



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

**Summary Document
of the Deloitte Report 2009**

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1 INTRODUCTION & CONTEXT

1.1 INTRODUCTION

There is a Ministerial commitment to build and develop Mental Health and Learning Disability services in Northern Ireland, in line with the recommendations of the Bamford Review of Mental Health and Learning Disability. Deloitte MCS Limited was commissioned by the Department of Health Social Services and Public Safety (DHSSPS) to undertake a workforce planning review to support the implementation of those recommendations. The successful implementation of the reform of MHLD services will rely on the development of an appropriately sized workforce with the necessary competencies to deliver the services required.

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

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

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

This summary document of the workforce report presents the main findings from the review.

2 BASELINE WORKFORCE ANALYSIS

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

1. DHSSPS Human Resources Management System (HRMS)

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

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

2. Data Returns from Trusts

3. NICVA Workforce Surveys

The Northern Ireland Council for Voluntary Action (NICVA) conducts annual surveys of the community and voluntary health and social care workforce. The data is likely to underestimate workforce numbers (not all organisations invited to respond to the survey do so) and cannot be disaggregated into the four main Bamford domains.

2.1 STATUTORY MENTAL HEALTH AND LEARNING DISABILITY WORKFORCE - HRMS

Workforce Composition

There are approximately 3,461 people working in mental health equating to 3,256.22 Whole Time Equivalents (WTEs). Nursing staff make up the largest proportion of the workforce accounting for just less than three quarters of the mental health staff identified through HRMS. As regards skill-mix, there are large numbers of support staff in the mental health sector:

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

Table 2.1

HRMS MH Workforce Figures (Headcount and WTE)

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

Source: HRMS March 2008

Note: it was not possible to identify all AHPs working in mental health

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

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

Table 2.2 **HRMS LD Workforce Figures (Headcount and WTE)**

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

Source: HRMS March 2008

Note: it was not possible to identify AHPs working in learning disability

Key Trends to note:

- **Gender** - across all staff groups, the workforce is predominantly (at least 70 per cent) female, with the exception of the medical workforce which is just under 60 per cent female. The proportion of female staff is particularly high in learning disability, with up to 85 per cent of social workers, social work support staff and nurses being female. In mental health, the assistant / trainee clinical psychology staff are almost entirely female (96 per cent). Of all of the staff groups identified, the medical staff in LD and the clinical psychology group are the youngest. Only 16 per cent of qualified psychologists are aged over 50 and more than half of the assistant / trainee psychology group is aged between 25 and 29;
- **Age** – many of those working in MHL D services are eligible to retire at age 55 and across all staff groups with exception of clinical psychology and medical staff, more than a fifth of each group is aged over 50. Within learning disability, 28 per cent of social work support staff are aged over 50 and 12 per cent are aged over 55. Within mental health, 22 per cent of social workers are aged over 50 and at least 7 per cent are aged over 55. Only 4 per cent of the medical workforce is aged over 55. Across the workforce, a considerable proportion of staff will become eligible to retire within the next five to ten years and many are already eligible to retire. This presents a significant risk in terms of succession planning and retention of knowledge and experience; and
- **Working Pattern** - the learning disability social work support staff group is the only group where the proportion of part-time workers (56 per cent) outweighs that of full-time workers (44 per cent). Part-time working is least common in mental health nursing and nursing support and medical staff working within learning disability, with fewer than one in five taking this option. In the other staff groups, between 19 and 32 per cent of staff work on a part-time basis.

Workforce Turnover

Overall, the information indicates a relatively stable workforce, with areas of growth. This suggests that despite the aging population within the MHLD workforce, many are choosing not to take up the option of early retirement.

Across the Northern Ireland Trusts in the period September 2007 to end of March 2008, turnover averaged 10.4 per cent (calculated on the basis of movers and leavers as a percentage of staff in post) and turnover rates for the various staff groups in MHLD services are considerably below this level based on the information available. It should be noted that this is inconsistent with the views of stakeholders consulting during the review who reported a high degree of turnover in some areas.

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

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

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

2.2 STATUTORY MENTAL HEALTH AND LEARNING DISABILITY WORKFORCE - HSC TRUST DATA RETURNS

Learning Disability Service Provision

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

Adult Mental Health Service Provision

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

Child and Adolescent Mental Health Service Provision

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

Older People's Mental Health and Dementia Services

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

2.3 THE NON-STATUTORY MHL D WORKFORCE

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

Mental Health

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

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

Learning Disability

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

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

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

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

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

2.4 RECRUITMENT AND RETENTION ISSUES

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

Key themes Identified by Trusts

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

expected – there is a need to clearly illustrate to trainees and potential recruits what working in the MHLD sector involves; and

- Scope for development of new services is also limited by difficulties in recruiting staff.
- **Career Pathways**
 - Lack of clear career pathway and commitment to continuing professional development impacts on recruitment and retention in the sector;
- **Challenging Nature of the Job**
 - Challenge of working with clients with challenging behaviour and working in small community-based units which do not have the same support structures for staff as hospital settings;
 - Professional isolation of staff working in smaller units in disparate locations across Trusts puts a large amount of pressure on these staff members; and
 - Long-term vacancies can pressurise existing staff and impact on retention.
- **Age of the Workforce**
 - A proportion of the workforce is eligible for retirement at 55 – loss of experience could lead to difficulties in service re-design and provision.

3 IMPLEMENTING THE BAMFORD VISION

3.1 OVERARCHING BAMFORD VISION AND PRINCIPLES

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

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

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

Provision of services which are readily accessible;

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

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

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

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

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

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

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

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

3.2 SUMMARY OF WORKFORCE IMPLICATIONS ACROSS THE FOUR DOMAINS

A summary of the main workforce implications is given below. The supporting information for the tables is provided in Appendix 1

	Recruitment	Retention	Training	Redeployment	Career Development Paths
All Domains	<p>Mental Health Nurses</p> <p>Learning Disability Nurses</p> <p>Social Workers specialising in Mental Health and Learning Disability</p> <p>Clinical Psychologists</p> <p>Psychological Therapists</p> <p>Psychiatrists</p> <p>AHPs specialising in Mental Health and Learning Disability</p> <p>Mental Health and Learning Disability Support workers including:</p> <ul style="list-style-type: none"> • Support Time Recovery Worker • Expert Users • Nursing support workers • Social care support workers 	<p>Retaining staff being redeployed from acute to community settings</p> <p>Reducing turnover across MHLD services</p>	<p>Attracting required numbers into pre-registration training for nursing, social work, AHP and psychology</p> <p>Embedding pre-registration training placements in Mental Health and Learning Disability settings (including community settings)</p> <p>Ensuring adequate pre-registration training places are available for the increased number of MHLD professionals needed</p> <p>Ensuring adequate provision of vocational training for the increased number of support workers needed</p>	<p>Redeployment of staff to community settings from acute settings</p>	<p>For all new roles and across extended services</p>

Summary of Bamford Workforce Implications: AMH

	Recruitment	Training	New & Extended Roles (including role description, competency identification, development framework)	Career Development Paths
AMH	<p>CMHTs:</p> <ul style="list-style-type: none"> Nurses, Social workers, Psychologists, and Psychological Therapists <p>Recovery Services</p> <ul style="list-style-type: none"> Nurses, Social Workers, OTs, Speech Therapists, Physiotherapy <p>Home Treatment</p> <ul style="list-style-type: none"> Nurses <p>Psychological Therapies</p> <ul style="list-style-type: none"> Psychological Therapists, Psychologists and Assistant Psychologists <p>Liaison Service</p> <ul style="list-style-type: none"> Nurses, Social Workers, Clinical Psychologist, Psychiatric Trainees, and Consultant Psychiatrists <p>Eating Disorder</p> <ul style="list-style-type: none"> Medical, Nurses, Psychological Therapists 	<p>Develop learning and development framework for CMHT roles</p> <p>Develop training for new roles</p> <p>Develop training for new ways of working for CMHTs</p> <p>Explore potential for NVQ in Direct Care and existing e-learning package for Home Treatment services</p> <p>For CMH service staff regarding Challenging Behaviour</p> <p>Awareness training for all HSC staff regarding Personality Disorders</p> <p>Specialist training for Eating Disorder staff working in acute settings</p> <p>Training for Dual qualified Midwife and Mental Health Nurse</p>	<p>Link Worker</p> <p>Support, Time and Recovery Worker (STRW)</p> <p>Psychological Therapists</p> <p>Eating Disorder specialists</p> <p>Personality Disorder specialists</p> <p>Dual qualified Midwife and Mental Health Nurse</p>	<p>For CMHTs</p> <p>For new roles</p> <p>For Psychological Therapists</p> <p>For Liaison Service</p> <p>For Personality Disorder Service</p>

Summary of Bamford Workforce Implications: Older People

	Recruitment	Training	New & Extended Roles (including role description, competency identification, development framework)	Career Development Paths
Older People	<p>Domiciliary Care</p> <ul style="list-style-type: none"> Domiciliary staff <p>Day Support</p> <ul style="list-style-type: none"> Nurses, social care support staff and volunteers <p>Respite care</p> <ul style="list-style-type: none"> Nurses, social care support staff and volunteers <p>Intermediate Care</p> <ul style="list-style-type: none"> Dementia Nurses, Social Workers, and AHPs <p>Day Treatment Units</p> <ul style="list-style-type: none"> Additional staff recruited to CMHTs <p>Crisis /Home Treatment / Out of Hours</p> <ul style="list-style-type: none"> Additional staff recruited to CMHTs <p>Challenging Behaviours</p> <ul style="list-style-type: none"> Nurses, psychologists and nursing support staff 	<p>For Domiciliary Staff</p> <p>All grades of staff (including in voluntary and community sector) working with older people with mental health issues regarding minimal restraint / restraint free care</p> <p>Training for Statutory, voluntary and community, and private sector staff regarding respite care</p> <p>Training for Palliative Care Teams, care home staff (statutory and independent), GPs and Consultants regarding palliative care approaches for older people with advanced dementia</p> <p>Training for Intermediate Care staff Dementia Nurses, Social Workers, and AHPs</p> <p>For additional staff recruited to CMHTs regarding older people with mental health issues</p>	<p>Liaison Nurse</p> <p>Key Worker</p> <p>Challenging Behaviour Roles</p> <p>Dementia Liaison Nurse (role expansion)</p>	<p>For all new roles and across extended services</p>

Summary of Bamford Workforce Implications: CAMHS

	Recruitment	Training	New & Extended Roles (including role description, competency identification, development framework)	Career Development Paths
CAMHS	<p>CAMHS Development Co-ordinators (following completion of job description being developed by CAMHS Advisory Group)</p> <p>Expansion of CAMHS teams Primary Mental Health (PMH) Workers</p> <p>Family Therapists</p> <p>Child Psychotherapists</p> <p>Occupational Therapists</p> <p>Community Development Teams</p> <ul style="list-style-type: none"> • Psychologists <p>Abuse and Sexually Harmful Behaviour</p> <ul style="list-style-type: none"> • Social Workers <p>Complex Needs</p> <ul style="list-style-type: none"> • Nurses and social workers 	<p>Family Therapists</p> <p>Social Workers and Nurses trained to become Child Psychotherapists</p> <p>Occupational Therapists trained in CAMHS</p> <p>Training for HSC staff in CAMHS regarding LD (longer term priority)</p> <p>Psychologists for Community Development Teams</p>	<p>Enhanced Practitioner</p> <p>Key worker (role expansion)</p>	<p>For all new roles and across extended services</p>

Summary of Bamford Workforce Implications: Learning Disability

	Recruitment	Training	New & Extended Roles (including role description, competency identification, development framework)	Career Development Paths
LD	<p>Community based assessment and treatment:</p> <ul style="list-style-type: none"> LD nurses & support, behaviour support (clinical psychologists, specialist nurses, social workers and vocationally qualified behaviour support staff), specialist forensic staff (nurses, psychology, psychiatry) and social workers <p>Respite Services:</p> <ul style="list-style-type: none"> LD nursing, social work, and support staff <p>Supported Accommodation for Adults & Permanent Placements for Children:</p> <ul style="list-style-type: none"> LD nurses, social workers and support staff, new roles for brokers, managers and team leaders, foster families for children <p>Day Care:</p> <ul style="list-style-type: none"> LD nurses, social workers, new roles for brokering, direct support and mentoring / guidance 	<p>Learning and development pathway for all LD careers</p> <p>Family, carers, volunteers and service users</p> <p>Direct Support Workers</p> <p>Generically trained health and social services professionals</p>	<p>Key Worker</p> <p>Family Support Worker</p> <p>Health Facilitator</p> <p>GP Link Worker</p> <p>Direct Support Worker</p> <p>Respite & Supported Accommodation Brokers, Managers & Team Leaders</p> <p>Day care Brokers & Mentors</p>	<p>Learning and development pathway for all LD careers</p> <p>For new and extended roles</p>

	Recruitment	Training	New & Extended Roles (including role description, competency identification, development framework)	Career Development Paths
	ASD posts (Regional Strategy)			

3.3 SUMMARY OF KEY MESSAGES

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

4 ESTIMATES

4.1 FUTURE SERVICE PROVISION

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

4.1.1 Adult Mental Health

Key Observations

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

4.1.2 Children and Adolescent Mental Health Services

Key Observations

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

4.1.3 Older People’s Mental Health and Dementia Services

Key Observations

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

4.1.4 Learning Disability Services

Key Observations

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

4.1.5 Alternative sources of Staffing Estimates

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

Table 4.1
Bamford Review and Sainsbury Adult Mental Health Staffing Estimates
Rates per 250,000 population

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

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

Furthermore, the below points should also be noted:

- The staffing ratios highlighted in the Sainsbury Centre report for acute/intensive care beds range from 1.6 for acute care to 3.2 for intensive care unit beds. This compares to the average figure of 1.3 used in the estimates in Table 4.1 above (based on advice from DHSSPS nursing advisors and a Trust). The difference between staffing ratios would have a significant impact on the numbers of staff required for the acute hospital setting; and
- The staffing estimates within the Bamford report cover only community mental health teams, and Bamford highlighted that staff would be needed to provide, for example, eating disorder, psychological trauma and challenging behaviour specialist services. The Sainsbury Centre report provides staffing estimates for a number of specialist services. These are based on populations of 250,000 and include; Eating Disorder services (38.5 staff per 1m population), Local Personality Disorder services (16 staff per 250,000 population) and Perinatal services (55.5 staff per 14,000 deliveries). These figures add to the overall staffing levels needed to deliver the full range of adult mental health services in England. Further

scoping work is required in Northern Ireland to ascertain the staff levels needed to deliver these specialist services.

4.1.6 Summary

Table 4.2 Current Statutory MHLD Workforce Compared to Estimated Additional Workforce Demand

	Domain	Current Workforce (WTE)		Estimated Future Demand (WTE)*		
		HRMS	Trust Returns	Bamford Estimates (10-15 yrs):		Trusts (2-3 yrs)
				Workforce Estimate	Additional Posts**	Additional Posts
LD	LD Total	1,882	2,259	Not Quantified		+247 (5 Trusts)
MH	Older People	-	330	+362 and Domiciliary Care	+362 and 20% increase	+89 (4 Trusts)
	CAMHS	-	299	389-474	+175	+62 (4 Trusts)
	AMH	-	2,640	1,778	-862	+92 (2 Trusts)
	MH Total	3,256	3,269	A reduction in MH staff of 325 (to 2944) + 20% increase in Domiciliary Care		Additional 243 Staff

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

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

Key Observations

- Based on the available information, estimates suggest that in the longer term the general MH staff complement should reduce by some 325 staff (to a figure of 2,944). However, this reduction does not include the full range of specialist MH services and does not account for a substantial increase to domiciliary care workers in older people's MH services. In addition, the figure does not reflect the significant level of redeployment from hospital to community settings that will be required within the system;
- Further analysis is required to determine the full workforce implications of implementing the recommendations for LD services, but a similarly significant impact on the workforce would be expected given the scale of reform set out;
- Information currently available from the Trusts indicates that in the short term, there is significant demand for staff - at least an additional 243 MH and 247 LD staff by 2011;
- Joint service development and workforce planning between providers will help to determine the impact on staffing within the independent sector. There is a need for a co-ordinated approach to ascertain the scope of services currently provided by the independent sector and the demand for services which is placed upon the sector by service users. It is critical that models of service provision need to be created and piloted to test their suitability, as the demand for services, including a range of specialist services, from the independent sector grows.
- Close monitoring of the age profile of the workforce should continue.

4.2 IMPACT ON MHLD TRAINING PLACES

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

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

- The scenarios in Table 4.5 assume that current attrition rates remain constant. Given the currently high attrition rates in MH and LD nursing (25 per cent) there is further scope to increase output within the figures shown. It is noted that there have been increases to MH and LD training places in recent years;
- The proportion of Social Work and AHP professionals qualifying who choose to enter MHLD careers was not available, Table 4.5 shows the total number of places. Increasing the proportion of these groups entering MHLD posts would make further contribution to meeting the additional workforce demand; and
- Table 4.5 only shows the potential increase to professional training places and does not account for support staff demand which is likely to be a substantial element of the workforce going forward, reflecting new ways of working and required productivity improvements.

Table 4.3

Professional Training Places – Potential Increases

Training Course	Current Inflow (minus attrition)	10% increase		20% increase		30% increase		50% increase	
		Current inflow +10%	Additional places	Current inflow +20%	Additional places	Current inflow +30%	Additional places	Current inflow +50%	Additional places
Mental Health Nursing	*124	136.4	12.4	148.8	24.8	161.2	37.2	186	62
Learning Disability Nursing	22	24.2	2.2	26.4	4.4	28.6	6.6	33	11
Social Work*	**281.5	309.7	28.2	337.8	56.3	366	84.5	422.3	140.8

Social Work Post-Reg	23	25.3	2.3	27.6	4.6	29.9	7.9	34.5	11.5
Clinical Psychology	10.7	11.7	1	12.8	2.1	13.9	3.2	16.1	5.4
AHP*	**196.7	216.3	19.6	236	39.3	255.7	59	295.1	98.4
Total	659.7	723.6	65.7	789.5	131.5	855.3	198.4	987	329.1

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

Key Observations

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

5 ACHIEVING THE VISION: RECOMMENDATIONS

5.1 RECOMMENDATIONS

5.1.1 Development Plan

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

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

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

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

5.1.2 Legislation, Regional Strategies and Reviews

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

It is also recommended that implementing Bamford's workforce plan should take cognisance of the proposed new mental capacity and mental health legislation, for example the Community Treatment Order proposals.

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

- New Strategic Direction for Alcohol & Drugs

- Autism Spectrum Disorder (ASD) Strategy
- Mental Health and Well-Being Strategy
- Tackling Domestic Violence at Home Strategy
- NI Suicide Prevention Strategy Northern Ireland – Protect Life
- The Response of the NI Executive to the Bamford Review of Mental Health and Learning Disability (July 2009) and supporting Action Plan for 2009-2011.
- NI Carers Strategy
- Personality Disorder Strategy
- Improving Access to Psychological Therapies Strategy

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

- The strengthening of the Child-Care and Mental Health Interface (Madeline O’Neill Independent Inquiry Report)
- Introduction of Family Group Conferencing to Mental Health Services (Madeline O’Neill Independent Inquiry Report)
- Child protection changes (Madeline O’Neill Independent Inquiry Report)
- Pro-active implementation of the 2004 Discharge Guidelines (McCleery Report) (- the 2004 guidance has been superceded by ‘Promoting Quality Care’ regional guidance on risk assessment and management issued in 2009 and augmented in 2010.)
- Effective interfacing of CAMHS, Addiction Services and Adult Mental Health Services for the benefit of individuals and families (McCartan Review)
- Ensuring the full implementation of Looked After Children (LAC) Policy and Procedures, the implementation of Understanding the Needs of Children in Northern Ireland (UNOCINI) and the provision of training for the staff in the field of disability with regard to the protection of children and vulnerable adults (Cherry Lodge Independent Review).

5.1.3 Suicide Prevention within MH Services

Within the statutory sector it is recommended that HSCB and PHA consider current models of good practice highlighted within the Review of the Northern Ireland Suicide Prevention Strategy “Protect Life” with the aim of standardising access and improving service provision regionally. Trusts in support of this should develop a change management plan to develop and

establish these models of good practice for their local population and embed these within their workforce plans.

It is recommended that cognisance be taken of the valuable and important contribution made by the voluntary and community sectors in delivering services to those who self-harm and / or are affected by suicide and across the spectrum of MHL. In the development of workforce plans for MH and LD services the voluntary and community organisations should be encouraged to build networks to enhance the overall service. Stronger links should be forged between the statutory and community / voluntary sectors in order to improve provision and tackle the issues of self-harm and suicide.

5.1.4 Prison Workforce Implications

It is recognised that there are high levels of MH disorders in prisons, particularly relating to personality disorder and substance misuse. It is recommended that the implementation of Bamford's workforce plans take account of this need, and the potential for primary care interventions and specialist mental health services to help address the need. Consideration should also be given to any future strategy for prison healthcare.

5.1.5 Increasing Role of Trusts in Workforce Planning

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

This should be a continuous and ongoing process in line with the evolution and development of services.

5.1.6 Workforce Planning Leadership Skills

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

5.1.7 Promoting MHLD Careers

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

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

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

It is recommended that the Department lead the campaign with input from providers in statutory, voluntary and community sectors.

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

5.1.8 Training Provision

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

Summary of Training-related recommendations

Target Group	Nature of Training
Generic HSC workforce	Immediate plans should be put in place for all HSC staff (existing workforce & those in initial training) to receive awareness training in aspects of MHLD e.g. recognising mental health issues, meeting the needs of patients with a learning disability etc. This should also help to promote MHLD as a career path and should become part of core training.
MHLD workforce	The Bamford Principles should be embedded into all MHLD training from 2009 onwards.
	All MHLD staff (regardless of their discipline) should receive induction training focusing on new ways of working under the reconfigured services when they assume a post within a MHLD team (including redeployed staff)
	Awareness training for all MHLD staff in relation to cognitive behaviour / psychological therapies and practitioner training for those who will provide these services to patients displaying low levels of need. The possibility of including this training in core professional training should be explored as a means of developing a critical mass of skills in talking therapies.
	Training for the users of LD services and their families/ carers to support greater self-determination in service uptake
	Induction training for Direct Support Workers employed by people with a learning disability
	Training for families providing respite and fostering placements for people with a learning disability
MHLD Team Specific	<p>Specific MHLD team / staff training should be developed and made available to staff delivering new and extended services including:</p> <ul style="list-style-type: none"> – an e-learning package for Home Treatment staff; – challenging behaviour training for staff in community MH and LD services; – specialist training for Eating Disorder staff in acute settings; – training for Palliative Care Teams regarding palliative care approaches for older people with advanced dementia; – specialist training to support ASD services; – training in managing challenging behaviours for LD staff in respite, supported accommodation and day centre services; – training in therapeutic services, forensics and challenging behaviours for LD staff in assessment and treatment services. <p>Where the independent sector is involved in the delivery of any MHLD services their staff should have the opportunity to avail of necessary training along with Trust staff.</p>

It is recommended that the following activities are undertaken:

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

5.1.9 Professional Training Places

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

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

- There is particular demand for LD and MH nurses in the short term and an existing shortage of these staff. The training places for MH and LD nursing should be increased by 50 per cent with effect from 2010/11. The promotional campaign noted above should specifically focus on attracting

people into LD and MH nursing courses and action should also be taken to reduce the attrition rates on these courses; and

- We recommend that the number of social work, psychology, and AHPs training places should be increased by at least 10 per cent in 2010/11, with additional action taken to tie these additional places to MHLD careers.

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

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

It is recommended that the Trusts establish and maintain workforce partnerships with voluntary and community sector service providers in order to facilitate workforce planning actions as they are identified and that processes are developed that facilitate voluntary and community sector staff working in MHLD to train with Trust staff. This would increase access to training for the voluntary and community sector and should help to facilitate cross-sectoral working and embed this into reconfigured services.

5.1.11 Defining Roles

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

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

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

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

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

The following priorities **are recommended**:

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

5.1.12 Retention Strategy

The implementation of Bamford's vision, particularly the shift in focus of service provision from acute settings to community settings, will require a significant staff redeployment exercise. **It is recommended that the Trusts develop and implement redeployment strategies for MHL** that aim to:

- Ensure that the transition of professional and support staff from one setting to another is as smooth and undistruptive as possible (for staff and patients);
- Retain skilled and experienced professional and support staff through redeployment maintaining skills during the harmonisation and reconfiguration of services; and

- Identify any specific training that professional and support staff will require to support them to work in their new roles / settings.

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

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

5.1.13 Reviewing Trust Recruitment Strategies

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

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

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

5.1.14 Conclusion

The new organisational arrangements across the HSC provide an opportunity to develop a new approach to multi-disciplinary workforce planning.

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