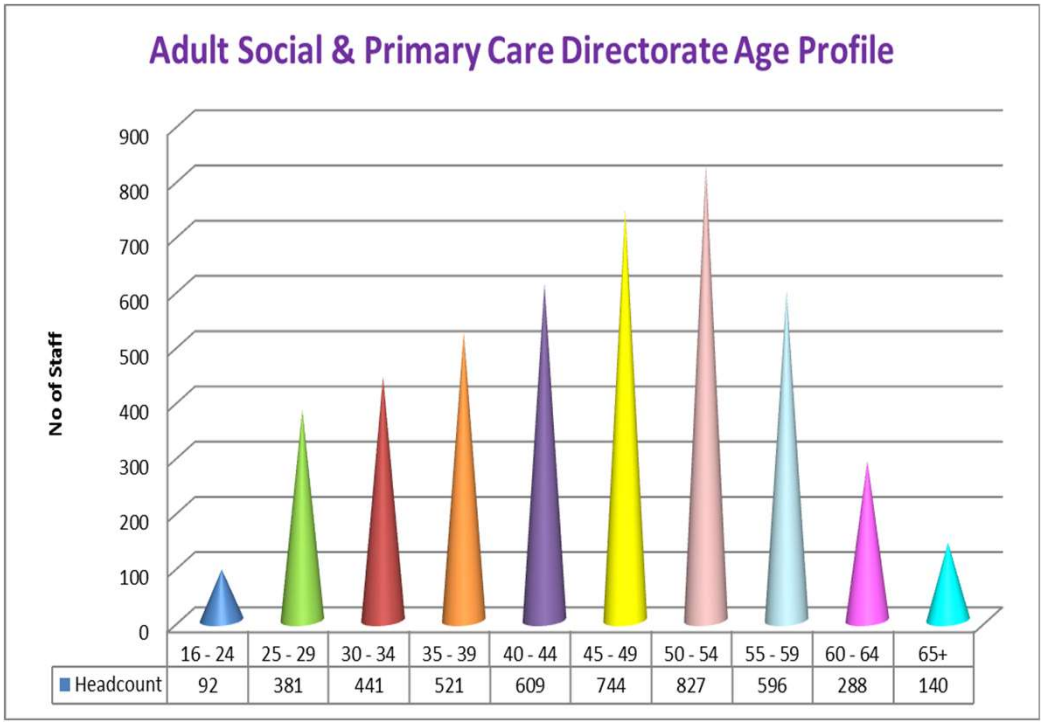
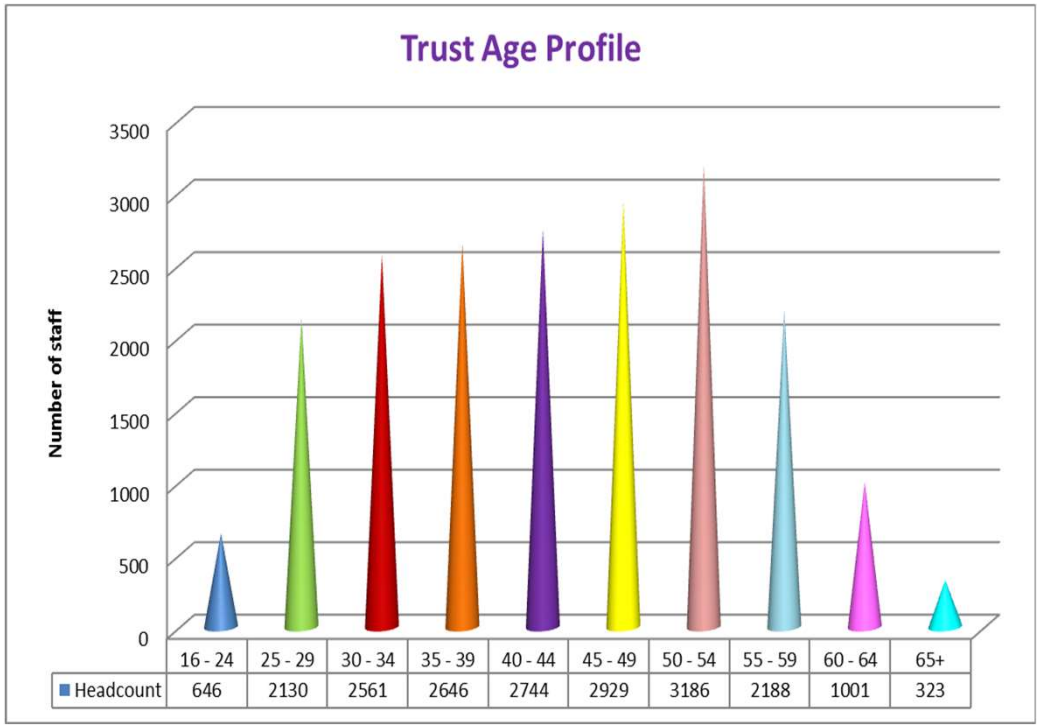
Key Workforce Findings Age profile





18% in the Directorate are aged 50 – 54 and compares to 16% Trust wide
13 % in the Directorate are aged 55 – 59 compared to 11% Trust wide
6% in the Directorate are aged 60 – 64 compared to 5% Trust wide
3% are aged 65+ compared to 2% Trust wide

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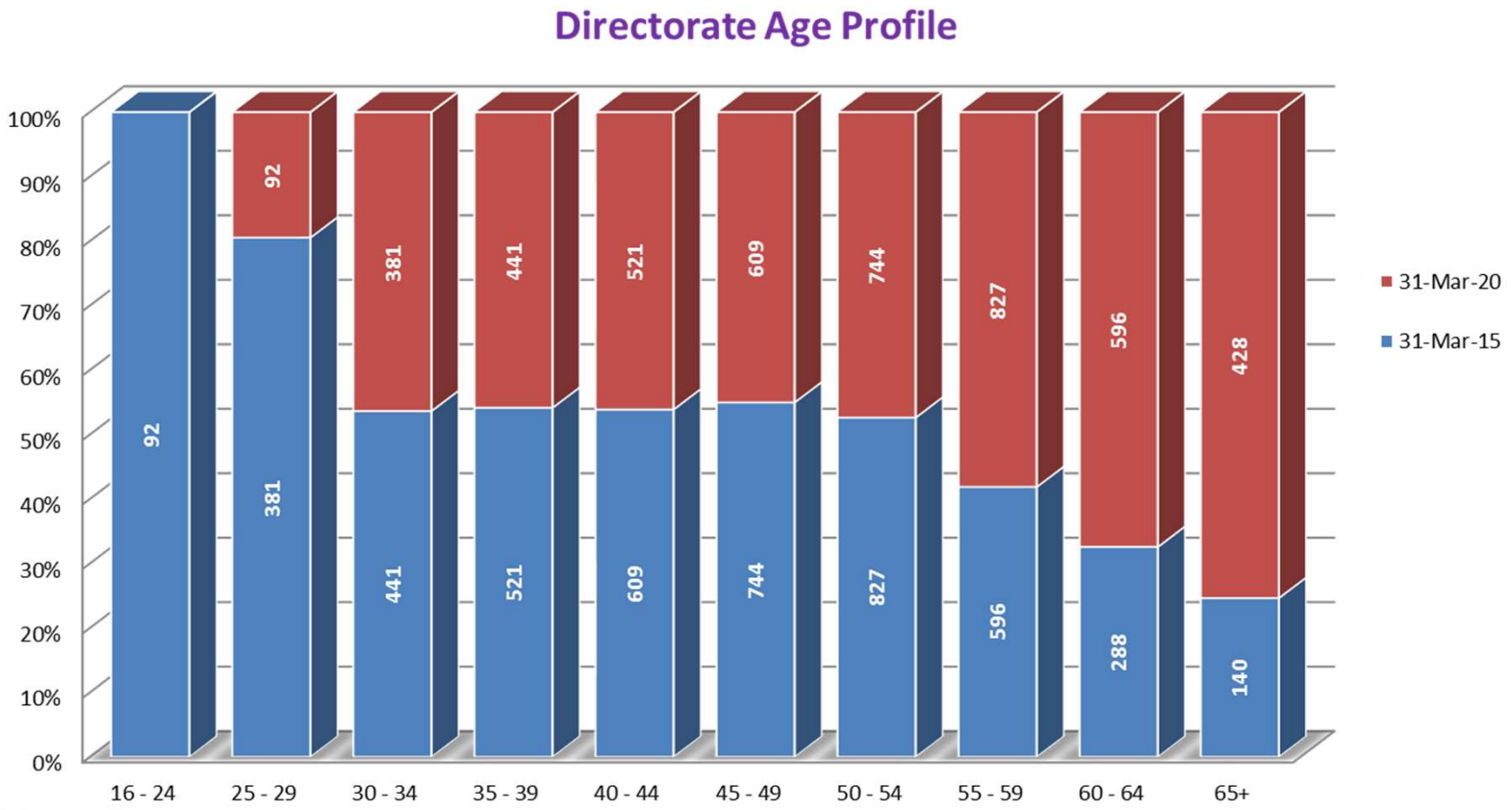
Key Workforce Findings – Age profile



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The case for succession planning - 120 senior staff aged 55+

Mental Health	Learning Disability	Older People Services	Psychology	Admin & Clerical
• **36 staff** • Medical • Nursing • Social Care • Professions Allied to health • Senior Manager	• **16 staff** • Senior Manager • Medical • Nursing • Social Care • Professions allied to health	• **60 staff** • Senior Manager • Medical • Nursing • Social Care • Professions allied to health	• **5 staff** • Professions allied to health	• **3 staff** • Senior Manager

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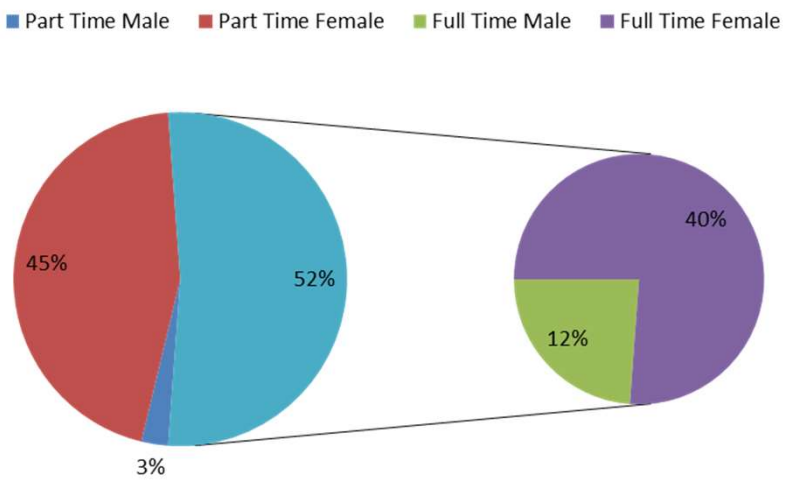
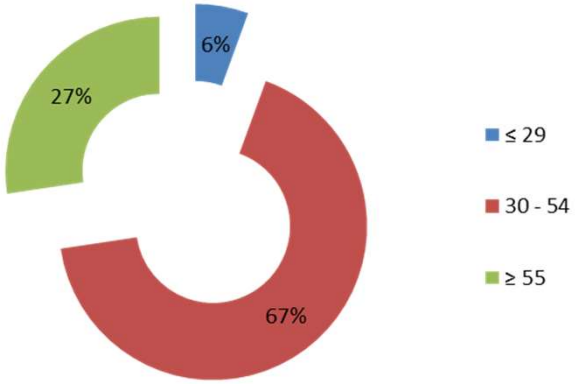
Key Workforce Findings – Gender & working profile

% Working Time by Gender



% Part time Staff by Age Range



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Key Workforce Findings – Sickness Absence

Sickness Absence	April 11 to March 12	April 12 to March 13	April 13 to March 14	April 14 to March 15	April 15 to Dec 15
TARGET BY MARCH	6.01%	5.31%	5.00%	6.71%	
Overall Absence %	6.39%	6.78%	7.4%	7.59%	6.81%
Variance	+0.38%	+1.47%	+2.4%	+0.88%	

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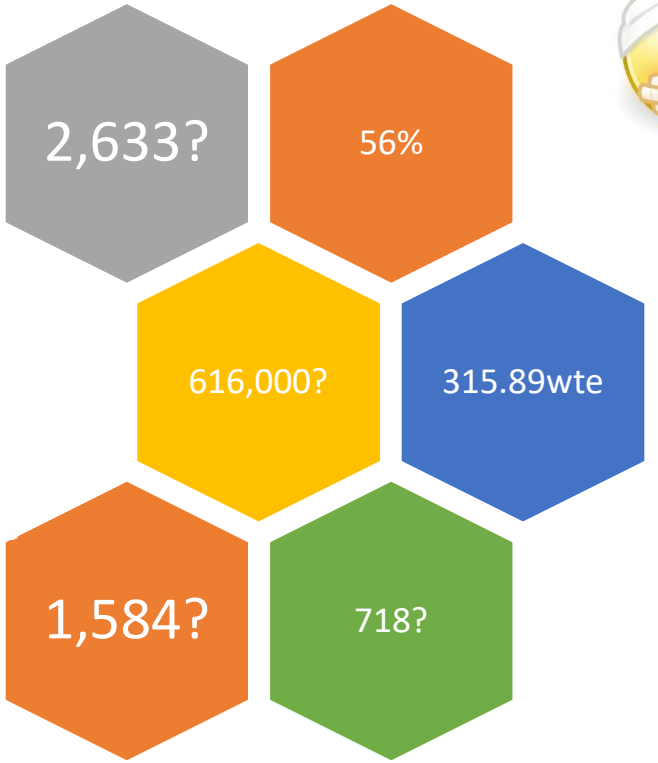
Key Workforce Findings – Sickness Absence

Top 8 Reasons For Absence	H/count
General Debility	960
Stress	331
Vomiting	245
Influenza	237
Back ache/pain	181
Other Chest and Respiratory	190
Grief/Bereavement	134
Post-surgical Debility	95



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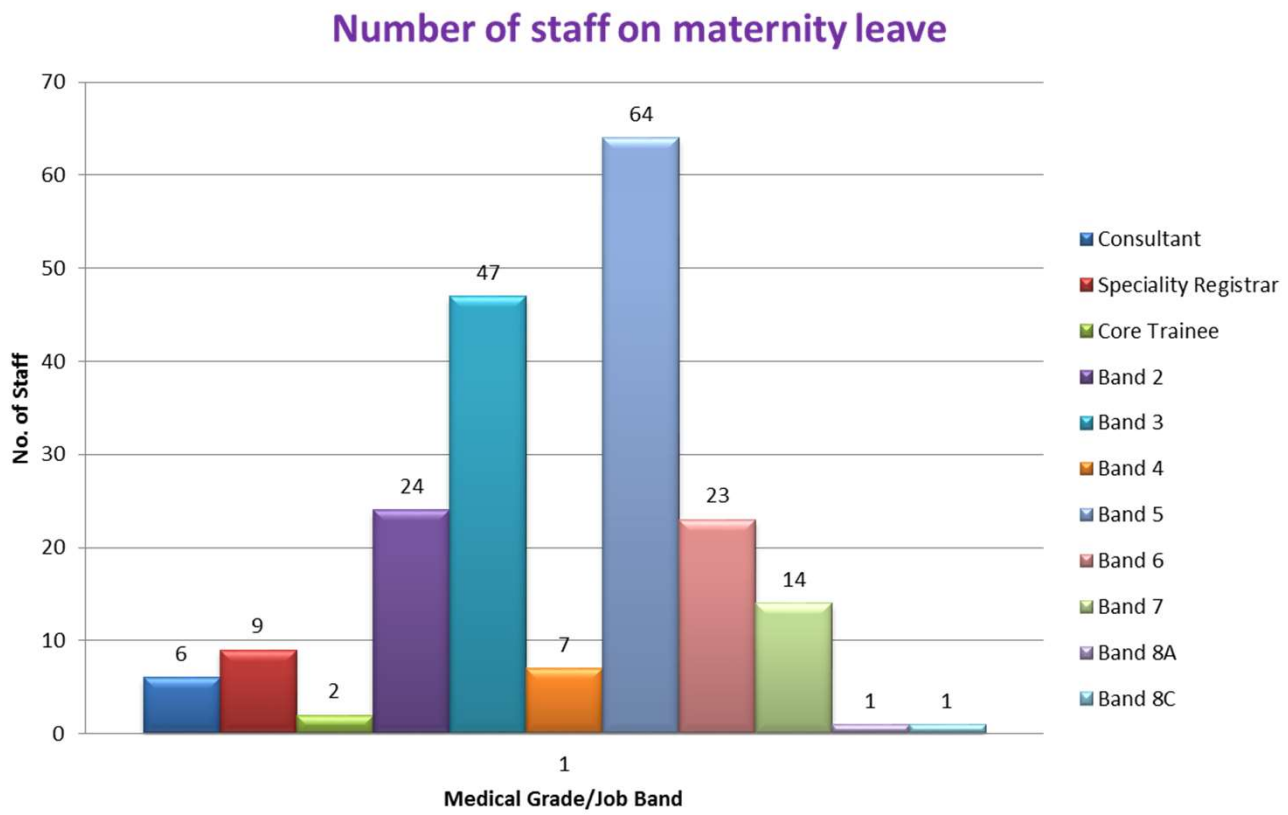
Key Workforce Findings - Maternity



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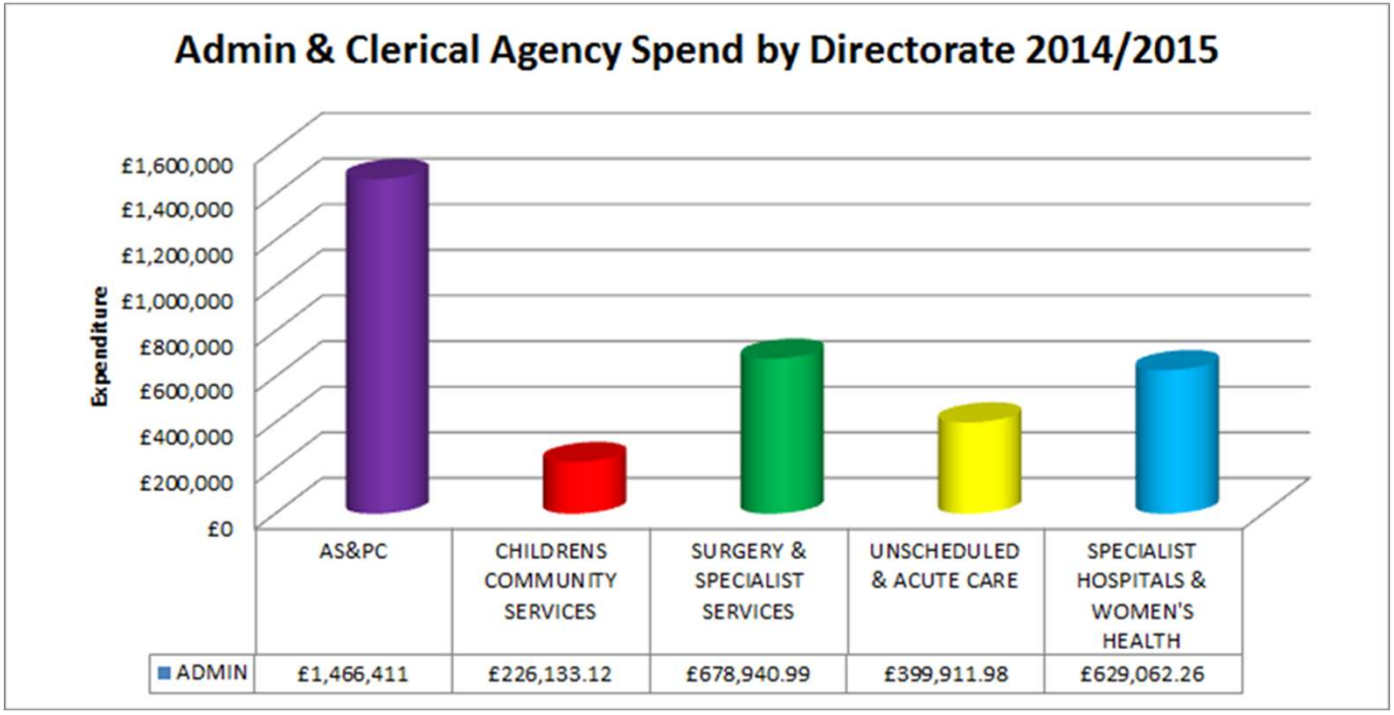
Key Workforce Findings – Agency Spend



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5 Developing an action plan

High Level Action Plan

Key Area	Action	Lead
1. Reform and proposed modernisation projects	➢ To ensure the workforce issues associated with the wide range and number of modernisation projects within the Directorate, as detailed in the plan, identify and map out the workforce implementation issues and actions. ➢ To apply the Trust's Framework on the Management of Staff affected by organisational change.	Co-Directors / Senior Managers
2. Workforce Reviews	➢ To complete and implement the local workforce reviews on: • Social Care Review. • District Nursing Review. • Admin Review (Older People Services). • Agency Staffing Reduction.	Co-Directors / Senior Managers Senior Mgrs
3. WTE's	To track movement and/or changes in WTE.	Workforce Planning Team

5 Developing an action plan

High Level Action Plan

Key Area	Action	Lead
4. Skill Mix	➢ To track and monitor shifts in skill mix primarily within: • Nursing. • Social Care.	Workforce Planning Team
5. Grade Mix	➢ To track and keep under review any grade mix change.	Workforce Planning Team
6. Changing Roles and Responsibilities	➢ To identify and meet the development needs of changing roles and responsibilities.	Senior Managers / HR / Professional Leads
7. New Roles	➢ To support the development and implementation of new roles, eg. Consultation, change process and associated banding.	Senior Managers/ HR / Professional Leads

5 Developing an action plan

High Level Action Plan

Key Area	Action	Lead
8. Professional Issues	➢ To support the implementation of the Revalidation process for nurses. ➢ To support the registration process within the Social Care Workforce.	Senior Managers / HR / Professional Leads
9. Recruitment & Retention Strategies and Actions	➢ To support the Directorate in the development of recruitment and retention strategies for identified hot spot areas. ➢ To review and monitor reasons for leaving to inform action.	Senior Leads / HR
10. Local Induction	➢ To review local induction arrangements.	Senior Managers / HR

5 Developing an action plan

High Level Action Plan

Key Area	Action	Lead
11. Succession Planning	➢ To take targeted action to provide succession planning development opportunities in identified groups and areas including: • Coaching. • Staff Development Review Process (PCF/PDP). • Growing Our People Today for Tomorrow: either bespoke or part of Trust-wide programme. • To undertake further analysis, eg. Survey or interviews to inform further actions.	Senior Managers / Modernisation & Workforce Planning Team
12. Improving Health and Wellbeing and Engagement within Directorate	➢ To develop bespoke health and wellbeing and engagement action plan for the Directorate. ➢ Consistent application of attendance management toolkit and Trust policy. ➢ Review underlying reasons for absence (root cause) and bespoke programme in place.	Co-Directors / Senior Managers / HR

5 Developing an action plan

High Level Action Plan

Key Area	Action	Lead
12. Improving Health and Wellbeing and Engagement within Directorate	➢ Increase awareness and knowledge of local 'BWell' and regional 'Choose Well' programmes. ➢ Increase Directorate representatives at the Health and Wellbeing and Engagement Forum. ➢ Support the development of Employee Advocates. ➢ Support the development of Engaging Managers. ➢ Support 'Living the Values' of the Trust within the Directorate.	Co-Directors / Senior Managers / HR
13. Technology	➢ To continue to improve access, knowledge and skills in the use of new technology. ➢ To embrace and utilise technology to support new ways for working.	Co-Directors / Senior Managers

Conclusions

- Increasing impact of Community Planning
- Succession Planning increasingly important
- Recruitment & Retention Issues
- Workforce Projections are indicative
- High levels of sickness absence
- Workforce Plan is a live document

Next Steps

- Implement Directorate wide Action Plan
- Review and evaluate progress against Action Plan
- Services to carry out workforce plan reviews
- Service Area Action plans to be implemented
- Workforce Plan to be shared
- Update and review Workforce Plan on an annual basis

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Adult Social & Primary Care Directorate

Integrated Workforce Plan

JK

April 2015 – March 2020

FOREWORD

The Belfast Health and Social Care Trust delivers integrated health and social care to 340,000 citizens in Belfast and part of the Borough of Castlereagh. It also provides a range of Regional Specialist Services to all of Northern Ireland. The Trust employs over 20,000 staff and has a transient bank / agency workforce of around 8,000 staff at any one time.

The Adult Social and Primary Care Directorate (hereafter referred to as the Directorate) is the second largest Directorate in the Trust with 4639 staff and 3906.10wte providing Services in over 50 locations.

It is vital that the Directorate workforce in the Belfast Trust is skilled and trained with the ability to be flexible, innovative and adaptive to future changes in Service delivery models whilst maintaining the vision that:-

"We will work together to promote health, wellbeing, independence and hope, supporting people to enjoy fulfilling lives in their community"

Our vision is underpinned by our values and principles which are at the core of everything that we do to support and assist our Service users.

- Services should be person centered (ie. Service users will have their rights respected and be supported to keep control of their lives).
- Services will be delivered at the right time, in the right place, by the right person, for the right length of time based on assessed needs.
- Everyone has the right to experience community living.
- Everyone has the right to experience the same level of Service provided by the Trust, regardless of location.
- Services will be planned, implemented and evaluated in partnership with users and carers.
- Service improvement and modernisation will be based on best practice.
- Staff will be supported in their professional and personal development.
- Services will be delivered in an efficient and effective manner within available resources.

We recognise our workforce is paramount to delivering high quality care and realising our vision and objectives. In order to achieve our vision and goals, managing, planning and developing our workforce to ensure that it is able to deliver high quality health and social care for both now and the foreseeable future is integral to the success of the Directorate.

To this end, as part of the Directorate's Modernisation Agenda I commissioned the development of an Integrated Workforce Plan to describe, identify and set out the key workforce issues associated with the Service Plans within the Directorate, including the future workforce Service needs of the Directorate.

This Workforce Plan therefore:-

- Sets out clearly the Directorates plan for future direction and the required workforce between 2015 and 2020;
- Explains the context and processes on which these decisions have been made;
- Provides aggregated workforce intelligence and trend analysis;
- Highlights key trends and emerging themes from the wider health and social care system that may have implications for Service delivery in future years;
- Identifies a range of key actions on workforce issues;

The Action Plan contained within this document aims to lay the foundation for the further development of a competent, compassionate, caring, supporting, confident, and innovative workforce for the future.

I would like to express my sincere thanks to the members of the Directorate's Modernisation Board and Workforce Planning Steering Committee who committed their time, energy and expertise to the development of this Workforce Plan I would also like to thank all of the individuals across the Directorate and from the corporate Directorates, Finance and Human Resources who have provided us with support, evidence and information and the wide range of stakeholder representatives who contributed to and participated in various meetings, workshops, focus groups and interviews during this process.

This Workforce Plan is the first Directorate wide workforce plan across the organisation and will be a key indicator of our progress towards meeting our challenging objectives and I look forward to reviewing, monitoring and evaluating progress at each milestone.

Catherine McNicholl

Mrs Catherine McNicholl
Director of Adult Social & Primary Care

Executive Summary

1. Introduction

The purpose of the Integrated Workforce Plan is to describe, identify and set out the key workforce issues associated with the Service Plans within the Directorate, including the future needs of the Directorate in terms of:-

- WTE's
- Skill mix
- Grade mix
- Changing roles and responsibilities
- New roles
- Workforce trends and requirements, turnover and recruitment
- Training requirements

It is important to note a number of other significant workforce reviews were already commissioned and underway within the Directorate, namely the 'Older People's Services Social Work and Social Care Modernisation and Workforce Review[1]' and 'District Nursing Workforce Review[2]'.

1.1 Range of Services

Currently there are four Service Group areas within the Directorate and the focus of the Integrated Workforce Plan :-

- Mental Health Services
- Learning Disability Services
- Older People and Physical and Sensory Disability Services
- Psychology Services

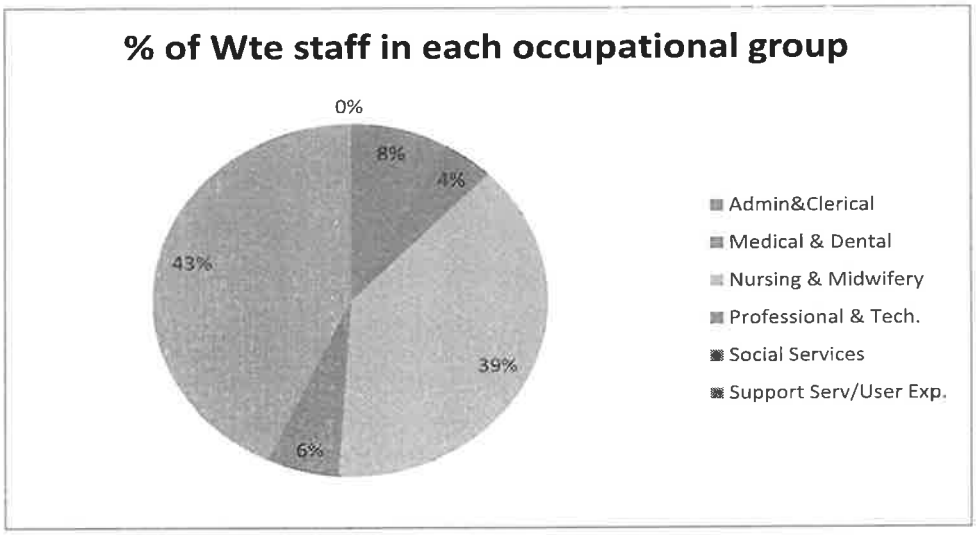
These are supported by a range of other Services including administration, planning and performance, Service improvements and governance.

1.2 The Workforce

The Directorate, the second largest in the Trust, employed at 31st March 2015, 4,639 headcount or 3,906.10 whole time equivalent (wte) across each of the occupational family groups as illustrated in the charts over:-

[1] Older People's Services Social Work and Social Care Modernisation and Workforce Review – September 2015

[2] District Nursing Modernisation and Workforce Review 2014/15 – Final Draft



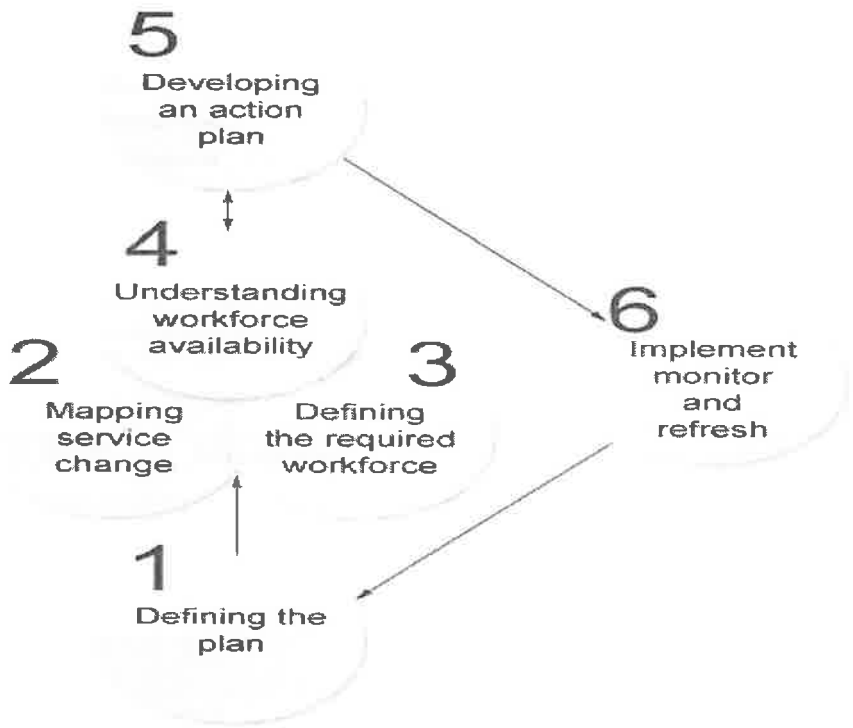
Occupational Group	Headcount	WTE
Admin & Clerical	380	318.62
Medical	192	163.50
Nursing	1,688	1,512.41
Allied Health Professions	263	234.8
Social Work & Social Care	2,113	1,674.18
Ancillary & General	3	2.6
Grand Total	**4,639**	**3,906.10**

1.3 Service Change

The Directorate has set out an ambitious strategic reform and modernisation programme to support the improvement in the delivery of Services and an improvement in the Service user experience. This is to be achieved within the financial envelope available which has an associated efficiency savings target of £7,522,000 in the first year of this plan 2015/2016. To support the delivery of this Service change 19 reform and modernisation projects are currently underway.

2. Methodology

The skills for Health Six Step Methodology to Integrated Workforce Planning has been applied to support the development of this Workforce Plan.



3. Six Step Approach

3.1 Defining the Plan

The primary purpose of the plan is to ensure we have the right people, with the right skills and competencies in the right place at the right time to ensure the right outcome for the Service Users.

There are a number of key drivers for change, including Transforming Your Care, 2015/16 Savings Plan, a number of Reviews including Donaldson[3], Bamford[4], Berwick[5], Cavendish[6], Keogh[7], and Nursing Normative Staffing levels, Regional Workforce Reviews and the introduction of New Technology.

[3] The Right Time Right Place – An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland
[4] The Bamford Review of Mental Health and Learning Disability (Northern Ireland) 2007
[5] A Promise to Learn : A Commitment to Act: by the National Advisory Group on the Safety of Patients in England
[6] The Cavendish Report : An investigation into what can be done to ensure that all people using Services are treated with care and compassion by Healthcare Assistants and Support Workers in the NHS and Social Care settings
[7] Review into the quality of care and treatment provided by 14 Hospital Trusts in England:Overview Report

The scope of the Plan focus' on :-

Mental Health Services :	In Patient
	Recovery / Rehabilitation
	Children Adolescent Mental Health Services (CAHMS)
	Primary Care Partnerships
Learning Disability :	Hospital Services
	Day Care Services
	Community Treatment and Support
Older People Services :	Statutory Residential Care
	Supported Living
	Reablement Services
	COPD and Respiratory Services
	Acute care at Home
	Review of District Nursing
	Review of Social Work and Social Care
	Self-Directed Support
	Stroke Services
	Unscheduled Care
	Social care Rapid Response
	Physical and Sensory Disability Services
	Psychology
	Admin and Clerical
Psychology Services :	Adult Psychology Services
	Neuro-Disability Psychology Services
	Children's Psychology Services

3.2 Mapping the Service Change

The implications of Transforming Your Care and the transition of Service delivery from predominantly acute based to community based settings is key to mapping the Service change required.

As outlined above in the Services provided, the Directorate is significantly involved in the provision of home, near to home, community based and hospital Services.

There are a wide range of proposed Service reforms and modernisation programmes within each of the Service Group areas. In summary these include:-

Mental Health Services

- New Mental Health Inpatient Unit (scheduled to open 2017);
- Retraction from long-stay Mental Health Wards and reprovision within Community settings;
- Rehabilitation and Recovery Services to be restructured to meet the requirements of patients as outlined in Bamford : Equal Lives;
- The outcome of the Department Review on CAMHS;
- Review of Day Centre Care Provision;

Learning Disability Services

- Resettlement of Learning Disability clients from Muckamore Abbey Hospital;
- Review of Learning Disability Day Care Services;
- Community Treatment and Support;

Older Peoples Services

- Older People Statutory Residential Care;
- Supported Living;
- Reablement;
- COPD and Respiratory Services;
- Acute Care at Home;
- Review of District Nursing and Social Work workforce;
- Stroke Services;
- Unscheduled Care;
- Social Care Rapid Response;
- Physical and Sensory Disability Services;
- Sleep-ins;

Psychology Services

- Provision of trust-wide life-span autism diagnostic and intervention Services.
- Increase access to psychological Services across the Trust.
- New model of Service delivery for Children's emotional, behavioural and mental health Services across the Trust.

Workforce Budget

The Directorates Workforce budget for the year ending 31st March 2015 was £150 million and non-pay was £140 million.

Agency Expenditure

The total level of Agency expenditure by the Directorate at the end of 31st March 2015 was £5,508,633, 21% of the total Trust expenditure on Agency.

3.3 Defining the Workforce

Workforce change is expected to support enhanced Community Services with an associated shift of resource from acute to community care. This will require re-training and redeployment of associated staff in each of the occupational family groupings.

Information is contained within the Plan on the WTE's, skill mix and grade mix both current and projected and defines the workforce within:-

- Mental Health Services
- Learning Disability Services
- Older People Services
- Psychology Services

Across all Service group areas during the course of the workforce plan significant change will be required within each job family.

Social Work and Social Care Workforce

This is currently the largest workforce group (43%) within the Directorate and during the course of this plan much work is required to rebalance the workforce within the Acute Hospital setting and across the Integrated Care Teams within Older People Services bringing about changes in skill mix and potential new roles to improve the Hospital Discharge process for example. The introduction of Self Directed Support will have a significant impact and we will need to ensure all social care staff are registered with the Northern Ireland Social Care Council (NISCC) as Health Minister Simon Hamilton wants Northern Ireland to lead the way across the UK in ensuring social care workers in domiciliary and day care are registered.

Nursing Workforce

In relation to the nursing workforce, which makes up 38% of the Directorate's total workforce, will be faced with changes to skill mix as normative staffing is rolled out, new roles will be required in the community, Nursing Revalidation will be introduced and Phase 2 of Delivering Care will become available which will focus on mental health and district nursing. A programme of work will also be required to promote and attract new graduates into a Care of the Elderly career pathway and investment to support our Ward manages to participate in leadership, management, staff development and audit is also required.

Medical Workforce

Whilst this workforce group, which accounts for 4% of the Directorate's workforce is set to remain relatively stable during the course of this plan, focused efforts to recruit and retain doctors within the Care of the Elderly Programme of Care is required. Participation in the Regional Workforce planning by Medical Speciality will also be required with Psychiatry scheduled to commence July to December 2015.

Administration and Clerical Workforce

This workforce makes up 8% of the Directorate's total workforce and during the course of this plan it is anticipated that it will increase, as a significant recruitment programme takes place to reduce agency usage with an associated reduction in spend. This staff group will also be deployed to the multidisciplinary teams and new skills will be required and technologies are set to be reviewed including 'Big Hand' the use of mobile devices and voice recognition.

3.4 Understanding Workforce Availability

To understand the workforce that is available, it is necessary to consider and analyse the trends amongst the existing workforce. Set out below are some high level workforce trends across the Directorate with comparisons drawn across the Trust.

Workforce Trends

Projection for Retirements: over the course of the Plan the Directorate has a potential retirement profile of 9.23%. It is projected 428 staff may retire i.e. those currently aged 60+. 37 staff within Mental Health Services, 58 within Learning Disability, 290 within Older People Services, 144 are Band 2 Domicilliary Care Workers and 26 are Band 3 District Nursing Support Workers.

Age Profile : the Directorate age profile identifies a systemic need for succession planning. 120 staff aged 55+ are in band 7 and above positions. This compares to a total of 709 staff aged 55+ in band 7 and above positions across the Trust.

Turnover : at September 2014 the Directorate turnover rate was 5.84% which compares to 4.88% across the Trust. Mental Health Service Group Area had the highest turnover rate of 9.67% at 31 March 2015.

Sickness Absence : the overall absence rate for the Directorate for the 12 months ending 31st March 2015 was 7.59% and is the highest it has ever been since the establishment of the Belfast Trust.

Gender Profile : 85% of the workforce are female which compares to 78% across the Trust.

18% of the total male workforce in the Directorate are in band 7 or above positions which compares to 13% across the Trust.

12% of the total female workforce in the Directorate are in band 7 or above positions which compares to 13% across the Trust.

Working Pattern profile : 48% of the Directorate workforce work part time which compares to 41% across the Trust.

27% of the Directorate's part time workforce are aged 55+ which compares to 20% across the Trust.

Length of Service : 63% of the workforce have 10+ years continuous Service.

3.5 Developing an Action Plan

In order to realise the benefits of this workforce plan an Action Plan is required to monitor progress and to ensure the plan is continually reviewed and updated to maintain its currency. The one constant in our health and social care sector is the need to change, to ensure our Services are the best they can be and fit for the future within an ever increasing ageing population, presenting with more complex needs. The demographics amongst our workforce are also changing and the key areas identified below for inclusion in the Action Plan at this stage are indicative and set to change over the course of the plan:-

Overview of Workforce Profile

Whole Time equivalents (WTE)
Over the course of the plan the WTE is projected to reduce by an indicative 24.4wte. It is important to note however, that workforce projections are set to evolve as projects and consultations progress. The projections to date are therefore indicative and speculative and subject to review.

Skill Mix
Over the course of the plan the skill mix amongst the Social Work workforce is projected to change within the Integrated Care Teams. Currently the Workforce Review[8][8] recommends a shift towards a higher professionally qualified workforce and this will be further reviewed and considered within the Trust.

Within the nursing workforce the skill mix is set to also change as they work to introduce normative staffing levels.

Grade Mix
The Social Care workforce is projected to change; to rebalance the integrated care teams and a shift of band 4 staff from the Community to the Hospital setting is projected[9]. Administration and Clerical numbers within band 2, 3 and 4 will increase owing to the move to recruit to substantive posts and reduce agency expenditure.

Changing Roles and Responsibilities
Throughout the course of the plan as Service areas implement the new models of Service delivery, for example Menal Health Inpatient Unit, changes to existing roles and responsibilities will take effect and these changes will need to be captured for the purposes of updating and monitoring progress.

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[8] Older People's Services Social Work and Social Care Modernisation and Workforce Review – September 2015
[9] As 8 above

New Roles

New roles have been identified and developed within the Acute Care At Home Team and as the Social Care Workforce Review moves towards implementation, new roles within the proposed 'Older Persons Care and Placement & Review Team' will also be developed.

Workforce Trends and requirements, turnover and recruitment

To ensure the currency of the workforce plan it is necessary to continually review and monitor the movements amongst the workforce, examining and analysing trends and identifying areas experiencing difficulties in recruiting and or retaining staff. A programme to promote Care of the Elderly as an attractive career pathway for nursing staff is to be developed as it is recognised that this is a difficult to recruit to area. A Recruitment and Retention Strategy for the appointment of Geriatricians will also be developed in line with the Regional Workforce plan in this area.

Training requirements

New skills will be required to support the shift from Acute to Community, and the utilisation of new technologies, e.g. Big Hand, Voice Recognition, and telehealth. Making the best use of systems and technology across all areas and developing the skills and knowledge base required to do so.

A local induction for newly qualified staff in particular those appointed as a result of the 'One Stop Shop' Recruitment Fair in June and those within administration and clerical will be required.

Compliance under statutory and mandatory training obligations will be necessary to ensure we have a competent workforce in place with the required skills and competences to fulfil their roles.

Succession Planning : Growing our People Today for Tomorrow. Due to the potential number of staff who may retire in senior management positions a succession plan will be needed to safeguard the Service.

This workforce plan sets out the key workforce challenges for the Adult Social and Primary Care Directorate over the course of the next five years, April 2015 to March 2020. The challenges facing the Directorate cannot be underestimated as it works to care, support and improve together, ensuring the right people with the right skills and competences, are in the right place, at the right time, to ensure the right outcome for the Service user.

The plan is divided into two sections. Section 1 of the plan sets out the macro Directorate wide workforce challenges and Section 2 considers the challenges at a micro Service area level.

DRAFT

High Level Action Plan

Adult Social and Primary Care Integrated Workforce Plan

Key Area	Action	Lead	Timescale / Update March 17
1. Reform and Proposed Modernisation Projects	To ensure the workforce issues associated with the wide range and number of modernisation projects within the Directorate, as detailed in the plan, identify, map out the workforce implementation issues and actions To apply the Trust's Framework on the Management of Staff affected by organisational change	Co-Directors / Senior Managers	
2. Workforce Reviews	To complete and implement the local workforce reviews on : ▪ Social Care Review ▪ District Nursing Review ▪ Admin Review (Older People Services) ▪ Agency Staffing Reduction	Co-Directors / Senior Managers	
3. WTE's	To track movement and/or changes in WTE	Modernisation & Workforce Planning Team	
4. Skill Mix	To track and monitor shifts in skill mix primarily within : ▪ Nursing ▪ Social Care	Modernisation & Workforce Planning Team	
5. Grade Mix	To track and keep under review any grade mix change	Modernisation & Workforce Planning Team	
6. Changing Roles and Responsibilities	To identify and meet the development needs of changing roles and responsibilities	Senior Managers / Human Resources / Professional Leads	

7. New Roles	To support the development and implementation of new roles, eg. Consultation, change process and associated banding	Senior Managers / Human Resources / Professional Leads
8. Professional Issues	To support the implementation of the revalidation process for nurses To support the registration process within the Social Care Workforce	Senior Managers / Human Resources / Professional Leads
9. Recruitment and Retention Strategies and Actions	To support the Directorate in the development of recruitment and retention strategies for identified hot spot areas To review and monitor reasons for leaving to inform action	Senior Leads / Human Resources
10. Local Induction	To review local induction arrangements	Senior Managers / Human Resources
11. Succession Planning	To take targeted action to provide successional planning development opportunities in identified groups and areas including : ▪ Coaching ▪ Staff Development Review Process (PCF / PDP) ▪ Growing Our People Today for Tomorrow : either bespoke or part of Trust-wide programme ▪ To undertake further analysis, eg. survey or interviews to inform further action	Senior Managers / Workforce Planning Team
12. Improving Health and Wellbeing and Engagement within Directorate	To develop bespoke health and wellbeing and engagement action plan for the Directorate Consistent application of attendance management toolkit and Trust policy	Co-Directors / Senior Managers / Human Resources

	Review underlying reasons for absence (root cause) and bespoke programme in place		
	Increase awareness and knowledge of local 'B'Well' and Regional 'Choose Well' programmes		
	Increase Directorate representatives at the Health and Wellbeing and Engagement Forum		
	Support the development of Employee advocates		
	Support the development of Engaging Managers		
	Support Living the Values of the Trust within the Directorate		
13. Technology	To continue to improve access, knowledge and skills in the use of new technology	Co-Directors / Senior Managers	
	To embrace and utilise technology to support new ways of working		

Contents

SECTION 1

1.1 INTRODUCTION

In May 2014, the Director of Adult Social and Primary Care commissioned the development of an integrated workforce plan for the Directorate as one of the key work streams of the Directorate's Modernisation Board. A Directorate Workforce Planning Steering Group was established as a result, the membership of the group is set out in Annex A and the Terms of Reference are set out in appendix 1.

A range of significant workforce reviews were already commissioned, some of which have been completed.

Commissioned Work Streams:

- A review of our District Nursing Workforce;
- A review of our Social Work and Social Care Workforce;
- Development of our new purpose built Mental Health Inpatient unit;
- Resettlement project in Muckamore Abbey Hospital;
- Development of Reablement Services;
- Stroke Services;
- BCH Direct;
- Acute Care at Home.

All of the above workforce reviews will supplement the Plan however this document will be the overarching document addressing the many issues currently facing the workforce. This document sets out the strategic workforce implications for the Directorate over the next five years.

1.1.1 The Format of the Document

Section 1 Sets out the Directorate overview, the Services provided, a description of the current workforce, the Terms of Reference of the Workforce Planning Steering Group, the Six Step Methodology, Guiding Principles applied, the purpose and the scope of the Workforce Plan, the drivers for change and ownership of the Plan. It then covers the key stages of the Six Step Model including mapping Service change, defining the required workforce, understanding workforce availability, developing an action plan and implementation and monitoring arrangements.

Section 2 Sets out a micro level Workforce Plan for four Services Areas.

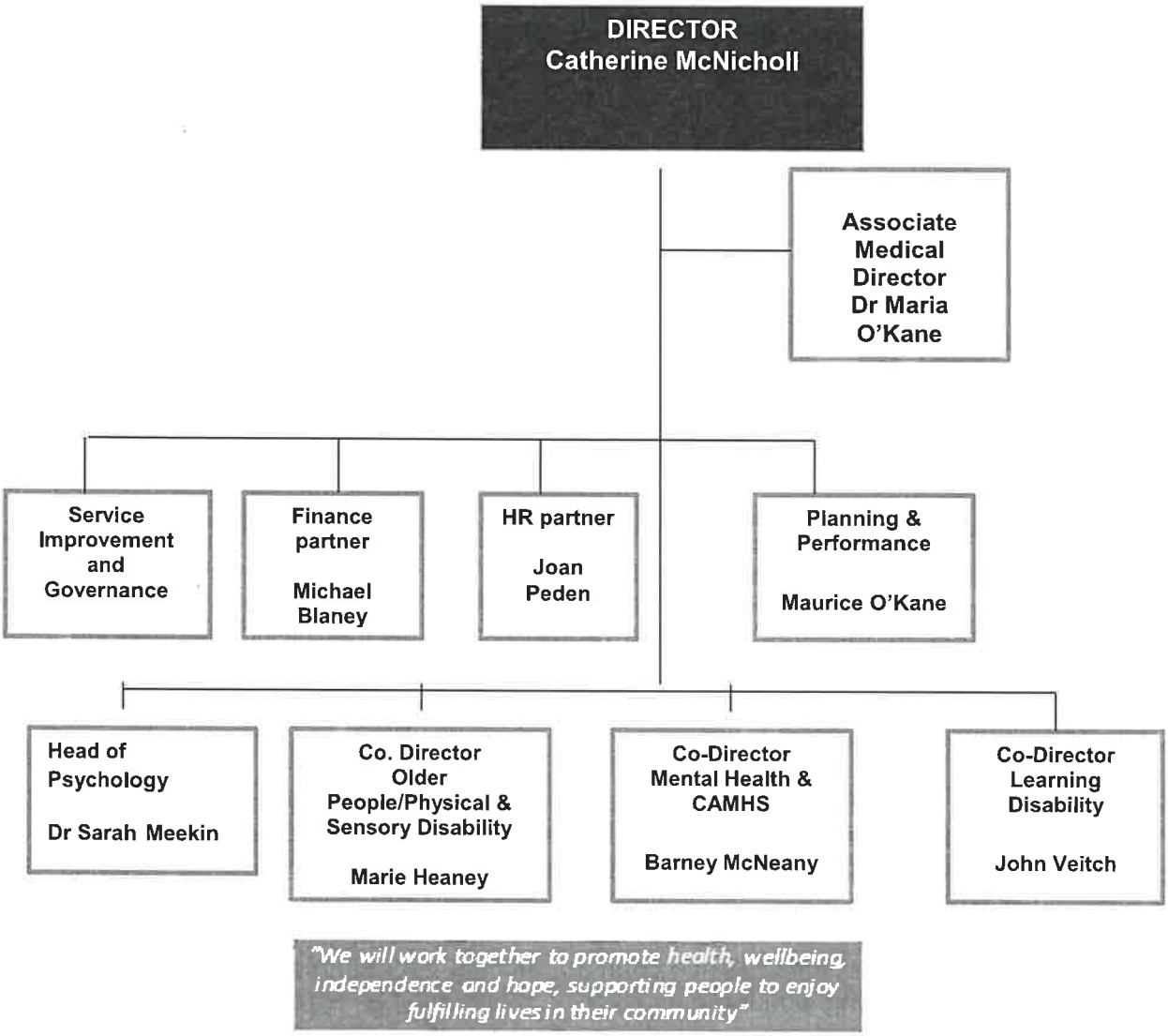
Section 3 Sets out the Summary of findings.

1.1.2 The Range of Services within the Directorate

Currently there are four Service Group areas within the Directorate:-

- Mental Health
- Learning Disability
- Older People and Physical Disability
- Psychology Services

These are supported by a range of other Services, including Admin Services, Planning and Performance, Service Improvement and Governance and Business Partner Services from Finance and Human Resources. The organisational structure of the Directorate is illustrated below.



The Directorate has grown and evolved and is committed to continue to provide a modern, responsive patient and client centred Service in the areas below.

- Mental Health – "Recovery"
  Within Mental Health there are four separate Service areas including:-
  - Primary Mental Health Care (including Psychological Therapies, Self-harm Team, Addictions and Trauma Support);

- Community Mental Health Services : comprising of - 4 geographical Community Mental Health Teams, Primary Mental Health Teams, One Point of referral, Early Interventions, Mental Health and Deafness, Community Forensics, Huntington Team, Perinatal Service, Community Support Team, 342 Ormeau Road and Weavers Hill (Supported Living), Resettlement Team;
- Acute (including Home Treatment, Acute Mental Health Hospital and Day Treatment Services;
- Children and Adolescents Mental Health Service (CAMHS), (including Home Treatment, Early Intervention Team, Beechcroft, Acute Mental Health Hospital).

- Learning Disability – *"Social Inclusion and Independence"*
  Within Learning Disability there are a range of Service areas including:-
  - Supported Living and Day Opportunities;
  - Community Treatment and Support;
  - Muckamore Abbey Hospital;
  - Iveagh Children's Unit.

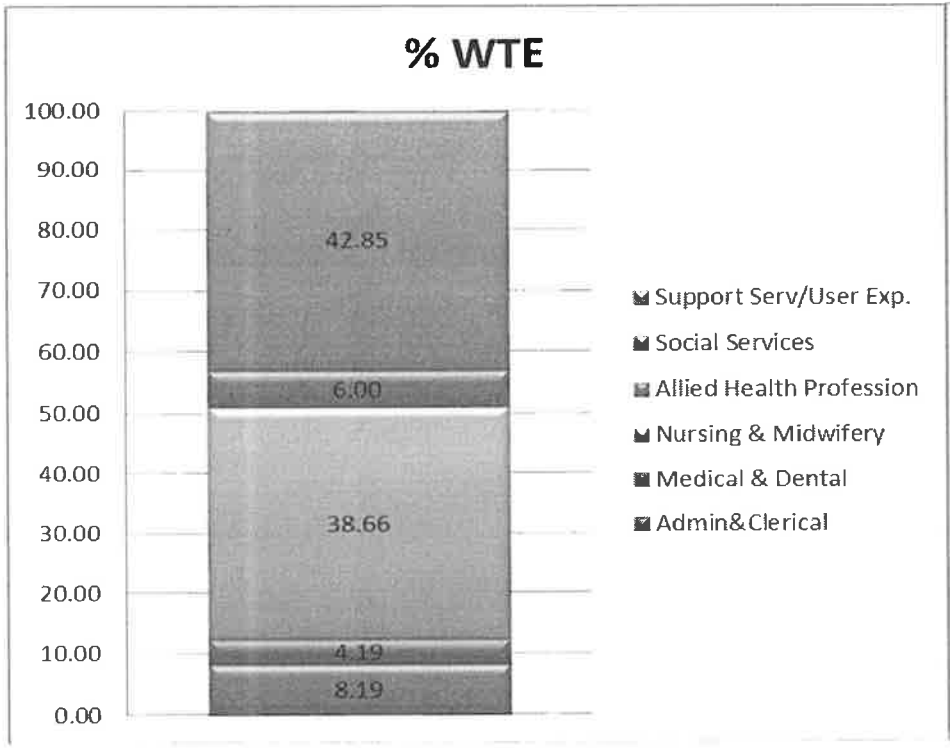
- Older People Services – *"Supporting people to maintain independence, inclusion within family and community, protection for vulnerable people"*
  Within Older People Services there are a range of Service areas including:-
  - South and East Belfast Locality and Older Peoples wards, Belfast City Hospital;
  - Intermediate Care, Mental Health and Dementia Inpatient and Outreach Services;
  - North and West Belfast Locality and Stroke Services, Royal Victoria Hospital/Mater Hospital.

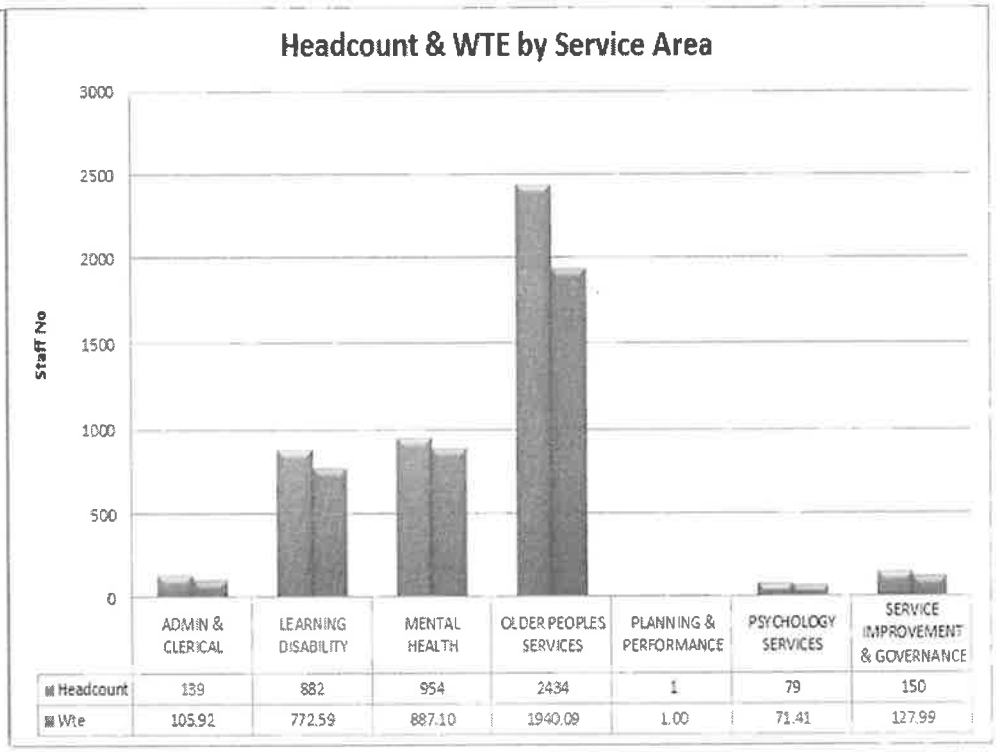
- Physical & Sensory Disability Services – *"Inclusion, Independence and Personalised Services"*
  - Social Work Teams;
  - Care Management Teams;
  - Supported Living & Day Opportunities;
  - Sensory Support Team;
  - Community Brain Injury Team;
  - Community Emergency Response Team.

- Psychology Services – *"Enhancing and enabling psychological health and wellbeing"*
  Within Psychology Services there are a range of Service areas including:-
  - Neuro-Disability Psychological Services (including adults with learning disability, acquired brain injury and neuropsychological problems);
  - Children's Psychological Services (including Children's Disability Services, Paediatric Psychology and Therapeutic Services).
  -

1.1.3 The Current Workforce

The Directorate, the second largest in the Trust, employed at 31st March 2015, 4,639 headcount or 3,906.10 whole time equivalent (wte) across each of the occupational family groups as illustrated in the graphs below.

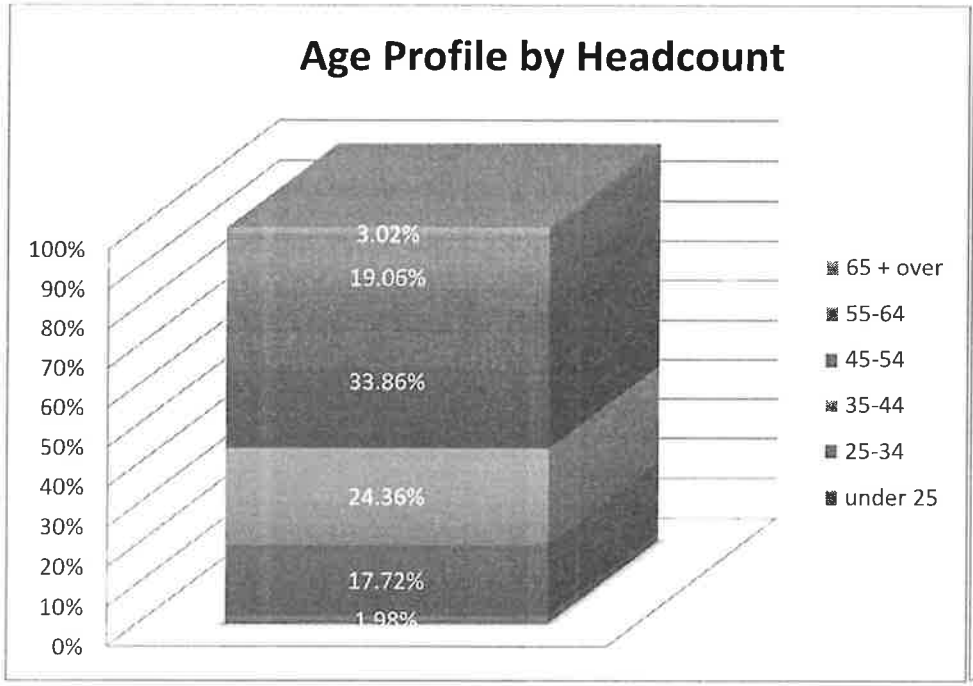


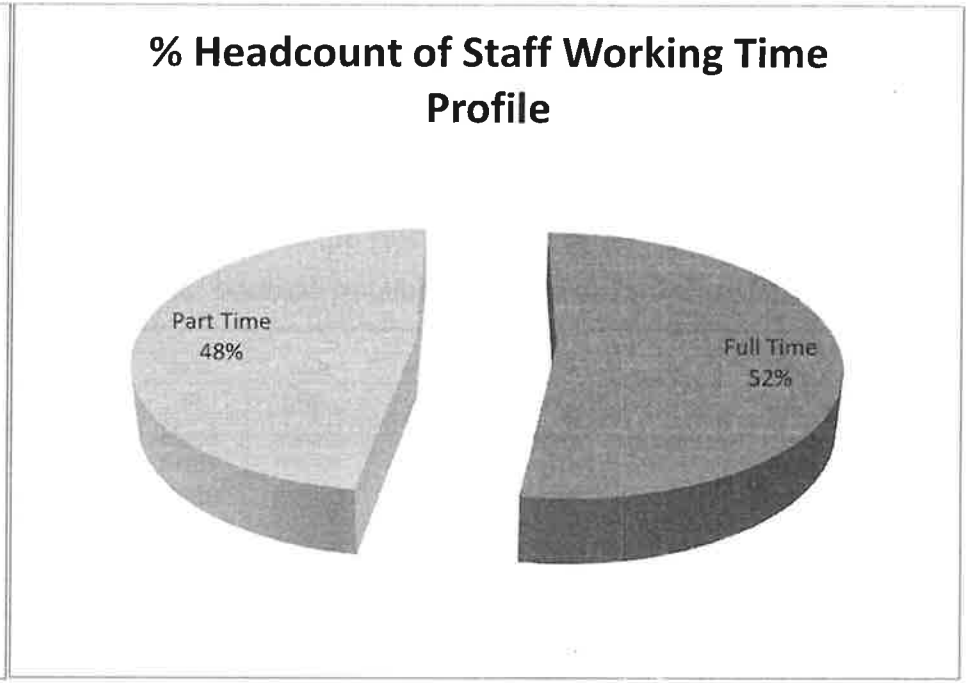


Social work & Social Care workforce is the largest staff group within the Directorate accounting for 42.85% of the total workforce.

Admin & Clerical staff accounts for 8.19% of the Directorate's workforce which equates to 10% of the Admin and Clerical workforce within the Trust.

- Older peoples Services Division employs the largest number of staff within the Directorate at 50%;
- Mental Health employs 22%;
- Learning Disability 20%.

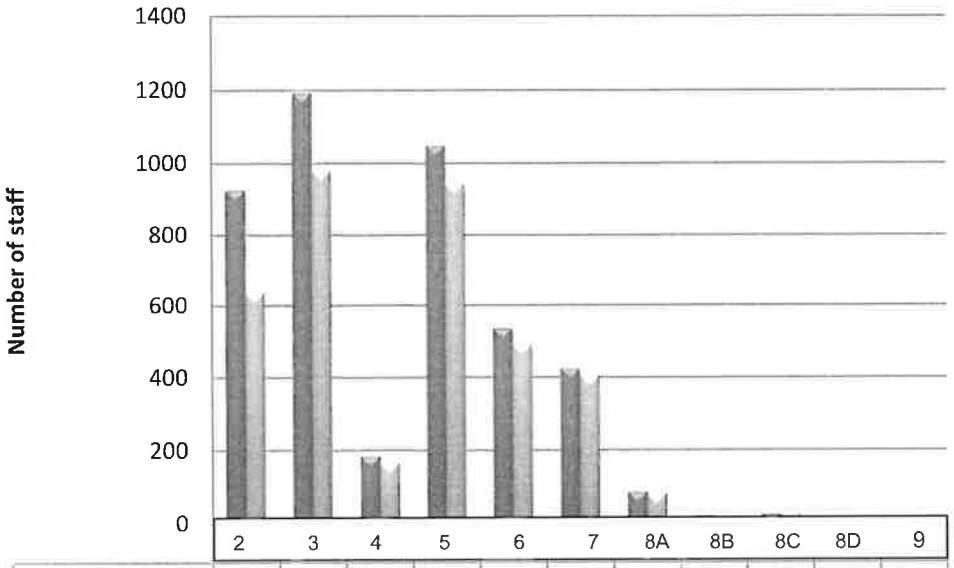




The age profile of the Directorate highlights a large number of staff 33.86% will fall into the over 55 age bracket over the course of the plan and further analysis has indicated there are 32 staff currently in senior posts, 16 at 8A, 7 at 8B, 4 at 8C and 5 at 8D which indicates the need to invest in Succession Planning within the Directorate.

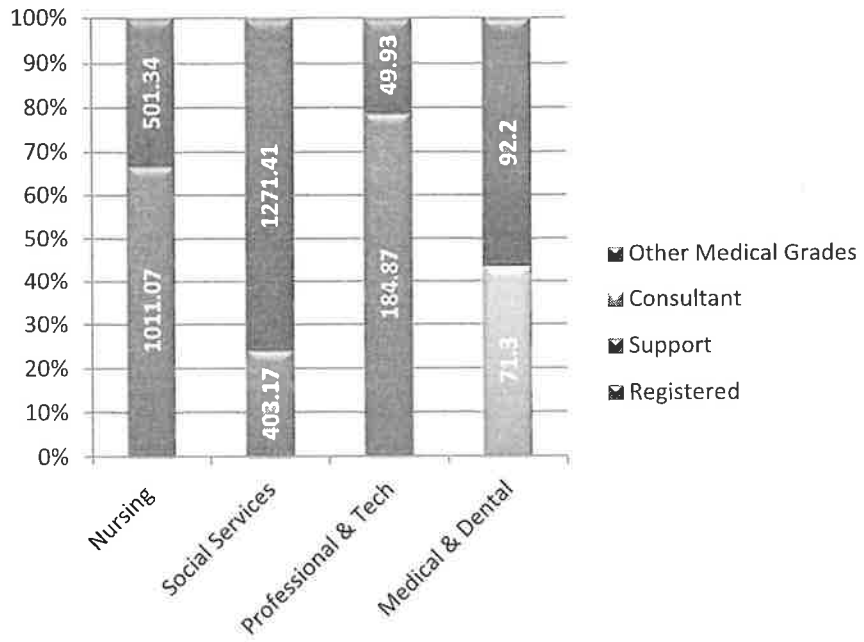
48% of the total headcount work part time, compared to 42% across the Trust; and of those 94% are female and 6% are male. The domiciliary care workforce make up the majority, 28% of the part time workforce. The part time workforce also indicates that the workforce are availing of the wide range of work life balance options available to staff. During the course of the last financial year a total of 214 work life balance applications were made and 211 of those were approved.

Band Profile



	2	3	4	5	6	7	8A	8B	8C	8D	9
Sum of H/count	924	1193	184	1048	535	423	87	20	25	6	1
Sum of wte	634.4	979.8	166.5	940.5	489.7	401.9	81.19	18.20	22.59	5.60	1.00

Skill Mix by WTE



The Directorate has a diverse range of staff across its grading structure with the highest number of staff working at a band 3 (25%). During the course of the last financial year Band 2 Domiciliary Care staff were moved to contracted hours contracts as opposed to zero hours contracts as a result of recognising the need to improve the delivery of Service to our Older People population in terms of continuity and flexibility of Service. A regional Domiciliary Care Workforce group have been tasked with developing a regional workforce plan within the Older People Programme of Care.

Skill mix is an important factor in ensuring we have the right people, with the right skills and competences delivering the right care. Within the Directorate the skill mix ratios are:-

- Nursing and midwifery 65:35
- Social Services skill mix ratio is 22:78
- Professional & technical skill mix ratio is 77:23
- Medical staffing skill mix ratio is 44:56

1.1.4 The Range of Services within the Directorate

The Directorate has set out an ambitious strategic direction and plan of health and social care reform and modernisation as set out within its Directorate Plan. This includes four key themes:-

Safety & Excellence
Partnership
Continuous Improvement
People & Resources

1.1.5 The Patient / Client

At the core of the Directorates vision is the Patient and Client Experience. Sir Liam Donaldson in his December 2014 report[10] identifies 'At the epicenter of our complex, pressurised, fast-moving environment is the patient. The primary goal of the care provided must always be to make their experience, the outcome of their condition, their treatment, and their safety as good as it gets'.

> 'Research shows that staff satisfaction and patient experience are closely linked – patients receive better care when staff are engaged and well led'.
> Sir Liam Donaldson

Workforce planning is a key component of setting the direction of travel for the Directorate over the next five years and this document has been developed using the Skills for Health Six step approach to workforce planning methodology. The Directorate recognises the need for change, as the impacts of demographic changes and a shrinking labour market are increasingly understood. Not only will the needs of our patients and clients continue to change and demand for our Services increase, but the workforce profile and characteristics of our staff will also change as our own workforce ages.

1.1.6 Terms of Reference

The terms of reference set out the project aim to determine an overall Directorate Workforce Plan which describes, identifies and sets out the key workforce issues, associated with the Service plans within the Directorate, including future Service needs of the Directorate.

- WTE's
- Skill mix
- Grade mix
- Changing roles and responsibilities
- New roles

[10] The Right Time, the Right Place : http://www.dhsspsni.gov.uk/ldreport270115.htm

- Workforce trends and requirements, turnover, recruitment
- Service integration across the Directorate/Organisation
- Statutory and legislative changes
- Working patterns
- Partnership working
- Service delivery
- Demographic changes

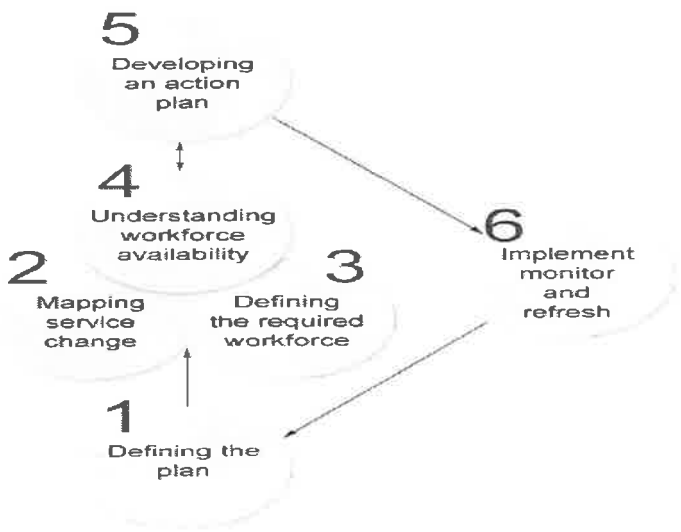
1.2 SIX STEP METHODOLOGY TO INTEGRATED WORKFORCE PLANNING

Within Health and Social Care, workforce planning has traditionally been viewed as a number crunching exercise. The Skills for Health approach to workforce planning however provides a clear methodology, fit for purpose and fit for the workforce planning requirements of the 21st Century. The Department of Health's Nursing & Midwifery Workforce Review document December 2014[11], defines workforce planning 'at its simplest, effective workforce planning ensures a workforce of the right size, with the right skills, organised in the right way, within the correct budget, delivering Services to provide the best possible patient and client care.'

Shirley Rogers, Director of Health Workforce in the Scottish Government during her visit to the NI Health Committee on 10 June 2015 stated "I would certainly put workforce planning at the top of my job description in terms of the things that we absolutely have to get right. Our approach has been that workforce planning is a bedrock thing from which you can vision, as opposed to a second-order thing that you come to when you get to it, because you cannot do without it."

The Skills for Health Six Step Methodology to Integrated Workforce Planning (2009) has been employed to support the development of this Workforce Plan and figure 1 illustrates the six steps and how they are interrelated.

Figure 1 : Six Step Methodology



[11] Evolving & Transforming to Deliver Excellence in Care – A workforce Plan for Nursing & Midwifery in Northern Ireland (2015-2025)

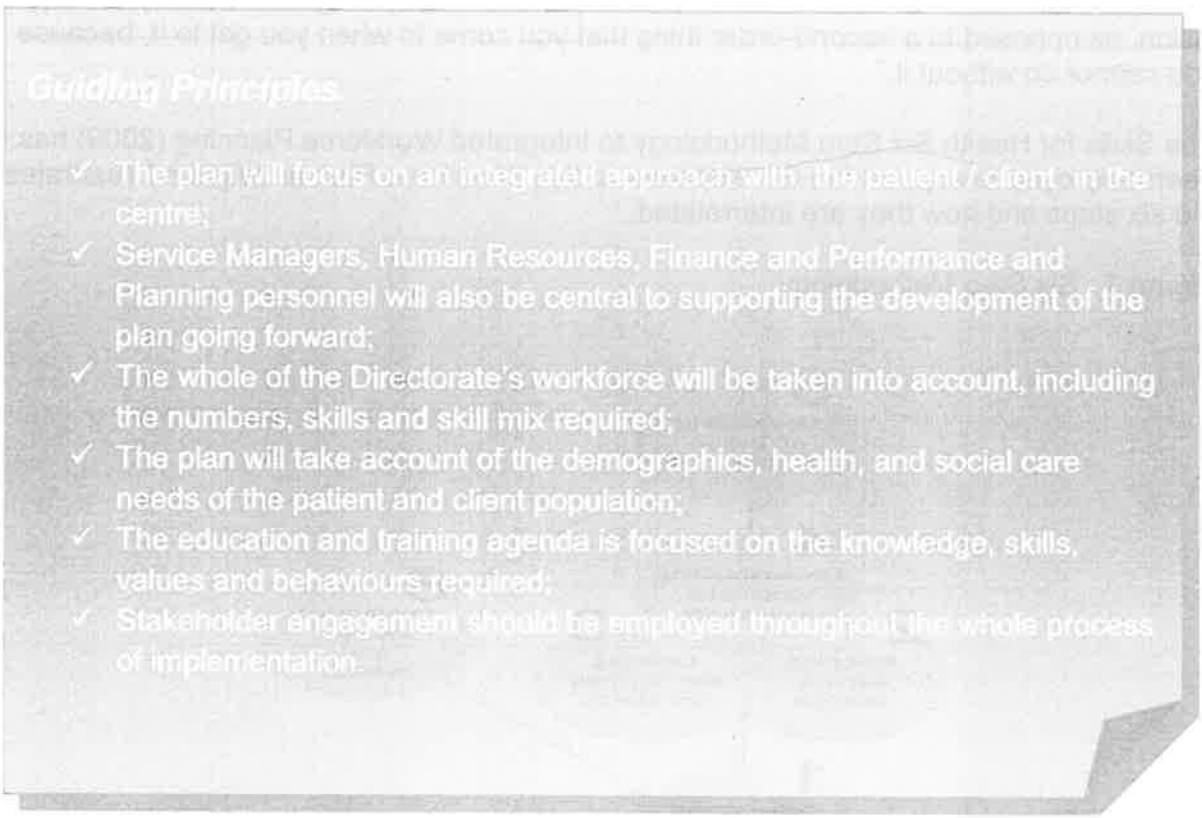
This high-level stepped approach has been the back bone in developing this workforce plan and has helped Service managers in their decision-making to support the establishment of information on the supply and demand dynamics relevant to their workforce, whilst also recognising uncertainty in that the decisions made today may change tomorrow as the nature of health and social care in Northern Ireland is fluid and ever changing.

The new Minister for Health Simon Hamilton during his visit to the Trust in June stated:-

> "We must all play our part in finding solutions. We are all part of the one team. We all want a world class health and social care sector. I am placing the opportunity for change firmly with frontline staff".

1.3 GUIDING PRINCIPLES OF THE DEVELOPMENT OF THIS WORKFORCE PLAN

The following principles were employed to guide the development of this workforce plan:-



1.4 STEP 1 : DEFINING THE PLAN

This is the critical first step in any planning process. You must be clear why a workforce plan is required and what it will be used for. You must determine the scope of the plan, whether it will cover a single Service area, a particular patient pathway or a whole health economy and given this, be clear who is responsible for ensuring the plan is delivered and who else will need to be involved in the planning process.

1.4.1 Purpose

The primary purpose of this plan is to ensure we have the right people, with the right skills and competences, in the right place at the right time to ensure the right outcome for the Service user.

The Plan will ensure:-

- A clear understanding of the future direction of directorate Services;
- An integration with Service and financial strategies;
- A base of realistic and affordable assumptions;
- Short and medium term changes to Service are taken account of;
- Engagement with all stakeholders;
- Equality Impact screening;
- Public consultation where necessary;
- A link to commissioning plans;
- Organisational / Strategic changes across the Trust;
- The provision of an evidence base.

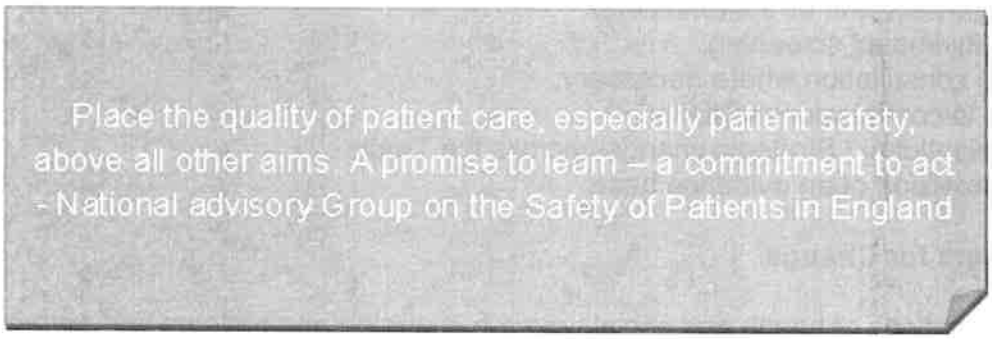
1.4.2 Drivers for Change

Public expectations of health and social care are changing and patients and carers expect high-quality services to be delivered close to their homes. The demand on our services is set to increase, with people living longer, with more complex needs, the workforce for the future will undoubtedly require retraining, new skills not least with the speed and introduction of new technologies and potentially the introduction of new roles. The demands for the services provided by the Directorate will become greater as the health and social care landscape in Northern Ireland continues to evolve, as the shift from acute to community healthcare services grows. There are many drivers for change particularly with the recent onus on quality and patient safety which has been highlighted in a range of regional and national strategies and reports including:-

- Transforming Your Care – A Review of Health & Social Care in Northern Ireland December 2011;
- 15/16 Savings Plans;
- The Right Time, The Right Place – An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland December 2014 Donaldson Review 2014;
- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013;

- The Bamford Review of Mental Health and Learning Disability (Northern Ireland) 2007;
- The Cavendish Report 2013 – an investigation into what can be done to ensure that all people using Services are treated with care and compassion by healthcare assistants and support workers in the NHS and social care settings;
- The Berwick Report – A Promise to Learn a Commitment to Act – Improving the Safety of Patients in England August 2013;
- Review into the quality of care and treatment provided by 14 hospital Trusts in England: Overview report Professor Sir Bruce Keogh KBE;
- Normative staffing levels;
- Anticipated Mental Capacity Bill;
- Regional workforce reviews in medical and nursing and midwifery;
- Improving & Safeguarding Social Wellbeing – A strategy for Social Work in Northern Ireland 2012 - 2022;
- Pension Reform
- Delivering Care:Nurse Staffing in Northern Ireland (2015)
- Quality 2020 – A 10-year quality vision for health and social care in Northern Ireland
- Introduction of new technology eg. Human Resources Payroll Travel & Subsistence System (HRPTS) and Community Information System (CIS).

The drivers outlined above are not an exhaustive list and there will be those that will impact on individual Services. Regardless of the source of the drivers it is essential that the impact is assessed and the requirements are factored into the model of Service delivery and the resources needed to meet the expected demands and targets.



1.4.3 Scope

This workforce plan is developed as a first step approach in supporting the Directorate meet its challenges. The Scope of the plan will focus on the workforce requirements for the delivery of Directorate Services which includes:-

1.4.3.1 Mental Health Services

Approximately 250,000 adults and 45,000 children and young people have a mental health need at any one time in Northern Ireland. This represents 1 in 6 of the population. There is a greater incidence of mental health in Northern Ireland than in the rest of the UK by 25%. It is estimated that 20% of young people are suffering 'significant mental health problems' by their 18th birthday.

In-Patient
The period covered by this plan will see the provision of a new inpatient mental health Service which meets the needs of the patients and Service users. This will include a new Mental Health unit which will be built on the Belfast City Hospital site and is expected to be completed during 2017.

Recovery / Rehabilitation
The rehabilitation / recovery Services will be restructured to meet the requirements, as outlined in Bamford "Equal Lives (2005)", to ensure that patients are provided with the Services they require and not limited by what is currently available. Opportunities to have Services provided in the community will be the first option / preference.

Children's Adolescent Mental Health Services (CAMHS)
A review of the CAMHS has identified the need for additional Services including inpatient provision; a primary mental health team in the community covering the Belfast & South Eastern Trusts and the development of the Crisis Assessment Intervention Team (CAIT).

The Personality Disorder Service will be reviewed as part of the Regional review into this Service. This review will help to inform the direction and model of the future Service delivery.

1.4.3.2 Learning Disability

Learning Disabilities affect about 1.5 million people in the UK and in Northern Ireland there is a population of approximately 26,500 people with a learning disability, of whom half are aged between 0-19 years. It is projected that the number of people with a learning disability will increase by one per cent each year over the next 15 years, and that children and older adults with complex physical needs will both be large areas of growth. The increased support needs of this population will require an associated growth in service provision to meet their complex physical health needs.

An estimated 26% of people with a learning disability are admitted to hospital, compared to 14% of the general population (National Patient Safety Agency 2004). Services can range from emergency care provision, outpatient appointments and day procedures, through to the need for surgical intervention and repeated lengthy admissions due to complex health needs. As a result of the demographic changes highlighted previously the Trust should work towards the implementation of the recommendations included in the Review of Implementation of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings, which are outlined later. In addition to the above and following the Bamford Review in 2005 it has been agreed regionally that all patients, where possible, should be resettled and given the opportunity to live in the community. This will have a direct impact on both the hospital and the community learning disability Services.

1.4.3.3 Older People's Services including Physical and Sensory Disability Services

There will be significant change to how we deliver our Services in the future to ensure that we meet the demands and requirements of TYC. This will include meeting commissioning specifications regarding Frail Elderly, Respiratory, Diabetes, Stroke and End of Life Care; the need to provide more opportunities to older people and their carers for self-directed support and an increase in the choices available to older people for independent living through additional supported living schemes.

The Directorate must ensure that it complies with statutory functions, including the review of the social work and social care workforce to ensure the necessary skills mix, capacity and appropriate organisational arrangements, are in place, to meet the requirements of delegated statutory functions.

There is also a need to review the Homecare Management Support structure to ensure it meets the requirements of the regulatory bodies. The Directorate is developing a Trust-wide Acute Care at Home programme. A focus will be to improve performance and efficiency across all hospital sites through improving patient flow and the management of complex delayed discharge pathways. The Directorate will need to ensure the safe, effective and timely discharge for patients receiving Inpatient Care within the Dementia Inpatient Service.

There will be a review of the day care opportunities within physical & sensory disability Services and the Directorate will link in with the regional workforce planning group on the development of a workforce plan for our domiciliary care workforce.

1.4.3.4 Psychology

A review of access to Psychological Services across the Trust will be undertaken to identify where these can be increased. The Directorate will work to ensure the provision of Trust-wide life-span autism diagnostic and intervention Services.

1.4.4 Ownership

The Workforce Planning Steering Group, Chaired by the HR Co-director was established to develop this Integrated Workforce Plan for the Directorate's Modernisation Board. This workforce plan is owned by the Directorate and will be continually reviewed, updated and evaluated to maintain its relevance and to reflect the ever changing health and social care environment today and in the future.

Workforce data has been obtained from our Human Resources, Payroll, Travel and Subsistence (HRPTS) System for the years ending 31st March 2014 and 2015 respectively and trend analysis identified using workforce data from our previous Human Resources Management System (HRMS). For the purposes of trend analysis consideration has been given to the period April 2011 to March 2015.

A range of methods were employed between April 2014 and March 2015 to meet the project aim and objectives including gathering and analysing statistical data, conducting a range of workshops, surveys, focus groups and interviews with stakeholders within the Directorate and reviewing relevant policies and strategies to identify proposed capital and Service developments or changes over the next five years.

The findings have been used to inform and shape the content and Action Plan and consideration has also been given to our Trust values:

The Trust and the Directorate has developed a strong focus on values, attitudes and behaviours of staff as focus for ensuring that individuals are living the Trust Values. This plan will seek to ensure the adequate supply of staff with the right skills, values and behaviours in the right numbers to deliver safe, effective high quality care. This is of the most significant importance to the Directorate and the Trust.

1.5 STEP 2 : MAPPING SERVICE CHANGE

This is the first of three interrelated steps. This is the process of Service redesign in response to patient choice, changes in models of delivery, advances in care or financial constraints. You must be very clear about current costs and outcomes and identify the intended benefits from Service change. You should identify those forces that support the change or may hamper it. There must be a clear statement about whether the preferred model better delivers the desired benefits or is more likely to be achievable, given anticipated constraints.

1.5.1 Population and Health Profile

Northern Ireland has the fastest growing population of any country within the UK (DHSSPS, 2013a). The Northern Ireland Statistics and Research Agency (NISRA, 2013) projected the population to rise from 1.79 million in 2010 to nearly 2 million in 2025 (an increase of almost 8%).

There are 430,763 children and young people, under the age of 18 in Northern Ireland (PHA, 2014) and the number of people aged 65 and over is forecast to increase by 42%, from 260,000 to 370,000. Significantly, though, the number of people of working age is only projected to increase by 1.4%, from 1,109,000 to 1,124,000, by 2025. Over the same period, the number of people aged 85 and over will increase by 25,000 to 55,000.

These statistics bear relevance to the population the Directorate serves.

- 26,500 people are living with a learning disability, and half are aged between 0-19 years
- 250,000 adults and 45,000 children and young people have a mental health need at any one time in Northern Ireland
- 20,000 older people are living in Northern Ireland with Dementia

Former Health Minister, Mr. Jim Wells said "Enabling people to live well with dementia is one of the greatest challenges that we face in health and social care at present and into the future. It is recognised that we need to work together to improve the understanding of dementia in wider society, and reduce stigma and isolation.

The Hemsworth Court scheme is a great example of what can be achieved for people with dementia and their carers to support them to live as part of the community for as long as possible. The facilities are state of the art and provide a safe and secure environment for people with dementia".

The Dementia Strategy (DHSSPS, 2011e) indicates that levels of dementia are projected to increase to 60,000 by 2051 from 19,000 in 2010. Between 17-21% of the population have a physical disability, and around 37% of households include at least one person with a disability (NISRA).

High levels of mental health problems, self-harm, suicide and alcohol and drug abuse are reported in the homeless population and an estimated 2/3 of prisoners have mental health problems (PHA, 2014). *Transforming Your Care* (DHSSPS, 2011b) highlighted that 24% of women and 17% of men in NI have a mental health problem – over 20% higher than the rates in England or Scotland. The Framework for Mental Health and Wellbeing Northern Ireland (DHSSPS, 2011d) highlights that 10-20% of older people (aged 65 years or over) suffer from serious mental health problems.

1.5.2 Financial Challenges

The Trust continues to face significant financial challenges and must work towards delivering the efficiencies required to meet the financial funding available. The implications of the efficiency challenges that face not only the Directorate workforce over the next five years will be significant, particularly in relation to meeting existing commitments; irrespective of any modernisation and reform.

A key financial objective with the TYC reforms is to ensure that financial resources appropriately reflect the proposed new Service models across all areas of care. This was described in *Transforming Your Care* as a shift left. The *Transforming Your Care* report highlights the intention to shift approximately 5% (£83m) of recurrent funding in real terms out of the projected cost of hospital based care and into a primary/community based setting within 3 years of a fully funded transformation programme commencing. In order to effect this shift of care and funding out of hospital Services and into the primary / community setting, the HSCB will commission Services to be delivered in a different way.

The Directorate in the first year of this workforce plan has identified the following in its savings plans for 2015/2016:-

- Proposed reprovision of statutory Elderly Person's Home, in line with client choices.
- Proposed retraction from long-stay Mental Health ward and reprovision within community settings.
- Proposed closure of Acute Day Treatment Service, with essential components of the Service carried out by the Home Treatment team.
- Proposed reprovision of Adult Mental Health Day Centre Services, centralising the provision of Mental Health day Services, with the remaining provision focused on those most in need for the duration that those individuals require a statutory Service.
- Proposed review of Day Services provided in the community and voluntary sector
- Proposed review of Beechcroft in the context of the regional requirements.
- Proposed review of directly managed Learning Disability Day Centres within the Trust taking account of locations.
- Proposed review of respite care within Learning Disability Services. Respite Services for approx. 350 clients would be reviewed.
- Reduction in Administration Costs.
- Staff Productivity-reduction in overtime and agency costs.

1.5.2.1 Workforce Budget

The Directorate's workforce budget for the year ending 31st March 2015 was £150million, and non-pay was £140million, making its workforce it's most expensive resource. The Directorate did breakeven and will continue to focus on managing its budget for the duration of this plan. The savings plan target for the Directorate for the current 2015/16 financial year is £7,522,000 broken down by £1,781,000 for Revenue & Expenditure and £5,740,000 for workforce modernisation.

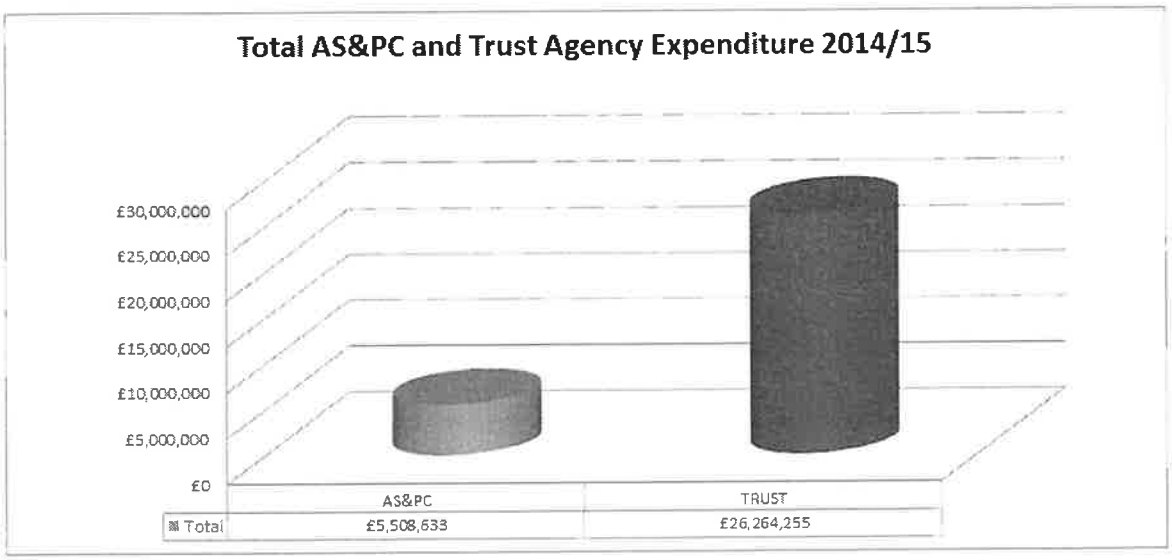
1.5.2.2 Agency Expenditure

The total level of Agency expenditure by occupational family group within the Directorate for the 12 months to 31st March 2015, was £5,508,633[12] as illustrated in Table 1 below:-

Table 1 : Agency Expenditure

FAMILY GROUP	AGENCY SPEND FOR THE 11 MONTHS TO 31st March 2015
ADMIN & CLERICAL	£1,466,411
ANCILLARY	£19,061
ALLIED HEALTH PROFESSIONS	£127,336
SOCIAL SERVICES	£1,263,150
NURSING	£1,524,174
MEDICAL	£1,108,501
TOTAL	£5,508,633

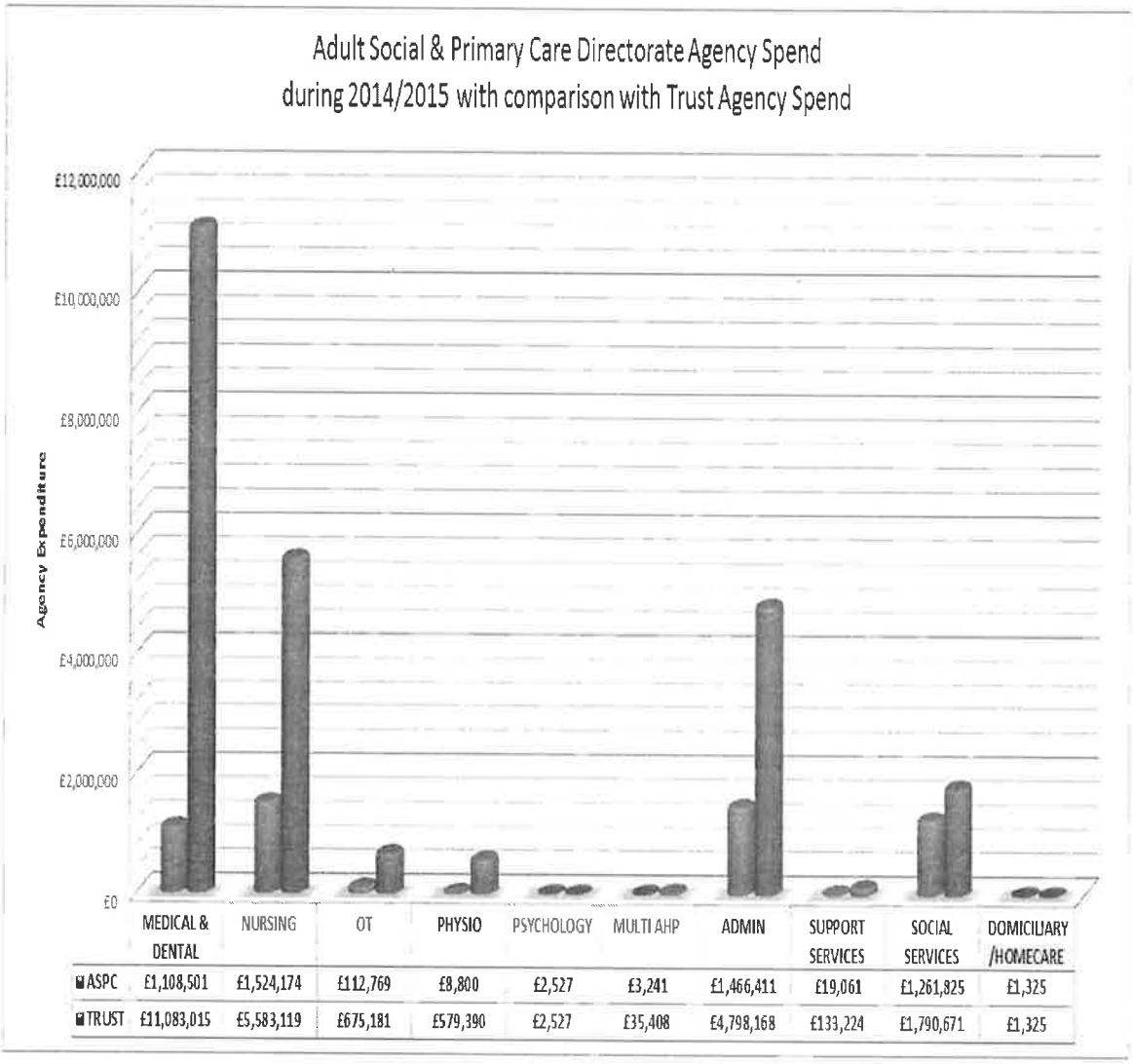
This represents 3.7% of the total salaries and wages budget for the Directorate. When the total Agency expenditure across the Trust is considered £26,264,255 the Directorate was accountable for 21% of that total expenditure as illustrated in the Graph below.



[12] Management Accounts Agency report as at 31 March 2015

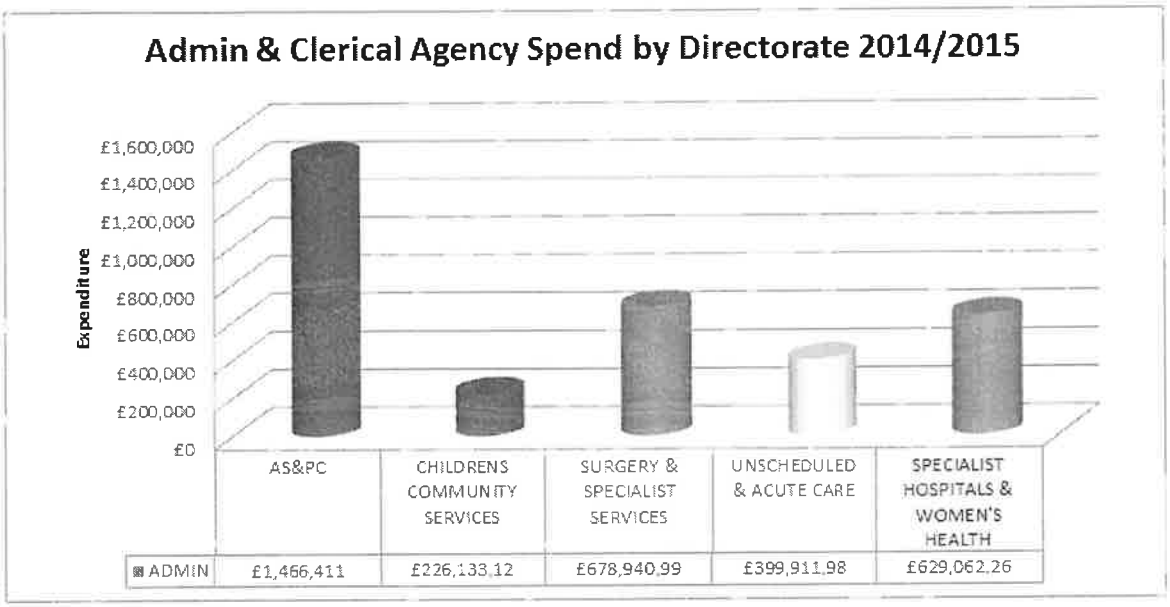
The graphs below highlight and compare the level of agency usage, across the clinical Directorates in the Trust, for those occupational groups with the highest levels of expenditure.

The graph below compares the level of agency expenditure within the Directorate to that of the Trust for 2014/15. This information is broken down further in this section to compare expenditure with the other clinical directorates within the Trust.

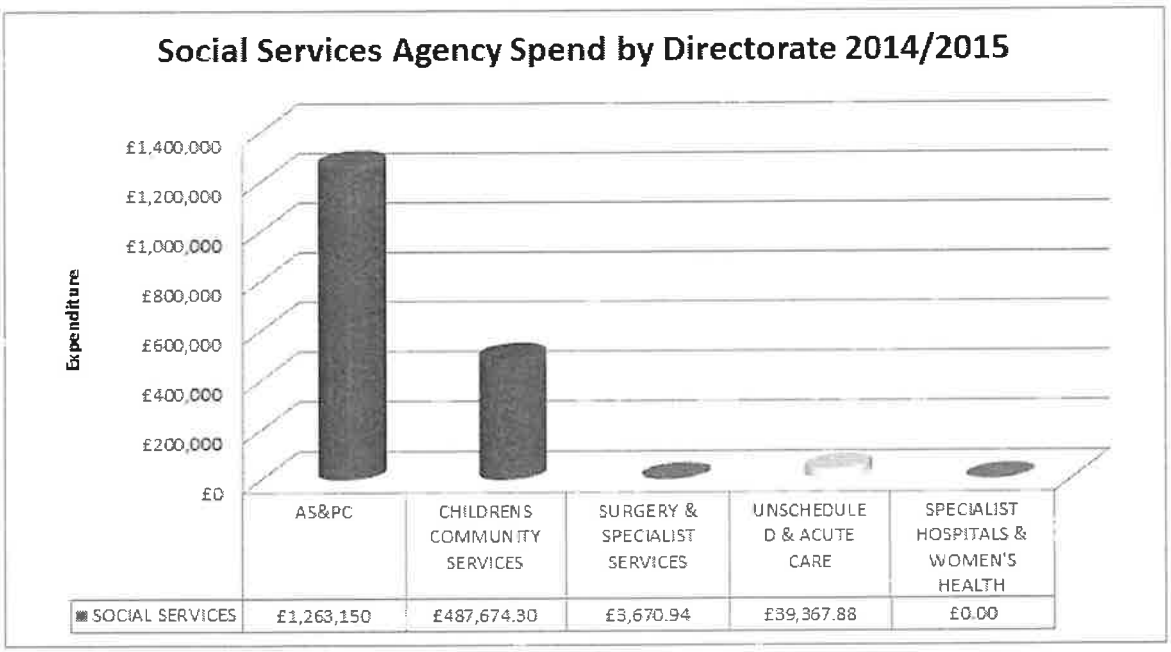


	MEDICAL & DENTAL	NURSING	OT	PHYSIO	PSYCHOLOGY	MULTI AHP	ADMIN	SUPPORT SERVICES	SOCIAL SERVICES	DOMICILIARY /HOMECARE
ASPC	£1,108,501	£1,524,174	£112,769	£8,800	£2,527	£3,241	£1,466,411	£19,061	£1,261,825	£1,325
TRUST	£11,083,015	£5,583,119	£675,181	£579,390	£2,527	£35,408	£4,798,168	£133,224	£1,790,671	£1,325

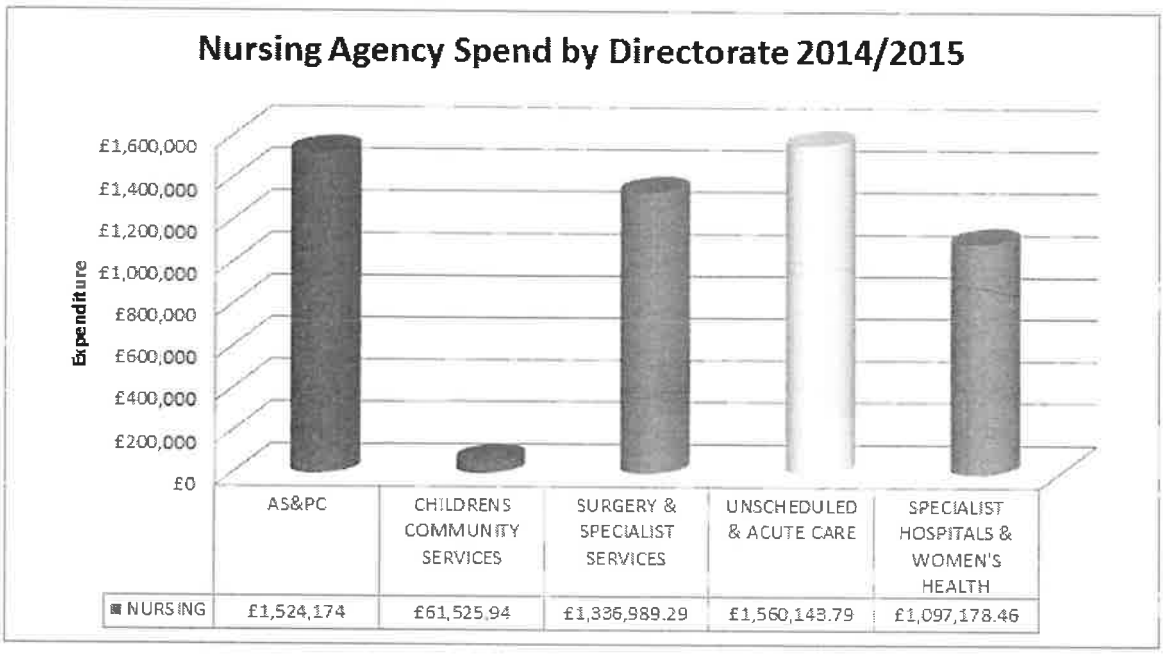
The Directorate had the highest level of agency expenditure for admin & clerical staff when compared to the other clinical Directorates as illustrated in the graph overleaf. The level of expenditure, within the Directorate, was approximately £1.45m for the year, which was over 43% of the total agency expenditure for this occupational group within the clinical directorates. This expenditure accounted for over 30% of the Trust's total spend on admin & clerical agency staff.



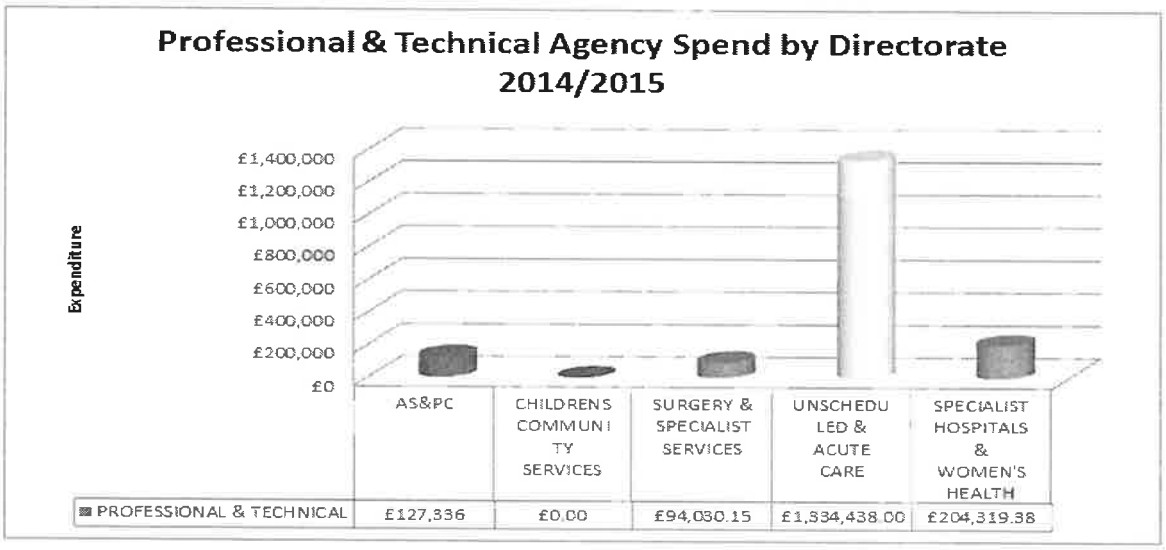
Social Service agency expenditure which includes both social work and social care within the Directorate (£1.26m) was higher than the other clinical directorates combined (£0.53m). This is not unexpected given that the Directorate employs the majority of social Services staff and therefore has greater responsibility for this functional area when compared to the other directorates.



Amongst the clinical directorates Unscheduled and Acute Care were the largest users of agency nursing staff during the year as illustrated in the graph overleaf. The Directorate, which was the second biggest user of agency nursing staff, accounted for over 27% of the total clinical directorates' agency nursing spend.



The graph below highlights the very low level of agency usage amongst Professional and Technical staff in the Directorate, accounting for only 7% of the expenditure in this area.



Within the Directorate a tight level of vacancy control is maintained, allowing resources to be used where they are most needed and assisting with financial controls and the modernisation programme.

1.6 STEP 3 : DEFINING THE REQUIRED WORKFORCE

This step involves mapping the new Service activities and identifying the skills needed to undertake them and the types and numbers of staff required. This will involve consideration of which types of staff should best carry out particular activities in order to reduce costs and improve the patient experience even where this leads to new roles and new ways of

1.6.1 Workforce Projections

More significant workforce change is expected to support enhanced community Services; with an associated shift of resource from acute to community care. This will result in re-training and re-deployment of associated staff in each of the occupational family groupings within the Directorate:-

- Social Services
- Nursing
- Medical
- Ancillary
- Allied Health Professions
- Administration & Clerical

1.6.2 Social Services Workforce

The Social Services workforce makes up the greatest proportion of the Directorate's workforce at 42.8% or 2113 headcount and 1674.58wte as illustrated in Table 2 below.

Table 2

Service Area	Skill Mix	H/Count	WTE
Learning Disability	Qualified Social Worker	70	65.89
	Social Care Support	8	5.47
	Social Work Support	373	317.88
Learning Dis Total		451	3891.24
Mental Health	Other AHP	4	3.80
	Qualified Social Worker	93	88.80
	Social Care Support	16	12.01
	Social Work Support	62	51.65
Mental Health total		175	156.26
Older Peoples Services	Qualified Social Worker	248	219.92
	Social Care	8	7.80
	Social Care Support	815	573.69
	Social Work Support	413	325.17
Older People total		1484	1126.58
Psychology Services	Qualified Social Worker	2	1.50
	Social Work Support	1	1.00
Psychology total		3	2.50
Grand total		2113	1674.58

Note the 4 Other AHP staff are counsellors held on the system against a Social Services job code & personnel area

There are no set guidelines as to what the skill mix registered to non-registered social worker should be. Within the Directorate however the ratio is 35 qualified social worker to 65 support.

The social care workforce is made up of social care managers at band 7 and the social care support workforce is largely made up of Home Helps / Domiciliary Care staff in Band 2. Table 3 below illustrates the makeup of the Social Care workforce by band, the majority of which, 75% are band 2.

Table 3

Social Care Workforce	H/count	WTE
Band 7	9	8.8
Band 5	37	34.65
Band 4	33	30.51
Band 3	143	103.31
Band 2	629	425.03
TOTAL	**851**	**602.36**

A regional domicilary care workforce plan is currently being developed and the recommendations from this piece of work will need to be considered in terms of the impact on our current workforce. Demand for this service will also need to be considered in light of recent announcements regarding the reduction in Independent Nursing Home placements.

Within Social Services consideration will need to be given to the integrated approach of the Social Worker from the hospital to the community setting and vice versa creating the pathway for greater continuity of care for the Service users. The impact of this on discharge planning would be a key performance indicator.

Much work has already taken place with the Social Work and Social Care Modernisation Workforce Review 2014/15 and key recommendations have been made in relation to strengthening the capacity of the workforce and Service in order to meet the current and future social care needs, in line with both Trust and Regional Strategic direction. This is particularly with regards to the streamlining of the social care and social work function in Integrated Care Teams, the development of new teams and roles in relation to hospital Social Work and the review of care home residents.

The Social Care Review has made several recommendations for both the Hospital Social Work and Integrated Care teams, which are outlined below.

Hospital Social Work

- There is a need for Social Work to redefine its professional standards, to set its vision for the future and to refine its role within the hospital context. This review advocates, that moving forward, this could be best achieved under a single line of management and accountability. To that end it is recommended that Hospital Social Work is managed under a unified professional and operational line of accountability, in the form of a single Assistant Service Manager who is a professionally qualified Social Worker.

- It is anticipated that an increased skills mix of Band 4 Social Care Assessors will be required across the Hospital Social Work Service to manage non-complex social care cases. These staff will be resourced within current funding levels, as it is envisaged that they will replace posts currently being filled by Band 6 Social Workers.

- Governance arrangements in relation to the Hospital Social Work Service are to be strengthened. This is to be achieved through the implementation of agreed standards and audit tools for professionally qualified staff and the introduction of operating, recording and audit standards for Band 4 Social Care staff.

- A 7 day Hospital Social Work Service is to be developed for the acute and unscheduled care sectors across Belfast City Hospital, Royal Hospitals, Mater Hospital, Ulster Hospital and Musgrave Park Hospital.

Integrated Care Teams

In relation to Social Care and Social Work in Integrated Care Teams, the review makes the following recommendations:

- It is proposed that the management and review of long term placements, is moved from the Integrated Care Team structures to a discrete Older Person's Care and Placement Review Team. This will enable the service area to ring fence resources to maximise the care and protection of our most vulnerable service users.
- A Band 7 Senior Case Manager should be created across the Service area and aligned to each Integrated Care Team. The Senior Case Manager will hold a small discrete caseload of high end complex cases and lead on practice development across the team. The Senior Case Manager will also act as a Designated Officer.

- The Care Management function should be integrated into the core Band 6 Social Worker role in the Integrated Care Teams. To that end, the review recommends streamlining the five current roles and job titles into four roles of *Senior Case Manager, Social Work Lead, Social Worker and Social Care Co-ordinator* under a unified line management structure accountable to the Team Leader.

- The review is proposing that the skill mix within teams should re-orientate towards a ratio of 75% Social Workers and 25% non-professional staff.

- For those service users who are identified as requiring an assessment of need, all initial assessments and comprehensive assessments of social care needs within ICT's should be carried out by a professionally qualified Social Worker. This will enable Social Care staff, in Integrated Care Team's, to be more holistic and prevention focused in the assessment of Older People.

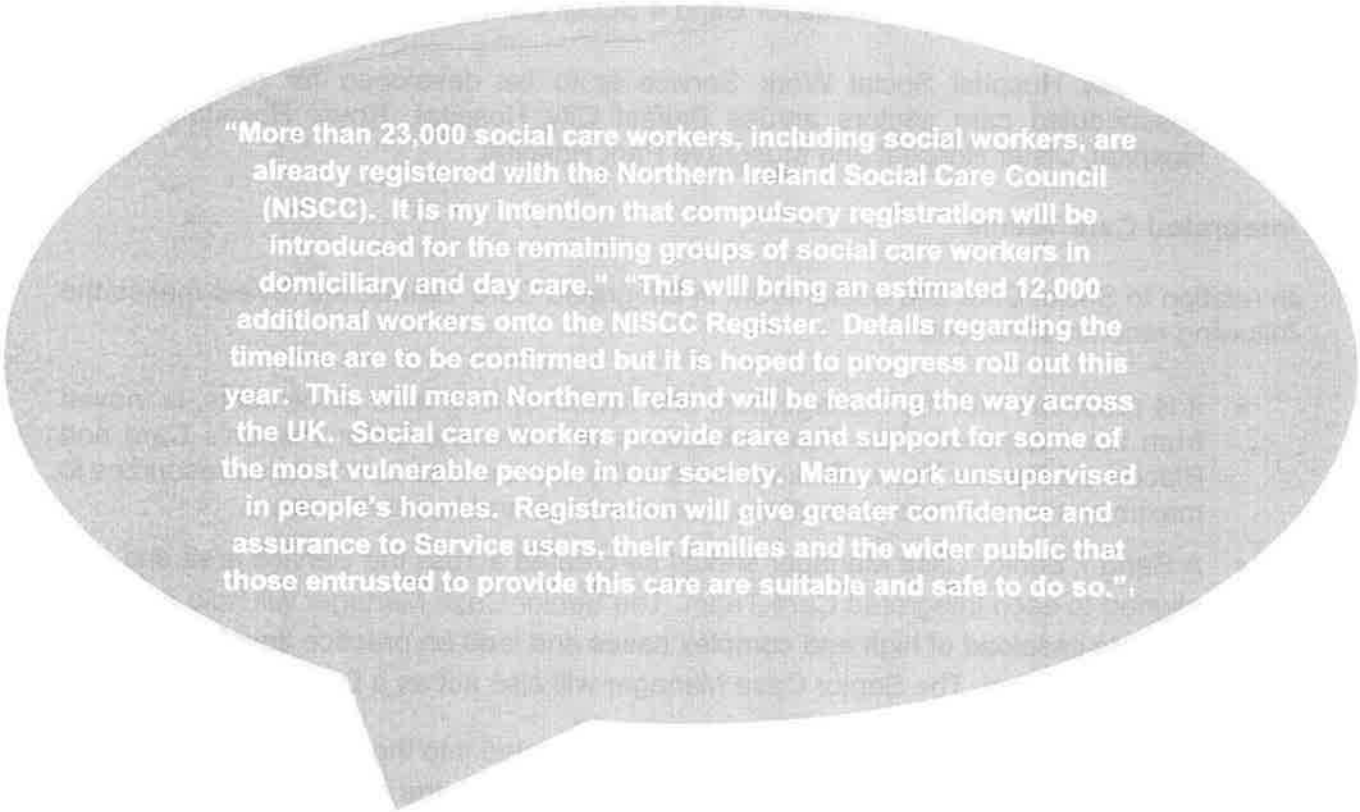
Generic Recommendations

- The review recommends the development and implementation of a case load analysis tool to support practitioners and managers to analyse both the breadth and complexity of work, and also the activity and demands of caseloads.

- It is recommended that eNISAT tools should be fully utilised by Social Care and Social Work staff across the Service area, in both hospitals and integrated care teams.

The Social Care Workforce in relation to demand, going forward will also need to consider the impact of the Social Care Strategy and confirm the best option from the review going forward.

Health Minister Simon Hamilton stated at the health and Social Care Board Adult Safeguarding event to mark World Elder Abuse Day on 18 June:-



1.6.2.1 Social Services Workforce Summary

In summary the social care workforce during the course of the plan faces considerable change particularly in relation to rebalancing the workforce across the Integrated Care Teams which is likely to mean new roles and revised skill mix in this area. The Domiciliary care workforce also faces significant change particularly in relation to the outcome of the Regional Domiciliary Care Review that is currently underway. The introduction of the Self Directed Support Model will have a significant impact and will be monitored during the course of the plan and work will need to commence to ensure all social care staff are registered with the Northern Ireland Social Care Council in line with the agreed timeline.

1.6.3 Nursing Workforce

There are currently 1688 headcount and 1512.41wte nursing staff within the Directorate as illustrated in Table 4 below.

Table 4

Service area	Skill mix	H/count	Wte
LEARNING DISABILITY	Nurse Support	217	184.42
	Qualified Nurse	186	173.06
LEARNING DISABILITY Total		**403**	**357.49**
MENTAL HEALTH	Nurse Support	139	132.97
	Qualified Nurse	415	397.26
MENTAL HEALTH Total		**554**	**530.23**
OLDER PEOPLES SERVICES	Nurse Support	236	183.95
	Qualified Nurse	491	436.74
OLDER PEOPLES SERVICES Total		**727**	**620.69**
PSYCHOLOGY SERVICES	Qualified Nurse	2	2.00
PSYCHOLOGY SERVICES Total		**2**	**2.00**
SERVICE IMPROVEMENT & GOVERNANCE	Qualified Nurse	2	2.00
SERVICE IMPROVEMENT & GOVERNANCE Total		**2**	**2.00**
Grand Total		**1688**	**1512.41**

Currently based on Human Resources Payroll Travel & Subsistence System (HRPTS) within our Older People Services the ratio based on wte is 70:30, within Mental Health it is 75:25 and within Learning Disability it is 48:52.

Demand for nursing in the Directorate is likely to increase based on recommendations contained in *Delivering Care: A Framework for Nursing and Midwifery Workforce* (DHSSPS, 2013b). The Nursing and Midwifery Leaders in Northern Ireland have defined skill mix for an adult hospital-based general medical or surgical care setting as 70:30 and at the same time recognises some flexibility within the stated skill mix in any given area will be tolerated, to maximise the use of support staff, where higher levels of dependency and lower levels of acuity exist and there is evidence to demonstrate that safe, effective, person-centred care is being provided. The skill mix should not, however, fall below 65:35, registered : unregistered staff.

During the course of this plan Phase 2 of Delivering Care will become available and considers Mental Health and District Nursing. Of those held on HRPTS against a District Nursing job code the ratio is 67:33. The District Nursing Review will need to be considered given the recognised increase in the number of education commissions in this area and the introduction of the Home Treatment Service, linked with BCH direct. This may mean a corresponding increase in the number of new District Nursing graduates recruited over the course of the plan.

The Delivering Care:A Framework for Nursing and Midwifery Workforce document also highlights that 'skill mix should take account of an allocation of 100% of a Ward Sister's/Charge Nurse's time to 'fulfil their ward leadership responsibilities; supervise clinical care; oversee and maintain nursing care standards; teach clinical practice and procedures; be a role model for good professional practice and behaviours; oversee the ward environment and assume high visibility as a nurse leader for the ward.'[13]

The Directorate will need to consider the numbers to be identified amongst its existing workforce to undertake specialist practice community programmes.

13 Delivering care: Nursing staffing in Northern Ireland Two: Using the Framework for medical and surgical care settings pg 3.

The review of the District Nursing Workforce[14] has highlighted a total of six recommendations including:-

- A consistent and equitable service over the 24hour period 7 days a week. District Nurses should be aligned to General Practitioners and also geographically zoned.
- Extension of the Acute Care At Home Team to 7 days for all professionals (currently just nursing and physiotherapy) and the Clinical Nurse In Reach to be aligned to the team as the hospital facing element.
- Amalgamate evening, night, twilight, and out of hours elements of the 24 hours Nursing Team.
- Develop referral pathways and communication systems with Acute Care At Home Teams and other interfacing teams.
- Standardisation City Wide
- Clinical support teams re-integrated back into District Nursing Teams.

1.6.3.1 Nursing Workforce Summary

In summary the Nursing workforce requires significant change in relation to supporting the 'shift left', new roles are likely to be required in the community and there will be skill mix changes to meet the requirements of normative staffing. Older Peoples Services in particular have a programme of work to promote and attract new graduates into a Care of the Elderly career pathway and investment is required to support our Ward Managers to participate in leadership, management, staff development and audit.

1.6.4 Medical Workforce

Northern Ireland Medical and Dental Training Agency NIMDTA have reduced the number of training posts in Psychiatric Medicine and the Directorate will need to review this to ensure they recruit and retain sufficient medical staff in this area over the course of this plan. As the focus moves to treatment in the community for mental health clients the Directorate will need to identify from their current supply how this demand for Service can be met. In August 2014, 2013 and 2012 there were 53 which compares to 57 in August 2009, 56 in August 2010 and 54 in August 2011, a gradual decrease of 4 over the course of the last six years.

The Kings Fund Report on Workforce Planning in the NHS April 2015 highlighted that the Centre for Workforce Intelligence identified two key indicators of pressures in the psychiatry workforce namely:-

- There is a high vacancy rate in psychiatry consultant posts (6.3%) (Health Education England 2015).
- Nearly one in five doctors undertaking core psychiatry training in 2014 did not progress into higher speciality training.

Within Psychiatry whilst we do not have the same level of vacancy at consultant level we are experiencing difficulties at trainee level and are nine trainees short which has now become a trend that is affecting patient provision.

[14] District Nursing Modernisation and Workforce Review 2014/15 Final Draft

Within Care of the Elderly it is recognised that there is a national shortage of adequately trained doctors and the Directorate has advertised repeatedly without success. It may now be relevant to consider recruitment campaigns internationally.

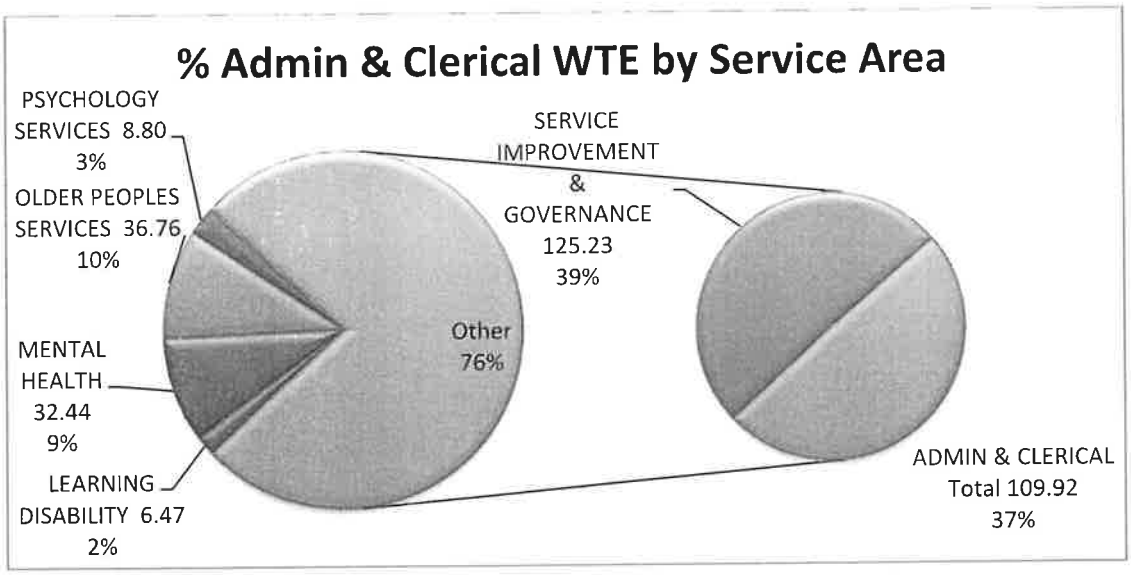
Across the region there is also a programme of workforce planning by speciality being undertaken with Geriatrics currently underway and Psychiatry scheduled to commence during July to December 2015. The Directorate will be required to participate in this process and the outcome of each will need to be incorporated into this local Directorate workforce plan going forward.

1.6.4.1 Medical Workforce Summary

In summary the medical workforce during the course of this plan is set to remain relatively stable with concentrated efforts on recruitment within Care of the Elderly.

1.6.5 Administration and Clerical Workforce

During the course of the year ending 31 March 2015 a decision was taken to move the administration and clerical staff from a centralised source to each of the functional areas. The graph below illustrates the distribution of the staff by Service area at 31 March 2015, with the majority of staff 39% in Service Improvement and Governance.



Going forward the administration and clerical workforce will be reviewed across the organisation and within the Directorate in the first quarter of this current financial year further changes have been made. Learning Disability Services now have 45.29 wte admin staff, and Mental Health Services have 107.02 wte staff.

Through agency expenditure 80.61 wte agency staff are currently in post in the Directorate and given this high agency usage and expenditure plans are in place to recruit to 44.92wte posts i.e 22.67 wte band 2, 49.12wte band 3 and 8.82 wte band 4. A further review of the remaining 35.69wte will take place during the course of this plan.

It is therefore anticipated that there will be a significant reduction in agency expenditure amongst this staff group within the Directorate as substantive appointments are made.

The deployment of this staff group to the multidisciplinary teams will require news skills and learning and a review of technologies including 'Big Hand' laptops and voice recognition will be undertaken during 2016/17.

1.6.5.1 Administration and Clerical Summary

In summary the Administration and Clerical workforce is set to see further changes during the course of this plan with more staff becoming part of the multidisciplinary team and perhaps also becoming a more stable workforce with the significant recruitment programme set to take place to reduce agency spend.

1.6.6 Acute Care At Home Workforce

A new Acute Care at Home Team is currently being established. This is a community based multidisciplinary team which will work in an innovative integrated way with Primary Care to meet the growing needs of Older People, carers and the Community. This dedicated team will add to existing Services in providing comprehensive and rapid specialist assessment, advice and intervention to those elderly people in most need of help and provide an appropriate alternative to hospital admission.

Table 5 below provides a breakdown of the additional new roles that are currently being recruited.

Table 5

Occupational Group	Job Role	Band	No. of posts
Nursing			
	Co-ordinator	8A	1
	Nurse Practitioner	7	4
	District sister / Charge Nurse	6	4
	Acute Nurse	5	3
	Healthcare Support / Rehabilitation Assistant	3	5
Allied Health Professions	Occupational Therapist	6	1
	Physiotherapist	6	3
Admin & Clerical	Information Manager	4	2
	Administrative Support	3	1
TOTAL			**24**

1.6.7 Sleep-ins

The Directorate Services have a number of residential settings where staff are required to sleep-in. Following the outcome of a recent case in respect of sleep-ins and working time compliance Trusts regionally are assessing this practice with a view to considering alternative options to meet compliance. This is to ensure that there are sufficient staff on duty to deal with emergency situations should they arise during the night. The practice now needs to be reviewed in light of the challenge raised by trade unions in connection with the legality of this way of covering work and potential breaches of the Working Time Directive.

Currently where staff undertake sleep-in duties they are paid an allowance of £30 per night while sleeping on the premises. However, if during this period they are called to undertake work this is remunerated at their current hourly rate. These periods are not counted towards their normal working week.

The cost of sleep-ins to the Trust was over £400,000 for the year of which £235,000 was attributed within the Directorate.

The review into sleep-ins is on-going, but it is likely that Services who use sleep-ins will have to cease this practice and the likelihood is that a move to waking nights will be required moving forward. There will be implications for the Service with this outcome, in terms of requiring additional financial and staffing resources.

1.6.8 Workforce Projections

Throughout the course of this plan our **workforce projections** are set to evolve as projects and consultations progress and this in turn will have an impact on the workforce going forward. The projections to date, detailed below, are therefore **indicative** and **speculative** and **subject to review** and are based on the following:-

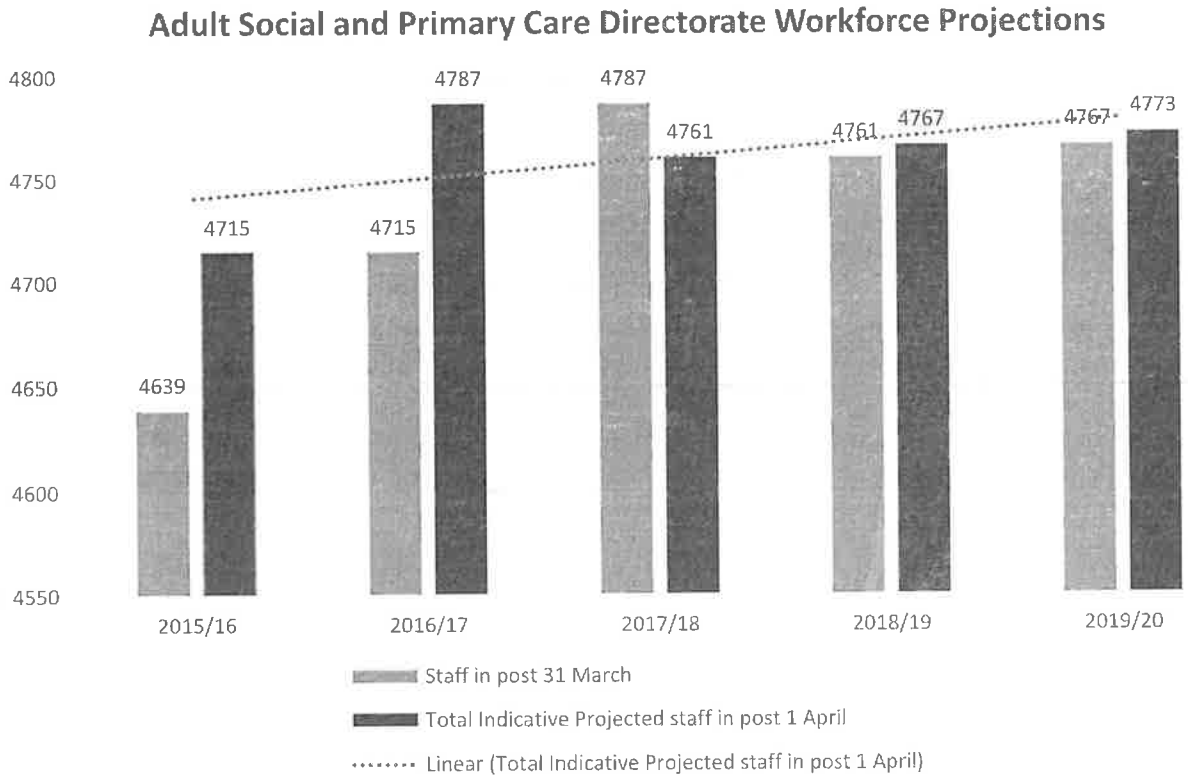
- Average number of leavers calculated on the average in the previous five years April 2011 – March 2016.
- Average number of new starters calculated on the average in the previous three years April 2013 – March 2016.
- A **speculative** reduction within Learning Disability as a result of the reviews currently being undertaken.
- A **speculative** reduction within Mental Health Services as a result of the reviews currently being undertaken and the opening of the new Inpatient Unit.
- An increase in staffing owing to the introduction of the Acute Care At Home Team.
- An increase in staffing owing to the recruitment of administration and clerical staff.

	2015/16	2016/17	2017/18	2018/19	2019/20
Staff in post 31 March	4639	4715	4787	4761	4767
Average No. of Leavers (Headcount) *	-302	-318	-318	-318	-318
Average No. of Starters (Headcount)*	378	326	326	326	326
Learning Disability Reviews		-29			
Mental Health Reviews	-6	-22	-34	-2	-2
Older People Reviews	67	50			
Admin & Clerical Reviews	16	65			
Total **Indicative** Projected staff in post 1 April	4715	4787	4761	4767	4773
Net Variance	76	72	-26	6	6

Table 6

* Information for 2015/16 are actual figures

Graph 1 overleaf demonstrates a trend line indicating marginal changes to the workforce in terms of headcount. As at 01 April 2016, 4715 will be in post with a projected 4,773 in post as at 31 March 2020 an indicative increase of 58 over the course of this five year workforce plan.



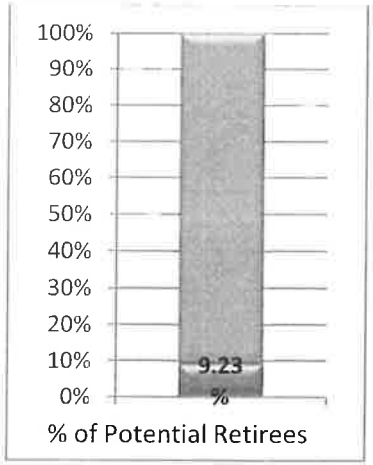
Graph 1

1.6.8.1 Projections for Retirement

Table 7 below identifies the % projections for potential retirements during the course of the plan and is based on the assumption that those over the age of 60 today will retire in the next five years. Therefore 9.23% of the Directorate's workforce or 428 staff will retire.

Table 7

Age Range	ADMIN & CLERICAL	LEARNING DISABILITY	MENTAL HEALTH	OLDER PEOPLES SERVICES	PSYCHOLOGY SERVICES	SERVICE IMPROVEMENT & GOVERNANCE	Grand Total
16 - 24		32	19	39	1	1	92
25 - 29	16	106	99	145	8	7	381
30 - 34	16	107	116	167	21	14	441
35 - 39	17	116	118	240	12	18	521
40 - 44	14	109	150	307	13	16	609
45 - 49	25	136	153	396	8	26	744
50 - 54	17	151	186	441	8	24	828
55 - 59	17	67	76	409	6	21	596
60 - 64	12	45	28	190	1	12	288
65+	5	13.00	9	100	1	12	140
% of Potential Retirees	12.23	6.58	3.88	11.91	2.53	16.00	9.23



The Directorate has a potential retirement profile of 9.23%. This equates to 428 headcount and 310.48 wte. This means that the number of individuals who may exit the organisation on the basis of retirement currently is significantly greater than in previous years when an average of 65 headcount and 54.42wte retired in the previous five years which compares to an average projection of 86 headcount and 62.1 wte in the five years to March 2020. During the year ending 31 March 2015, 96 headcount and 76.83 wte retired which was a significant increase when compared to the previous year when 60 headcount and 53.26 wte retired.

The impact of the pension reforms however may mean for a considerable number of staff who have not yet reached the age of 60 are more likely to remain in the work place for longer when compared to those who are in the 60+ age bracket today.

The introduction of the Voluntary Exit Scheme (VES) in this current financial year will also have an impact as applications to support voluntary exit must be associated with our 2015/16 Financial Reform and Efficiency Plans.

1.6.8.1 Special Classes

Special Class status is a historical provision awarded to certain professions, which, subject to qualifying criteria being met, allows a member to retire at age 55 without a reduction to their benefits. It was abolished for all new entrants to the NHS Pension scheme after 6 March 1995 and for those previously holding the status, who have a break in pensionable employment of any one period of five years or more. It applies to Nurses, Physiotherapists, Midwives, Health Visitors, Nurse Auxiliaries and Occupational Health Nurses. Within the Directorate there are currently 85 staff who may potentially qualify who are nurses with 20 years or more Service.

1.6.8.2 Mental Health Officer Status (MHO)

MHO status is a historical provision that was introduced to compensate members caring for patients suffering from mental health disorders. MHO status was abolished for all new entrants to the NHS Pension Scheme after 6 March 1995, and for those previously holding the status, who have a break in pensionable employment of any one period of five years or more. MHO status does not apply in the 2008 Section or the 2015 Pension Scheme. Those who do qualify and who have 20 years MHO membership can retire from age 55, without any reduction to benefits, providing they are still in pensionable MHO employment on the day before they retire. Unlike Special Classes MHO members can count each complete year of MHO membership, after building up 20 years, as 2 years for benefit purposes, and this is known as 'doubling'. Within the Directorate there are currently 250 staff who may potentially qualify with 20 years or more Service. Over the course of the year to 31 March 2016, 7 nursing staff retired at the age of 55, 5 within Mental Health services and 2 within Learning Disability. This compares to a total of 5 nurses who retired at age 55 across the other clinical directorates.

1.6.9 Hot Spot Areas

The main *Hot Spot Areas* and key factors which will have an impact on the workforce projections over the next five years are presented below:

1.6.9.1 Recruitment

During the course of the financial year, ending 31st March 2015, a total of 375 new staff have been appointed to the Directorate. This compares to 468 in 2013/14 and 456 in 2012/13. A total of 231 ad requisitions were processed, broken down by occupational group as shown in table 8 below.

Table 8

OCCUPATIONAL GROUP	NO. OF AD REQUISITIONS	NO. OF APPLICANTS
Admin & Clerical	16	630
Nursing	123	4566
Medical	11	28
Social Care	77	2826
AHP	4	21
TOTAL	**231**	**8071**

It is worth noting, from the general Band 5 Adult Nursing advertisement a total of 2116 applications were received and of those only 28 cited Older People as a preference area to work in.

It is recognised that our growing and ageing population with multiple long term conditions will require more staff to care for our older population. Based on the statistics above it is important the Directorate invest in promoting, the care of the elderly nursing, as an attractive area to work in for prospective new graduate recruits. This has been identified as an area of risk by Older People Services and an Action Plan is in place.

In recent months the impact of additional recruiting in Unscheduled Care has exacerbated problems in Older People Services and an Action Plan is currently being drafted to address the recruitment difficulties. The fact that we are going out to recruit additional staff for acute care at home and for district nursing as indicated above will also add to this challenge. Overseas recruitment may be necessary as well as the need to speed up recruitment processes at all stages, to reduce time from vacancy arising to getting new staff on the ward. The Directorate participated in the Trust's 'One Stop Shop' Recruitment Fair on 6 June where 27 recruitment panels interviewed 311 potential employees and 271 were offered positions subject to the necessary pre-employment checks. The Directorate appointed 27 staff nurses to Learning Disability, 14 Permanent and 13 Temporary and 38 successful applicants have indicated Care of the elderly as a first, second or third preference area to work. The Directorate are continuing to work with Corporate Nursing and Human Resources to complete the recruitment process and induct the new staff. This exercise will undoubtedly help to improve the situation. In addition a previous recruitment exercise earlier in the year secured a further 8 permanent appointments in Learning Disability and within Mental Health a waiting list with 21 successful candidates recorded has been established.

1.6.9.2 Graduate Recruitment for nursing staff

Currently recruitment for new graduates is carried out Trust-wide for Band 5 newly qualified staff in January and June with adhoc recruitment taking place for band 6 and above during the course of the year as and when the need arises. Table 9 overleaf demonstrates that the number of pre-registration nursing and midwifery places commissioned has fallen in recent years from 790 in 2008/2009 to 685 in 2014/2015.

Table 9 – Nursing & Midwifery pre-registration Training Commissions

Branch	Pre-Registration Commissioned Places by Year						
	08/09	09/10	10/11	11/12	12/13	13/14	14/15
Adult	525	535	471	471	444	444	444
Adult OU	0	18	0	9	9	7	9
Mental Health OU	36	18	18	9	9	18	16
Children's	55	60	60	60	55	55	55
Mental Health	99	99	99	99	96	96	96
Learning disability	15	30	30	30	30	30	30
Midwifery D/Entry	30	30	30	30	35	35	35
Midwifery, Additional Registration	32	35	35	35	25	25	0
Totals	**792**	**825**	**743**	**743**	**703**	**710**	**685**
Year of completion	**11/12**	**12/13**	**13/14**	**14/15**	**15/16**	**16/17**	**17/18**

Prior to the recruitment event in June the Directorate recruited a total of 122 headcount, 119.48 wte newly qualified staff as illustrated in Table 10 below.

Table 10

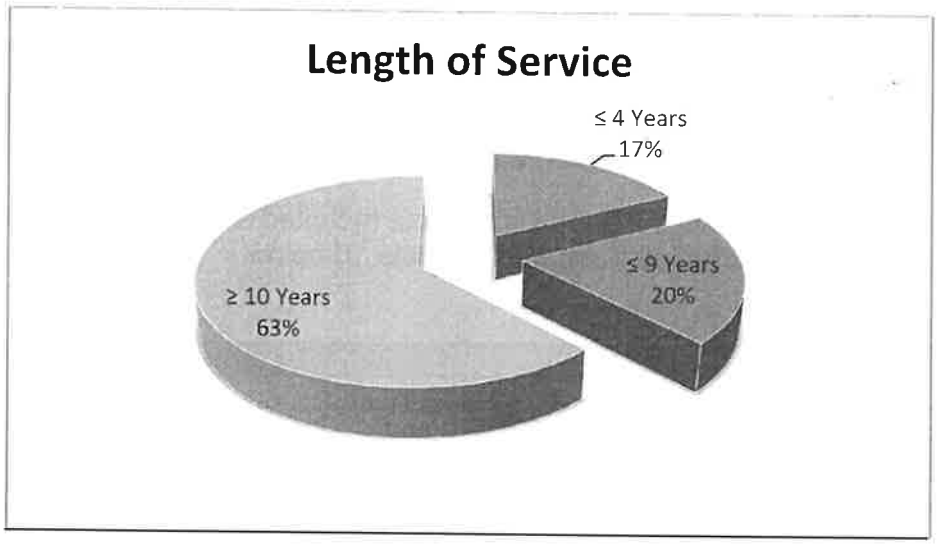
Occupational Group and Job	H/count	Wte
ALLIED HEALTH PROFESSIONS	**15**	**15**
7A75 OCCUPATIONAL THERAPIST (5) X005	10	10
7B35 ASSISTANT PSYCHOLOGIST (5) X005	4	4
7S45 OCCUP THERAPY - SUPPORT (5) X005	1	1
NURSING	**94**	**91.7**
5A15 ACUTE NURSE (5) X005	31	30.6
5A45 DISTRICT NURSE (5) X005	17	16.4
5A55 TREAT ROOM/PRACTICE NURSE (5) X005	1	0.5
5A65 MENTAL HEALTH NURSE (5) X005	29	28.8
5A75 LEARNING DISABILITY NURSE (5) X005	16	15.4
SOCIAL SERVICES	**12**	**11.78**
6A35 PHYS DIS/SENS IMPR SOC WR (5) X005	1	1
6S25 ELDERLY SOCIAL WORKER SUPP (5) X005	6	5.58
6S35 PHYS DIS/SENS IMPAIR SUPP (5) X005	2	1.8933
6S55 LEARNING DIS SOC WR SUPP (5) X005	1	1.3067
6S95 COMMUNITY SOCIAL CARE SUPP (5) X005	2	2
Grand Total	**122**	**119.48**

31 Acute nurse appointments were made from the 491 students due to complete in 2014/15, 29 mental health nurses from the 99 students and 16 from the 30 students in Learning Disability. Perhaps further analysis could be undertaken to ascertain the numbers across the region particularly in regard to mental health and learning disability as the trust appointed 29% and 53% respectively of those new graduates available to the Region.

It is worth noting however that there is an upward trend of newly qualified staff taking up posts outside Northern Ireland, as reported in the Nursing and Midwifery Workforce Plan[15] 'a survey conducted by Queen's University, Belfast in 2012 demonstrates an increasing trend (currently 21%) for newly qualified nurses and midwives being employed outside Northern Ireland following completion of their programmes'.

1.6.9.3 Retention

Within the Directorate 63% of the staff have 10 years or more continuous Service, 20% have 5 – 9 years' Service and 17% have less than five years' Service as illustrated in the chart below.



Of those staff with less than 5 years' Service 295 belong to Nursing and 284 are within social Services. The Directorate recognises retention amongst nursing staff within older people Services as a concern and have identified the following:-

- Possible deficits in how staff are inducted and mentored.
- Recognition of the need to engage more with staff who leave the Service to ascertain their reasons for leaving.
- Need to engage more directly and more often with nursing teams to get feedback and ensure their solutions are facilitated.
- Sisters /Charge nurses not being facilitated to be off the rota to undertake management /staff development work /audit
- Under uptake of our ward sisters of development programmes

Older People Services have identified in their objectives for 15/16 to over recruit and release band 7 staff as this will be more cost effective than off contract agency and increasing absenteeism.

[15] As 11 above Evolving & Transforming to Deliver Excellence in Care

1.6.10 Role Redesign

This requires consideration of who is best placed to carry out the task. Within Social Services depending on the Option chosen it is likely that roles will be redesigned to improve the Hospital Discharge Process. Within Mental Health, undergraduates now do undertake a module in cognitive behaviour therapy which supports the modernisation agenda within this area and the treatment plans provided for Service users. Within Community Learning Disability the pool of potential applicants will be extended to attract individuals from an OT or Social Services background for example into Behaviour Practitioner roles which would have traditionally been only available for Nursing staff to apply.

Throughout the Directorate it will be necessary to ensure staff are well equipped with the right training, knowledge and skills to work in both the Acute and Community settings across a range of professional and support roles.

1.6.11 Professional Issues

The Nursing & Midwifery Review identified that the range of professional issues listed below will have a significant impact on the nursing and midwifery workforce:

- Revised NMC Code of Conduct
- Changes to Revalidation
- NMC Pre-Registration Standards
- NMC Standards for Learning and Assessment in Practice
- Advanced and Specialist Practice roles
- Preceptorship
- Mentorship and practice training in community settings
- Supervision Standards

The new Code of Practice for Nurses and Midwives became effective from 31st March 2015, and reflects the world in which we live and work today, and changing roles and expectations of nurses and midwives. It is structured around four themes namely:-

- prioritise people,
- practise effectively,
- preserve safety and
- promote professionalism and trust.

Developed in collaboration with many who care about good nursing and midwifery, the Code can be used by nurses and midwives as a way of reinforcing their professionalism. Failure to comply with the Code may bring their fitness to practise into question.

Revalidation is a process that all nurses and midwives will need to engage with to demonstrate that they practise safely and effectively throughout their career. It is easy, straightforward and will help nurses and midwives develop as professionals. It is anticipated that the revalidation process will commence in October 2015 and will begin with those whose current registration is due to expire in April 2016. Within the Directorate there are currently 105 nursing staff who fall into this category.

The directorate will need to ensure that all nursing staff are engaged in this process and working on developing their portfolios together with a process of renewal every three years. They also need to ensure all nursing staff have a registered NMC online account.

1.6.12 Career Development and Specialisation

The Directorate will need to consider how they will promote and support the proposal identified in the Nursing & Midwifery Review 2015 to 2025 to introduce a rotation model for student and newly qualified nurses and midwives, across the hospital, community and independent sectors as well as the partnership graduate programme between the statutory and Independent/Private sector whereby the nurse would undertake a number of modules at Masters level while spending equal time between sectors.

> *Transforming Your Care* (DHSSPS, 2011b), and the shift from predominantly hospital based care to the community and the increasing role of the independent sector highlights the importance for student nurses to experience hospital, community and the independent sector during their training. Consequently, this will prevent a limitation on experience in these sectors and increase workforce flexibility.

This may also be considered as an approach to develop the flexible workforce across the Directorate and indeed in readiness for the first cohort of such under and post graduate students.

1.6.13 Technology and Technical Skill Demands

Changes in technology continue and the Directorate needs to embrace these changes in order to realise the benefits that they will bring in terms of more efficient and effective working.

Already facilities such as video conferencing, digital dictation, e-learning, electronic prescribing, use of I-Pads and remote/home working are starting to become a reality for many of our workforce. It is difficult to comprehend how much technology might have changed by the end of this workforce planning period. However, in order to gain maximum benefit from future technological change the Directorate will require a workforce with increasing proportions of computer literate staff, many of them with advanced skills and enthusiasm to respond to on-going changes.

> Communication, IT and Business skills are key skills for the future workforce and access to a wide range of training and development to achieve competencies should be included in staff development programmes. The requisite training and development to acquire these skills is necessary at all levels of care delivery.

The introduction of new technologies will change the way health care is delivered in the future and will improve the level of Services provided to our Service users. Service users will be able to provide essential health information, such as blood pressure readings, through the new technologies, to Trust staff, without the need to leave their home. However the introduction of new technologies will require training for the staff delivering the Services and possibly the Service users and/or their carers.

1.7 STEP 4 : UNDERSTANDING WORKFORCE AVAILABILITY

This step involves describing the existing workforce in the areas under consideration, its existing skills and deployment, plus assessing any problem areas arising from its age profile or turnover. It may be the case that the ready availability of staff with particular skills, or, alternatively, the shortage of such staff itself contributes to Service redesign and steps 2 and 3 will need to be revisited. Consideration should be given to the practicalities and cost of any retraining, redeployment and / or recruitment activities that could increase or change workforce supply.

1.7.1 Workforce Figures (based on HRPTS data at 31st March 2015)

Workforce data and information in relation to the overall workforce within the Directorate and wider Trust has been downloaded from Human Resources, Payroll, Travel and Subsistence System (HRPTS). This system was introduced in the Trust in November 2013 and deployed to all staff at band 6 and above in March last year. The HRPTS data is continually updated and managed locally by each manager on the system.

The figures included within this workforce plan are reported as they have been recorded on HRPTS. To allow meaningful analysis, Trust bank staff and staff on career breaks have been excluded. Where staff have more than one post in the same organisational unit, or even within a different organisational unit, each post will have been counted in the 'Staff in Post' headcount, but the whole-time equivalent (WTE) will reflect the proportion of standard hours that are worked in each post. Staff who are temporarily absent from their position, for example due to sick leave, have been included in the analysis.

The data obtained for the purpose of this Workforce Plan includes a breakdown of the current workforce figures, inter alia, by:

- **Occupational Group;**
- **Service area (eg. Mental Health, Learning Disability, Psychology, Older People Services);**
- **Age;**
- **Gender;**
- **Headcount (HC) and Whole Time Equivalents (WTEs);**
- **Full-time or part-time status.**

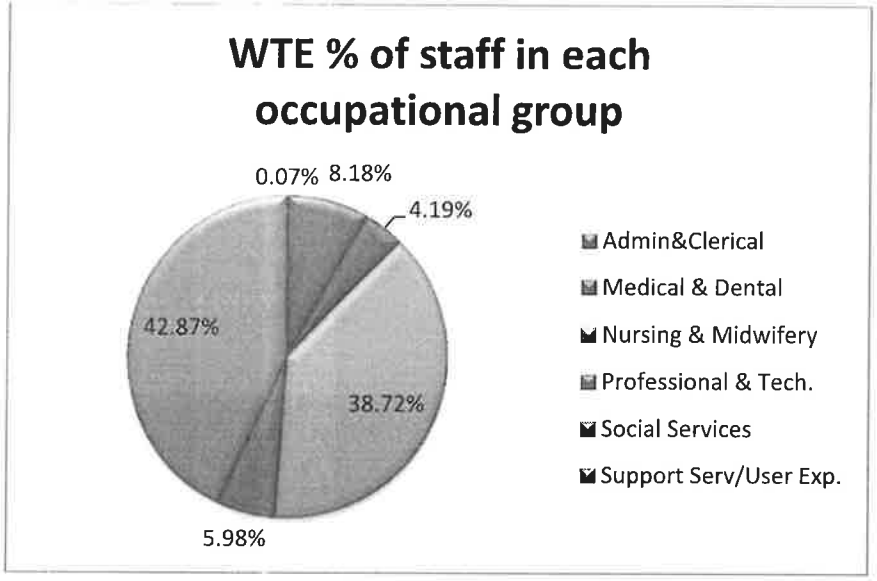
1.7.1.1 HRPTS

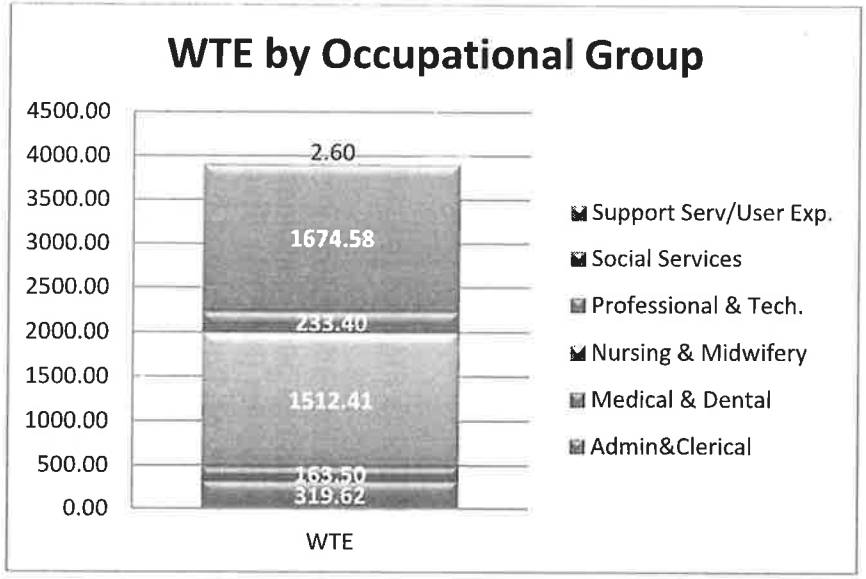
During the course of this plan all managers within the directorate will be provided with training on their own Manager self-Service management information reports. This will help to build the capacity and capability across the directorate and achieve benefits realisation as well as support managers in making their business decisions in relation to workforce planning. A suite of 23 Manager Self Service Reports are available and include for example, headcount, absence analysis, joiners, leavers, movers, work life balance, vacancies and learning participants and cancellations.

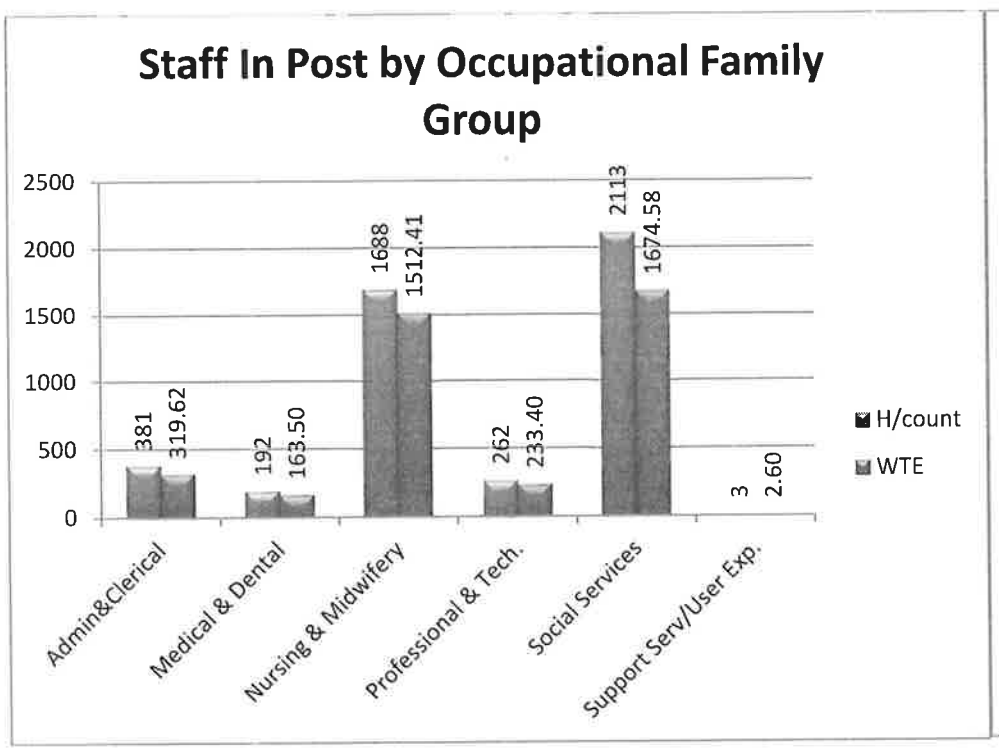
The data relating to the directorate workforce available on HRPTS provides a reasonable baseline demonstrating the numbers presently employed within the Directorate, across each family group as demonstrated in the workforce profiles below. The workforce information is based on staff in post as at 31 March 2015.

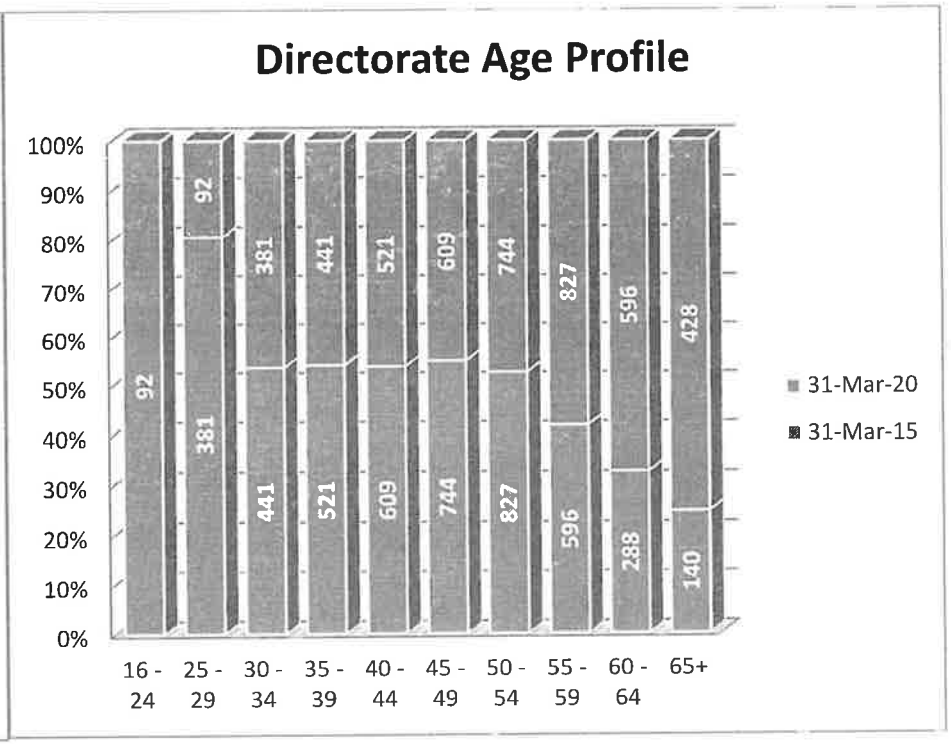
1.7.2 Directorate Workforce Profile

The Directorate employs 4639 or 3906.1 Whole Time Equivalent (WTE) staff (excluding Trust wide bank staff and career breaks) with a comprehensive range of skills and knowledge geared towards meeting the needs of patients and clients.









The majority of the Directorate's workforce is employed within Social Services 42.87% and whilst this is set to remain, over the course of the plan there should be a move from the acute to community in all areas, with staff being redeployed accordingly.

It is accepted that we have an ageing workforce and over the course of the next five years the likelihood is that more staff will be working longer and a larger proportion of the Directorate's workforce will be aged 55+. The Directorate will need to ensure it is age aware and has in place measures to ensure age diversity is promoted.

1.7.2.1 Skill Mix

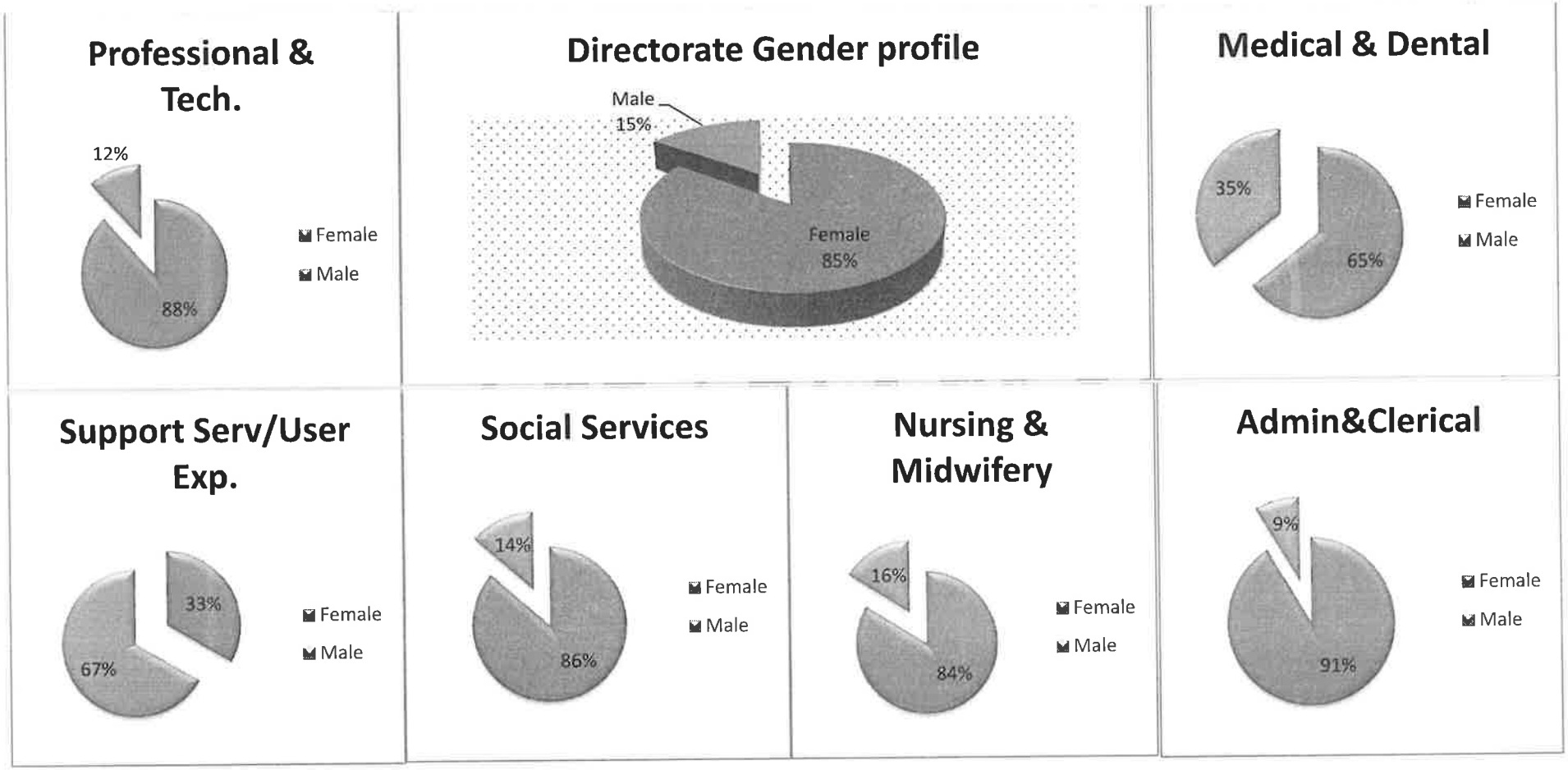
Table 11 below highlights the skill mix ratios amongst the clinical workforce groups and this is set to change particularly within nursing as normative staffing levels are introduced over the next five years.

Table 11

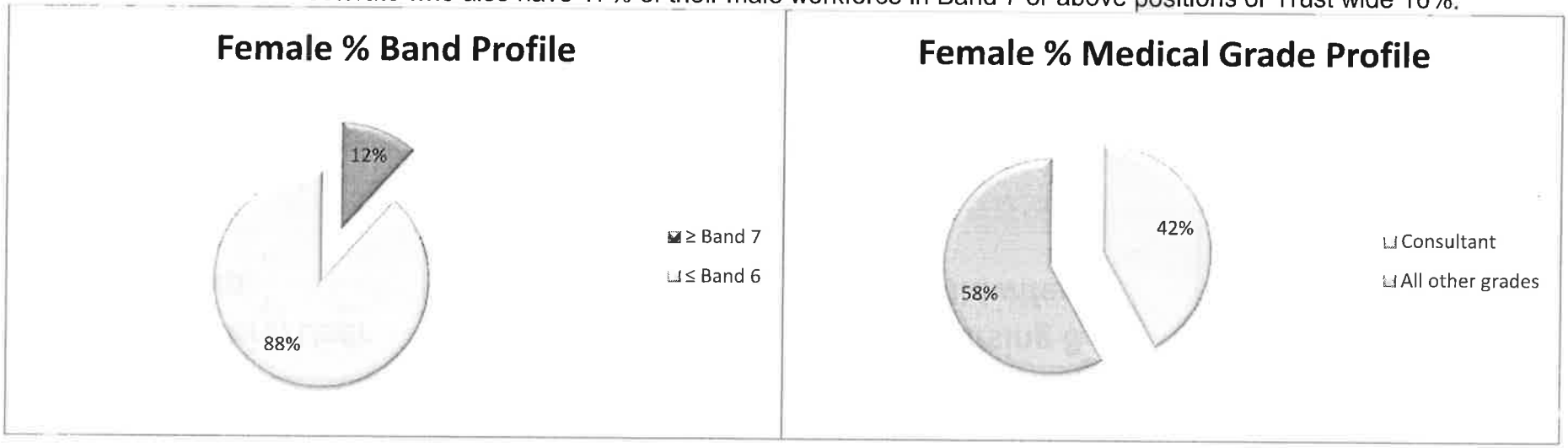
Combined Grades in each Family Group	Headcount	WTE	Ratio WTE	Projected Ratio	
Medical			**44:56**		
Consultant	84	71.30			
All other grades	99	92.20			
Nursing			**67:33**	**Nursing**	
Qualified Nurse	1096	1011.07		Acute Medicine	70:30
Nurse Support	592	501.34		Mental Health	TBC 2016/17
				District Nursing	TBC 2016/17
Social Services					
Social Work			**35:65**		
Qualified Social Worker	400	376.11			
Social Work Support	834	695.70			
Social Care			**1:99**		
Social Care	8	7.80			
Social Care Support	819	593.56			
Allied Health Professions					
Clinical Psychology	86	78.08	**84:16**		
Psychology Assistant	16	15.01			
OT	84	78.45	**92:8**		
OT Support	7	6.96			
Other AHP	34	28.34	**50:50**		
Multi AHP Support	36	27.96			
Ancillary					
Ancillary	3	2.60			
Admin & Clerical					
Admin & Clerical	377	319.62			
Grand Total	**4575**	**3906.10**			

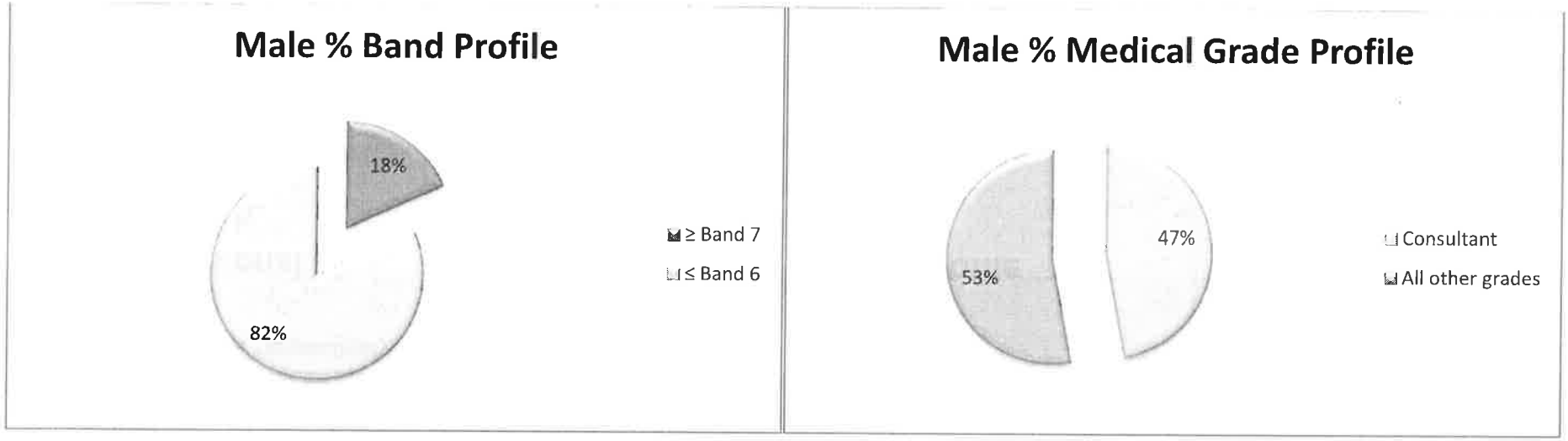
1.7.2.2 Gender Profile

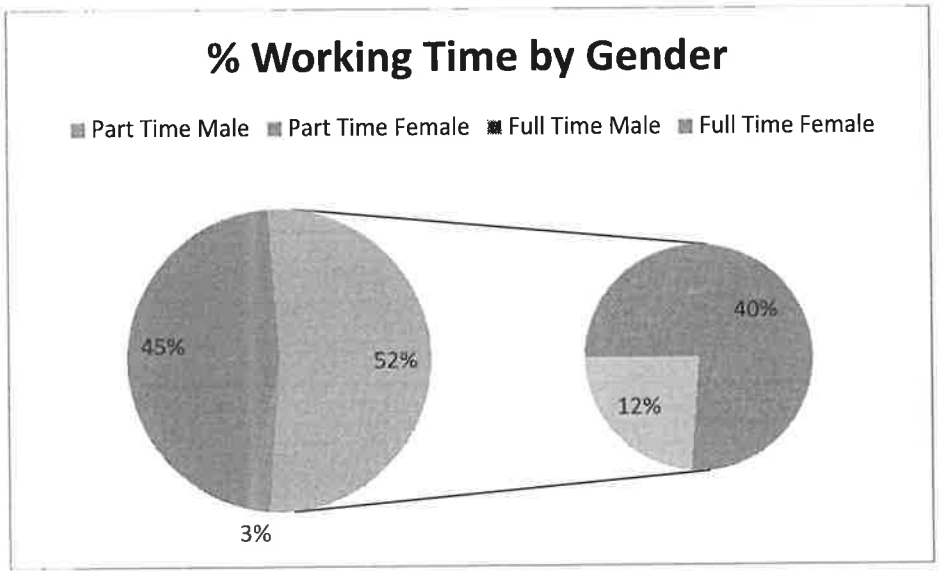
Within the Directorate the gender profile is 85% female and 15% male as illustrated in the pie charts below by Directorate and occupational group. Of the total Directorate workforce 3,941 are female and 698 are male this compares to 15,862 females and 4,502 males within the Trust 78% and 22% respectively.

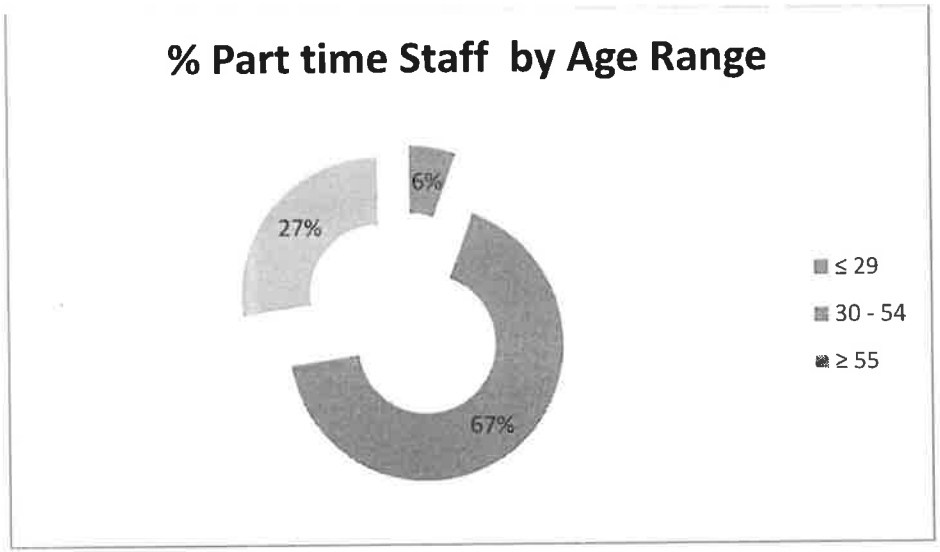


When considering the gender profile and band profile there is a greater proportion of males in band 7 or above positions, 18%, than the proportion of females,12% and this again is reflected amongst the medical workforce and their grade profile as illustrated in the pie charts below. 42% of the female medical workforce are consultants which compares to 47% of the male medical workforce. This is comparable to the Unscheduled Care Directorate who also have 17% of their male workforce in Band 7 or above positions or Trust wide 16%.









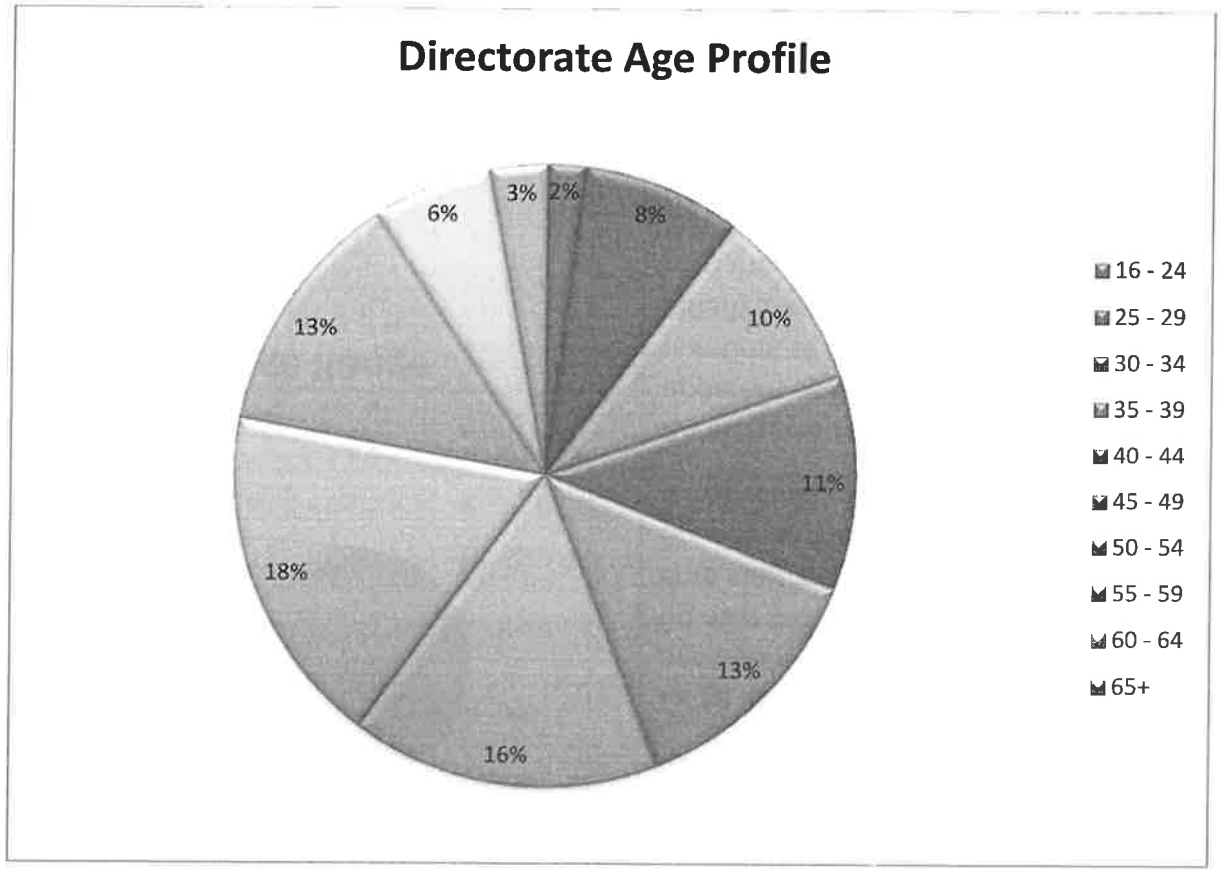
48% (2211) of the total headcount of staff within the Directorate work part time and of those 2091 are female and 120 are male, 95% and 5% respectively. Of the 52% (2428) of the workforce who work full time 1850 or 76% are female and 578 or 24% are male.

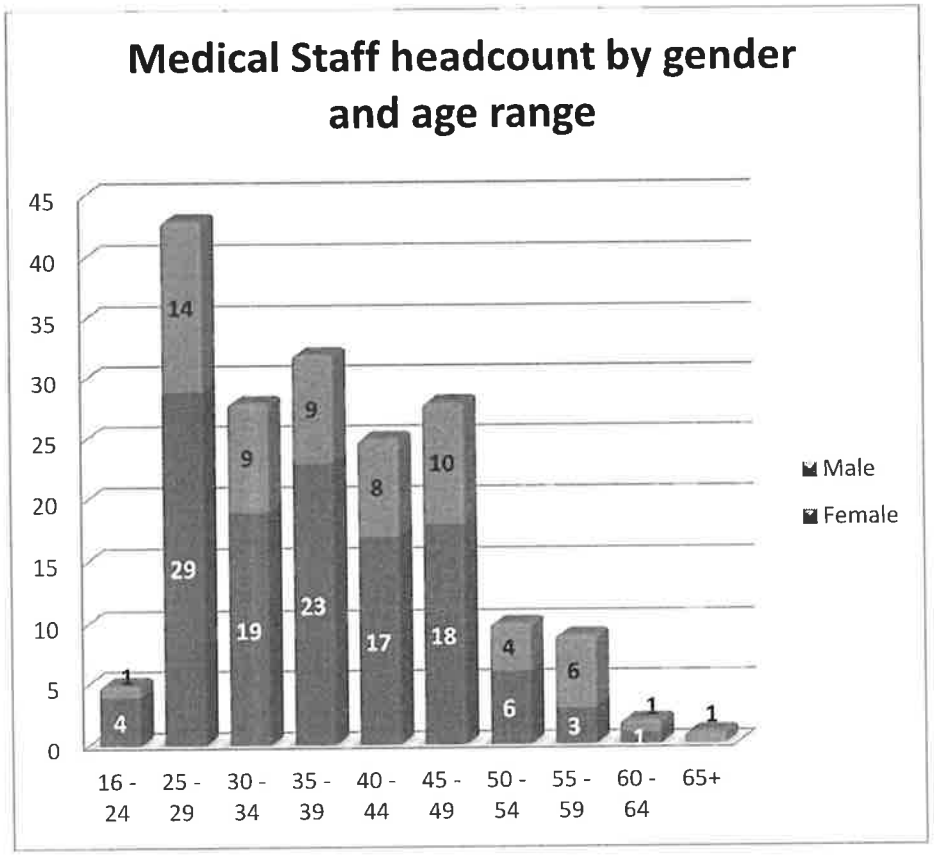
Of all those working part time 6% are age 29 or younger, 67% are between the age of 30 – 54 and 27% are 55 or over. It may be over the course of the next five years that the number of part time staff increases as more wish to avail of flexible working options and this may also become more evident with the introduction of shared parental leave.

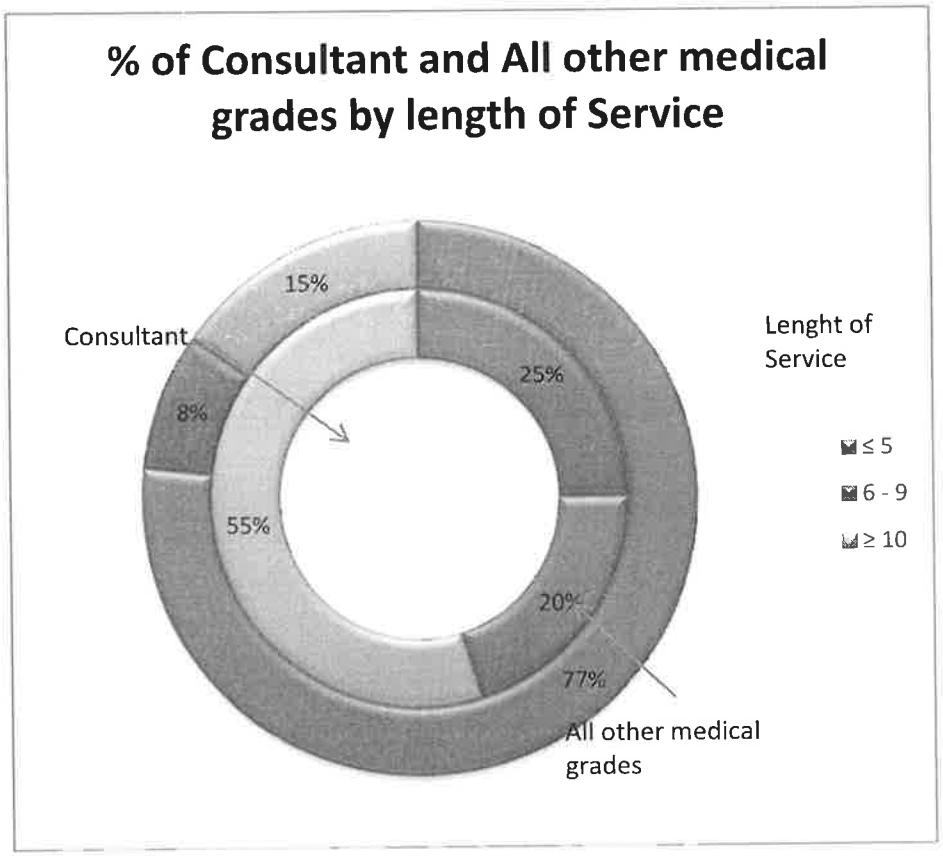
An increase within the older workforce may also become apparent as the population ages it may be the case that greater numbers of the workforce wish to reduce their hours to look after elderly parents for example. It is likely over the course of this plan that more staff will be recruited to support the move to more Services being offered 24 hours 7 days a week and more staff working fewer hours to meet work life balance requirements.

1.7.2.3 Age Analysis

As the population demographic is aging so too is our workforce as demonstrated in the pie chart below. 40% of the Directorate's workforce is aged 50+ and as indicated earlier it is likely that more staff will work longer.







The Medical workforce is a relatively young workforce with the majority of staff falling within the 25 – 29 age bracket. The average age of a Consultant within the Directorate is 37 years and 7 months and 55% of the consultant workforce has 10 or more years' Service. This compares to the average age of 46 years and 7 months of a Consultant across the Trust.

In terms of the number of staff within the Directorate who are aged 55 or over there are 1024 or 799.1 wte. Of those 120 are in band 7 or above positions as highlighted in Table 12 below. 83 are in the range 55 – 59, 31 aged 60 – 64 and 6 are, 65 or over.

Table 12

Age Range	Band	H/count	WTE
55 - 59	7	50	48.01
	8A	11	10.53
	8B	6	4.60
	8C	2	1.29
	8D	5	5.00
	Medical Staff	9	5.68
55 - 59 Total		**83**	**75.11**
60 - 64	7	21	18.86
	8A	5	3.80
	8B	1	1.00
	8C	2	1.80
	Medical Staff	2	2.00
60 - 64 Total		**31**	**27.46**
65+	7	4	3.23
	Medical Staff	2	0.30
65+ Total		**6**	**3.53**
Grand Total		**120**	**106.10**

A further breakdown is provided by Service Group Area in Table 13 overleaf.

Table 13

Service area	AGE RANGE	BAND	H/count	Wte
LEARNING DISABILITY	55-59	Medical Staff	1.00	1.00
		7	6.00	6.00
		8a	3.00	3.00
		8d	2.00	2.00
	60-64	7	2.00	2.00
		8a	2.00	1.00
LEARNING DISABILITY Total			**16.00**	**15.00**
MENTAL HEALTH	>=65	Medical Staff	1.00	0.30
		7	1.00	1.00
		8a	1.00	1.00
	55-59	Medical Staff	8.00	4.68
		7	11.00	10.80
		8a	2.00	1.53
		8b	2.00	1.00
		8d	1.00	1.00
	60-64	Medical Staff	1.00	1.00
		7	5.00	5.00
		8a	2.00	1.80
		8c	1.00	1.00
MENTAL HEALTH Total			**36.00**	**30.11**
OLDER PEOPLES SERVICES	>=65	Medical Staff	1.00	0.00
		7	2.00	1.23
	55-59	7	32.00	30.21
		8a	4.00	4.00
		8b	3.00	2.60
		8d	1.00	1.00
	60-64	Medical Staff	1.00	1.00
		7	14.00	11.86
		8a	1.00	1.00
		8b	1.00	1.00
OLDER PEOPLES SERVICES Total			**60.00**	**53.91**
PSYCHOLOGY SERVICES	55-59	7	1.00	1.00
		8c	2.00	1.29
		8d	1.00	1.00
	60-64	8c	1.00	0.80
PSYCHOLOGY SERVICES Total			**5.00**	**4.09**
ADMIN & CLERICAL	55-59	8a	3.00	3.00
ADMIN & CLERICAL SERVICES Total			**3.00**	**3.00**
Grand Total			**120.00**	**106.10**

Succession planning will need to be addressed during the course of the plan particularly in light of the number of staff considered to be in high level senior positions. The Trust has in place a Succession Planning Model "Growing Our People Today for Tomorrow". To date five staff from the Directorate have participated in the Succession Planning programmes. Given the identified issues for the systemic need to invest in Succession Planning within the Directorate, this is a key action measure for the Action Plan.

1.7.2.4 Turnover

Turnover is considered a key workforce measure considering the number of staff who leave in a period as a percentage of the number of staff employed during the same period. The formula used within the Trust is:

$$\frac{\text{Number of leavers in period}}{\text{Average number of staff employed in period}} \times 100$$

The average number of staff in the period is taken at the start of the period added to the number working at the end of the period and the total divided by two.

Whilst there is no set level at which point employee turnover starts to have a negative impact on an organisation's performance some key issues for consideration include:-

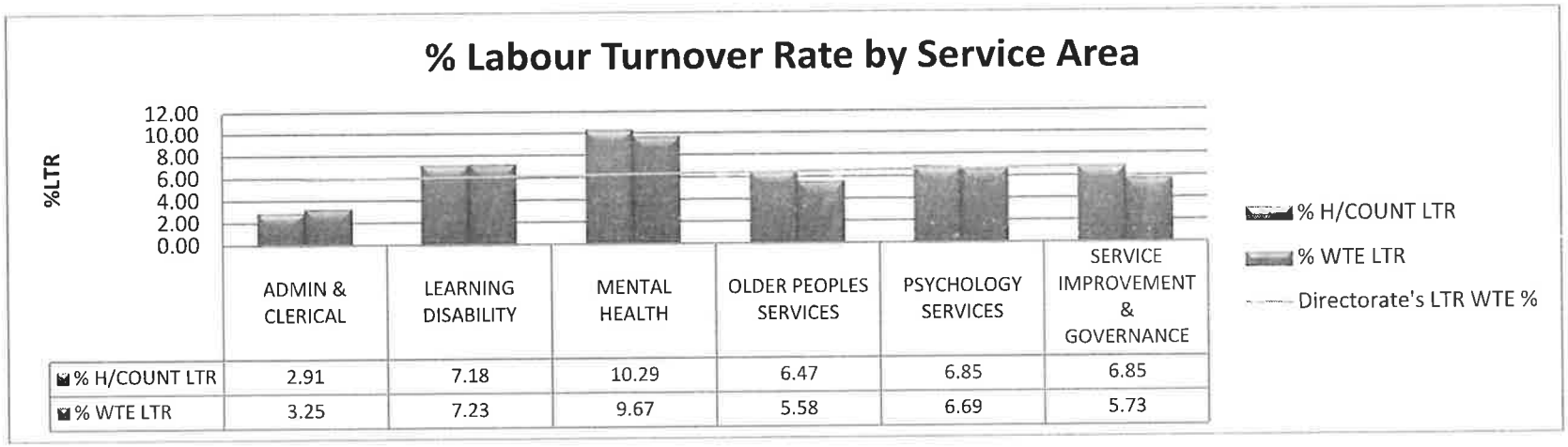
- The reason why people are leaving
- The average length of time taken to recruit
- The average length of time taken to train a new recruit
- The grade of people leaving
- The area in which the people are leaving

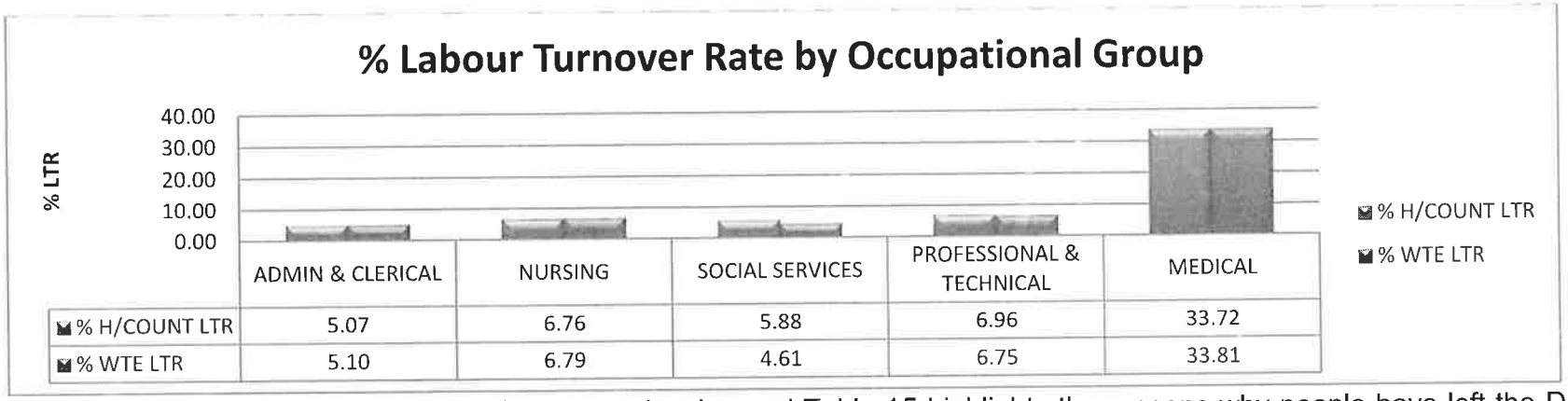
Over the course of the twelve month period ending 30 September 2014 the Trust's overall turnover rate was 4.88% which compares to 5.84% within the Directorate.

Table 14 below indicates the number of leavers from the Directorate over the past five years and notably the number of leavers has remained relatively static.

Table 14

Number of Leavers			
Year	H/count	WTE	+/- from previous year wte
2010/11	309	273.04	
2011/12	330	287.44	14.4
2012/13	316	268.79	-18.65
2013/14	309	272.76	3.97
2014/15	343	267.84	-4.92





Perhaps more important is the reason why employees are leaving and Table 15 highlights the reasons why people have left the Directorate over the past five years.

Table 15

REASON FOR LEAVING	2010-2011		2011-2012		2012-2013		2013-2014		2014-2015	
	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE	H/C	WTE
Age Retirement	58	50.02	64	52.17	73	61.34	35	31.78		
Caring for children					1	0.53				
Completion of training			1	1						
Death	4	3.31	2	2	2	2	3	1.99	4	3.34
Disciplinary action	4	3.07	5	4.74	3	3	3	3	4	3.25
End fixed term contract	62	60.8	63	62.06	64	61.9	48	46.36	15	12.35
External Secondee Out							1	1	1	0.8
Family	1	1	1	0.53						
Full time education	1	1			2	1.33	4	3.8		
Further education/training	8	7.08	13	9.54	1	1	2	2		
Ill Health Retirement	18	15.36	19	16.85	12	9.86	9	7.38	17	14.76
Ill Health Termination	27	20.75	28	22.58	22	17.96	20	15.74	34	20.37
Medical Rotation							13	12.6	41	39.2
Other Employment	60	55.21	81	70	51	44.84	15	12.97		
Personal	20	15.79	15	14.13	10	8.03	3	2.08		
Premature/Efficiency	2	2								
Premature/redundancy	1	1	2	2						
Promotion	1	1	4	3.65	8	7.5	6	4.86		
Redeployment					5	4.53				
Resignation							106	91.13	104	72.32
Retirement							25	21.48	96	76.83
Secondment	2	1.5	1	1	1	1	1	1		
Transfer			1	0.5	17	15.6	8	6.99		
Transfer to other HSC Org							2	2	17	15.8
Unknown	32	27.39	13	9.78	21	18.16	3	2.8		
Voluntary Early Retirement (Abated)			3	2.59	1	0.61	1	1		
Voluntary Early Retirement	8	6.76	14	12.32	3	2.62				
VER - Actuarilly Reduced							1	0.8	10	8.82
Voluntary Redundancy					9	6.98				
GRAND TOTAL	**309**	**273.04**	**330**	**287.44**	**316**	**275.21**	**309**	**272.76**	**343**	**267.84**

It should be noted, whilst sickness absence remains a major concern within the Directorate, considerable efforts have been made to address the issue and the year ending 31st March 2015 demonstrates the highest number of ill health terminations over the past five years.

1.7.2.5 Sickness Absence

The overall sickness absence rate for the Directorate for the twelve months ending 31st March 2015 was 7.59% and is the highest it has ever been since the establishment of the Belfast Trust, as demonstrated in Table 16 below. Also included is the current year to 31 December 2015, highlighting 6.81% for the nine months.

ASPC sickness absence rates

SICKNESS ABSENCE	Apr 11 - Mar 12	Apr 12 - Mar 13	Apr 13 - Mar 14	Apr 14 - Mar 15	Apr 15 - 31 Dec 15
TARGET BY MARCH %	**6.01**	**5.31**	**5.00**	**6.71**	**7.40**
OVERALL ABSENCE % FOR Social & Primary Care Services	6.39	6.78	7.46	7.59	6.81

Table 16

It should be noted that following the implementation of HRPTS, sickness absence from 2013/14 to 2014/15, has been recorded by managers in hours on Manager self-Service.181 different reasons why staff were off sick have been recorded during the course of the year. Table 17 demonstrates the top eight reasons with stress being cited as the second reason and back ache/pain as the fifth highest.

REASON FOR ABSENCE	H/C	HRS LOST
General Debility	960	102,457
Stress	331	96,450
Vomiting	245	23,598
Influenza	237	8,590
Back ache/pain	181	27,711
Other Chest and Respiratory	190	13,474
Grief/Bereavement	134	22,458
Post-Surgical Debility	95	25,619

Table 17

The total number of staff who were absent due to sickness over the course of the year ending 31st March 2015 was 2,633 which equates to 56% of the Directorate's total workforce. A total of almost 616,000 hours were lost, which equates to 315.89 wte or 8.1% of the workforce were absent for the full year. Of the 2,633 staff who were absent during the year, 1,584 were absent on 1 occasion, 718 on 2 occasions, 227 on 3 occasions, 83 on 4 occasions, 16 on 5 occasions, 4 on 6 occasions and 1 on 7 occasions.

The Directorate has taken steps to improve levels of attendance. There has been an increase in training for Managers / Supervisors in the management of absence, more consistent application of the Management of Absence Policy, more focus on the management of long-term absence and the referral of cases to Case Manager.

The Trust has recently launched its focus on Health and well-being strategy and action plan and as part of this renewed approach to Health and Wellbeing, a series of mandatory 1.5hour Attendance Management workshops will take place for all managers within the Directorate in September 15. The purpose of the workshops is to "walk through" the new Manager's Toolkit for Managing Sickness Absence, which is designed to provide practical support and advice for line managers, ensuring consistent and fair application of the Managing Attendance Protocol.

The Toolkit includes 2 new requirements from Managers:

1. Implementation of attendance management meetings where staff have unacceptable attendance.
2. Completion of a quarterly return to the Co-Director and HR in relation to management actions where all staff reaching trigger points / long term sickness leave.

A letter from the HR Director to all staff highlighting the new focus on Health and Wellbeing and Attendance Management was issued on the Hub on 22 May, and provided to all managers to discuss at team meetings and return to work interviews.

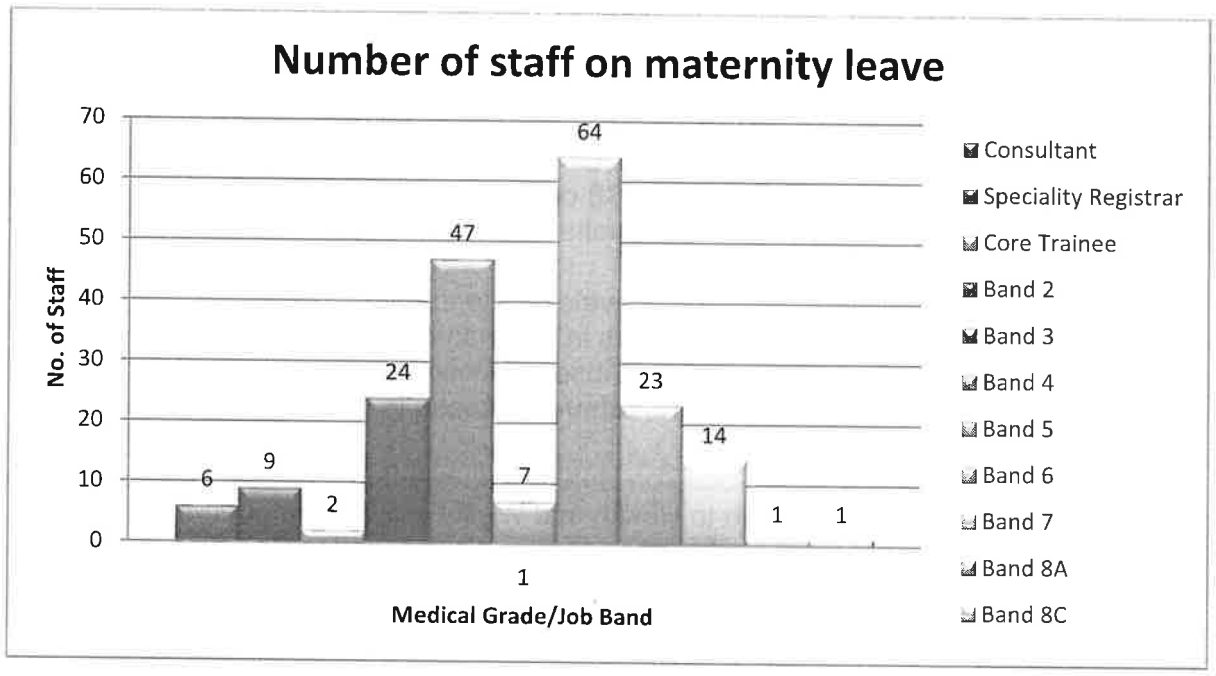
In addition, more detailed analysis on the reasons for sickness absence within the Directorate will take place over July and August, to ensure any relevant support / interventions can be considered in line with the 2015/16 Health and Wellbeing Action Plan.

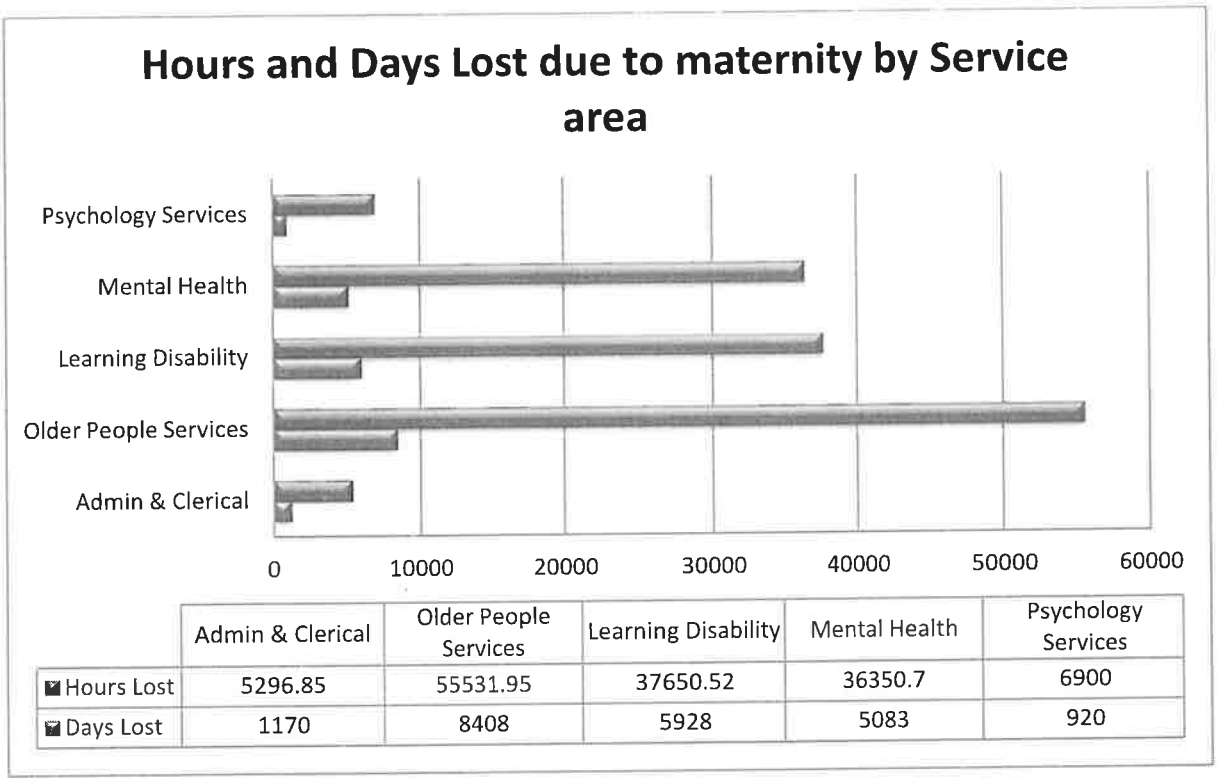
HR and Occupational Health will be launching a FAQ guide for all employees in the Autumn in relation to sickness absence, in addition to delivering bespoke training sessions for employees regarding their responsibilities under the Managing Attendance Protocol.

The HR Directorate will be implementing the Health and Wellbeing Action Plan within the Directorate, benchmarking will also take place with additional similar Service providers from other Organisations to identify any best practices the Directorate can undertake to reduce its absence cost.

1.7.2.6 Maternity Absence

During the course of the year ending 31 March 2015 there were a total of 198 staff off on maternity leave with a total of 149,432.52 hours and 22,492 days lost to the Service as illustrated in the graphs below. The average age of those off on maternity leave was 33.33 years.





	Admin & Clerical	Older People Services	Learning Disability	Mental Health	Psychology Services
Hours Lost	5296.85	55531.95	37650.52	36350.7	6900
Days Lost	1170	8408	5928	5083	920

In the previous year a total of 202 staff had time off owing to maternity leave with 23,825 days lost and 149,278.7 hours. It is anticipated therefore during the course of the next five years that this level of absence owing to maternity leave is set to continue.

Of the 198 staff who had time off due to maternity, 95 also had time off during the year owing to sickness as illustrated in Table 18 overleaf.

Reason for Absence	Number of Staff
General Debility	30
Other pregnancy rela	9
Back ache/pain	5
Morning sickness	5
Vomiting	5
Influenza	4
Post Natal	4
Stress	4
Diarrhoea	3
Other chest and resp	3
Ante Natal	2
Depression	2
Gastroenteritis	2
Oth ear/nose/throat	2
Road Traffic Accidnt	2
Urinary tract infect	2
Accident-work relatd	1
Grief/Bereavement	1
Hypertensive disease	1
Inj to foot or ankle	1
Inj to shoulder/arm	1
Migraine	1
Other inj/fracture	1
Other musculoskeleta	1
Sinusitis	1
Sore throat	1
Stress-Work Related	1

Table 18

During the course of the plan those off on maternity leave could be monitored to ascertain the length of time off due to sickness and if the sickness occurs before or after the period of maternity leave. This analysis would support the review and impact on backfill.

Table 19 below indicates the number of staff off on maternity leave across each of the clinical directorates for comparison purposes.

Staff on Maternity Leave for Period 1 April 2014 – 31 March 2015	Headcount	Hours Lost	Days Lost
Acute & Unscheduled Care	384	285,964.49	42,869
Surgery & Specialist Services	237	190,260.93	27,803
Adult Social & Primary Care	198	150,572.52	22,644
Specialist Hospitals & Womens Health	189	130,491.75	19,588
Childrens Community services	76	54,515.3	8,018
Grand Total	**1084**	**811,804.99**	**120,922**

Table 19

1.8 Step 5 : Developing an Action Plan

This step involves reflecting on the previous three steps and determining the most effective way of ensuring the availability of staff to deliver redesigned Services, even if this means some further Service redesign. A plan for delivering the right staff, with the right skills in the right place needs to be developed with milestones and timescales. You should also include in your plan an assessment of anticipated problems and how you will build a momentum for change.

The main major developments for the Directorate over the next five years will be focused around the implementation of Transforming Your Care and the move from Acute to Community based Services. In relation to the Action Plan required to implement and deliver this workforce plan, below in Table 20 are the key elements required going forward. As expected with any major reform and modernisation programme, timescales below are indicative and set to change as they are subject to communication, consultation and due process.

Table 20	**Action Plan for Adult Social and Primary Care 2015 to 2020**		
Service Area	**Action**	**Person Responsible**	**Timescale**
Learning Disability	Completion of MAH Resettlement project, including the redeployment of affected staff	Esther Rafferty	31 March 2016
Learning Disability	Review of community Day Centres and the redeployment of affected staff	Neil Kelly	31 March 2016
Learning Disability	Reduction in the sickness absence rate within the Service area from 9.03% to 8.03%	John Veitch	31 March 2016
Learning Disability	Confirmation on future direction of Iveagh linked with CAMHS and implementation of outcomes	Esther Rafferty	31 March 2020
Learning Disability	Confirmation of the required workforce going forward within all areas	John Veitch	31 March 2016
Mental Health	Relocation of DGU & redeployment of affected staff	Mel Carney	31 March 2016
Mental Health	Completion of CAMHS review and implementation of outcomes	Billie Hughes	31 March 2020
Mental Health	Proposed opening of the new Inpatient Mental Health Unit	Mel Carney	31 March 2018
Mental Health	Proposed review of Approved Social Worker Role to be completed by March 2016	Mary O'Brien	31 March 2016
Mental Health	Proposed review of the need for Eating Disorder Services	Peter Bohill	31 March 2018
Mental Health	Proposed review of the provision of Day Services	Peter Bohill	31 March 2016
Mental Health	Implement the outcome of the Criminal Justice Service Review as it impacts on Unscheduled Care Court Service	Mel Carney	31 March 2017
Mental Health	Reduction in the sickness absence rate within the Service area from 7.8% to 6.8%	Barney McNeany	31 March 2016
Mental Health	Confirmation of the required workforce going forward within all areas	Barney McNeany	31 March 2016

Older Peoples Services	Implement outcome of district nursing review	Gabby Tinsley	31 March 2020
Older Peoples Services	Roll out Keith Hurst toolkit to all relevant areas	Bridget Denvir	31 March 2016
Older Peoples Services	Implement outcome of Social Work & Social Care Review	Katie Campbell	31 March 2020
Older Peoples Services	Extend BCH Direct in conjunction with IMPACT developments	Catherine Collins	31 March 2016
Older Peoples Services	Promotion of Care of the Elderly as an attractive area to work	Marie Heaney	Ongoing
Older Peoples Services	Introduction of Acute Care At Home Service	Gabby Tinsley	31 March 2016
Older Peoples Services	Complete merger of Reablement & Social Care Rapid Response – Katie Campbell	Katie Campbell	31 December 2015
Older Peoples Services	Proposed review of Adult Physical Sensory Disability Day Opportunities	Bernie Kelly	31 March 2016
Older Peoples Services	Proposed review of Domiciliary Care Workforce linked to development of regional workforce plan	Marie Heaney	31 December 2015
Older Peoples Services	Reduction in the sickness absence rate within the Service area from 10.37% to 9.37%	Marie Heaney	31 March 2016
Older Peoples Services	Confirmation of the required workforce going forward within all areas	Marie Heaney	31 March 2016
Directorate	Reduction of Sickness Absence by 1%	ALL	31 March 2016
Directorate	Implementation of Attendance management Toolkit to reduce sickness absence including health and well-being at work strategy	ALL	31 March 2016
Directorate	Implementation of Nurse Revalidation process	ALL	Ongoing
Directorate	Implementation of Normative Staffing	ALL	Ongoing
Directorate	Implementation of Recruitment & Retention Strategies particularly in hotspot areas older people Services and medical staff	ALL	Ongoing
Directorate	Implementation of NISCC Registration for all Social Care Workers in domiciliary and day care	ALL	Ongoing
Directorate	Ensure statutory and mandatory training compliance	ALL	Ongoing
Directorate	Develop and implement Succession Planning Strategy – Growing our People Today for Tomorrow	ALL	31 March 2016

Directorate	Implement Induction Programme for all new recruits	ALL	Ongoing
Directorate	Promote age awareness and age diversity as more staff remain in the workplace longer	ALL	Ongoing
Directorate	Promote Living the Values and Behaviours	ALL	Ongoing
Directorate	Develop new roles to support the 'shift left'	ALL	Ongoing
Directorate	Develop the Workforce Plan detailing the required workforce going forward in terms of WTE's Grades, Band, Skill Mix and costings	ALL	Ongoing

1.8.1 Pressure Points Identified for Supply and Demand

A number of key areas have been identified within Directorate that need to be considered to ensure supply and demand measures can be met. Many challenges are likely to arise within the next five to ten years as a result of various dynamics within the workforce. These include the following:

- The numbers and the health and well-being of staff, particularly those aged 55 or older and in the front-line Service areas;
- The numbers of staff aged 45 – 54 years who will start to retire within the next five to ten years (or who may otherwise be more liable to leave the Service for other reasons), particularly in the front-line Service areas;
- The impact and cost of Normative Staffing;
- The impact and cost of new models of Service delivery. Productivity gains and efficiency savings are becoming increasingly difficult to achieve, with long term demand drivers likely to significantly outweigh improvements in productivity;
- The impact of new technology and the need to develop new skills to fully utilise the resource;
- A global shortage of nurses and geriatricians and other countries competing for newly qualified or existing staff, offering more attractive terms and conditions;
- The impact of *Delivering Care: Nurse Staffing in Northern Ireland*. The Framework is being developed using a phased approach to include nursing and midwifery workforce ranges across hospital and community settings in all programmes of care;
- The impact key policies, strategies and Service developments will have on specific Service areas, such as, district nursing, specialist nursing, mental health nursing (eg. Transforming Your Care, Bamford Action Plan, Dementia Strategy, Donaldson Review);
- The impact of the new Mental Health In-patient unit with single room patient accommodation and difficulties associated with observations and assessments;
- The impact of other professions e.g. medical workforce and the difficulties in recruiting to ED Departments and General Practice;
- Future of workplace – Nurse Consultants and Advanced Practice Nurses;
- The need to develop new skills for the autonomous practitioner to support the shift left from acute to community across all staff groups.
- The need to develop capacity and capability to develop robust workforce plans to meet the growing changing needs of the population, resulting in an engaged workforce with the required skills, knowledge, competencies, behaviours and values;
- Recruitment and Retention difficulties resulting in inappropriate grade and skill mix;
- A systemic need for succession planning.

SECTION 2

2.1 MENTAL HEALTH SERVICES

This section of the plan will highlight workforce planning issues associated with the provision of Services within mental health. The Trust's mental health teams provide Services to the population of Belfast and across the region through Adult Inpatient Services, Recovery/Rehabilitation, CAMHS and Primary Care Partnerships. Mental health Services are provided by a workforce of 954 staff, details and an analysis of which are provided later in this section.

Mental health Services are separated into four distinct Service areas:-

- In-patient Service, which has 86 beds located on two sites the Mater and Knockbracken sites
- CAMHS, which is located at Beechcroft, has 33 beds
- Primary Care Services, which includes the mental health therapy Hubs, the Court Diversion Scheme and the Eating Disorder Service
- Community Mental Health Services : comprising of - 4 geographical Community Mental Health Teams, Primary Mental Health Teams, One Point of referral, Early Interventions, Mental Health and Deafness, Community Forensics, Huntingtons Team, Perinatal Service, Community Support Team, 342 Ormeau Road and Weavers Hill (Supported Living), Resettlement Team.

2.1.1 The Drivers

- There is a drive to shift from acute to community mental healthcare Services and deliver a person centred approach.

This has been highlighted in a range of recent regional reports including: The Bamford Review of Mental Health and Learning Disability (Northern Ireland) 2007, Transforming Your Care – A Review of Health & Social Care in Northern Ireland December 2011. This shift from acute Service provision to one which is more community based is likely to impact on the resources needed to deliver these Services safely. This focus to become person centred and deliver Services in the community is reflected within Adult Social & Primary Care values and principles.

Services should be person centred (i.e. Service users will have their rights respected and be supported to keep control of their lives)

- There is drive to provide for patient safety and high quality Services.

This has been highlighted in a range of recent national and regional strategies and reports including Quality 2020 (DHSSPS, 2011c);The Francis Report (2013); The Cavendish Review (2013); The Keogh Report (2013) and The Berwick Report (2013).

- Anticipated Mental Capacity Bill

The draft Mental Capacity Bill will introduce a single, statutory framework governing all situations where a decision needs to be made in relation to the care, treatment (for a physical or mental illness) or personal welfare, of a person aged 16 or over, who lacks capacity to make the decision for themselves.

The bill will work to ensuring that an individual's capacity to make decisions about their health, care and personal welfare is respected. Appropriate safeguards are also included to ensure that an individual's best interests are respected where their capacity is comprised. This is again in line with the person centred approach.

2.1.2 The Future Models of Service Delivery

Services will be planned, implemented and evaluated in partnership with users and carers

2.1.2.1 In-Patient Services

Table 1 illustrates the changing provision of inpatient mental health Services within the Belfast Trust.

Mental Health Inpatient Services			
	Previous Inpatient bed provision prior to 2013	**Current Inpatient bed provision – since 2013**	**Planned Inpatient bed provision - 2017**
	Avoca 16	Avoca 9	BCH 80
	Rathlin 24	Rathlin 24	
	Windsor 35	Mater 53	
	Mater 55		
Total	**130**	**86**	**80**

Table 1

The preferred model of Service delivery will be the centralisation of inpatients facility on the Belfast City Hospital site. There will be a total of 80 inpatient beds, including 6 Psychiatric Intensive Care Beds located in the new psychiatric unit. The number of beds has been reduced, by 50, from 130, which were located at three sites, Knockbracken HealthCare Park, the Mater Infirmorum Hospital and the Belfast City Hospital. The implications for the workforce of this change are provided later in this section.

2.1.2.2 In-Patient Recovery Services

There will be a total of 54 recovery beds within the Trust, which will be a reduction from the current position of 110 beds. In future recovery Services will be based in the Shannon Clinic (34 beds), with a further 20 beds in Clare Ward, low secure unit. There will be a review of the Neuro-Rehabilitation Unit (NRU) to identify the need for these Services and how they can be best met in the future. The outcome of this review, when completed, will be incorporated into the plan. In meeting the recommendations set out in the Bamford Review the patients, whose Services are provided in the Dorothy Gardner Unit, will have these provided in the community from 1 February 2016. Currently there are 10 patients being cared for in the unit, with another 5 in a phased discharge process.

Where possible staff will be given the opportunity of following the patients and provide the care in a community setting.

The care of the patients residing in the community will continue to be managed by 5 teams split geographically in addition to the Clozapine and Lithium Service.

2.1.2.3 CAMHS

A review of the CAMHS has identified the need for additional resources including inpatient provision; a primary mental health team in the community covering the Belfast & South Eastern Trusts and the further development of the Crisis Assessment & Intensive Intervention Team (CAIIT).

The Service is currently awaiting the outcome of the Acute CAMHS review to outline a clear commissioning statement and the role of Beechcroft within the stepped care model. There will be 33 beds available for the CAMHS, comprising of 18 beds for adolescents and 15 beds for children.

The development of a one point of referral system for the whole of the CAMHS will be completed during the course of this workforce plan. The CAIIT will develop and provide an alternative to hospital admission and respond to A&E Central point of referral. The Crisis Assessment and Intensive Intervention Team which provides an alternative to acute intervention will be expanded and provide a Service to the South Eastern Trust.

The Personality Disorder Service will be reviewed as part of the Regional review into this Service. Recommendations coming from the review will be incorporated into this workforce plan, as and when it is concluded.

2.1.2.4 Primary Care Partnerships – Referral Hub

Following a successful pilot in 2013 the local Commissioning Groups have made a commitment to the establishment of Mental Health Talking Therapy Hubs across Belfast. Currently there are two Hubs in operation for east and west Belfast. The aim of the Hub will be early intervention when someone is referred by their GP with a mental health problem and they will be triaged by the Co-ordinator (Band 7) and where necessary will be referred on for assistance. There is a one week target for making the initial contact with the individual. The Hubs will enable emotional well-being and mental health care to be co-ordinated by providing an all-inclusive approach from a variety of partners. The Services to be provided to patients will include; counselling; cognitive behaviour therapy; facilitated self-help; life coaching and signposting to other support Services e.g. fitness centres.
During the course of this plan the Trust will be establishing a Mental Health Hub in north and south Belfast. In total there will be four Talking Therapy Hubs across the Trust and it is anticipated that it will take up to 2 years for full implementation of this project. This Service will be delivered in partnership with external agencies which will assist in the provision of Services, such as life coaching skills, cognitive therapy and Gyms.

2.1.2.5 Day Centre Provision

Given the underutilisation of the Services spread over the locations the proposal is to centralise Trust day Services from the two centres to one. This project is currently at the public consultation stage with a closing date of 26th November 2015. Once this has been completed there will be a review to determine if a more central location would be more suitable than either of the two centres that are currently open.

2.1.2.6 Court Diversion Scheme

The current court diversion scheme, whereby a dedicated Service is provided to the court Service is no longer sustainable in its current format and will need to change. The existing Mental Health Court Diversion Scheme has been integrated into the 24 hour Unscheduled Care Mental Health Team. At this stage there are no additional resources being put into the Service. This position may change following the completion of the Criminal Justice Service review, which is currently underway. The outcome of this review will impact on the future provision of this Service and will help the Service to plan the way forward.

2.1.2.7 Eating Disorders Day Treatment Service

Currently there is no funding available to develop this Service; however, early developmental work has been carried out to highlight the cost of extra contractual referrals as high cost cases are transferred to England/Scotland. This revenue could be redirected to Day Treatment Services within the Belfast Trust thus making it a more patient centred Service.

The RQIA have conducted a Regional Review into the treatment of eating disorders and the Service is awaiting the outcome of this review to inform its future Service provision.

The local Commissioning Group have confirmed that they will provide recurring funding for a Band 5 to provide an early intervention Service relating to eating disorders.

2.1.2.8 Addiction Services

The Health & Social Care Board are looking to expand the Substance Misuse Liaison Service. This Service provides early intervention and protection of substance misuse related conditions within the general hospital setting. There will be 3 additional posts available for this Service with effect from April 2016.

2.1.2.9 Mental Health – Recovery

2.1.2.9.1 Resettlement Team

This Team was set up to work with Service users who had effectively lived in hospital for the most of their lives who have now been resettled back into the community. The resettlement process is now in its latter stages and the focus of this team is moving towards working with those individuals who require an intensive community rehabilitation Service. There has been significant investment in the Service with more to follow. Investment to date has seen the team increase its staffing levels with the addition of 1 x band 6 OT, 1 x band 6 S/W, 1 band 6 CPN and 3 x band 3 support workers. These posts are in the recruitment process at present. There will be further appointments made of 1x band 7 S/W, 3 x band 3 support workers, 1 x band 7 Psychologist, 1 x band 5 OT in the next six months. This Team will be renamed the Community Rehabilitation Team.

2.1.2.9.2 Adult Safeguarding

The responsibility for the discharge of Adult Safeguarding sits with the Associate Director for S/W for Mental Health and CAMHS with the operational responsibility delegated to the Principle S/W for Mental Health and CAMHS. There has been a significant rise in Adult Safeguarding Referrals in recent months following an assertive awareness campaign. The rise in referrals has necessitated the increase in the workforce within this area with the additionality of 2 x band 7 S/W. 1.5 of these posts are a current cost pressure within the Service area.

2.1.2.9.3 Implementing Recovery through Organisational Change

This was an eighteen month project which concluded in Oct of 2014, the Service area took on three specific challenges from a list of ten as part of the implementation of the project, one of these challenges was to set up a Recovery College, which would deliver co-produced and co-delivered courses open to Service users, carers, family and staff. The programme are currently recruiting 1 x Band 7 Co-ordinator as a cost pressure and it is anticipated that further recruitment of band 4 and 5 staff will be required within the next two years, numbers of which to be agreed as the College develops.

One of the other Challenges was entitled "Transforming the Workforce", this is targeted at employing peer staff within the programme i.e. staff who have live experience of mental health difficulties. Three staff have been employed to date, these where vacant band 3 posts. It is envisaged that any further band 3 posts within the programme will be considered for peer staff. This will be utilisation of current resources rather than additional posts.

2.1.3 The Workforce required to Deliver the Future Services

This section identifies the resources that the Mental Health Services will need to deliver its Services in the future as highlighted earlier.

The changes that are due to take place throughout the Directorate over the course of the period covered by this plan will result in changes to the workforce. New models of Service delivery, the demands of TYC and the need to ensure that high quality cost effective Services are delivered will have an impact on the resources that are required going forward. These will reflect the needs of the Services in the future and in some areas will mean a radical departure from what is currently in place.

2.1.3.1 Projected Workforce

Table 2 outlines the projected workforce in mental health Services which is based on the starting workforce at the beginning of the plan and the average number of leavers and new starts. Also included are the known workforce changes in relation to the projects currently underway or planned to be completed during the course of this plan. The plan projects an increase in the workforce in the Service area by 22 staff, which is due to the fact that on average there were more starters than leavers over the last 5 years impacting on the projected workforce.

Mental Health Services Workforce Projections 2015/2020

	2015/16	2016/17	2017/18	2018/19	2019/20
Staff in Post at 31 March	954	960	957	942	959
Average No. of Leavers *	-74	-76	-76	-76	-76
Average No. of starters *	86	95	95	95	95
Reviews	-6	-22	-34	-2	-2
Total indicative projected staff in post 1 April	960	957	942	959	976
Net Variance	6	-3	-15	17	17

* figures for 2015/16 are actual figures

Table 1

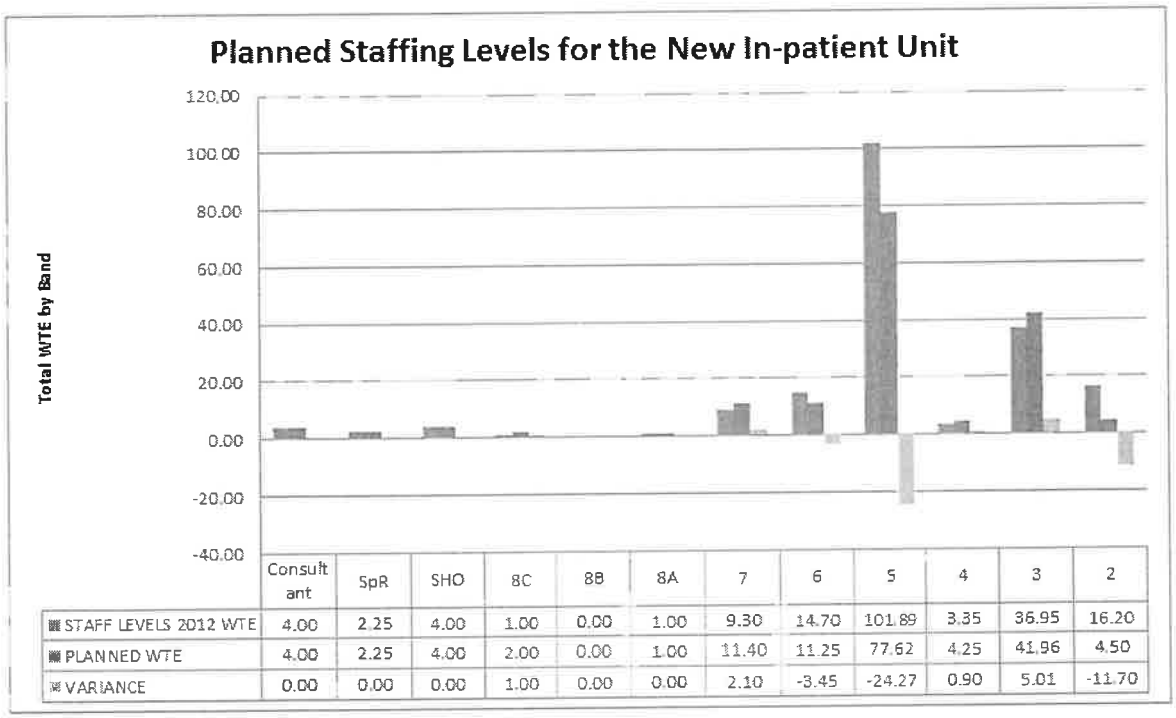
The resources identified by Service area are based on the need to deliver Services as they are currently planned. These may be subject to change to accommodate changes that arise during the period of the plan, but are not yet identified.

Services will be delivered at the right time, in the right place, by the right person, for the right length of time based on assessed needs

2.1.3.2 In-Patient Unit

Following the completion of the new in-patient unit, scheduled for August 2017, being built on the Belfast City Hospital site there will be capacity for 80 patients to be treated within the Trust. Graph 1 highlights the resources required in the new in-patient unit and compares these to the resources that were previously required to provide the Services. In the new unit all patients will have their care provided in individual rooms. The move to individual rooms, as opposed to wards is a progression of the Trust's approach to care provision in the future. It provides the patient with the privacy of their own room, which provides a place to go if they are stressed, thereby helping to reduce stress levels and assisting patient care. The individual rooms are more secure, providing greater protection of the patient's possessions.

There will be implications for the staff as it may take more time to check on patients in their own rooms as it would have on the wards, but this has been factored into the staffing requirements needed to provide the Service.



	Consultant	SpR	SHO	8C	8B	8A	7	6	5	4	3	2
STAFF LEVELS 2012 WTE	4.00	2.25	4.00	1.00	0.00	1.00	9.30	14.70	101.89	3.35	36.95	16.20
PLANNED WTE	4.00	2.25	4.00	2.00	0.00	1.00	11.40	11.25	77.62	4.25	41.96	4.50
VARIANCE	0.00	0.00	0.00	1.00	0.00	0.00	2.10	-3.45	-24.27	0.90	5.01	-11.70

Graph 1

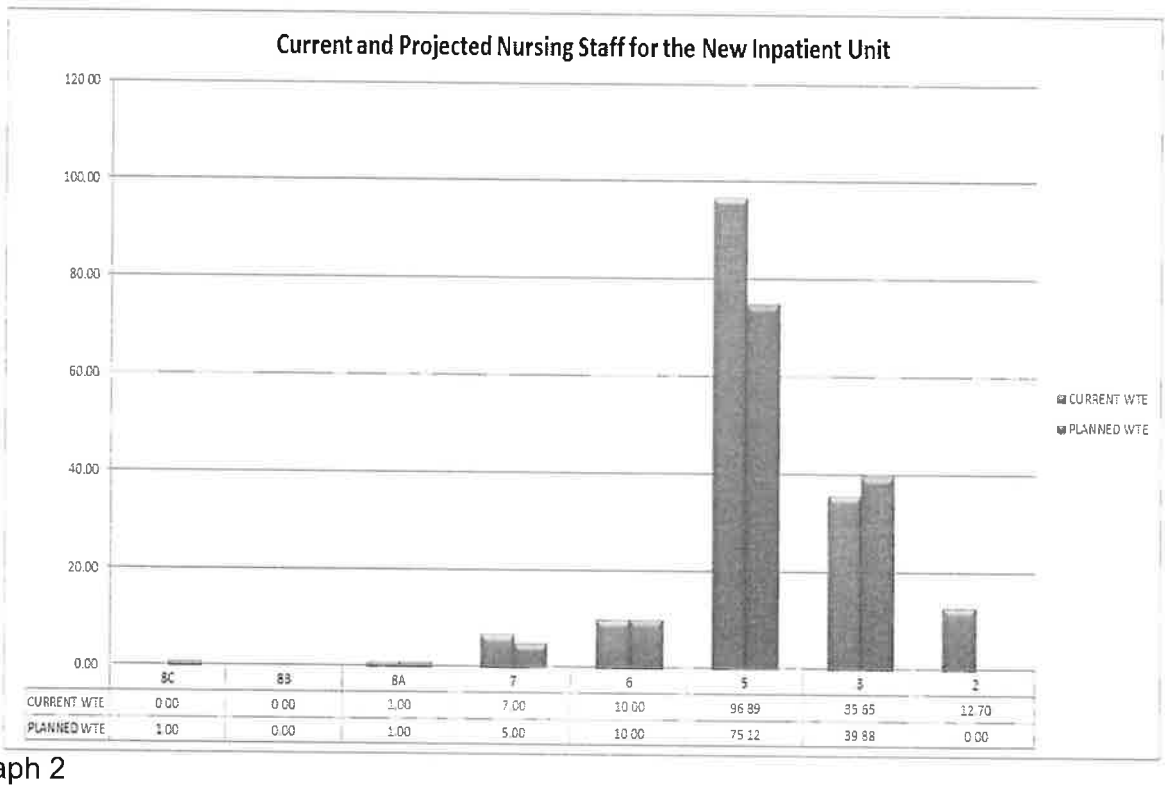
It is expected that there will be a decrease in the total number of staff required to provide the Services in the new in-patient unit than was needed before. Overall, including all bands of staff, the number of staff will reduce from 194.64 wte to 164.23 wte.

There will be an increase of Band 8c managers from 1 to 2 and there will also be a slight increase in the number of Band 7 staff by 1.0 wte; however there will be a significant reduction in Band 5 staff by 24.27 wte, which is due to the reduction in the number of patients that will be treated in the new unit. The table also appears to show a significant decrease in the number of Band 2 staff needed in the new unit from 16.2 to 4.5 wte; however this is due to the regrading of the nursing support staff following the Agenda for Change review of their banding. Some of those staff who have been regraded will be included in the Band 3 staff numbers in the new unit.

The new Mental Health In-patient Unit will see an overall reduction of 31.24 wte nursing staff, when compared to the resources needed in the previous facilities. The skill mix will however remain unaltered at 70:30 registered to support staff.

Nursing Skill Mix	Current WTE	Planned WTE
Registered	114.89	92.12
Support	48.35	39.88
Total	**163.24**	**132.00**

Table 3



Graph 2

2.1.3.2 Recovery – Community

Through the continued progress achieved under TYC more patients/Service users will be provided with the opportunity to return to the community. To ensure that the new model of Service delivery is achieved the resources required are identified in table 4.

Staff Required	Number of Staff Required
Team Leaders	8.0
Social Workers	16.0
Community Psychiatric Nurses	22.0
Occupational Therapist (Band 7)	1.0
Occupational Therapist	4.0
Psychologist	4.0
Dual Diagnosis Worker	1.0
Phlebotomists	2.0
Band 3 Support Staff	16.0
Band 7 Practitioners	6.0
Full Weight Psychiatrist	1.0
Band 6 Nurse	1.0
Care Co-ord. Band 7	2.0
Clinical Services Manager	1.0

Table 4

2.1.3.4 Primary Care Services

The Hubs, which have been outlined earlier in this plan will meet weekly and will require the Trust staff highlighted in the table 5 to deliver the Services. In addition to the Trust employees the Services will be provided by a number of local private, community and voluntary organisations.

Staff Requirements for Therapy Hubs	
Band	**Required**
Band 7	4.0 WTE
Band 4	1.0 WTE
Band 3	2.8 WTE

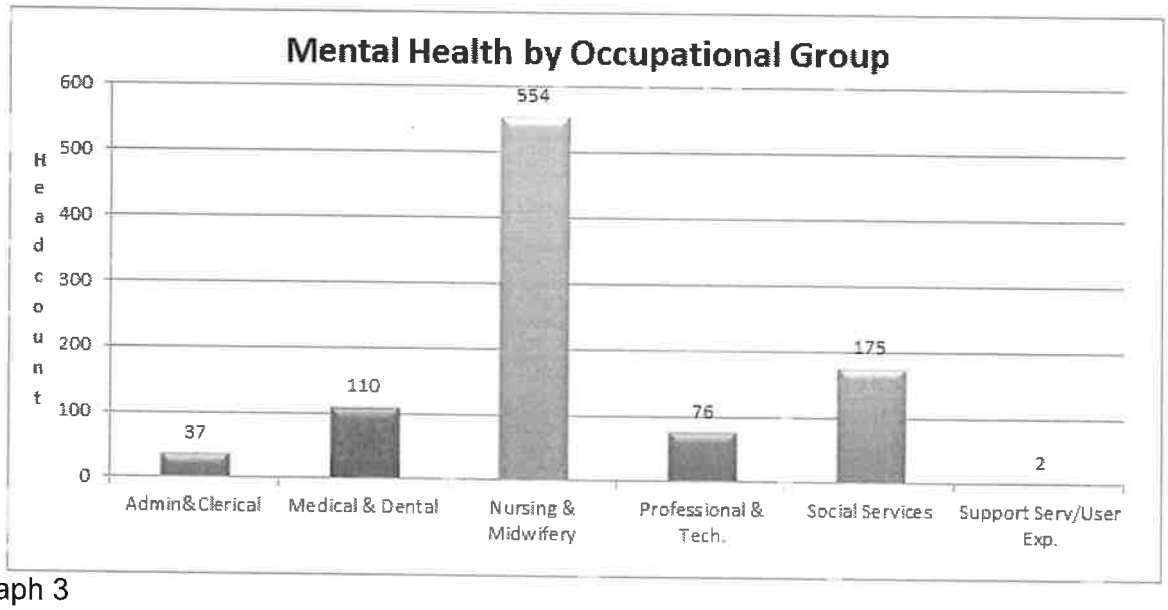
Table 5

There will be a review of Day Care Services undertaken, by the Service area, during 2015/16 and the recommendations coming out of this review will be used to plan the future provision of Services within Day Care.

2.1.4 Workforce Supply

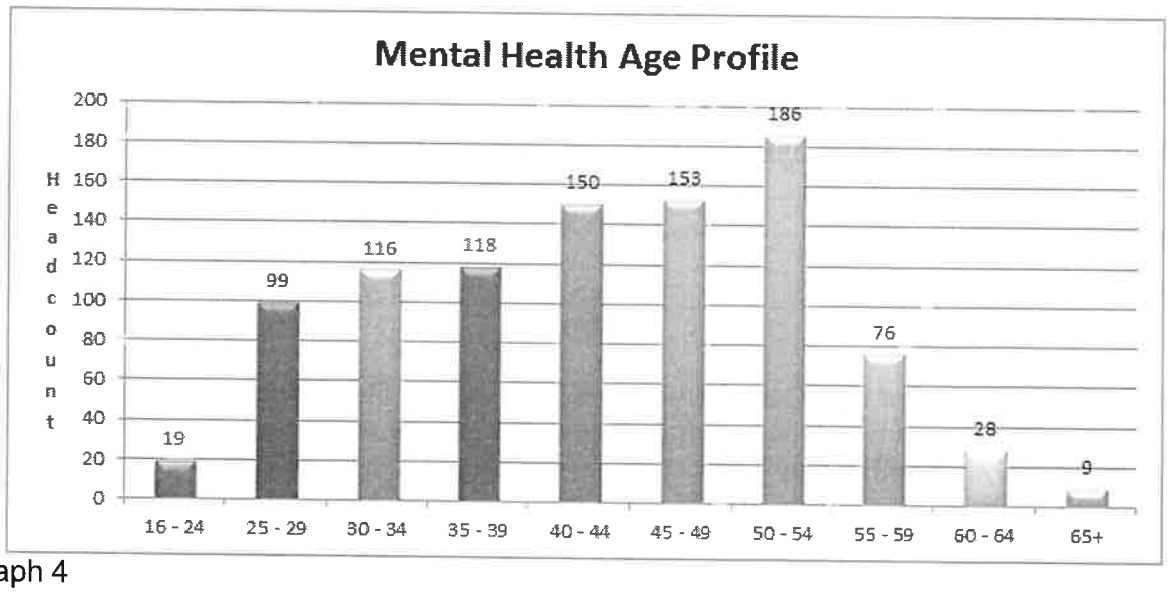
The workforce that has been identified in this workforce plan will in the main be made up from the existing workforce, with the need, in some areas, for reskilling or new staff. This section of the report looks at the resources that are currently available within Mental Health Services, which is the second largest of the Service areas within the Directorate and is based on the staff in post at 31 March 2015.

Graph 3 highlights that over half of the workforce (58%), within Mental Health is made up of nursing staff, and 22% are social Services staff.



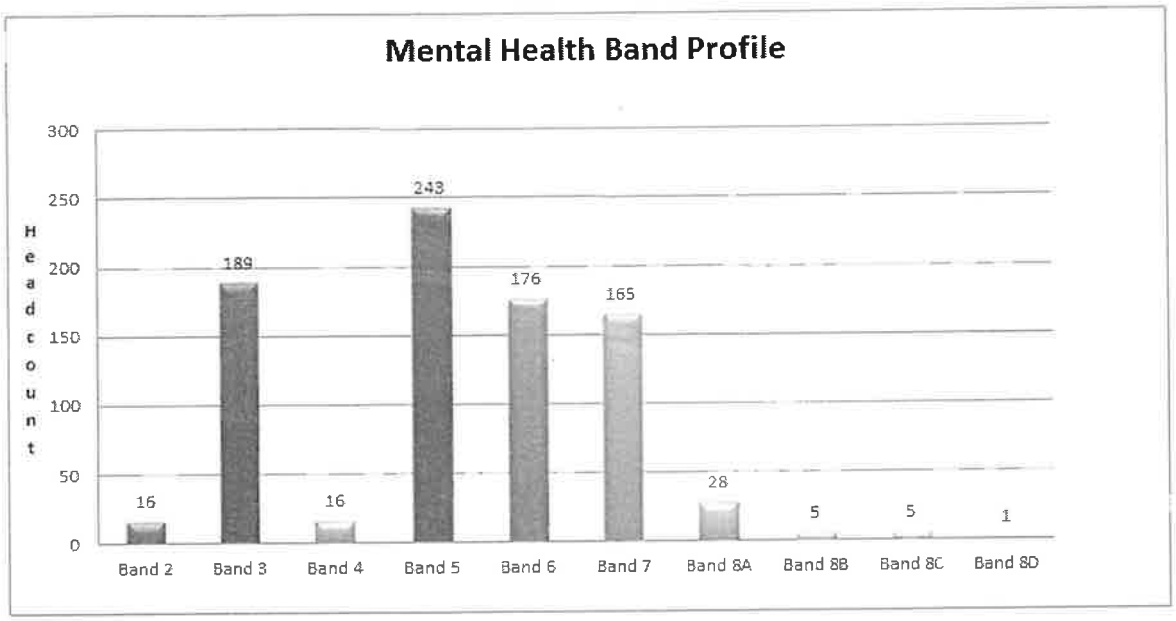
Graph 3

The age profile of staff working in Mental Health Services is provided in the graph 4. There is a fairly even distribution of staff across the age ranges, with the largest group of staff aged between 50 and 54, which has almost 20% of the workforce within the Service area.



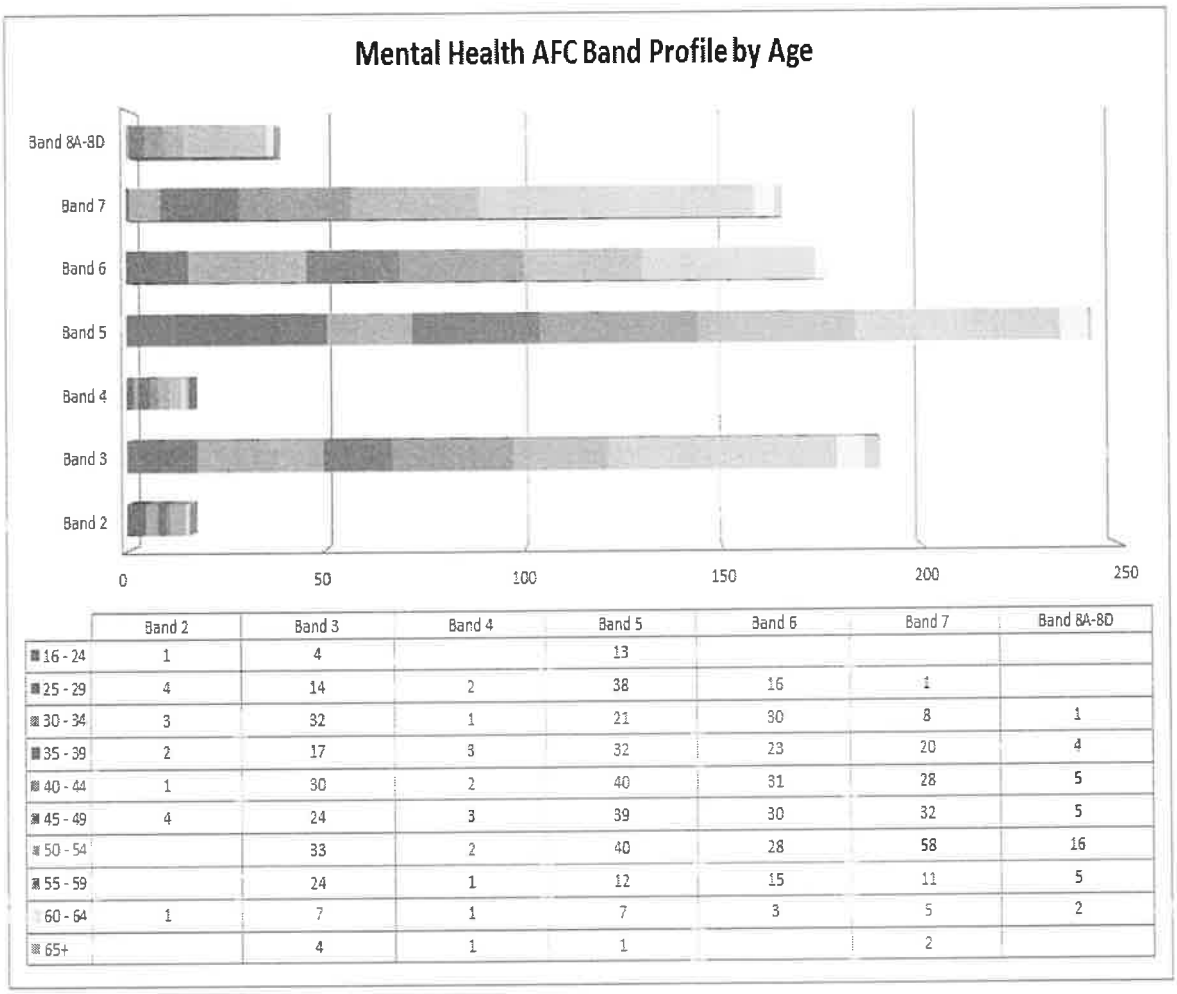
Graph 4

Within the Service area, staff who are aged 55 and above, account for approximately 12% of the total workforce, which is less than the Directorate figure of 22%. An area of concern is that over 31% of the workforce is over 50 and may have the option to retire in 5 years and only 25% are under the age of 35.



Graph 5

Graph 6 looks at possible links between bands and the age profile for the Service area to identify any issues that may have to be addressed as part of this workforce plan.



	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A-8D
16 - 24	1	4		13			
25 - 29	4	14	2	38	16	1	
30 - 34	3	32	1	21	30	8	1
35 - 39	2	17	3	32	23	20	4
40 - 44	1	30	2	40	31	28	5
45 - 49	4	24	3	39	30	32	5
50 - 54		33	2	40	28	58	16
55 - 59		24	1	12	15	11	5
60 - 64	1	7	1	7	3	5	2
65+		4	1	1		2	

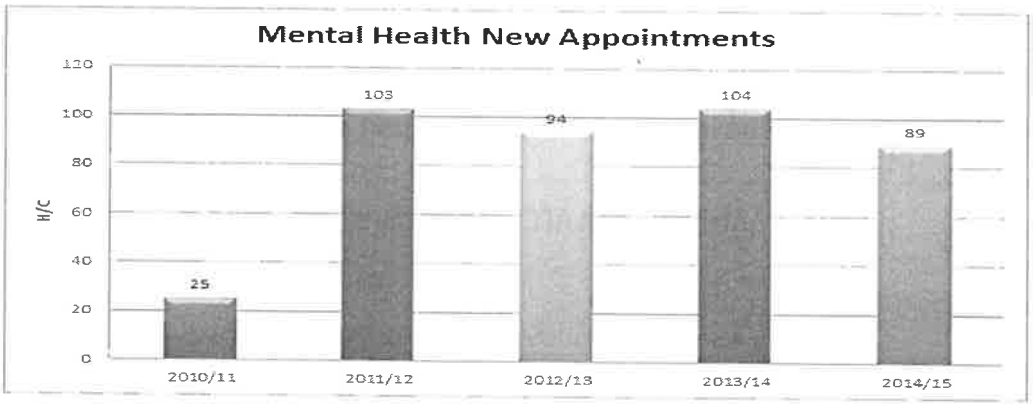
Graph 6

At Band 7 manager level 11% of the staff are aged 55 or older, however, there is three times this number between the ages of 50 and 54. The indication, based upon the current age profile, is that 46% of the total staff at this grade will be 55 or over by 2020, which may have implications for succession planning and the potential loss of skills.

It is also worth highlighting the age profile of the staff in senior management positions within the Mental Health Service area. There is a total of 38 senior managers, from 8A to 8D, of these 7 are aged 55 and over, which is approximately 18% of the total senior managers. If we include the age group 50-54 in these figures there are 23 managers who account for approx. 61% of the total number of senior managers in the Mental Health Service area. Succession planning will be required for this group of staff as with the Band 7 staff above.

2.1.4.1 Recruitment

Graph 7 shows that 415 staff have been appointed to positions within the Mental Health Service area, over the last 5 years.



Graph 7

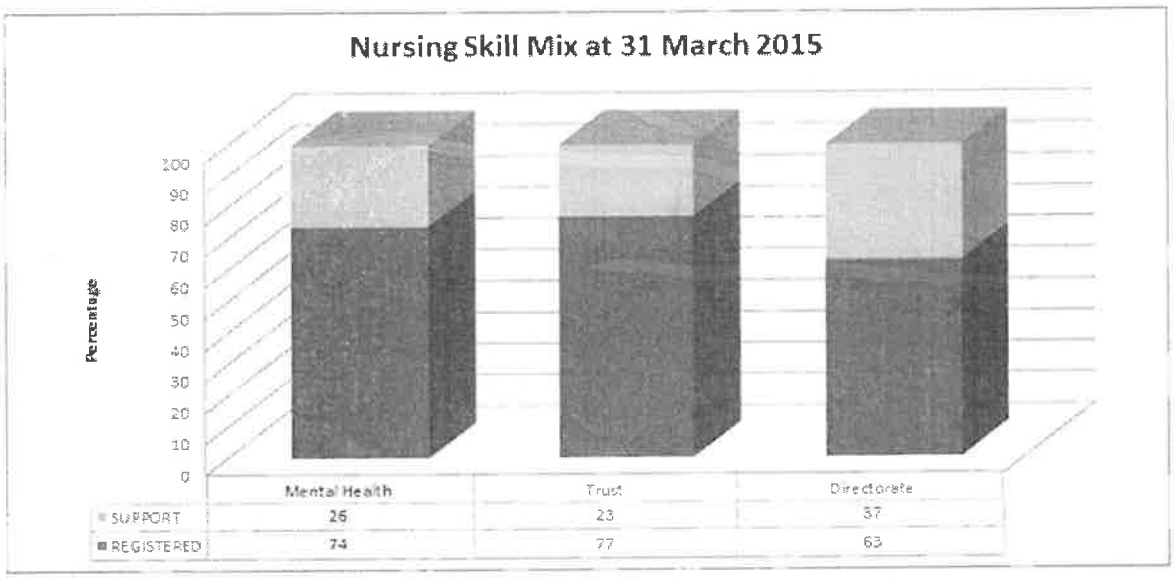
During this period 146 Band 5 staff have been appointed across the Service area, which has the highest number of new appointments. Band 6 staff, with 99, has the second highest total of staff appointments within the Service area. There has been 15 Band 8a and above staff appointed to the Mental Health Service area.

Graph 8 illustrates the reasons recorded for staff leaving the Mental Health Services between 1st April 2014 and 31st March 2015. During this period 96 staff from the Service area left the Trust with resignation and retirement accounting for 50% of the reasons recorded. Ill-health was recorded for almost 11% of the total number of leavers. Staff leaving to go to another health care organisation was recorded against only 7 staff (7%). Included in the total number of leavers is 37 staff that were on temporary contracts, the majority of whom, 21, were on medical rotation.

Graph 8

2.1.4.2 Skill Mix

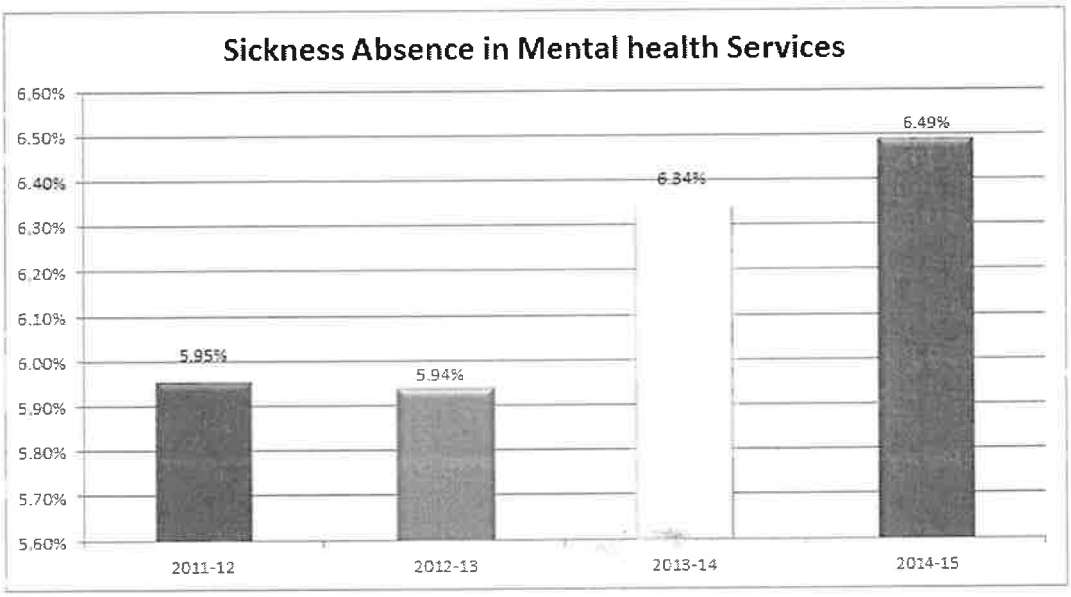
Graph 9 provides the skill mix in nursing staff within Mental Health Services. Currently, in Mental Health Services the nursing skill mix is 74:26 Registered to Non-registered staff. The ratio of qualified nurses in mental health Services is lower than that for the Trust as a whole which is 77:23. It is not anticipated that there will be significant changes across this Service area during the period of this workforce plan.



Graph 9

2.1.4.3 Sickness Absence

The levels of sickness absence within Mental Health Services, for the period 1st April 2011 to 31st March 2015, are illustrated in Graph 10. Over this period the level of absenteeism due to sickness has risen by approximately 0.54%. In the 12 months to 31st March 2015, a total 18,000 days (126,000 hours) were lost due to sickness within the Service, this equates to 81 WTE staff being absent for a year. This level of absence will have impacted on the level of expenditure on agency staff.



Graph 10

In the period from 1st April 2014 to 31st March 2015, the main reasons recorded against sickness absence were, General Debility; Stress; Depression, Grief/Bereavement and Back Ache, which in total accounted for approximately 59,380 hours of sickness absence. These reasons accounted for approximately 47% of the total sickness recorded for that year. General Debility was recorded against 18,855 hours, 15% of the total sickness for the Service area and was the number 1 reason for sickness absence.

During the period 1st April 2014 to 31st March 2015, the Service area lost a total of 5745 hours due to work related stress. Table 5 provides the cost associated with this absence, based on the mid point of the band recorded in this absence. The information does not include any agency costs that may have been incurred as a result of this absence.

Mental Health Services

Band	Absence Hours	Cost £ (based on midpoint of scale)
3	963.74	8799
5	1654.5	20218
6	1354.5	20670
7	450	8199
8A	375	8115
Total	**5744.74**	**66001**

Table 5

2.1.4.4 Agency Expenditure

Agency expenditure within Mental Health Services amounted to £550,000 for the year 2014/2015. Expenditure on admin & clerical staff, at £290,000, was the highest closely followed by medical and dental agency staff at £225,000.

This comparatively lower level of expenditure reflects that mental health had a lower level of sickness than other areas in the Directorate as well as a lower number of vacant posts during the year reducing the need for agency expenditure.

MENTAL HEALTH Comparison of Agency Expenditure with sickness Levels and Vacant Posts 2014/2015	
Sickness Absence Hours	132,005.06
Number of staff Lost due to Sickness Absence	80.7 WTE
Agency Expenditure	£554,991
Vacant Posts	156

Table 6

2.1.5 Summary

There are many changes, within mental health Services that have been identified and will take place during the next five years. These changes vary in terms of the scope and size of the project ranging from the completion of the new Inpatient Unit during 2017 to the reorganisation of the Court Diversion scheme. There are other changes which, the Service is confident will take place over the next five years, but clarity as to the direction of travel has still to be obtained. In some cases the outcome may identify a variation of an existing

Service such as the Court Diversion Scheme, whilst for others the review may lead to the introduction of a new Service such as a scheme for people with eating disorders. These projects are awaiting the outcome of reviews, both internal and external to the Trust. These will impact on the Services that are provided within the Service area.

It is not anticipated that the current projects and those that are in the planning stage will have a significant impact on the overall workforce resources needed to deliver the Services. However it will only be when each review is completed that the full workforce implications will be known and these will be incorporated into the workforce plan during the reviews, which take place over the next 5 years.

The management team will need to address the issue of the level of sickness absenteeism within the Service, including the time lost due to work related stress. Availing of the support of the Attendance Management team within HR will assist the management team when addressing these issues. Reviewing the use of agency staff across all family groups and in particular admin & clerical should also be carried out to identify issues and remedial action.

2.1.6 Action Plan

The development of the workforce plan has identified actions required to be undertaken by the Service. These have been highlighted in the table below. As we proceed through the period covered by this plan more actions will be identified and will be added to the list during the reviews.

Table 18 Action Plan for Mental Health Services 2015 to 2020

Service Area	Action	Person Responsible	Timescale
Mental Health	Closure of DGU & redeployment of affected staff	Mel Carney	31 March 2016
Mental Health	Completion of CAMHS review and implementation of outcomes	Billie Hughes	31 March 2020
Mental Health	Opening of the new Inpatient Mental Health Unit	Mel Carney	31 March 2018
Mental Health	Review of Approved Social Worker Role to be completed by March 2016	Mary O'Brien	31 March 2016
Mental Health	Review of the need for Eating Disorder Services	Peter Bohill	31 March 2018
Mental Health	Review of the provision of Day Services	Peter Bohill	31 March 2016
Mental Health	Implement the outcome of the Criminal Justice Service Review as it impacts on Unscheduled Care Court Service	Mel Carney	31 March 2017
Mental Health	Reduction in the sickness absence rate within the Service area from 6.49% to 5.49%	Barney McNeany	31 March 2016
Mental Health	Confirmation of the required workforce going forward within all areas	Barney McNeany	31 March 2016
Mental Health	Develop and implement succession planning strategy – Growing our People Today for Tomorrow	Barney McNeany	31 March 2017
Mental Health	Implement Induction programme for all new recruits	Barney McNeany	31 March 2016
Mental Health	Promote age awareness and age diversity as more staff remain in the workplace	Barney McNeany	31 March 2016
Mental Health	Ensure statutory and mandatory training compliance	Barney McNeany	31 March 2016

2.2 LEARNING DISABILITY

This section of the plan will highlight workforce issues associated with the provision of Services within Learning Disability. Learning Disability teams provide both a regional Service and a local Service to the population of Belfast. Services can range from emergency care provision, outpatient appointments and day procedures, and repeated lengthy admissions due to complex mental health and behavioural needs. These Services are provided by a workforce of 896 staff, details and an analysis of which are provided later in this section.

The learning disability Services are separated into three Service areas:-

- In-patient Service for adults and children, located on two sites the Muckamore Abbey Hospital (MAH) and the Iveagh Unit;
- Residential Supported Living and Day opportunities, which currently provide over 750 day care places;
- Community Treatment and Support Service.

"We will work together to promote health, wellbeing, independence and hope, supporting people to enjoy fulfilling lives in their community"

2.2.1 The Drivers

2.2.1.1 Hospital Services

- There is a drive to shift from acute to community healthcare Services consistent with a person centred approach and accompanied by a hospital model
- Deliver a modern acute inpatient Service

This has been highlighted in a range of recent regional reports including: The Bamford Review of Mental Health and Learning Disability (Northern Ireland) 2007, Transforming Your Care – A Review of Health & Social Care in Northern Ireland December 2011. This shift from acute Service provision to one which is more community based is likely to impact on the resources needed to deliver these Services safely. This focus is currently demonstrated in the resettlement project currently underway at Muckamore Abbey Hospital, which will see all long stay patients resettled into the community.

- There is drive to provide for patient safety and high quality Services.

This has been highlighted in a range of recent national and regional strategies and reports including Quality 2020 (DHSSPS, 2011c); The Francis Report (2013); The Cavendish Review (2013); The Winterbourne View Report (DH, 2013); The Keogh Report (2013) and The Berwick Report (2013)

Services should be person centred (i.e. Service users will have their rights respected and be supported to keep control of their lives)

The children and adolescent Service, provided at the Iveagh Unit in Belfast, will be unaffected by the above resettlement exercise and will continue to provide the current level of Service provision.

2.2.1.2 Day Care Services

Health & Social Care Board recommendations for future day opportunities provision in Northern Ireland which give clear direction to increase the amount of day opportunities provided by the voluntary and private sectors will result in a reduced number of adults with a learning disability attending Trust day centres.

Traditionally the Trust has provided day care to people with a learning disability mostly within Trust learning disability day centres. As recommended by Bamford and included in the HSCB recommendations the Services are looking to increase the amount of day support and day opportunities provided outside of our day centres and within local communities. This will involve greater use of the voluntary and private sector as well as other departments and agencies such as DEL, DARD, DSD, Education and Belfast City Council. The implications of this change in emphasis will mean that the Trust will propose to reduce the number of its day centres. This will have a knock on effect in relation to the use of voluntary and charitable providers and the staffing requirements needed in this area.

The aim of this proposal is to reduce the number of statutory day places provided in our day centres and, as per policy direction, increase our partnerships with other sectors regarding day opportunities for adults with a learning disability. This will result in those with complex needs getting a specialist Service with the possibility of those who can avail of a wide range of Services having these provided by other agencies. This will happen through the assessed needs of our clients in a person centred manner. Presently 'A Consultation on the Delivery of Learning Disability Day Services for People Living in Belfast' is due to close on 26 November 2015.

We are also reviewing our residential and supported living services. This may result in our residential provision moving to a supported living model which may involve the provision of Services by the voluntary and private sectors.

Our review, which is due for completion by 31 March 2016, could result in Belfast Trust considering to no longer be the provider of residential services for adults with a learning disability with a move to supported housing. This review could also result in a move by the Trust to reduce direct service provision regarding supported living services which will have an impact on our staffing levels.

2.2.1.3 Community Treatment & Support

The community treatment and support service will, like other service areas within this Directorate, have to deal with the challenges presented by demographic change. This will mean an increase in both the number of people requiring our services and the degree of complexity that the Trust will be required to treat and support.

We will also be expected to develop Services to meet the requirement to reduce the number of hospital admissions in the future; to reduce the incidence of delayed discharges from hospital and promote greater use and carer involvement.

2.2.1.4 Adult Safeguarding

Adult safeguarding is a growing area of demand in learning disability services, particularly large scale complex investigations in group care settings which require skilled and experienced staff and make heavy demands on staff resources. In addition, the new regional safeguarding policy widens the scope of the Trust's safeguarding responsibilities to people who would not always meet access criteria for the Trust's service areas. This could create additional demand.

2.2.1.5 Social Work Strategy

The regional social work strategy is a 10 year plan which has three central themes, strengthening the capacity of the social work workforce, improving social work services and building leadership and trust in the profession. All of these areas have significant workforce implications for the Trust.

2.2.1.6 Approved Social Worker

The Trust is currently struggling to meet the demands of providing ASW services. There are considerable problems with workload issues and availability of sufficient numbers of qualified staff. A review has recently been undertaken and the findings of this review will be incorporated into the plan during the monitoring process.

2.2.1.7 Anticipated Mental Capacity Bill

The draft Mental Capacity Bill will introduce a single, statutory framework governing all situations where a decision needs to be made in relation to the care, treatment (for a learning disability, physical or mental illness) or personal welfare, of a person aged 16 or over, who lacks capacity to make the decision for themselves.

The bill will work to ensure that an individual's capacity to make decisions about their health, care and personal welfare is respected. Appropriate safeguards are also included to ensure that an individual's best interests are respected where their capacity is comprised. This is again in line with the person centred approach.

While the bill's impact is to a great extent unknown at this stage, there will certainly be a significant requirement for initial and ongoing training, a significant increase in requirements for formal capacity assessments, formal best interests decision making and applications for legal authority to carry out certain actions. In addition, the Trust will need to set up and staff its own formal authorisation mechanisms.

2.2.2 What our Services will look like

During the period covered by this workforce plan there will be changes to the Services delivered by the learning disability teams. These changes are highlighted in this section. It is worth noting that some of these projects are at different stages of development.

Services will be planned, implemented and evaluated in partnership with users and carers

2.2.2.1 Hospital Services

Upon completion of the community integration project which is anticipated in December 2016, MAH aims to; in agreement with the HSCB; introduce a phased approach to the modernisation of the core hospital. It is anticipated that the remaining core wards will have approximately 50 beds which will provide assessment and treatment, Psychiatric Intensive care and regional low secure forensic Services.

The hospital will no longer have long stay beds on the site with patients completing treatment and active discharge planning back to community placements. Wards previously used for care of long stay patients will be closed and decommissioned on a phased basis, leaving only the newly built "core" wards.

A day Services facility will also be retained providing therapeutic, support and treatment Services to the acute in patient wards. Iveagh Children's inpatient Services will continue to provide tier 4 inpatient Services and with HSCB approval aim to develop an enhanced outreach Service to support community placements and avoid potential admissions.

2.2.2.2 Supported Living and Residential Provision

The Trust will strive to ensure all our clients have suitable living arrangements based on the assessed need of the individual. To achieve this, the Trust will review how Services are delivered in order to ensure the best outcome for our clients. This will result in the Trust enhancing and developing partnerships with the voluntary and private sectors while reducing statutory provision, but maintaining a well-motivated workforce able to meet the assessed needs of our client group.

The new Service will ensure our clients get the best, most effective, inclusive Service possible, this model will have enhanced involvement by the voluntary and private sector which will be closely monitored by Trust staff. The Trust will continue to support and monitor the same number of clients who receive day opportunities, residential and supported living Services involving an increase in the use of other sectors in accordance with the regional model.

2.2.2.3 Community Treatment & Support

The model of delivery identified for the community treatment and support Services will include five teams, a care management team and four multi-disciplinary community based teams. In addition the Trust provides an Intensive Support Service; a Psychological Therapies Service; a Forensic Psychology Service; a Safeguarding Service and a Health Facilitation Team.

2.2.3 The Workforce Required to Deliver the Services in the Future

The changes that are due to take place throughout the Directorate over the course of the period covered by this plan will result in significant changes to the workforce. New models of Service delivery, the demands of TYC and need to ensure that high quality cost effective Services are delivered will have an impact on the resources that are required going forward.

Services will be delivered at the right time, in the right place, by the right person, for the right length of time based on assessed needs

This section of the workforce plan identifies the resources that the Learning Disability Services will need to deliver its Services in the future. The changing landscape of the area in which Learning Disability Services operate will undoubtedly impact on the delivery of future Services. This may require different resources to those delivering the current Services, which will include the competency of the workforce as well as the number of staff required to deliver high quality Services in the future.

2.2.3.1 Workforce projections

Table 1 illustrates the projected changing workforce in Learning Disability Services which is based on the starting workforce and the average number of leavers and new starts over the last three years. Also included are the known workforce changes in relation to the projects currently underway or planned to be completed during the course of this plan. The plan projects an increase in the workforce in the Service area by 73 staff.

Learning Disability Services Workforce Projections 2015/2020

	2015/16	2016/17	2017/18	2018/19	2019/20
Staff in Post at 31st March	896	938	924	939	954
Average No. of Leavers *	-53	-72	-72	-72	-72
Average No. of starters *	95	87	87	87	87
Reviews		-29			
Total indicative projected staff in post 1st April	938	924	939	954	969
Net Variance	42	-14	15	15	15

* figures for 2015/16 are actual figures

Table 1

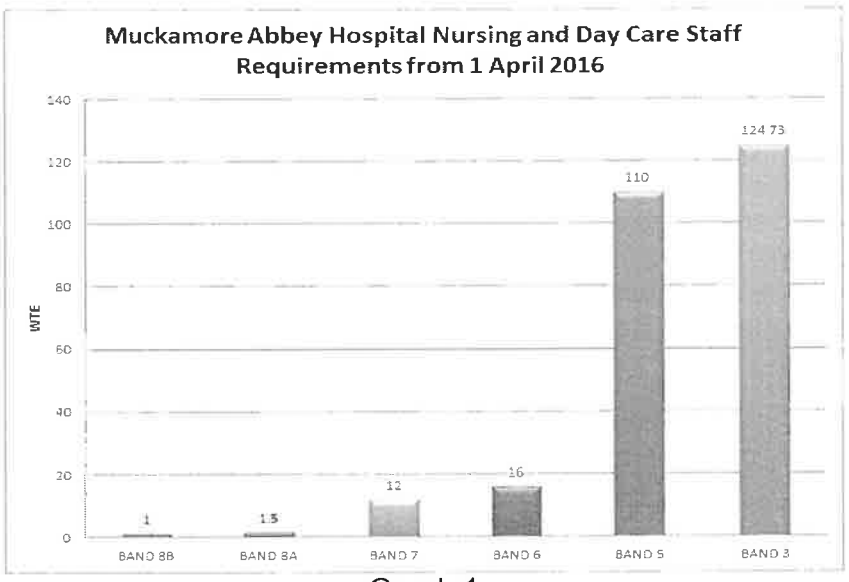
2.2.3.2 In-patient – Muckamore Abbey Hospital

The change in the model of Service delivery to a modern acute inpatient assessment and treatment Service with associated intensive care unit will require a revised level of resources to reflect the changes in patient profiles and acuity. A robust multi-disciplinary team will be required to deliver treatment and interventions to ensure as short a period in hospital care as possible. The current resource needs to address multi professional deficits. The proposed retraction plan for nursing staff does not address the normative staffing, skill mix and ratios needed or safeguarding requirements that will be a feature of acute tier 4 inpatient services.

A revised nursing plan will increase the number of band 7, 6, and 5 registrants – with a reduction in band 3 healthcare support workers.

It must be noted that representation must be pursued to increase the number of pre-registration students to address projected retirements from the Service over the next 5 – 10 years with anticipated turnover of registrants being over 40%.

The staffing model proposed needs to address the Trusts recurrent cost pressure of supervision requirements for those admitted for inpatient care thus reducing the reliance on the use of bank staff or agency.



Graph 1

2.2.3.2.1 Medical workforce

There is also the need to review the input and bandings of all specialist services, including the medical staffing compliment. The Trust is exploring whether the resource would be better placed in "owning" Trusts taking into account the current Service commissioning arrangements to the Northern and South Eastern Trust community Services.

2.2.3.3 Community Services – Residential, Supported Living and Day Opportunities

Management of Learning Disability Services envisage a reduction in staff as the Residential Supporting Living and Day Opportunity model rolls out across day care, residential and supported living services over the next five years from 487 staff currently, to 441.8 wte, a reduction of 45.2wte. This reduction in staff will impact on staff at Band 3, Band 5, Band 6 and Band 7 as the proposed new model of service delivery is developed.

Band	Existing Staff WTE	Required Staff WTE
BAND 3	216	194.4
BAND 4	7	7
BAND 5	142	127.8
BAND 6	57	51.3
BAND 7	37	33.3
BAND 8A	9	9.0
BAND 8B	3	3.0
BAND 8D	2	2.0
MEDICAL STAFF	14	14.0
Total	**487**	441.8

Table 2

Table 2 confirms the impact that the proposed changes to the current model of Service delivery will have on the workforce within Learning Disability Community Services.

2.2.3.4 Sleep-ins within Learning Disability Residential and Supported Living

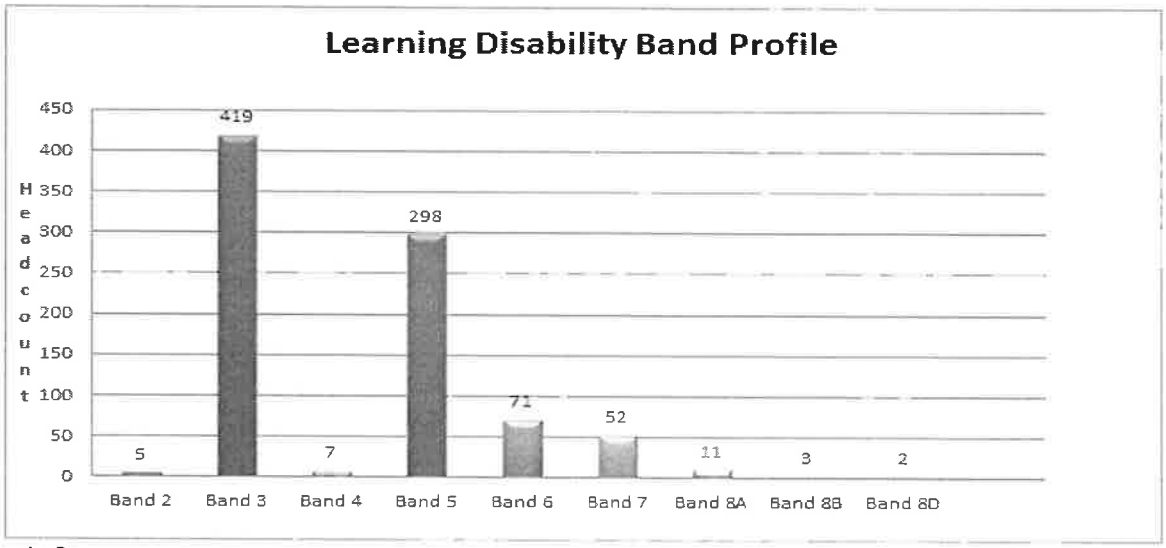
Currently sleep-ins, within the Trust residential and supported living Services, are provided by staff ranging from Band 3 to Band 7. This Service is currently provided to supplement the waking staff who are on duty, in the event they are required in an emergency. In Learning Disability Services eight of the units have a need to use sleep ins. This practice is currently under review across the Trust and the outcome of this review will impact on the delivery of Services in residential homes in Learning Disability Services. Should sleep-ins cease in the future, there will be an additional cost pressure for the Service in that staff will be engaged in waking nights, which will be more expensive than the current rate paid for sleep-ins.

There will also be a need for additional staff because of the need to adhere to the Working Time Directive. This prevents staff from working more than 48 hours, including the overnight hours that would have previously been covered by sleep-ins, which did not count towards working time.

2.2.4 Current Workforce

This section of the plan looks at the resources that are currently available within Learning Disability Services, which has almost 900 staff, covering the inpatient units at Muckamore and the Iveagh unit in Belfast and the community Services. The information provided in this section is based on the staff in post as at 31st March 2015.

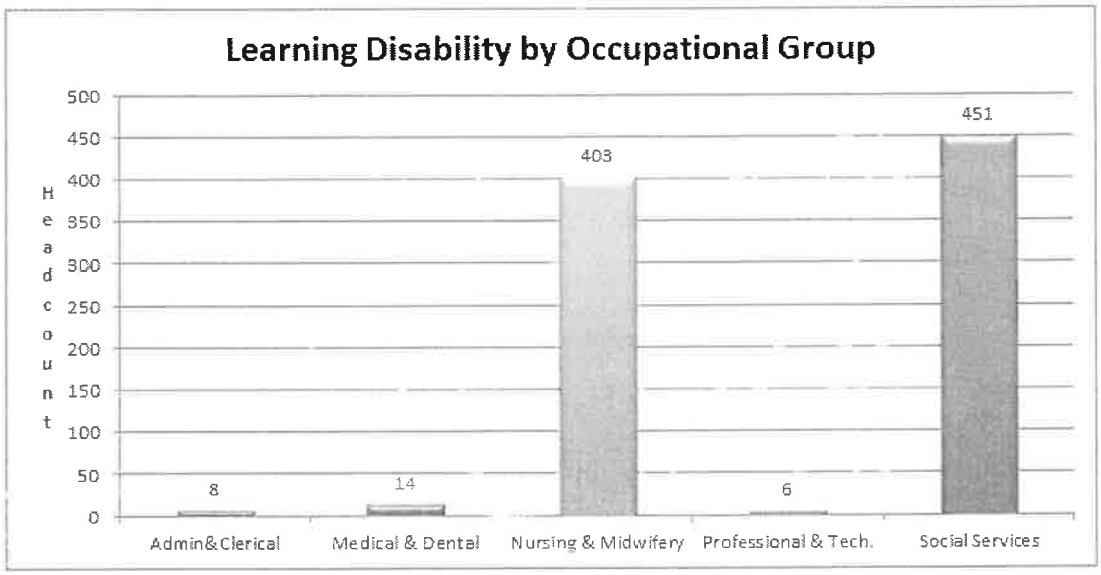
Graph 2 highlights the fact that the majority of the staff are employed at Band 3 and Band 5, with support staff accounting for almost half of the Service's workforce. Given the transformation in the Service delivery, more patients cared for in the community, it is anticipated more support staff will be employed. However the changing focus of Service at MAH is away from long stay patients to one of providing a treatment and assessment function. The implications of this are already being evidenced by the reduction in the number of support staff required on this site.



Graph 2

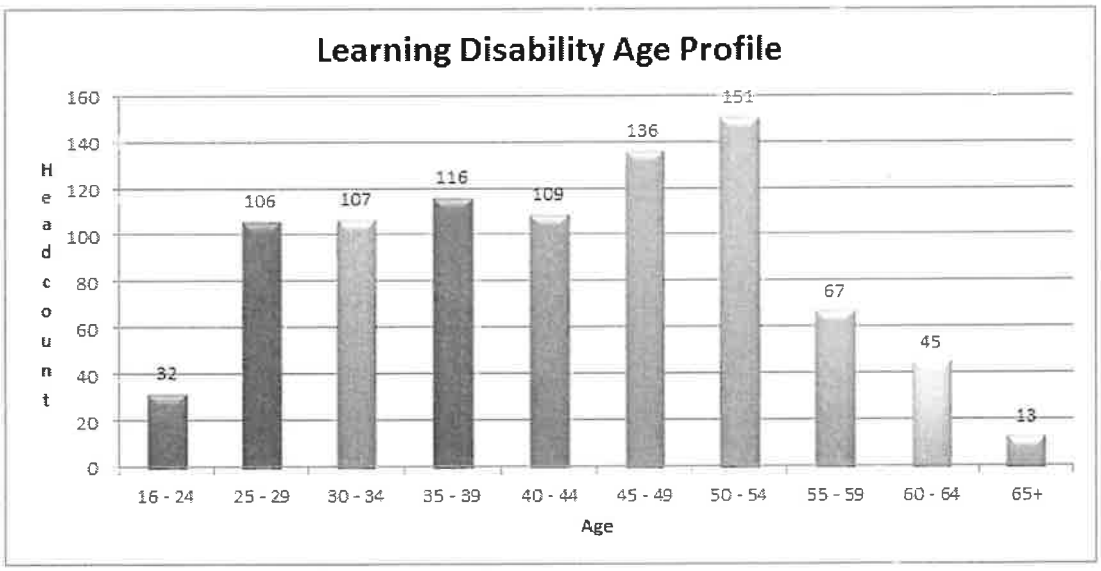
The management at MAH have included in their plan a need for fewer Band 3 support staff and an increase in Band 5 nursing staff.

Graph 3 illustrates that social Service staff make up over 50% of the total workforce within the Service area. This section of staff accounts for approximately 21% of the total social Service staff within the Directorate.



Graph 3

The age profile for the Learning Disability Service, in graph 4, highlights that 125 members of staff (14%) are above the age of 55. By the end of the period covered by this workforce plan another 151 members of staff will fall into this category, which based on current staffing levels would mean by 2020 31% of the workforce within the Service area will be aged 55+.



Graph 4

The age profile highlights a fairly even distribution across the Service with the exception of the 16-24 age range, which is significantly lower than the other with the exception of staff aged 65+.

Staff in the 50-54 age group account for 17% of the Service workforce; across the Trust 14.8% of the staff are found in the same age group. A significant number of the staff in this age group will be in a position to retire by the end of the period covered by this plan, including nursing and staff with Mental Health Officer status.

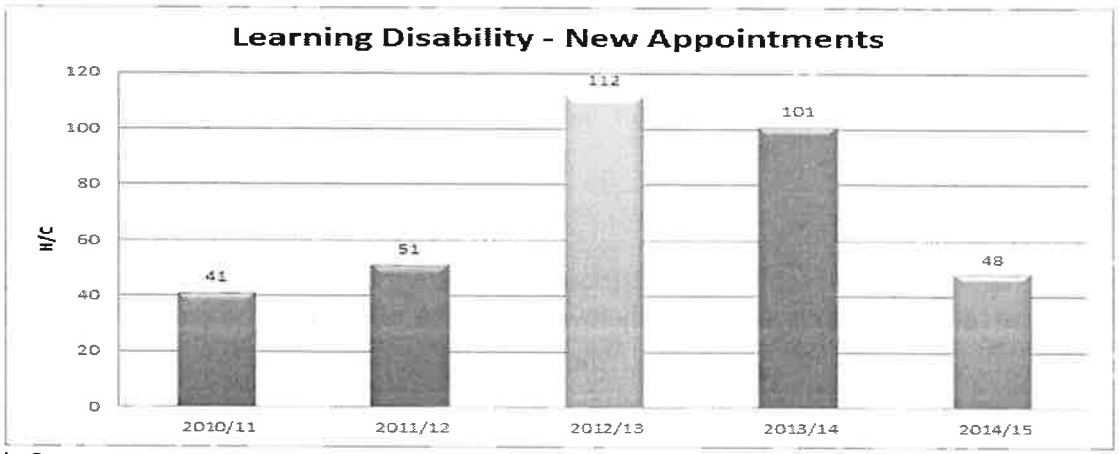
Graph 5 highlights the age profile of the staff and the impact it will have on the different grades of staff. At Band 7 manager level 13% of the staff at this grade are aged 55 or older, however, there is twice this number between the ages of 50 and 54. The indication is that 44% of the total staff at this grade will be 55 or over by 2020, which may have implications for succession planning and potential loss of skills and knowledge.

There is 71 staff at Band 6 within the Service area. Within this band of staff 8 are aged 55 and above. However there is a further 16 staff in the 50-54 age group and when added to the older age groups this gives a total of 34% of the total Band 6 staff aged 50 and above. Again this may require succession planning to be put in place or at least to address the potential loss of skills and experience.

Graph 5

2.2.4.1 Recruitment

Graph 6 illustrates the total number of new appointments in Learning Disability Services over the last 5 years.



Graph 6

Over the last 5 years 353 staff have been appointed to positions within the Learning Disability Service area. These include appointments for staff to new and replacement posts. During this period 160 Band 3 staff have been appointed across the Service area, which has the highest number of new employees. Band 5 staff, with 113, has the second highest total of staff appointments. There has been 14 Band 8a and Band 8b staff appointed to the Learning Disability Service Group.

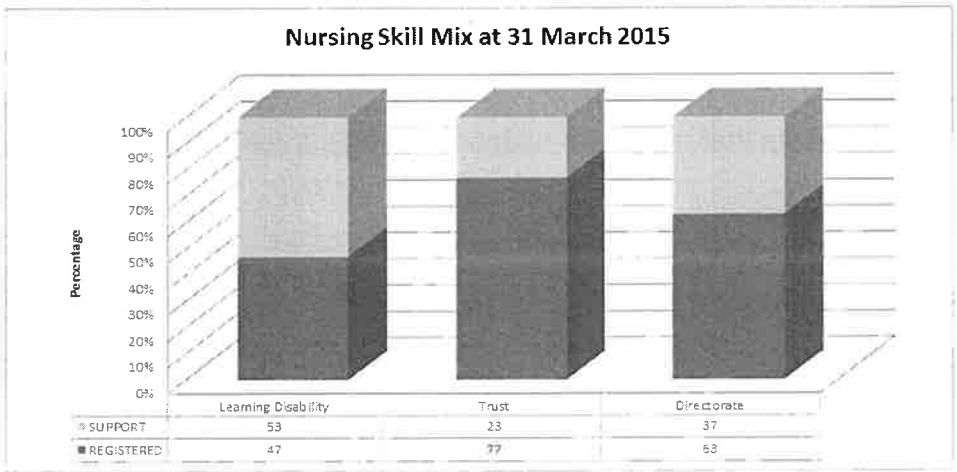
Graph 7 illustrates the reasons recorded for staff leaving the Learning Disability Services between 1st April 2014 and 31st March 2015.

Graph 7

During this period 65 staff from within the Service area left the Trust. Resignation and retirement accounted for approximately 69% of the reasons recorded for staff leaving. Ill-health was recorded for almost 20% of the total number of leavers. Staff leaving to go to another health care organisation was recorded against only 4 staff (6%). Included in the total number of leavers is 14 staff that were on temporary contracts.

2.2.4.2 Skill Mix

Graph 8 compares the nursing skill mix in Learning Disability Services with that of the Trust and the Directorate. Currently, in Learning Disability the nursing skill mix is 47:53 Qualified to Non-Qualified staff. It is not anticipated that there will be significant changes across this Services area during this workforce plan. However there will be small areas of change for example at the MAH site where the number of registered nursing staff will decrease slightly, which when coupled with a large decrease in support staff will change the skill mix on this site.

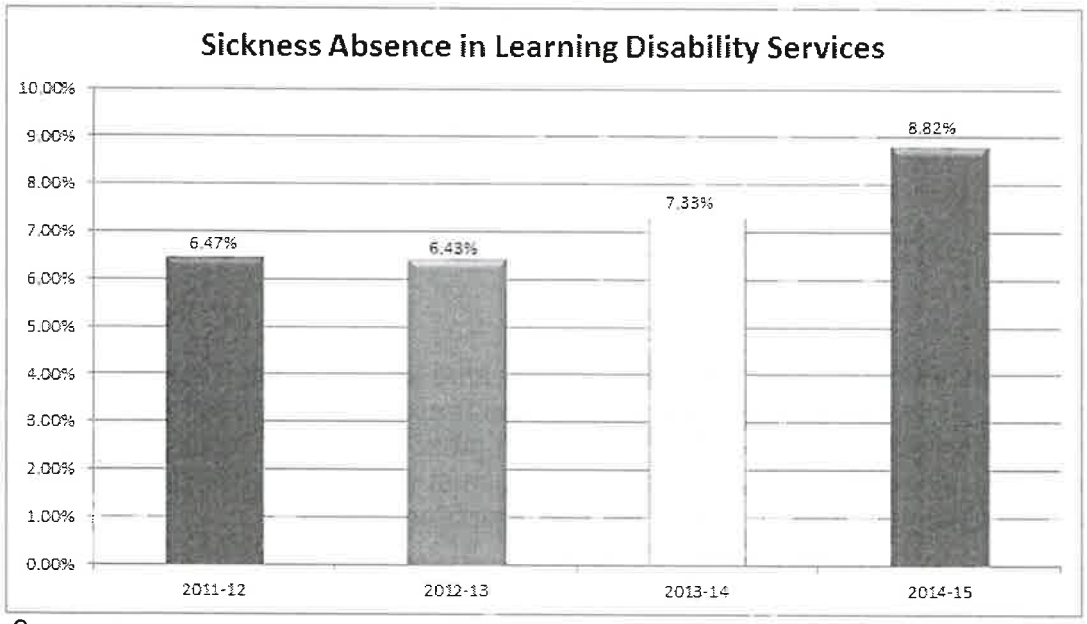


Graph 8

As mentioned earlier, in this plan, the changing needs of the patients at MAH will impact on the nursing skill mix. However it would be expected that as the resettlement project is completed more support staff will be required to provide the Services to the same patients in a community setting. To date 15 support staff have been redeployed from MAH into community areas.

2.2.4.3 Sickness

The levels of sickness absence within Learning Disability Services, for the period 1st April 2011 to 31st March 2015, are illustrated in graph 9. Over the last 4 years the level of absenteeism due to sickness has risen by 2.35%. In the 12 months to 31 March 2015, a total 21,500 days (142,000 hours) were lost due to sickness within the Service, which equates to 97 WTE staff being absent from work for the year.



Graph 9

The main reasons recorded against sickness absence were, Stress; General Debility; Post-Surgical Debility, Back ache and Depression, which in total accounted for approximately 71,364 hours of sickness absence. The reasons outlined above accounted for approximately 50% of the total sickness recorded for that year. Stress, which was the number 1 reason for sickness absence, was recorded against 26,000 hours, 18.3%, of the total sickness for the Service area.

Over the period 1st April 2014 to 31st March 2015, the Service area lost a total of 5465 hours due to work related stress. Table 3 provides the cost associated with this absence, based on the salary of the Bands recorded for this absence. The information does not include any agency costs that may have been incurred as a result of this absence.

Learning Disability Services

Band	Absence Hours	Cost £ (based on midpoint of scale)
3	2555.21	23329
5	2460	30061
7	450	8199
Total	**5465.21**	**61589**

Table 3

2.2.4.3 Agency Expenditure

Learning Disability Services spent approximately £890,000 on agency staff during 2014/15. There was over £400,000 spent on social Services staff; over £200,000 on admin & clerical agency staff and approximately £190,000 on nursing agency staff.

The level of agency expenditure can be explained in part due to the fact that learning disability Services had considerably more vacant posts during the year with 241 vacancies, which was the highest in the Directorate. Table 4 compares the agency expenditure with sickness absence and vacant posts.

Comparison of Agency Expenditure with sickness Levels and Vacant Posts 2014/2015	
	LEARNING DISBAILITY
Sickness Absence Hours	131363.1
Number of staff Lost due Sickness Absence	67.37
Agency Expenditure	£849,806.75
Vacant Posts	241

Table 4

2.2.5 Summary

There are several projects that will impact on the workforce within Learning Disability, which have been identified during the development of this workforce plan. The completion of the MAH Resettlement project will see the transformation from a hospital where the majority of patients were long stay to a facility with no long stay patients, providing an assessment and treatment Service. The plan has also identified that a review of Day centres will be undertaken and the identification of the future model of service delivery is due for March 2016. This may involve greater use of the voluntary and charitable sector in the provision of Services. These projects will impact both on the Service users and the workforce and an important consideration will be to minimise the impact on both groups. The completion of these projects is unlikely to have a significant impact on the workforce resources needed within Learning Disability Services.

Like many Services, Learning Disability uses sleep-ins and this use is currently being reviewed by the Trust across all Services. The outcome of this review will have implications for the Service as the status quo will not remain. All Services will have to find an alternative method through which to provide their Services, which will probably require additional resources in workforce and financial terms.

The level of sickness absence and agency expenditure is high in this area. These are two areas that will require attention and action by the management team to reduce the levels of absence and expenditure. In connection with the sickness absence the Attendance Management Team within HR are available to provide support and assist in addressing this issue.

2.2.6 Action Plan

The development of the workforce plan has identified actions required to be undertaken by the Service. These have been highlighted in the table below. As we proceed through the period covered by this plan more actions will be identified and will be added to the list during the reviews.

Table 18	Action Plan for Learning Disability Services 2015 to 2020		
Service Area	**Action**	**Person Responsible**	**Timescale**
Learning Disability	Completion of MAH Resettlement project, including the redeployment of affected staff	Esther Rafferty	31 March 2016
Learning Disability	Re-configuration of day opportunities provision and the potential redeployment of affected staff	Neil Kelly	31 March 2016
Learning Disability	Reduction in the sickness absence rate within the Service area from 8.82% to 7.82%	John Veitch	31 March 2016
Learning Disability	Confirmation on future direction of Iveagh linked with CAMHS and implementation of outcomes	Esther Rafferty	31 March 2020
Learning Disability	Confirmation of the required workforce going forward within all areas	John Veitch	31 March 2016
Learning Disability	Develop and implement succession planning strategy – Growing our People Today for Tomorrow	John Veitch	31 March 2017
Learning Disability	Implement Induction programme for all new recruits	John Veitch	31 March 2016
Learning Disability	Promote age awareness and age diversity as more staff remain in the workplace	John Veitch	31 March 2016
Learning Disability	Ensure statutory and mandatory training compliance	John Veitch	31 March 2016

2.3 Older Peoples Services including Physical and Sensory Disability

2.3.1 Introduction

Older Peoples Services is the largest section within the Adult Social and Primary Care Directorate. This Service area contains the largest number of staff within the Directorate with 2,434 providing the Services. It has the highest number of social care staff, 1,484 in the Trust.

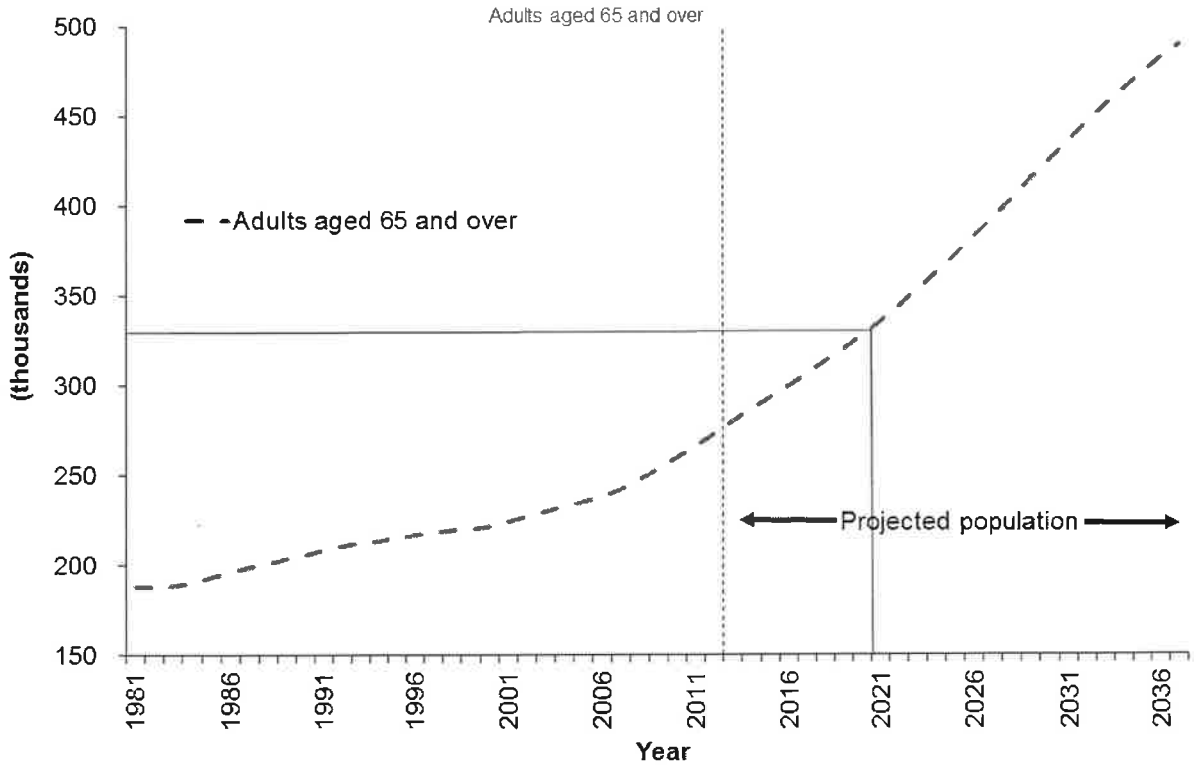
The Service is organised into five teams which are outlined below:

- Complex Discharge Unit
- South & East Belfast Locality & Older People's Wards BCH
- Provider Services North & West Belfast Locality & Older People's Wards RVH/Mater
- Physical & Sensory Disability Service
- Intermediate Care & Mental Health Services, Residential, Day Care and Domiciliary Services (S&E Locality) & Gateway Adult Protection

2.3.2 The Drivers

2.3.2.1 Responding to population needs

We have an ageing population who may place additional and more complex demands on the Trust's Services, which will be a major driver for this Service area. The graph below illustrates the projected population for those who will be over 65, which is expected to be over 327,000, by 2020 (NISRA 2010).



The Belfast Trust contains 7 out of the top 10 most deprived areas in Northern Ireland. Deprivation impacts on health issues and disease prevalence e.g. COPD, Heart Disease, Cancer, Asthma and Diabetes. North, West and East Belfast have the lowest life expectancy in Northern Ireland and some of the highest chronic disease prevalence in Northern Ireland.

2.3.2.2 Transforming Your Care (TYC)

There will be significant changes as to how we deliver our Services in the future to ensure that we meet the demands and requirements of TYC. This will include meeting commissioning specifications regarding Frail, acute, Elderly, Respiratory, Diabetes, Stroke and End of Life Care; the need to provide more opportunities to older people and their carers for self-directed support and an increase in the choices available to older people for independent living through additional supported living schemes.

2.3.2.3 Complying with statutory functions

We need to ensure we meet the requirements of delegated statutory functions and that we are fit to meet the demands placed on the Service in the future. This will include the registration of all Domiciliary and Day Care Workers. Following the announcement by the Health Minister to introduce compulsory registration of all social care workers practising in Domiciliary care, Day Care and supported living Services the Trust will have to work to achieve this by a possible deadline of 31st December 2016.

2.3.2.4 Responding to Regional Reviews / Initiatives

2.3.2.4.1 Provision of Residential Services

The outcome of the regional review into the provision of residential Services will help to inform the Trust's approach to its residential care Services.

2.3.2.4.2 Reablement Service

Reablement is a regional initiative which has been developed in response to the Transforming Your Care (TYC) agenda. The initiative dictates that all clients who are referred for social care input, and meet Reablement criteria, should have a period of Reablement care, needs assessed and care planned by an OT and delivered by trained Reablement Support Workers following client specific Intervention Plans. Care is delivered using the 'hands off' Reablement model. The Reablement Service will be fundamentally different from a standard domiciliary care Service in that the re-ablement support worker will not just meet the day to day needs of the older person but will actively help them to achieve maximum independence at the earliest opportunity. It is designed to enable older people to regain the skills and confidence they may have lost as a result of poor health or as a consequence of having spent a period of time in hospital or residential care.

2.3.2.4.3 Domiciliary Care

A regional workforce review is currently underway. The purpose of the group that has been established to oversee the project is to carry out a workforce review of domiciliary care which will inform planning to ensure the availability of a workforce to meet future demand and redesigned Services. One of the objectives of the review is to produce a Workforce Plan in early 2016. The outcome of the regional review into the provision of Domiciliary Care Services will help to inform the Trust's approach to its residential care Services.

2.3.2.4.4 Responding to Trust Reviews

There are reviews currently underway which will highlight areas where change may be necessary. The outcomes of these reviews, once they are completed, will be included in the workforce plan. It may not be possible to include this information in the first year of the plan, but will be factored into the plan during the monitoring and reviews of the plan.

2.3.2.4.5 Review of Supported Living

A review of the provision of supported living is to be undertaken by the Trust, the outcome of this review will impact on the resources needed to deliver the Services in the future and will require close monitoring to ensure the Trust is prepared for the changes and challenges this may present.

One of the challenges in relation to supported living, which will help to promote the client's independence, is the fact that clients are not as familiar with this model of care.

2.3.2.5 Stroke Services

Stroke Services are currently undergoing a significant change project with the introduction of Early Supported Discharge (ESD). The main driver for this change is that the evidence shows that patient outcomes are improved when patients are discharged to undergo rehabilitation in their own homes, as soon as they are medically fit, as opposed to in a hospital setting.

2.3.2.6 Review of Social Workers

The aim of the project is to review and modernise the social work and social care and care management workforce within Older Peoples Services, in order to be best placed to meet the requirements and key objectives of "Transforming Your Care" and the NI Social work Strategy (Improving and Safeguarding Social Wellbeing – A Strategy for Social Work in Northern Ireland 2012 – 2022).

The review will consider staffing levels, WTE's, skill mix, grade mix, ways of working, changing roles and responsibilities, new roles and also current and emerging workforce trends and requirements, turnover, recruitment and training.

2.3.2.7 Review of District Nursing

The challenges facing nurses and midwives during this period of transition include a growing number of older people and other vulnerable groups requiring nursing at home; the rise in the number of people with long-term conditions requiring complex nursing care; the associated drive to prevent hospital admissions and to ensure end of life care at home; the advent of telehealth and telemedicine; the requirement for advanced physical assessments and non-medical prescribing; the increase in the delivery of nurse led Services and measuring the quality of care received by patients in a world of 7 day/24 hour community Service delivery.

The development of TYC health functions such as management of acute respiratory illness, stroke, and urgent unscheduled care will be increasingly managed in community setting as opposed to hospital admissions. As such having access to wrap around district nursing Services to support informal carers or provide services such as domiciliary care packages to these being cared for at home rather in hospital.

2.3.2.8 Review of Unscheduled Care

The RQIA requirements, including those highlighted following the Inspection in Unscheduled Care (July 2014), found that there were significant challenges being experienced by older people within the Belfast Trust. Frail older people, attending the emergency department, can result in multiple assessments and transfers and may lead to deterioration in their condition.

To help reduce the risk of deterioration in the person's condition and to alleviate the pressure on the emergency department at the RGH a Service dedicated to assessing the needs of frail elderly people rather than their attendance at the RGH has been developed. The new unit based at the BCH site will be opened to provide a new Service to frail older people, which will provide Services from 9.00am to 9.00pm. Older patients will attend the new unit rather than attending the Emergency Department at the RGH. It is expected this will relieve pressures on the E.D. and provide a more efficient Service to the older patients.

Older People who need urgent assessment rather than emergency care can wait for several hours, after services have been contacted, before they are brought by ambulance to hospital. Many older people admitted via RVH Emergency Department may wait for several hours before transfer to a bed, usually in the Acute Medical Unit. If beds in Acute Medical Unit are not available they will be transferred as an outlier to another ward area. Following assessment in Acute Medical Unit the patient may be referred to the care of a Geriatrician but can wait for a period of days before transfer to a specialist Geriatric bed in either BCH or Musgrave Park Hospital. Transfers between hospitals frequently occur in the evening period and many patients were often being cared for outside locations that were designed to deliver the care required.

2.3.2.9 Acute Care at Home

The Acute Care at Home Team (ACHT) is being established, through the support of the Belfast Integrated Care Partnerships, to support older people to manage unexpected illness in their own home instead of being admitted to hospital. This team of skilled health professionals will treat the patient and manage their care at home during an acute period of illness.

Should hospital admission be necessary, the ACHT will coordinate with staff at emergency departments and acute medical units to discharge patients as soon as possible. The team will also organise the individually tailored package of care each patient will need, to be as independent as possible.

2.3.2.10 COPD and Respiratory Services

There are approximately 8,500 patients with COPD in the Belfast Trust, for which there is no cure. Respiratory disease is one of the main causes of emergency hospital admission. There is a need for investment in the existing COPD Services to move towards a model, located in the community, which will provide greater promotion of prevention, self-care, management of the condition in the community and the avoidance of unnecessary hospital admission. The delivery of a fully coordinated and joined up approach, involving all the relevant health and social care providers, will be essential for the health and wellbeing of the Service users and reduce the burden on already overstretched emergency departments.

2.3.2.11 Sleep-ins

Currently, sleep-ins are provided by staff ranging from Band 3 to Band 7. Sleep-ins are required within the Service to ensure that care is provided, in residential settings, in an efficient and economical way. Older people Services make use of sleep-ins to a significant extent and are the biggest user of this facility within the Directorate.

2.3.3 What Older People Services will look like

As demonstrated through the drivers there are a number of changes within this Service area, many of which are directed at moving Services away from the acute setting and more into the community as indicated in the Transforming Your Care agenda. These Services are at different stages of progression from the planning stage to those that are well under way in their development path, but all are due to be completed within the timescale of this workforce plan. This section of the plan describes what the Services will look like.

Services will be planned, implemented and evaluated in partnership with users and carers

2.3.3.1 Reablement and Social Care Rapid Response Services

The Reablement Service has recently merged with the Social Care Rapid Response Service. In the future Services will be provided using the re-ablement approach i.e. promoting independence in the Service user. It is envisaged that those assessed as being suitable for a period of re-ablement will have had their maximum independence restored within 6 weeks. The Reablement Service will be provided over a seven day week and may reduce need for Services such as homecare.

2.3.3.2 Supported Living

This Service is being reviewed. One of the tasks that needs to be undertaken is that the Trust needs to raise awareness of the concept of supported living for older people as a model of care, as well as proposals for better promoting the facilities within their area.

The Trust needs to explore the possibility of taking on an element of risk sharing with the housing associations. Risk sharing may in fact act as an added incentive for the Trusts to better promote their supported living facilities. This would be assisted through more joint planning between the Trusts and housing associations before decisions are made to commission new facilities.

2.3.3.3 Social Work and Social Care

This Service is being reviewed. The review will consider the roles and functions of social work and social care within the hospital setting and within the integrated care teams with a view to developing a range of responsive multi-disciplinary community Services for older people with a range of complex health and social care needs.

The development of TYC health functions such as management of acute respiratory illness, stroke, and urgent unscheduled care will be increasingly managed in community settings as opposed to hospital admissions. There is a need for community teams to be able to deliver

a range of practical, social and environmental supports in a personalised flexible manner whilst at the same time standardising access to Service and managing resources through Regional Eligibility Criteria.

The hospital discharge agenda and attendant pressures continue to test community systems and responses. Transitions of care from acute hospital to community settings, for frail elder older people, require sound planning and safe and effective reliable discharge pathways. There is a pressing need for a clear access and referral process for hospital discharges to community, and 'in reach' or 'outreach' approaches to provide seven day access to community Services.

A number of options have been identified as a result of the review including no change to current Service provision; creating additional Band 6 posts to each ICT; maintaining the current model with the standardisation of staffing levels across the ICTs or streamlining care management into social work/social care roles and creating new roles such as Senior Social Worker Case Manager.

2.3.3.4 District Nursing

This Service is being reviewed. Many health tasks provided in hospital today are the community district nursing tasks of tomorrow.

There will be eight Integrated Care Teams (ICTs) that will provide an enhanced range of Services, which stabilises and cares for their patients to prevent admission and to facilitate early discharge from hospital. Key task for ICT's will be timely assessment of need along the continuum from prevention, support and enablement, towards complex and long term case management provision of home based care as alternative to institutional or hospital care, management of risk , end of life care, capacity, consent mental capacity decision making . This may involve greater involvement in comprehensive geriatric assessment at home, and development of district nursing as members of the multi-disciplinary assessment.

These enhanced Services will be provided on a trust wide basis 24 hours a day, 7 days per week. This new model of Service delivery will provide rapid access to the Community Urgent Care Team.

The preferred model will also include an Acute Care at Home Team, which will provide support to District Nursing patients between 11.00pm and 8.00am seven days per week. This Service will also manage the hyper-acute patients at home for a period of up to 72 hours. Rapid access to assessment/clinical investigations and social care Services will be delivered by this team.

2.3.3.5 Unscheduled Care

The BCH Direct Service which was set up in 2014 to provide a more effective and safer Service to older people and to help alleviate the pressure on the emergency department at the RGH will be reviewed over the next 12 months. The Service has had a significant impact on caring for older people and the review will look to identify how this can be best developed to meet the needs of the future.

2.3.3.6 Self-Directed Support

Self-directed support provides Service users with the opportunity to manage their care in a way that best suits their needs. The Service users have control over the way their support is provided and as much control as they wish over their own budget. This option is available to everyone who is assessed as being in need of social care support.

The Trust wants to significantly increase the uptake on this resource as approximately only 4% of care is provided through this route. It is anticipated that following the appointment of a Project Officer there will be significant uptake in the Services available.

2.3.3.7 Complex Discharges

The Service area's new Community Complex Discharge Team (CCDT) has been operational from June 2014. The key objectives of the team have been to improve performance and efficiency across all hospital sites through improving patient flow and the management of complex delayed discharge pathways. The team works collaboratively across all teams and sites to improve interface pathways and has an oversight and responsibility for progressing and challenging causes for delay and defining future Service developments to meet patient needs.

The team is responsible for gathering and providing information to all levels of the organisation on complex delayed discharges. It provides a link for both internal and external Trusts in relation to expediting complex discharges. The CCDT manages patient flow from acute to community Services and within and across community Services and will challenge where necessary performance and decision-making on discharge pathways to ensure the safe and efficient discharge of patients.

The impact of the Service is currently being reviewed and there is a possibility that there will be recommendations for increasing some community Services i.e. Reablement/Domiciliary Packages. Work is currently underway to combine and extend the two hubs into 1 as well as providing the Service 7 days per week.

2.3.3.8 Supported Housing Development – Dementia

The development of a supported housing Service for brain injury will be developed in west Belfast. It is expected the development will commence in March 2015 and take 12-18 months to complete.

2.3.3.9 Physical & Sensory Disability Service

The growing demands on the Service, to meet hospital discharge targets will impact on the Physical and Sensory Disability Service. These demands will include care packages having to be ready within a short timeframe, meeting the needs of the growing ageing population which correlates with increasing ill health, a rise in Korsakoff's Service users (alcohol related), the potential impact of Mental Capacity Bill and a rise in adult safeguarding referrals since new Gateway Model in Older People Services and PSD commenced support for carers.

2.3.3.10 COPD and Respiratory

The expansion of current Services to include the development of additional community based respiratory Services, will be supported by ICP arrangements and funded by the Belfast Local Commissioning Group. The existing team will be expanded to specialist GP, nursing and physiotherapy staff and will become the ICP Respiratory Team.

The expanded Services will include improved support for patient's at home, thereby helping the patient and their carer to better manage their condition at home. If hospital admission is necessary the length of stay will be reduced as the joined up package of care will help to avoid readmission. Services will be provided 7 days per week in the community, meaning that patients can be discharged at the weekend and support and advice will be provided out of hours. The development of these expanded Services will also be supported by a new home oxygen Service.

The Service will also provide greater support in the area of self-care. New education programmes will be provided for newly diagnosed COPD patients. These will be provided by voluntary and community organisations, in addition to quicker access to rehabilitation programmes in the community and improved access to quit smoking Services.

2.3.3.11 Stroke Services

Following the merger of the stroke wards on the BCH and RVH sites and the need to deliver on TYC, the future focus for the stroke Service has shifted away from hospital based Services. There is a need to develop an appropriate model and structure for Services to be delivered in the community to enable stroke patients to be cared for at home. Increased availability of stroke Services for patients living at home and in the community will support more people across Belfast. This will assist more patients to be discharged from hospital at the earliest opportunity and receive specialist rehabilitation at home.

Work is now underway, through Belfast ICPs, to improve the management of Transient Ischaemic Attacks (TIAs) and to enhance the level of rehabilitation support available to stroke survivors. This will include Service provision 7 days per week, and those at greatest risk of a stroke following a TIA are seen within 24 hours. There will be enhanced input from Allied Health Professionals such as Physiotherapists, Occupational Therapists and Speech and Language Therapists, in both hospital and in the community to improve quality of life and reduce the need for long term care.

2.3.3.12 Acute Care at Home

The Acute Care at Home Team (ACHT) is being piloted, through the support of the Belfast ICPs. This team of skilled health professionals will treat the patient and manage their care at home during an acute period of illness. Should hospital admission be necessary, the ACHT will coordinate with staff at emergency departments and acute medical units to discharge patients as soon as possible.

This Service will be available 24 hours a day, 7 days per week and 365 days a year. It will help to protect the independence of frail older people; reduce the potential onset of confusion that can be caused by going to hospital and promote a quicker recovery. The team will also organise the individually tailored package of care each patient will need, to be as independent as possible.

2.3.4 Sleep-ins

As previously stated the practice of using sleep-ins is currently under review across the Trust and the outcome of this review will impact on the delivery of Services in residential homes in Older People Services. Should sleep-ins cease in the future, which is likely, there will be an additional cost pressure for the Service in that staff will be engaged in waking nights, which will be more expensive than the current rate (£30) paid for sleep-ins.

2.3.5 What will be the Required Workforce

The changes to the Services that are due to take place throughout the Directorate over the course of the period covered by this plan will result changes to the workforce. New models of Service delivery, the demands of TYC and the need to ensure that high quality cost effective Services are delivered will have an impact on the resources that are required going forward. These will reflect the needs of the Services in the future and in some areas will mean a radical departure from what is currently in place.

Services will be delivered at the right time, in the right place, by the right person, for the right length of time based on assessed needs

The required workforce identified in this workforce plan will be made up from the existing workforce, with the need, in some areas, for reskilling or the recruitment of new staff. This section of the report looks at the resources that are currently available within Older People's Services, which is the largest of the Service areas within the Directorate. When the preferred option from the Social Work and District Nursing Reviews have been confirmed these will be incorporated into the plan.

Table 1 below highlights the projected changing workforce in Older People Services which is based on the starting workforce and the average number of leavers and new starts. Also included are the known workforce changes in relation to the projects currently underway or planned to commence during the course of this plan, which projects an increase in the workforce of 34 staff.

Older People and Physical & Sensory Disability Services Workforce Projections 2015/2020

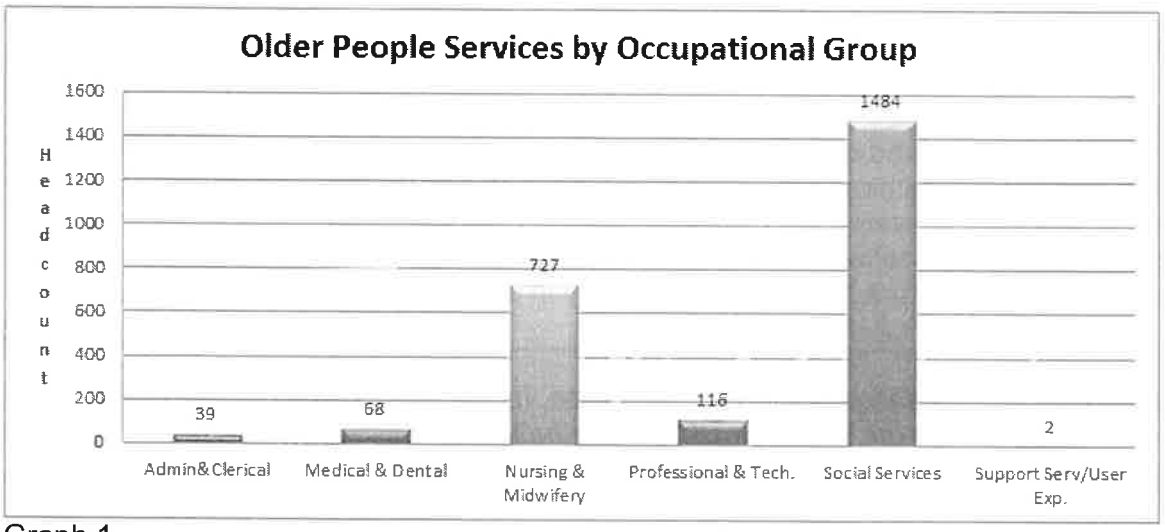
	2015/16	2016/17	2017/18	2018/19	2019/20
Staff in Post at 31st March	2514	2598	2623	2598	2573
Average No. of Leavers *	-164	-165	-165	-165	-165
Average No. of starters *	181	140	140	140	140
Reviews	67	50			
Total indicative projected staff in post 1st April	2598	2623	2598	2573	2548
Net Variance	84	25	-25	-25	-25

* figures for 2015/16 are actual figures

Table 1

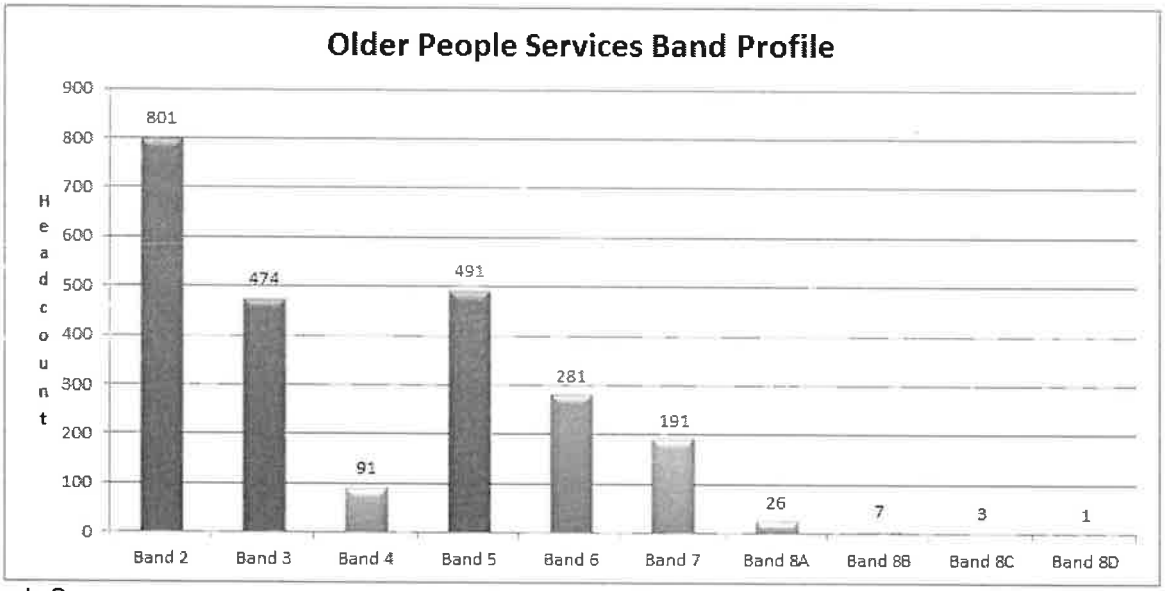
2.3.6 The Current Workforce

The information provided in the graphs below gives detail on the staff profile of the current workforce in Older People Services. Social Services staff make up approx. 61% of the total workforce in the Service area. In comparison to the social Services staff across the Trust, Older People Services, account for almost 50% of this group of staff.



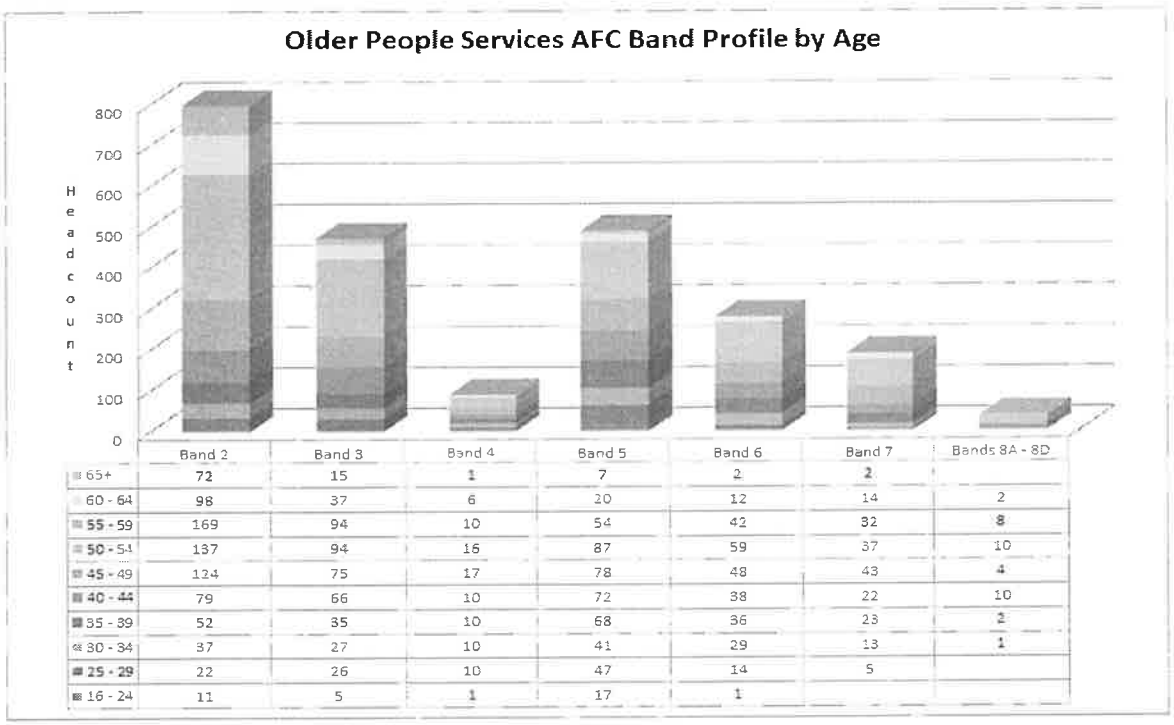
Graph 1

Graph 2 highlights that support staff, Bands 2 – 4, account for 58% of the staff within the Service area.



Graph 2

There is within Older People Services 697 staff who are aged 55 and over. This age group currently makes up 29% of the workforce within the Service area. By the end of the 5 year period, an additional 441 staff will fall into this category, giving a total of 1140 staff (47%), who will be over the age of 55. Across the Trust there is 3492 staff aged 55 or over, equating to approximately 17.5% of the Trust's total workforce. There is 351 staff under the age of 35, which equates to 14% of the Service's workforce.



	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Bands 8A - 8D
65+	72	15	1	7	2	2	
60 - 64	98	37	6	20	12	14	2
55 - 59	169	94	10	54	42	32	8
50 - 54	137	94	16	87	59	37	10
45 - 49	124	75	17	78	48	43	4
40 - 44	79	66	10	72	38	22	10
35 - 39	52	35	10	68	36	23	2
30 - 34	37	27	10	41	29	13	1
25 - 29	22	26	10	47	14	5	
16 - 24	11	5	1	17	1		

Graph 3

Graph 3 highlights the age profile for Older Peoples Services broken down by band of staff. There is a total of 37 staff at bands 8A- 8D and of these 20 are aged 50 and over. Whilst this may not have a major impact on the efficient functioning of the Service during the initial period of the workforce plan; it is clear that preparation for the loss of these skills and experience must be given consideration.

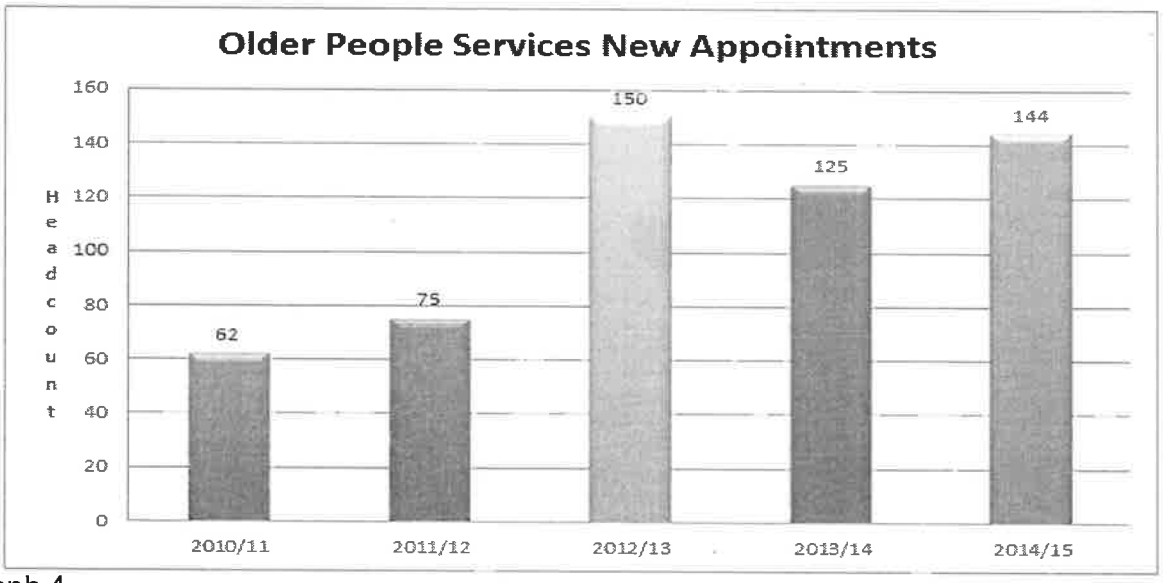
Staff at Band 7 level, within the Service area, have a total complement of 184 and 85 of these 46% are aged 50 and above. By the end of the 5 year period covered by the plan and additional 43 staff will fall into this age category, which will account for 70% of the total Band 7 workforce in Older Peoples Services. Within Older Peoples Services the majority of staff are employed at Bands 2 and 3, which make up a total of 54% of the workforce for the Service area.

There is a total of 801 staff at Band 2 and of these 42% are aged 55 and over. By the end of the next 5 years there will be an additional 137 staff in this age category, based on the current age profile of the staff.

Band 3 staff, of which there are 474, account for 20% of the total staff within the Service area. There is 146 Band 3 staff who are aged 55 and over, which is 31% of the total band 3 staff within the Service area. Based on the current age profile for the Service there will be an additional 94 Band 3 staff who will fall into this category within 5 years.

2.3.6.1 Recruitment

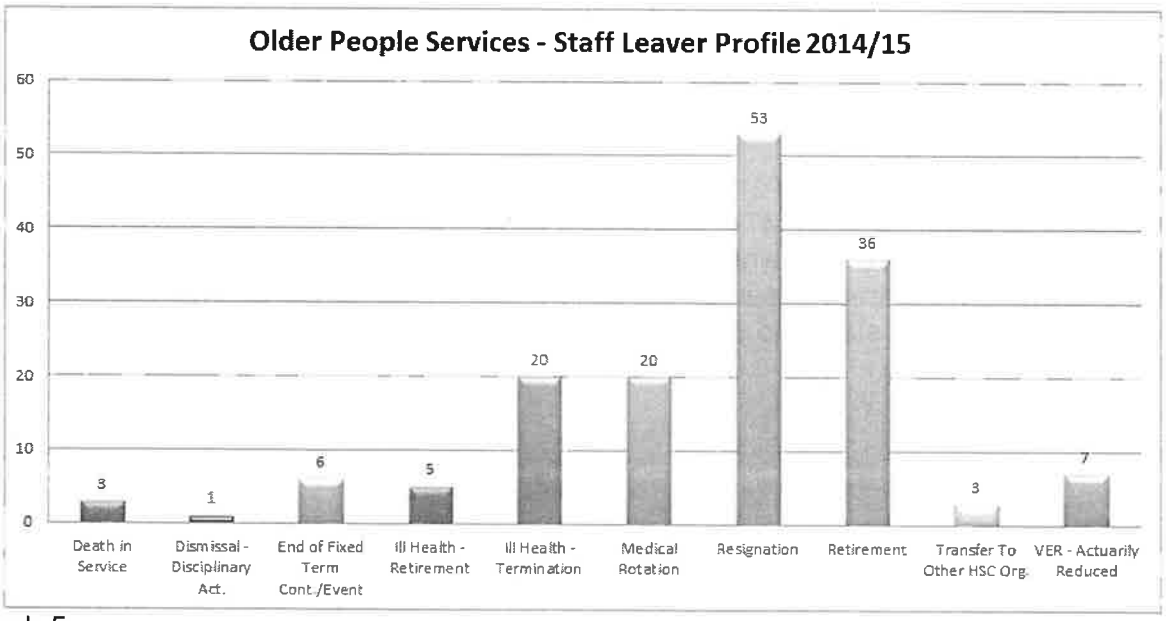
The chart below illustrates the total number of number new appointments in Older People's Services over the last 5 years.



Graph 4

Over the last 5 years 556 staff have been appointed to positions within the Older People's Service area, this includes internal and external appointments. During this period 154 Band 5 staff have been appointed across the Service area, which has the highest number of new employees. Band 3 staff, with 100, has the second highest total of staff appointments within the Service area. There has also been 74 Band 7 appointed to Older People's Services. In the last year 33 staff were appointed to new posts and of these 21 were in support roles, the majority of which are based in the community.

The graph below illustrates the reasons recorded for staff leaving the Trust from Older People's Services between 1 April 2014 and 31 March 2015.

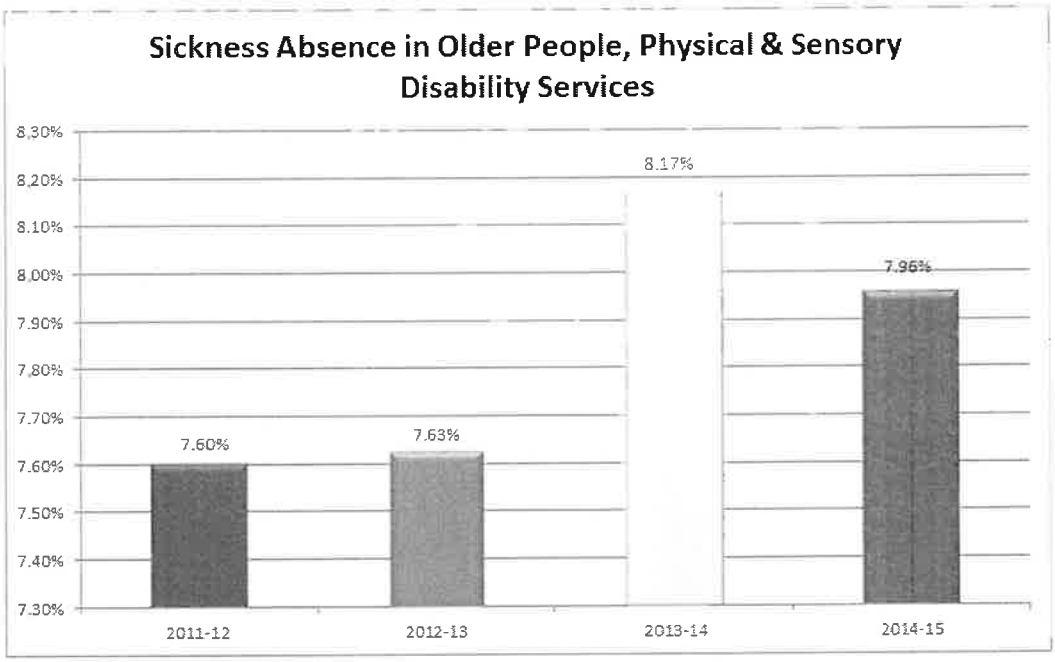


Graph 5

During the period 154 staff left the Service area. Resignation and retirement accounted for approximately 58% of the reasons recorded for staff leaving. Ill-health was recorded for almost 16% of the total number of leavers. Staff leaving to go to another health care organisation was recorded against only 3 staff (2 %), however as there is a high number of staff who have recorded resignation, with no additional details.

2.3.6.2 Sickness Absence

The levels of sickness absence within Older Peoples Services, for the period 1 April 2011 to 31 March 2015, are illustrated in graph 6. Over this period the level of absenteeism due to sickness has risen by 0.36%. In the 12 months to 31 March 2015, a total 43,700 days (260,000 hours) were lost due to sickness within the Service, this equates to 197 WTE staff being absent for a year.



Graph 6

The main reasons recorded against sickness absence, in the Service area were, General Debility; Depression; Stress; Post-Surgical Debility and Back Ache, which in total combined for approximately 139,155 hours of sickness absence. The reasons outlined above accounted for over 53% of the total sickness recorded for that year. General Debility, which was the number 1 reason for sickness absence, was recorded against 61,000 hours, 23.5% of the total sickness for the Service area.

It is not surprising that there will be a higher number of hours of sickness absence in this Service area, due to the higher staffing levels. However, this does not readily explain why General Debility accounts for twice as much sickness absence in this area, in percentage terms, when compared to Mental Health and Learning Disability Services. The number of hours recorded for General Debility in Older People's Services is almost five times the hours recorded in the two other main Service areas.

The only other reason, in the top four, common to the three areas is Stress. Again Older People's Services account for the highest number of hours recorded against this reason, approximately 32,900. The incidence of stress recorded absence in this area (12.6%) is higher, than that of Mental Health at 11.9%, but lower than Learning Disability at 18.3% of the total recorded sickness for their Service areas.

Over the last year the Service area lost a total of 7063 hours due to work related stress. The table below provides the cost associated with this absence. The information does not include any agency costs that may have been incurred as a result of this absence.

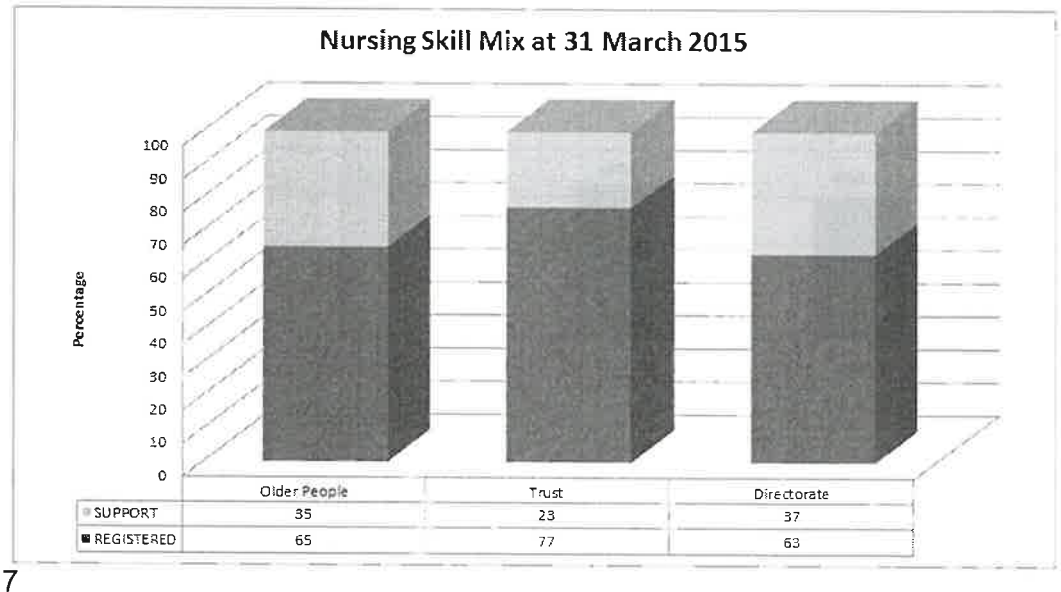
Older People and Physical & Sensory Disability Services

Band	Absence Hours	Cost £ (based on midpoint of scale)
2	1176.4	9305
3	2268.54	20712
5	2712	33141
6	260.9	3981
7	645	11752
Total	**7062.84**	**78891**

Table 2

2.3.6.3 Skill Mix

Graph 7 highlights the nursing skill mix within the Older Peoples Services at 31st March 2015.



Graph 7

The nursing skill mix within the Older People Services is 65:35 (Registered: Non-Registered). Whilst there have been changes in some function areas, the new BCH Direct unit and the further development of the Reablement Service, there would not be any expectation of a significant change in the skill mix for the Service area as a whole. It is not anticipated that other areas within this Service area will experiencing changes that will impact significantly on the nursing skill mix.

2.3.6.4 Agency Expenditure

Older Peoples Services had the highest level of agency expenditure within the Directorate at £2.4 million. It also has the highest number of staff, within the Directorate, which may be a contributory factor in its use of agency staff. This coincides with the area having the highest number of hours lost due to sickness absence. The Service area accounted for almost twice the level of agency expenditure that mental health and learning disability had combined.

Within the Service area expenditure on nursing agency £1.26 million and social Services with £860,000 were the highest. Older people's Services had lower levels of expenditure on admin & clerical staff than either mental health or learning disability.

Older Peoples Services Comparison of Agency Expenditure with sickness Levels and Vacant Posts 2014/2015	
Sickness Absence Hours	316111.74
Number of staff Lost due Sickness Absence	162.11 WTE
Agency Expenditure	£2,405,629.54
Vacant Posts	180

Table 3

2.3.7 Summary

Old People Services is the largest function area within the Directorate. It is also the service area that will experience the greatest amount of change during the next five years. There are several key issues that are impacting on the Service area including, the changing demographics of the region; the requirements of TYC for example the review of Stroke Services and the establishment of the Acute Care at Home Service; the need to adapt to the outcomes of regional reviews e.g. the introduction of the Reablement Service and the outcomes of the Trust's own reviews into Services e.g. District Nursing and Social Care workforces.

The changes required to address these 4 key areas have resulted in a number of projects that are currently underway such as the merger of the Reablement and Social Care Rapid Response Service and those that are in the planning stage such as the review of the Unscheduled Care Services based at BCH; the reviews of Social Work and District Nursing staff and the greater emphasis on providing more opportunities to Service users for self-directed support. When the reviews that are currently underway across the region and within the Service area have been completed they too will have an impact on the Service and consequently the workforce resources necessary to deliver their outcomes.

It is projected that over the course of the next 5 years there will be a projected reduction in the staff levels by over 100, within the Service area, through the implementation of the identified projects. There will be further projects identified as the Service area progresses through the next 5 years that are not yet known. As these requirements of these projects are identified the workforce implications will be determined and these will be incorporated into this plan as part of the review process.

In addition to these individual projects the Service area will have to address the issues of agency expenditure, sleep-ins and staff absenteeism. Assistance from the Attendance Management Team is available for Service managers to help address the challenge presented by the high level of sickness absenteeism. Agency expenditure, within the Service area, is the highest in the Directorate at over £2.4m and needs to be addressed by the management team. Sleep-ins will present a significant challenge to the service area. The review currently underway across the Trust regarding sleep-ins will identify the course of action to be taken by the Service area address this issue, which will probably mean the need for additional resources.

2.3.8 Action Plan

The development of the workforce plan has identified actions required to be undertaken by the Service. These have been highlighted in the table below. As we proceed through the period covered by this plan more actions will be identified and will be added to the list during the reviews.

Table 18	Action Plan for Older People Services 2015 to 2020		
Service Area	**Action**	**Person Responsible**	**Timescale**
Older Peoples Services	Implement outcome of District Nursing Review	Bridget Denvir / Gabby Tinsley	31 March 2020
Older Peoples Services	Roll out Keith Hurst toolkit to all relevant areas	Bridget Denvir	31 March 2016
Older Peoples Services	Implement outcome of Social Work & Social Care Review	Jillian Martin	31 March 2020
Older Peoples Services	Extend BCH Direct in conjunction with IMPACT developments	Catherine Collins	31 March 2016
Older Peoples Services	Promotion of Care of the Elderly as an attractive area to work	Marie Heaney	Ongoing
Older Peoples Services	Introduction of Acute Care At Home Service	Gabby Tinsley	31 March 2016
Older Peoples Services	Complete merger of Reablement & Social Care Rapid Response	Katie Campbell	31 December 2015
Older Peoples Services	Review of Adult Physical Sensory Disability Day Opportunities	Bernie Kelly	31 March 2016
Older Peoples Services	Review of Domiciliary Care Workforce linked to development of regional workforce plan	Marie Heaney	31 December 2015
Older Peoples Services	Reduction in the sickness absence rate within the Service area from 7.96% to 6.96%	Marie Heaney	31 March 2016
Older Peoples Services	Confirmation of the required workforce going forward within all areas	Marie Heaney	31 March 2016
Older Peoples Services	Develop and implement succession planning strategy – Growing our People Today for Tomorrow	Marie Heaney	31 March 2017
Older Peoples Services	Implement Induction programme for all new recruits	Marie Heaney	31 March 2016
Older Peoples Services	Promote age awareness and age diversity as more staff remain in the workplace	Marie Heaney	31 March 2016
Older Peoples Services	Ensure statutory and mandatory training compliance	Marie Heaney	31 March 2016

2.4 Psychology Services

2.4.1 Introduction

Psychology is the smallest of all the Service areas with 79 members of staff however this Service is a core component to the delivery of Services across the whole Directorate. The Service contributes to reviews across the Directorate to ensure the best use of limited psychological resources and responds to training needs across the Directorate by establishing training programmes as required.

2.4.2 Drivers

2.4.2.1 Engagement with Services users, carers, community and voluntary groups

Psychological Services have identified the need to improve Service user and carer involvement in design and delivery of psychological Services. The Service area have also recognised the need to increase support and partnership with community and voluntary groups.

2.4.2.2 Strategy for the Development of Psychological Therapy Services DHPSS NI (2010)

This strategy followed on from Delivering the Bamford Vision –Action Plan (2009-11). The strategy recognises that Services need to be redesigned around the needs of individuals. The strategy identifies that improving provision of psychological therapies can help individuals and families by providing early psychological interventions. One of the recommendations from the strategy was that "Trusts should re-design mental health and learning disability Services around a stepped care model with access to psychological therapy Services at all levels

2.4.2.3 Respond to DHPSS Ministerial Targets

There is a ministerial target that has been in place from April 2012 that no patient waits longer than 13 weeks for psychological therapies.

2.4.3 What Psychology Services will deliver in the Future

Psychology Services will work to provide trust-wide life-span autism diagnostic and intervention Services. This will be achieved through the further development and expansion of autism Services to the adult community.

Psychology Services will work to increase access to psychological Services across the trust. The Service will continue to work with Mental Health PCP and DOH and Trust Mental Health Services to develop models of increasing access to psychological therapies.

The Service will expand the development and availability of consultation & training and supervision to community providers e.g. suicide prevention groups.

Develop model for delivery of psychological support using principles of self-care to those diagnosed with long term health conditions in partnership with community & voluntary sectors and other trust colleagues.

In partnership with DOH/PHA and trust physical health and mental health colleagues, develop a model for the delivery of a "psychological medicine" framework within the acute Services in BHSCT, referencing liaison mental health Services, liaison alcohol Services and clinical health psychology Services.

In partnership with mental health CAMHS Services and Children's Services directorate the Service will deliver a new model of delivery of Children's Emotional, Behavioural and Mental Health Services across the Trust.

2.4.4 The Workforce required to deliver the Future Services

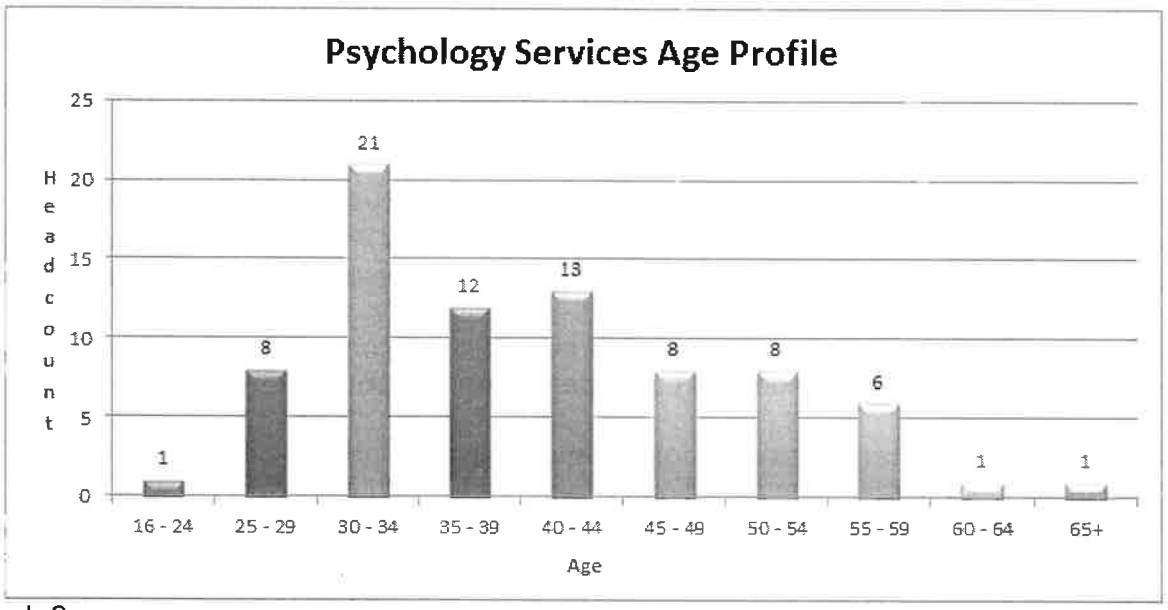
The Service is engaged in various projects across the directorate, which will identify the resources that will be required to meet the demands on the Service.

2.4.5 Workforce Supply

The information provided in this section is based on available data as at 31st March 2015. There is a total of 79 staff who work in Psychology Services, which provides a Service right across the Directorate. Unsurprisingly the majority of staff are from the Professional and Technical Occupational Group indeed 81% of staff in this group are registered Psychologists.

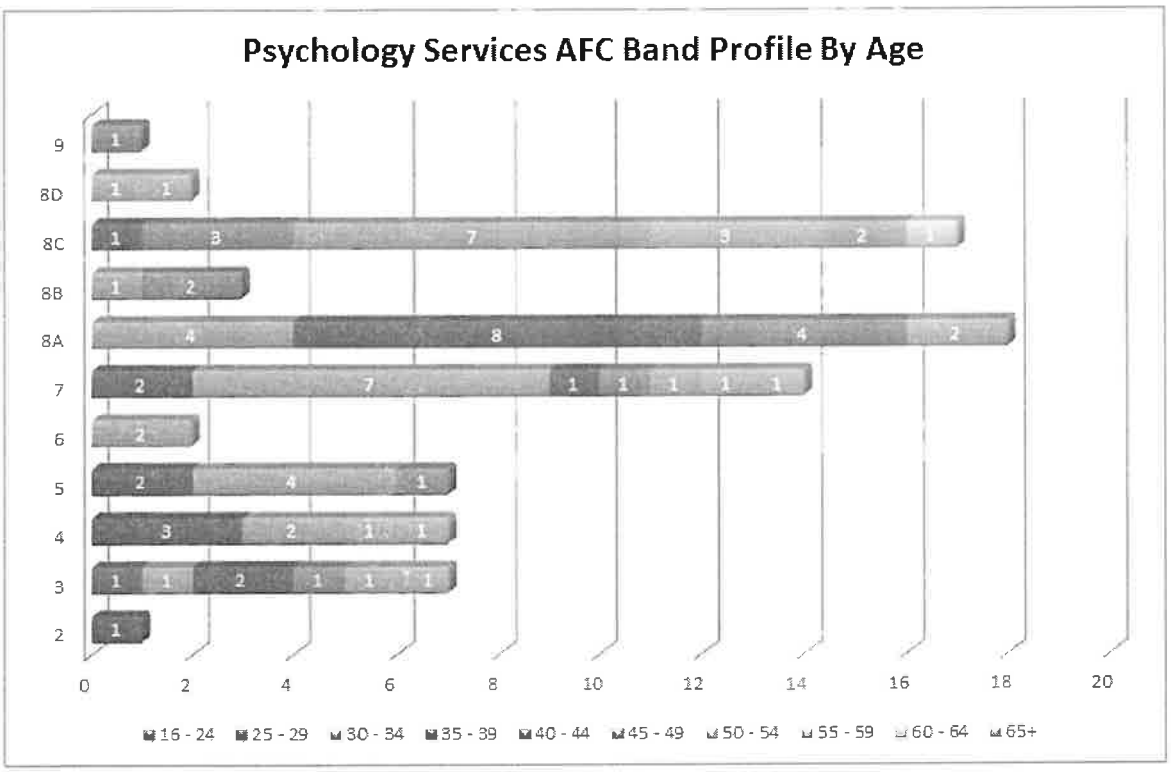
Graph 1

Graph 2 illustrates the age profile for the Service area and as can be seen there is a fairly even distribution of age ranges amongst all the staff with the possible exception of the number of staff in the 30-34 age group.



Graph 2

Graph 3 considers the age profile of the staff and the impact it will have on the different grades of staff. Unlike the other Service areas within the Directorate Psychology Services age profile indicates a greater number of staff in the younger age groups. At bands 8A to 8D level 10% of the staff at this grade is aged 55 or older, with a further 10 %of staff at this grade between the ages of 50 and 54. The indication is that 20% of the total staff at this grade will be 55 or over by 2020, which may have implications for succession planning and potential loss of skills and knowledge. Within the Service area 40 of the staff, 51%, are at Band 8A to Band 8D.

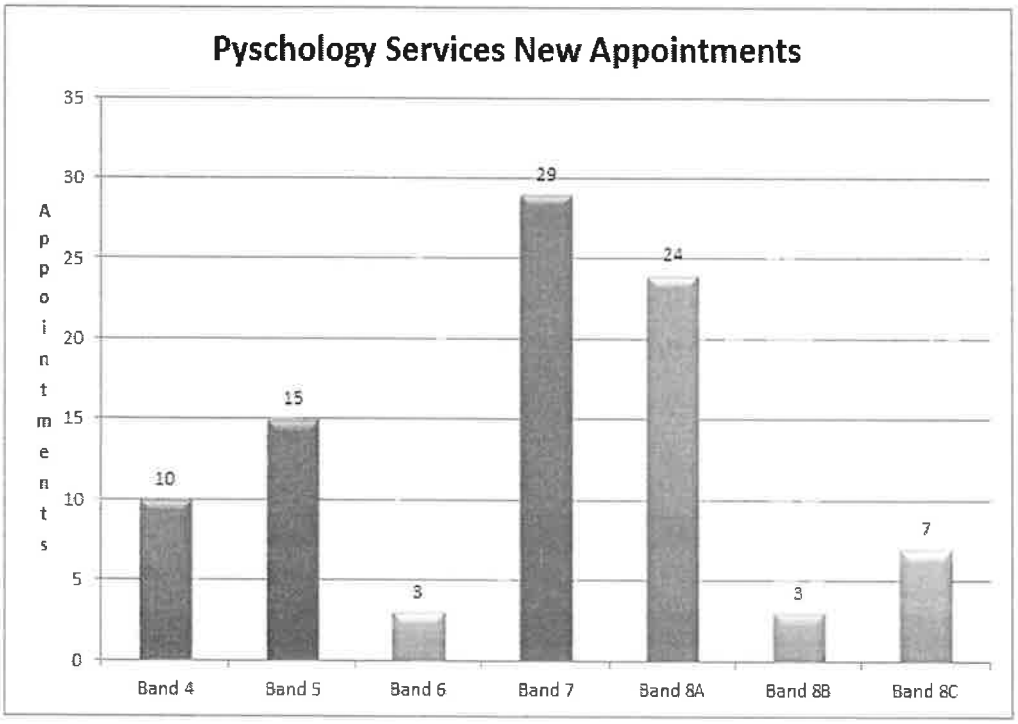


Graph 3

2.4.5.1 Recruitment

In the five year period up to 31 March 2015 there were 91 appointments made to Psychology Services.

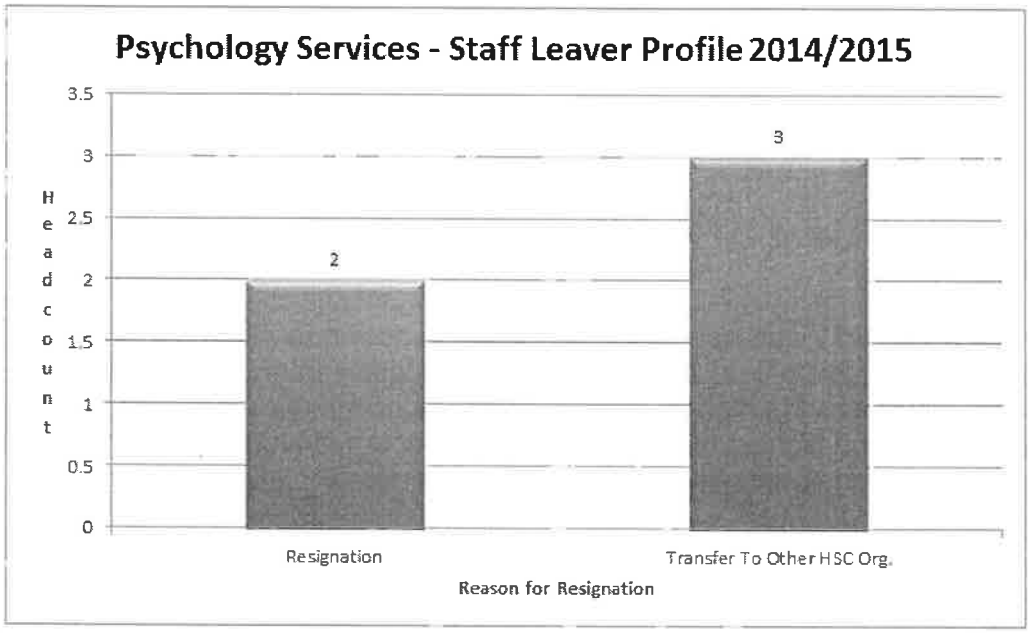
Over the last 5 years 91 staff have been appointed to positions within the Psychology Service area. During this period 29 Band 7 staff (31%) have been appointed across the Service area, which has the highest number of new appointments. Band 8A staff, with 24 (26%), has the second highest total of staff appointments within the Service area. There has been 10 Band 8 staff appointed to Psychology Services.



Graph 4

During the last 12 months four staff were appointed to new posts, including 3 qualified members of staff and 1 support staff.

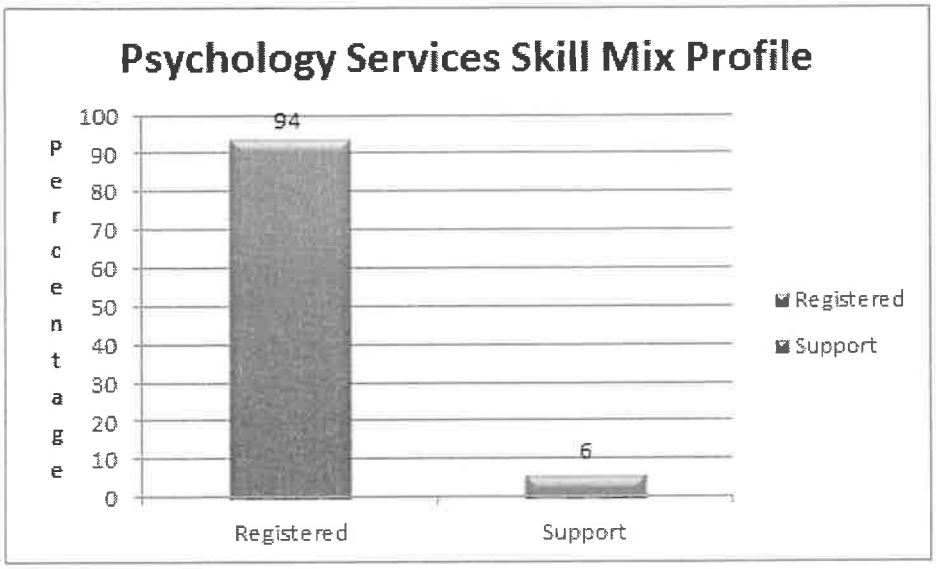
Graph 5 illustrates the reasons recorded for staff leaving the Psychology Services between 1st April 2014 and 31st March 2015. During this period 5 staff left the Service area.



Graph 5

2.4.5.2 Skill Mix

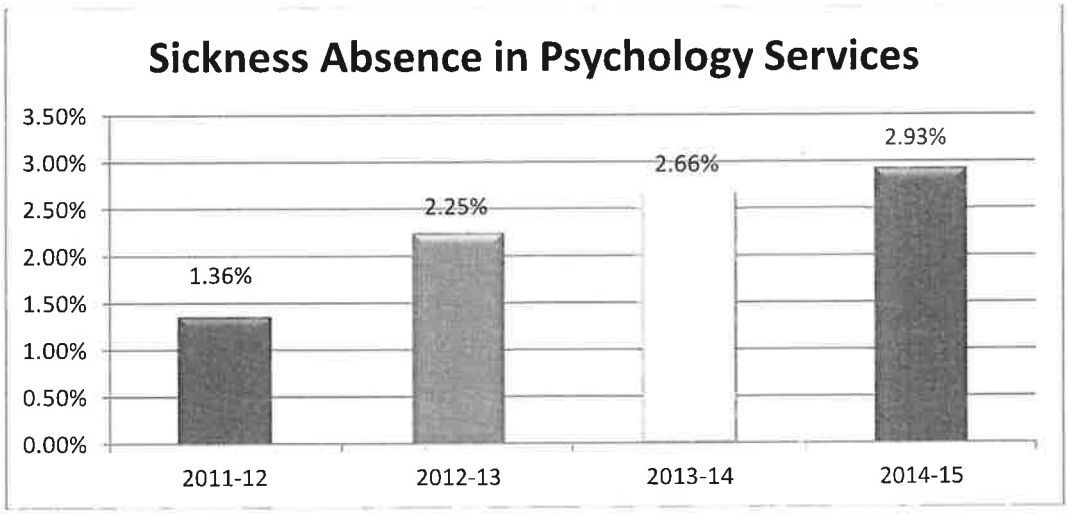
Graph 6 below highlights the skill mix for Psychology Services.



Graph 6

2.4.5.3 Sickness Absence

Graph 7 reflects the level of sickness absenteeism in Psychology Services between 1st April 2011 and 31st March 2015. As can be clearly seen the trend is in an upward direction. By 31st March 2015 the level of absenteeism was over twice the rate as that at 31st March 2012. In total there were 559 days lost due to sickness in the last year, which equates to 2.5 WTE staff.



Graph 7

In the period up to 31st March 2015 there was approximately 4,000 hours (2.4 wte staff) lost within the Service due to sickness absenteeism. The four most common reasons recorded for these absences are Disc problems, 720 hours; Post-surgical Debility, 698 hours; Vertigo, 332 hours and work related Stress, 1012 hours. Over the last year the Service area lost a total of 1012 hours due to work related stress. Table 2 over provides the cost associated with this absence. The information does not include any agency costs that may have been incurred as a result of this absence.

Psychology Services

Band	Absence Hours	Cost £ (based on midpoint of scale)
3	600	5478
7	412.5	7516
Total	**1012.5**	**12994**

Table 2

2.4. Summary

The Psychology Service is a small, but key Service within the Directorate. Services are provided across the other three key areas within the Directorate. As a consequence of this role the Service responds to the demands of the other Service areas and delivers Services accordingly. Planning for the future is more challenging because of this as the management team need to be aware of the demands of the main Service users, before they can fully identify and plan their own Service initiatives and changes.

Sickness absence within the Service has almost doubled and assistance is available from the Attendance Management Team in HR to address any areas of concern relating to this issue.

3. Summary of key Findings

The Directorate, like every clinical Directorate is a care provider and vitally dependent on its staff who are required to be in the right place, at the right time, with the right skills, delivering the right care to the right Service users. Workforce planning is therefore vital to ensure we have a clear plan of how the current workforce can meet the challenges ahead and at the same time continue to put the patient first every time all of the time.

This Workforce Plan is very much a working document that will evolve over time and be continuously reviewed, updated and monitored as the Directorate adjusts over the course of time to the challenges it faces. Getting the balance between the workforce demand and supply is in itself a key challenge and undoubtedly workforce planning is a hugely complex exercise.

A number of key findings have been identified throughout the document and include:-

- A continued focus on high quality service provision to improve the Service User experience.
- A greater focus on delivering Services at home, near to home, or in community based settings.
- Our workforce will require greater skills in the use of technology to enhance both their working environment and the Service User experience.
- Our workforce is ageing and a focus on their health and well being will be required to support staff working longer.
- New roles will need to be developed to support staff moving from the acute to the community.
- New ways of working to support more Services being delivered 24 hours a day, 7 days a week.
- A greater focus on managing attendance.
- The importance of workforce intelligence and good quality data to support the review, and update of this workforce plan and to aid business decision making.
- A focus on the required workforce going forward in terms of WTE's, Grade and skill mix requirements.
- A renewed focus on registering our social care workforce with NISCC to give greater confidence and assurance to Services Users, that those providing their care are suitable and safe to do so.

Overall this Workforce Plan is linked directly to the strategic vision and priorities of the Directorate. The ongoing development of the workforce to ensure it is flexible, skilled and trained to deliver different models and patterns of care will be an area of focus over the next five years, ensuring that we maintain a positive attitude as we care, support and improve together.

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5. Annexes

Annex A

Membership of the Workforce Planning Steering Committee

Joan Peden, Co-Director of HR
Monica Molloy – Senior HR Manager Modernisation & WFP
Stephanie Read – Senior HR Manager Modernisation & WFP
Neil McDaid – HR Manager Modernisation & WFP
John Veitch – Co-Director Learning Disability
Barney McNeaney – Co-Director Mental Health
Marie Heaney – Co-Director Older People Services
Bridget Denvir – District Nursing Review
Neil Kelly – Learning Disability Community
Jillian Martin - Social Services Review
Damien Maguire – NIPSA
Roberta Magee - Unison

Annex B

Membership of the Workforce Modernisation Board

Catherine McNicholl (Chair), Adult Social & Primary Care Director
Joan Peden, Co-Director of HR, BHSCT
John Veitch, Co-Director Learning Disability Services
Barney McNeaney, Co-Director Mental Health Services
Marie Heaney, Co-Director Older People and Physical & Sensory Disability Services
Michael Blaney, Finance Partner
Maurice O'Kane, Performance & Service Planning
Roberta Magee – Unison
Joe Lynch – Unison
David Kerr – RCN
Damien Maguire - NIPSA

6. APPENDIX ONE

Belfast Health and Social Care Trust

Terms of Reference

Adult Social and Primary Care Directorate
Steering Group
on the
Development of an Integrated Workforce Plan

1) Project Aim
To determine an overall Directorate Workforce Plan for which describes, identifies and sets out the key workforce issues, associated with the Service plans within the Directorate, including future Service needs of the Directorate
   - WTE's
   - Skill mix
   - Grade mix
   - Changing roles and responsibilities
   - New roles
   - Workforce trends and requirements, turnover, recruitment
   - Training requirements

Project Description
A broad description of the Integrated Workforce Plan is as follows :-

   - Overview of Directorate
     - Vision
     - Values
     - Priorities and Plans
     - Description of Workforce and Workforce Trends and Issues 2013

   - Service by Service Review
     - Define the Plan / Purpose / Scope
     - Visioning the Future / Mapping the Service Change
     - Application of the Six Step Model
     - Assessing the required workforce
     - Identifying Workforce availability
     - Development an Action Plan
     - Implementation Plan
     - Overview for Directorate
     - Conclusion and Implementation and Monitoring Plan and Arrangements

2) Role and Responsibilities
   - To oversee the development of the Workforce Plan in accordance with the Project Plan
   - To report to and update the Modernisation Board on Progress

3) Membership

3.1 Chair

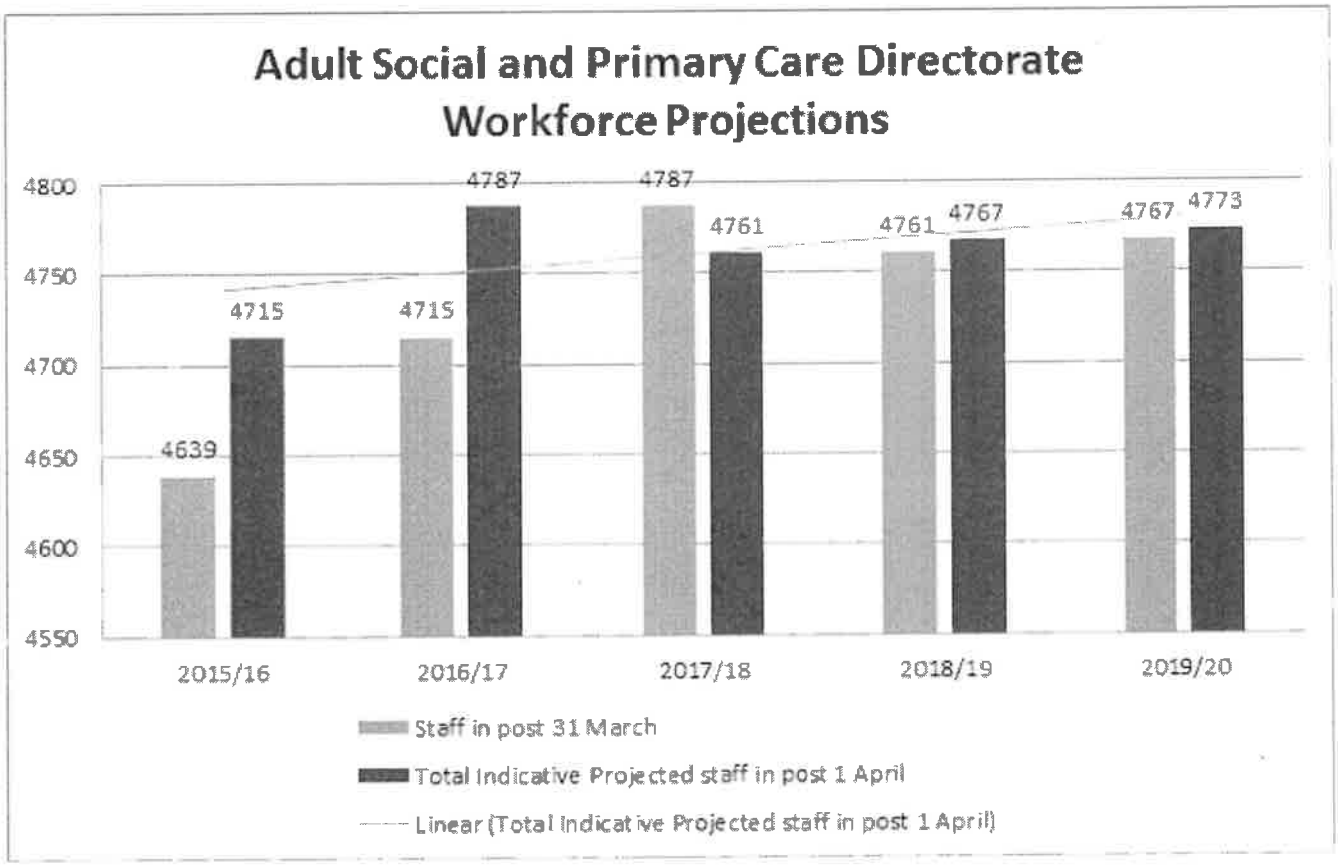
The Chair of the Steering Group will be Joan Peden : Co-Director, Human Resources and Adult Social and Primary Care HR Business Partner

3.2 Members

4) Timescale

As set out with the Project Plan

5) Frequency of Meeting


Adult Social and Primary Care Directorate
Workforce Projections
4800
4750
4700
4650
4600
4550
4639
4715
4715
4787
4787
4761
4761
4767
4767
4773
2015/16
2016/17
2017/18
2018/19
2019/20
Staff in post 31 March
Total Indicative Projected staff in post 1 April
Linear (Total Indicative Projected staff in post 1 April)