Department of Health
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DEPARTMENT OF HEALTH POSITION STATEMENT ON THE MENTAL HEALTH WORKFORCE REVIEW

This report reflects the outworkings from the Mental Health Workforce Review, which was commissioned in February 2022 to address the commitment set out in Action 32 of the Mental Health Strategy 2021-2031, which commits to '*undertake a comprehensive workforce review considering existing workforce need and training, and the development of a new workforce, such as allied health professions, therapists and physician associates*'.

Led by an external review team (EY) and with considerable input from a broad range of health and social care representatives and other key stakeholders, the review report sets out a number of recommendations to ensure we have a mental health workforce fit for the future. In particular, the report makes a number of recommendations on a future workforce profile for both Child and Adolescent Mental Health Services (CAMHS) and adult services over the next decade, including increasing current staffing levels and expanding the workforce to include some new professions. The recommendations take account of projected demand for services and best practice approaches adopted elsewhere, as well planned service developments, including improvements and reforms being progressed as part of the wider Mental Health Strategy.

Since the report was commissioned in early 2022, the political and financial landscape has changed considerably. In particular, the current financial constraints within which departments are operating mean that the ability to secure additional investment in our mental health workforce is severely constrained. The report makes clear that implementation of the recommendations in the report will be subject to future budget availability, and phased implementation of those recommendations will therefore need to consider cost and deliverability implications. As such, the report should be viewed in this context.

I would wish to place on record my thanks to the external review team in EY and, in particular, to the broad range of stakeholders and representative bodies that contributed their time and expertise to this review. It is hoped that the recommendations contained within this report will serve as a useful starting point in considering how our mental health workforce can be transformed to meet our future mental health needs.

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Northern Ireland Mental Health Services Workforce Review 2022 – 2032

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Abbreviations

Term	Definition
ACE	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
AHP	Allied Health Professional
AMH	Adult Mental Health
ANP	Advanced Nurse Practitioners
BHSCT	Belfast Health and Social Care Trust
BPS	British Psychological Society
CESR	Certificate of Eligibility for Specialist Registration
C&V	Community and Voluntary
CAMHS	Children and Adolescents Mental Health Services
ID CAMHS	Intellectual Disability Children and Adolescents Mental Health Services
CAPT	Child and Adolescent Psychotherapist
CBT	Cognitive Behavioural Therapist
COVID-19	Coronavirus
DAMHS	Drug and Alcohol Mental Health Services
DOH	Department of Health
DOHNI	Department of Health Northern Ireland
GP	General Practitioner
HCPC	Health and Care Professions Council
HRPTS	Human Resources Payroll and Travel System
HSC	Health and Social Care
HSCNI	Health and Social Care Northern Ireland
KOI	Knowing Our Identity (Gender Identity Service)
LOS	Length of Stay
MCA	Mental Capacity Act
MDT	Multidisciplinary Team
MH	Mental Health
MHS	Mental Health Strategy
MHO	Mental Health (Northern Ireland) Order 1986
MHP	Mental Health Practitioner
MOC	Model of Care
NHS	National Health Service
NHSCT	Northern Health and Social Care Trust
NI	Northern Ireland
NICE	National Institute for Health and Care Excellence
NICPLD	Northern Ireland Centre for Pharmacy Learning and Development
NIMDTA	Northern Ireland Medical and Dental Training Agency
NISRA	Northern Ireland Statistics and Research Agency
OT	Occupational Therapist

PHA	Public Health Agency
PICU	Psychiatric Intensive Care Unit
PTSD	Post-Traumatic Stress Disorder
PWP	Primary Wellbeing Practitioner
QNCC	Quality Network for Community CAMHS
QNIC	Quality Network for Inpatient CAMHS
QUB	Queens University Belfast
RPS	Royal Pharmaceutical Society
RQIA	Regulation and Quality Improvement Authority
SARS	Severe acute respiratory syndrome
SAS	Specialty Doctor, Associate Specialists and Specialist Grade Doctors
SEHSCT	South-Eastern Health and Social Care Trust
SHSCT	Southern Health and Social Care Trust
SLT	Speech and Language Therapist
SPPG	Strategic Planning and Performance Group
TZS	Towards Zero Suicide
UK	United Kingdom
UU	Ulster University
WHSCT	Western Health and Social Care Trust
WTE	Whole Time Equivalent
WPD	Workforce Policy Directorate

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1. Executive Summary

Introduction

This Mental Health Workforce Review 2022-2032 has been delivered in response to Action 32 of the Mental Health Strategy (MHS) which called for; "a comprehensive workforce review considering existing workforce need and training, and the development of a new workforce, such as allied health professions, therapists and physician associates." This workforce review for Northern Ireland will be a key enabler for delivery of many actions outlined within the Mental Health Strategy 2021- 2031.

The purpose of the review is to consider the existing workforce and new models of working, with a view to providing a future workforce profile that will meet the needs of the population into the future. It is anticipated that this review will also help to inform decision making in relation to training requirements, and recruitment and retention.

This review is focused on statutory services delivered by Health and Social Care (HSC). It is recognised that there is significant inter-connectivity between Mental Health Services and other services. In recognition of other reviews currently underway, several areas have not been included within the scope of this review. This review will therefore focus on the provision of services for those service users with a primary assessment of mental health. It has been agreed that those with a primary assessment of dementia and learning disability in adult services, and those with a primary assessment of neurodevelopmental disorder, such as Autism and ADHD, within Children and Adolescents Mental Health Services (CAMHS) services, will be excluded from this review. Mental Health Services will align closely with the respective reviews to ensure the mental health needs of these patients are identified to inform the mental health workforce. This will be included within subsequent revisions of this review.

Methodology and Approach

The approach to this review included data and information collation through a series of interviews and included the formation of working groups for (i) adult mental health and (ii) CAMHS. This enabled ease of access to key Mental Health Professionals to contribute to the review. The working groups facilitated the development of the optimal team configurations for all individual services, leveraging best practice and relevant guidelines to develop the future workforce profile. Additionally, representatives from the Department of Health's Strategic Planning and Performance Group (SPPG), the Health and Social Care Trusts, and the Professional Bodies were also involved to ensure this review has been adequately interrogated to validate the future needs of Mental Health Services.

Alongside these working groups, data was collated to determine the current workforce in place. A breakdown of whole-time equivalents (WTE), detailed by profession, were collated, and validated by each Trust. To estimate future demand, current demand for services was evaluated from activity and waitlist returns received from the DoH SPPG. This demand was overlayed with prevalence, deprivation, and population trends, thereby providing a future demand profile. This demand modelling and the proposed future team configurations were combined to develop the future Mental Health Workforce Profile.

Defining the Future Workforce Profile

Developing a future workforce profile is complex, with many factors shaping the staff types required to deliver future service models. In addition to demand for services, the future workforce model has been informed by benchmark information, best practice guidelines, service and discipline reviews and insight from Trusts and Service Leads on emerging areas of new practices. This includes professions that are well established in other jurisdictions that are limited or absent from NI Mental Health Services currently.

The outcome of the engagement has led to a robust multi-disciplinary presence across Mental Health Services Teams to deliver a recovery-focussed, outcomes driven, model of care. A standardised team configuration has been agreed and applied for all Mental Health Services. This means each service, across all Trusts, has the same team composition per individual service to deliver a consistent delivery model across all Trusts. This consistent approach is aligned to the vision for the single Regional Mental Health Service (MHS Action 31). The proposed developments of the workforce were designed around the stepped care model, to ensure that appropriate intervention is delivered at the appropriate time by the most appropriate professional to improve preventative care and reduce reliance on crisis and inpatient demand. For example, the development and expansion of Crisis teams to better manage and prevent admissions will be a key enabler to reduce pressure on acute services; in addition, the development of capacity and capability within community services to focus on prevention and early intervention will be transformational for all people with mental health needs.

Within CAMHS, all current services have been included, and in addition the planned future expansion of Intellectual Disability (ID) CAMHS to all Trusts, the inclusion of a Regional Deaf CAMHS service and a pilot within Youth Justice Services. The following is an overview of the services provided in CAMHS services:

Overview of CAMH services

CAMH Services	
Primary Mental Health Teams (Step 2)	Intellectual Disability CAMHS (ID CAMHS) *(Within SHSCT currently, to be expanded to all Trusts in future model)*
Core CAMHS (Step 3)	Crisis Resolution & Home Treatment
Drug and Alcohol Mental Health Services (DAMHS)	Regional Family Trauma Centre
Eating Disorders	Regional Inpatient Unit (Beechcroft)
Regional Deaf CAMHS	Youth Justice pilot
Lifespan Gender Identity Service (accounted for within adult workforce numbers)	

Within Adult Services, all services outlined below are currently operating and will continue into the future. There are several services that have revised delivery models planned such as Personality Disorder Services, Rehabilitation Services, and Crisis services which have been included also. The following is an overview of Adult Mental Health Services provided:

Overview of Adult Mental Health services

Adult Services	
Community Assessment Team	Day Services
Community Intervention Teams	Supported Living/Floating Support
Community Addictions	Mental Health & Deafness Service
Eating Disorder Service	Rehabilitation Service
Early Intervention Psychosis	Mental Health Liaison Services
Personality Disorder Service	Crisis Response & Home Treatment
Community Forensic Service	Acute Inpatient Services (including Psychiatric Intensive Care Unit (PICU))
Condition Management Service	Inpatient Addiction Service
Lifeline Service	Medium Secure Service
Lifespan Gender Identity Service	Multi-Agency Triage Team
Psychological Therapies Service	

Key findings

Based on the modelling approach undertaken through this review, the following is the total Northern Ireland Mental Health Workforce proposed across Adult and CAMH services.

Proposed Future Workforce across Adults and CAMHS (WTE)

	Current	Future	% Change
Adult	3794	5245	38.2%
CAMHS	443	895	102.1%

Within Adult Mental Health Services, this review has concluded that a 38.2% increase in workforce resource is needed to deliver future Mental Health Services. This increase in workforce profile is due to increased demand forecast for services, adult population growth of 5.3%, and the incorporation of optimal team configurations based on best practice and planned service developments impacting on the resources needed to deliver. Aligning to standards, such as Delivering Care 5A for nursing and equivalent standards, has provided minimum ratios of staffing for safe staffing standards which have been included in this review.

In CAMHS, a 102.1% increase in workforce resource is needed. Whilst growth appears very high in comparison to the current workforce profile, when compared to comparator CAMH services within England, it indicates that the NI CAMHS future workforce profile is placed in approximately the 80th percentile against peers (NHS Benchmarking Network) per 100,000 population. This indicates that, while this workforce profile will see significant growth in numbers, it is within the upper range of comparator NHS Trusts. The future model for CAMHS has a broader range of multidisciplinary team professionals to include professions that are

well established in other jurisdictions but may be limited or absent in NI. In addition, the expansion to an ID CAMH service for each Trust represents a significant uplift in total workforce numbers and expansion of professions is contributing to the growth in numbers.

Across Adult and CAMHS, an expansion of Allied Health Professionals such as Dietetics, Speech and Language Therapy, Physiotherapy, Creative Therapies and other professions such as Child and Adolescent Psychotherapy, Adult Psychotherapy and Pharmacy has been incorporated.

Total Workforce Profile by Discipline

Based on outputs from the demand and capacity model, and a review of all service team configurations, the following is the total future workforce profile broken down by profession. It highlights significant growth in several emerging professions, demonstrating the shift to blended multidisciplinary teams. This better aligns with the blended multidisciplinary teams observed in other jurisdictions.

Total Workforce Profile (WTE) by Profession (CAMHS and Adults Combined)

Profession	Current	Future	Change
Nursing	1316	1842	40%
Medical	203	331	63%
Social Work	582	663	14%
Psychology	118	246	108%
OT	159	307	93%
Physiotherapist	7	79	985%
SLT	28	96	238%
Dietetics	7	78	973%
CAPT & Adult Psychotherapist	2	43	2613%
Psychotherapist (CBT)	16	73	369%
Pharmacy	2	162	7979%
Art/Music/Drama Therapists	2	100	6586%
Mental Health Practitioner	52	202	285%
Social Care	199	224	13%
Counsellors	52	52	1%
Management & Admin	533	891	67%
Nursing Support	791	343	-57%
Psychology Associate	13	92	598%
OT Support	21	10	-52%
SLT Support	0	5	N/A

Physio Support	0	11	2697%
Physician Associate	1	1	0%
Assistant Practitioner	131	230	76%
Peer Support Worker	0	53	N/A
Independent Advocates	2	2	0%
Transition Worker	0	5	N/A
Total	**4237**	**6140**	**45%**

Within this review, the Mental Health Practitioner (MHP) role is only included with the MDT teams within the GP Federations; it was agreed that the MHP role would not be included in the future workforce profile across Mental Health Services. In addition, the defined role of the Counsellor and CBT Psychotherapy is only included for the Lifeline Service and Psychological Therapies Service as outlined within the assumptions in section 5.1.

It should be noted that there are several future service developments that have not been encapsulated within this review, as these proposed services are in the early stages of planning. Additional detailed service development work is needed prior to identifying the workforce profile. These future developments include, but are not limited to, the workforce impact of the full implementation of the Mental Capacity Act and proposed new Adult Safeguarding legislation, future developments within the Regional Trauma Network, the Multi-Agency Triage Teams and Student Mental Health Services. In addition, development of low secure beds within the Forensic Managed Care Network, expansion of a pilot within Youth Justice Services and re-development of a Regional Neuro-Psychiatry service will be further developed in the coming months and years.

It is recognised that over the life of this workforce plan, additional service developments will be identified and approved and will need to be added to this workforce plan to reflect the needs of the population when appropriate.

Key Recommendations:

Following extensive engagement across Mental Health Services, several themes have been identified with specific recommendations that will support the successful delivery of this Workforce Review. The key themes are outlined below with associated recommendations.

Workforce Capacity & Profile

1. Funding and Resourcing this Workforce Review: The cost of this future workforce profile should be evaluated to inform the requests for additional funding and to plan the phased delivery of this workforce review.

2. Recruitment: A task and finish group should be established to complete a prioritisation of service developments and to plan the recruitment of key appointments and other team members. This should include agreement on the number of pre-registration training places and number of posts to be recruited through normal recruitment processes. Recruitment should start with appointing key personnel who will lead on the development of the service.

3. Maximise the contribution of the Community & Voluntary sector in the delivery of Mental Health Services: Assess the capacity and capability available within the Community and Voluntary Sector to inform optimisation of existing structures and ways of working to co-deliver the full range of Mental Health services required.

Workforce Capability

4. Re-defining and standardising roles: A job profile standardisation exercise should be completed to clearly define and standardise each job profile per profession within specialist teams.

5. Measuring the Benefit of New and Emerging Roles: A task and finish group should agree a structured approach to evaluating the benefit of new and emerging roles prior to the full roll out of the full workforce profile outlined in this review.

6. Advanced Training Review: Complete an analysis of all resources with advanced training qualifications across all Mental Health Services within each Trust to understand the status of those trained and practicing to the top of their license.

7. Psychological Therapies Framework: A Psychological Therapies Framework should be developed for NI which should include a taxonomy of all psychological professions, defined career pathways and access routes to training programmes for existing and emerging psychological professions.

Pathways into the workforce

8. Undergraduate training: For undergraduate programmes of professions that are expanding significantly in this workforce review e.g., SLT and Dietetics, liaison with the University Institutions is required to agree ways to improve awareness of mental health services e.g., through dedicated lectures and/or modules.

9. Supported training roles: A task and finish group should evaluate and develop an implementation plan for a single pathway for supported training programmes across key disciplines.

10. Diversifying the workforce: A task and finish group should explore the development of new Professions that can be 'profession agnostic' which will allow access to a wider pool of resources e.g. psychology graduates training to be Psychological Wellbeing Practitioners.

Workforce Recruitment and Retention

11. Education and Training: Define training needs and develop a single process to apply for all advanced training programmes across all commissioning bodies based on service need.

12. Specified Training Places for Critical Skills: Evaluate, with HR Trust Directors, Universities and Professional Bodies, the ability to ringfence training places under specific conditions to address critical skill shortages.

13. Incentive Packages: Create and implement a communication plan to increase staff and external candidates' awareness of the benefits and incentives of working in the HSC.

14. Recruitment Campaigns: Agree targeted localised recruitment campaigns per Trust that can leverage regional campaigns.

Scope of Services

15. Evaluation of Mental Capacity Act (2016) on mental health workforce demand: Complete a review of all activity required to meet MCA legislation requirements across all Programmes of Care, to identify specific Mental Health resources required to meet demand.

16. Incorporation of mental health demand from Learning Disability, Dementia, Attention Deficit Hyperactivity Disorder (ADHD) and Autism Reviews: To ensure a joined-up approach to all relevant reviews outside the scope of the Mental Health workforce review, identify Mental Health representation to evaluate the mental health demand and associated resources required to meet the needs of these cohorts of patients.

Other

17. Standard Service Terminology and Scope: Aligned to the vision for a Regional Mental Health Service, review and align scope of all services and naming conventions to have single definitions per service across Mental Health Services.

18. Data Quality, Collection and Analytics: Aligned to the Encompass Programme and other work underway, a regional standardisation of datasets including clinical, activity and operational outcome measures and key performance indicators should be agreed across all services to monitor benefit and to underpin future service improvements plans. This should align to Action 34 in the Mental Health Strategy to develop an Outcomes Framework to underpin and drive service delivery.

Conclusion

This future workforce review is a key enabler to deliver on the Mental Health Strategy 2021-2031, providing more equitable access to Mental Health Services across NI. This workforce review encapsulates service developments planned for Mental Health Services. It provides an overview of the proposed workforce profile for the next 10 years. It is recognised that over the life of this workforce plan, additional service developments will be identified and approved and will be added to this workforce plan to reflect the needs of the population. This plan will need to remain agile to demand changes, new evidence base, recruitment, attraction, and funding challenges to meet Northern Ireland population needs in the coming years.

This workforce review has established current demand drivers and planned a future focused workforce profile based on best available evidence, benchmarks, guidelines, and knowledge throughout the system. It has focused on developing team configurations that will meet the complexity of presentations seen within services.

This review afforded the opportunity to grow the participation of some professions that were limited or absent from the current workforce, to align with other jurisdictions and identify new roles that can be integral parts of teams going forward. These include an expansion of AHP roles, Pharmacy, Child and Adolescent Psychotherapy, Assistant Practitioner roles amongst others. There is an expectation and opportunity for new roles to emerge in the coming years where the HSC have limited access to specific types of skills and require more diverse options to fulfil the skills needed by services.

Whilst attracting, retaining, and funding the workforce is an ongoing challenge within Mental Health Services and the broader HSC, some practical recommendations have been provided to support development of clear career pathways for professions, improve undergraduate access to Mental Health training, and establish supportive career pathways for support workers to further develop their skills and aid retention of the workforce.

The pace at which this review can be delivered will largely be determined by the extent to which additional funding is made available. That being said, the ambition of the Mental Health Strategy, and the delivery of the recommendations set out in this review, have the potential to transform Mental Health Services to improve outcomes for all requiring services across Northern Ireland, by ensuring an effective future workforce model which can provide better access to care within the context of a Regional Mental Health Service.

2. Introduction

2.1. Strategic Context

This Northern Ireland Mental Health Workforce Review is seen as a key enabler of the Mental Health transformation agenda and a key part of the Mental Health Strategy 2021-2031[1] to deliver a single Mental Health Service that meets the needs of the population and will support a more sustainable health and social care system for the 21st century. The Mental Health Strategy forms a key role in the delivery of Delivering Together 2026[2], a ten-year road map for the transformation of Health and Social Care (HSC) services in Northern Ireland and as an action from Strategic Framework for Rebuilding; Rebuilding Health and Social Care Services (2020) to combat the impact COVID-19 has placed on all health services. The impact that COVID-19 has had on the mental health of all people within Northern Ireland is yet to fully emerge and will drive additional demand and complexity in the coming years.

Action 32 of the Mental Health Strategy[3] called for; "*a comprehensive workforce review considering existing workforce need and training, and the development of a new workforce, such as allied health professions, therapists and physician associates***.**" This review is a key enabler of the overall Mental Health Strategy and will help support the delivery of other actions as set out within the strategy.

As was clearly set out in Health and Wellbeing 2026: Delivering Together[4], the HSC faced significant strategic and operational challenges prior to COVID-19. Challenges included an ageing population, increasing demand, long and growing waiting lists, workforce pressures, and ongoing budgetary constraints. Some of these pressures are a catalyst for supporting a move towards multi-disciplinary care and expansion of the scope of different roles to reduce reliance on scarce resources e.g., deficits in consultant availability. There is an opportunity to leverage the Advanced Nurse Practitioner, Nurse Prescriber role, introduction of Consultant Nurse, Consultant AHP, Consultant Pharmacist and other similar advanced roles to strategically align to the strategic priorities of the Workforce Plan for Nursing and Midwifery 2015-2025[6] and the respective reviews completed by Allied Health Professionals and Pharmacy. In addition, it is an opportunity to align absent or limited professions that are well-established in other jurisdictions and to introduce and expand the role of emerging professions within Mental Health to deliver better outcomes to patients. This will help to diversify the workforce profile, while providing a clear career pathway within Mental Health Services. It will also support the delivery of alternative models of care.

Prior to the publication of the Mental Health Strategy 2021-31 in June 2021, the Strategic Framework for Rebuilding[7], published in June 2020, highlighted the compound effect which COVID-19 has had on existing challenges such as delays in diagnosis and treatment. The long-term implications of those delays to diagnosis and treatment will impact demand for

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[1] Department of Health. (2021). *Mental Health Strategy* [Online]. Available from: doh-mhs-strategy-2021-2031.pdf (health-ni.gov.uk) [Accessed 07 June 2022].
[2] Department of Health. (2016). *Health and Wellbeing* [Online]. Available from: health-and-wellbeing-2026-delivering-together (health-ni.gov.uk) [Accessed 10 June 2022].
[3] Department of Health. (2021). *Mental Health Strategy* [Online]. Available from: doh-mhs-strategy-2021-2031.pdf (health-ni.gov.uk) [Accessed 10 June 2022].
[4] Department of Health. (2016). *Health and Wellbeing* [Online]. Available from: health-and-wellbeing-2026-delivering-together (health-ni.gov.uk) [Accessed 10 June 2022].
[5] Department of Health. (2016). *A Workforce Plan for Nursing and Midwifery in Northern Ireland* (2015 – 2025) [Online]. Available from: DHSSPS Workforce Plan for Nursing Midwifery 2015-2025 May 2016 (health-ni.gov.uk) [Accessed 11 June 2022].
[6] Department of Health. (2016). *A Workforce Plan for Nursing and Midwifery in Northern Ireland* (2015 – 2025) [Online]. Available from: *DHSSPS Workforce Plan for Nursing Midwifery 2015-2025 May 2016 (health-ni.gov.uk)* [Accessed 11 June 2022].
[7] Department of Health. (2020). *Strategic Framework for Rebuilding; Rebuilding Health and Social Care Services* [Online]. Available from: Rebuilding Health and Social Care Services | Department of Health (health-ni.gov.uk) [Accessed 14 June 2022]

health services and increase the risks to Northern Ireland (NI) citizens' quality of life and overall health wellbeing. The Strategic Framework for Rebuilding focused on building capacity to ensure NI manages Preventable Mortality, a key measure of the NI Executive's Programme for Government Outcome 4[8], ''We enjoy long, healthy, active lives'' and Outcome 8, ''We care for others, and we help those in need''. Similarly, there is a risk that the inability to address access to critical Mental Health Services will further impact the percentage of people who are satisfied with HSC services. As a result of the impact which COVID-19 has had on service delivery over the last two years, NI has been challenged to return to previous levels of activity, further impacting the ability to address the deepening waiting list backlogs and increased unmet demand, including those who are presenting later with more complex needs. Nevertheless, the pandemic has presented an opportunity to Rebuild Better, and this workforce review will be a lever to maximise delivery of care across all NI Mental Health services. In addition, it will help to deliver on the new substance use strategy, "Preventing Harm, Empowering Recovery"[9], which prioritises the need to address co-occurring mental health and substance use presentations within both mental health and substance use services and the RQIA review of MH services in prisons; highlighting the need for immediate actions to support this vulnerable cohort of patients. [10]

This workforce review is timely as, as seen across Health & Social Care, demand for Mental Health Services is increasing on an annual basis, driven by an array of complex and multi-faceted factors including increasing complexity of presentation. This has resulted in long waiting lists for care requiring specialist and intensive support with a growing number of people waiting over 9 weeks for adult Mental Health Services. In addition, COVID-19 has placed further pressure on the system through its impact on face-to-face appointments and growth in demand for Mental Health Services, leading to a greater degree of complexity in cases across an array of presentations.

The importance of acting now is further illustrated through children and young people statistics, with 1 in 10 experiencing emotional problems, with anxiety and depression being 25% more common in children in Northern Ireland compared to other parts of the UK. NI's children and young people deserve every opportunity to experience their young lives free of mental illness and the Mental Health Strategy provides a window of opportunity to make that happen.

Within the Health survey Northern Ireland, the mental health general health questionnaire (GHQ12) which is a screening tool designed to detect the possibility of psychiatric morbidity in the general population has shown a growth in respondents being classified as having a possible psychiatric disorder from a constant of 18% pre-Covid (years 2010-2019) to 27% in 2020/21, it is clear the impact of Covid is exacerbating the prevalence of Mental Health problems[11]. This is in addition to legacy complexities associated with Northern Ireland's recent past. It is critical that this challenge is tackled head on. This is an opportunity to understand current capacity and address current and future needs across Northern Ireland.

As outlined, in the Mental Health Strategy 2021 – 2031[12], there are several actions that will benefit from the completion of this review. This workforce review will be a key enabler to identify the future workforce to deliver a fit for purpose clinical model providing equitable access across Northern Ireland. This review will also identify the workforce necessary for a

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[8] *Northern Ireland Executive. (2016) Draft Programme of Government Framework [Online]. Available from: Draft Programme for Government Framework 2016-2021 (northernireland.gov.uk)*

[9] *Department of Health (2021) Preventing Harm, Empowering Recovery: A Strategic Framework to Tackle the Harm from Substance Use (2021-31) [Online]. Available from: doh-substanceuse-strategy-2021-31.pdf (health-ni.gov.uk)*

RQIA (2021) [10] *Review of services for vulnerable persons detained in Northern Ireland Prisons Available from: Effective Penalty Enforcement – A Review of the impact of current fine default strategy and services (rqia.org.uk)*

[11] *Department of Health (2022). Health Survey NI Trend Tables [Online]. Available from: Tables from health survey Northern Ireland | Department of Health (health-ni.gov.uk)*

[12] Department of Health. (2016). *Mental Health Strategy* [Online]. Available from: doh-mhs-strategy-2021-2031.pdf (health-ni.gov.uk) [Accessed 07 June 2022].

regional Mental Health Service as outlined within From Silos to Systems Report for Northern Ireland[13]

With limitations on the supply side, driven largely by workforce challenges around recruitment and retention, an unsustainable system is created which impacts on the ability of services to meet population needs. This review will provide recommendations that will tackle some of the challenges identified.

This Mental Health Workforce Review is an opportunity to look forward to the next ten years to plan a workforce that can deliver on the ambitions of Mental Health Services to meet the mental health needs of the population of Northern Ireland.

2.2. Purpose

The purpose of the review is to consider the existing workforce, new models of working and demand drivers across Mental Health Services to create a workforce for the future that will meet the needs of the population over the next ten years. This review will outline current capacity and anticipated future demand, providing a future workforce profile. The review will take cognisance of care pathway re-design underway, new service developments, insights from other jurisdictions and use of technology. It will consider the breadth of professions delivering mental health services in other jurisdictions and best practice and applied this to the NI context to define the future workforce required for Mental Health Services in Northern Ireland.

This review provides a regional workforce profile that strives to provide equitable access for all citizens and all others requiring services in Northern Ireland. It will take cognisance of different deprivation levels, rates of mental illness, existing activity across services, waitlist information and geographical issues that impact on the delivery of care of Mental Health Services. It will also consider any new or developing service areas that need to be considered as part of the future delivery model for Mental Health Services.

It also provides a list of recommendations in the sourcing, attraction, training and retention of the workforce and other associated considerations that may impact on the delivery of this workforce review.

[13] Department of Health. (2021). *From Silos to Systems: Report of the Project for a Regional Mental Health Service for Northern Ireland.*

2.3. Scope

The scope of this review is defined within the Terms of Reference[14], and includes those Mental Health Services that are delivered across the statutory organisations within the HSC sector. Aligned to the Stepped Care Model, this review focuses on the services across community and inpatient services for adult, and child and adolescent services[15]. For adults, this is Step 3 – Step 5 services, and for CAMHS Step 2 – Step 5 services.

The professions that are included within the scope of this review are:

- Consultant Psychiatrists and Specialty Doctor, Associate Specialists and Specialist Grade (SAS) Doctors
- Nurses
- Social Care Workers
- Approved Social Workers
- Social Workers
- Assistant, Associate and Clinical and other Practitioner Psychologists
- Counsellors
- Assistant, Child and Adolescent Psychotherapists and Adult Psychotherapists
- Allied Health Professionals (Occupational Therapists (OT), Dieticians, Physiotherapist, Speech and Language Therapists (SLT))
- Support workers
- Physician Associates
- Pharmacists
- Peer Support Workers
- Independent Advocates
- Other Therapists e.g., Art/Drama/Music Therapists
- Supporting Administrative/Clerical staff

EY have been engaged to complete this independent workforce review on behalf of the Department of Health's Mental Health Directorate. EY have worked closely with all stakeholders throughout the review to encapsulate the breadth of workforce considerations across Mental Health Services.

2.4. Limitations of the Review

In setting out the scope of this review, it is acknowledged that the breadth of mental health services is vast. As part of the initial engagement, consultation was held with the relevant Programmes of Care, with input from the representative bodies in the NI Mental Health Workforce Steering Group to consider several critical areas that have significant alignment or overlap with Mental Health Services. As part of the scoping of this review, all clinical services delivered within the HSC were reviewed for inclusion within this review. To ensure that the scope was clearly defined, it was agreed to limit the scope of the review to services delivering care to patients with a primary assessment of a mental health issue. In addition, where there is a parallel Programme of Care or additional analysis is required, an informed decision was made in the best interests of the patient group.

[14] *Terms of Reference Action 32: Review of Mental Health Workforce* (2022) Department of Health

[15] Health and Social Care Board. (2014). *Regional Mental Health Pathway* [Online]. Available from: health-and-social-care-pathway(hscni.net)
[Accessed 10 June 2022].

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It is recognised that there is significant inter-connectivity between different programmes within Mental Health Services. For specific areas that were not included within this review, there is a clear understanding that work is being undertaken within different Programmes of Care which Mental Health Services have committed to input to. Mental Health Services will remain aligned to the different Programmes of Care and input appropriately to those reviews to ensure Mental Health Services are represented and accounted for as necessary.

For other areas deemed outside of scope of this review, there was a recognition that specific analysis is required to make an informed decision on workforce requirements. It was therefore agreed that it would not be viable to complete within the timeline of this review. However, it is acknowledged that this review will be a living document and there will be a need for reviews to reflect additional workforce requirements to meet planned service developments and changing regulatory requirements over the next 10 years.

Scope of CAMHS

Within CAMHS services, it was agreed that a specific review for neurodevelopmental disorders, such as autism and ADHD is required to understand the best management of these services. This will be considered in the future.

Mental Health demand within the Education sector has been excluded from the scope of this review; however, there is recognition within the education sector that demand for Mental Health Services is growing. Delayed access for children and young people into Mental Health Services is having a downstream impact on educational supports needed. The outcome of this review will aim to provide additional capacity within CAMHS services to ensure timely and equitable access to services.

Infant Mental Health is managed within universal children's service and on that basis has not been included within this review.

Scope of Adult Services

A review of Adult Learning Disability Services is currently underway. Phase one includes a review of all existing services across all Programmes of Care for people with a Learning Disability. While subsequent phases of work have yet to be fully defined, the objective of the review is to holistically review and plan for all patients with a primary Learning Disability, including those with a Mental Health co-morbidity. Therefore, it was agreed that those with a primary diagnosis of a moderate to severe Learning Disability have been excluded from this review. As is current practice, patients presenting with a Mental Health need with a co-existing mild learning disability have been included within the scope of the review. While there is 'no wrong door' to access services, a joined-up approach is needed to meet the complex needs of this cohort of patients and close links will be maintained to ensure all mental health aspects of care are effectively managed within the Learning Disability Review.

Development of new pathways of care for dementia are currently underway and will form part of the transformation of the dementia pathway. For this reason, dementia services have been excluded from the scope of this review.

Perinatal services have been excluded from the review as the model has already been developed and is in the early stages of rollout.

All Services

Due to the complexity and scale of the issues within the Mental Health workforce in the statutory sector, it has not been possible to include the Community & Voluntary (C&V) sector within the scope of the review. The C&V sector currently plays a critical role in the delivery of HSC services, and the Mental Health Strategy commits to fully embed this sector in the future delivery of MH services. It is also acknowledged that the C&V workforce issues are closely interrelated to those in the statutory sector e.g., challenges attracting and retaining staff. In that context, it is envisaged that a separate assessment of the C&V sector structure and capacity will be undertaken as part of the ongoing engagement between the Department of Health and the C&V sector.

The Mental Capacity Act (2016) is a ground-breaking piece of legislation that, when fully commenced, will fuse together mental capacity and Mental Health law for those aged 16 years old and over within a single piece of legislation, as recommended by the Bamford Review of Mental Health and Learning Disability. This legislation is having, and will continue to have, a significant impact on demand for qualified persons which will put further demand on finite resources. As such, given the uncertainty of the impact of the full adoption of the Act, this has been excluded from the review until a full evaluation of demand is completed to understand in full the workforce implications.

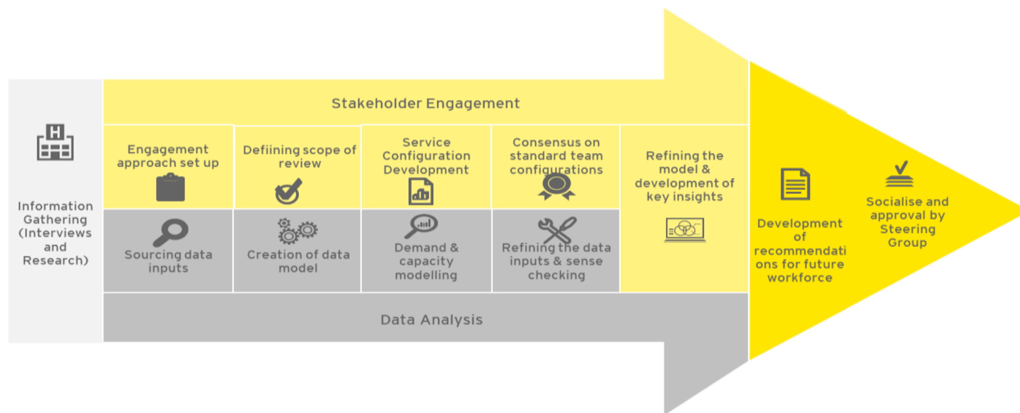
It should be noted that there are additional service developments identified that are in the early stages of planning. Workforce numbers have not been attributed to these services until detailed planning is complete. These will need to be incorporated following due process to align to approval and funding processes. These are outlined in section 4.

2.5. Methodology and Approach

2.5.1 Approach

The approach to this review considers the existing workforce, new ways of working and future workforce demand. The approach aligns to the HSC Workforce Planning Framework – Six Step Methodology Framework[16] method to ensure that the workforce configuration meets the needs of the NI population into the future.

Figure 1: Methodology Approach



Defining the Plan: As part of the initial phase of work, defining the scope and delivery method for the project was completed. This included the development of a robust engagement plan to engage with a broad range of stakeholders across NI Mental Health Services.

Initial Information Gathering and Stakeholder Interviews: An initial period of information gathering through a series of interviews was conducted to get an overview of the Mental Health Services landscape, the current workforce challenges, service developments and expansion of discipline roles. This included the confirmation of the scope of the review and engaging and aligning with other reviews underway, ensuring an integrated approach is taken to the completion of this review.

Development of stakeholder groups for consistent input to the review: To ensure there was a robust engagement process, two working groups were established for (i) Adult MH services and (ii) CAMHS. These groups were set up to enable ease of access to key Mental Health Professionals to facilitate input to the review and to provide a robust challenge function. In addition, engagement also took place with Department of Health and Discipline, Trust and Mental Health Service Leads to test and refine the workforce plan.

Data Request and Collection: To understand the current workforce within NI Mental Health Services, a detailed data gathering exercise was conducted, gathering data from a broad range of sources (including staff in post, vacancies, absence), and demand data (activity, waitlist, prevalence, population growth). These data sources are key factors in developing a demand and capacity model that would identify the key priorities for the future workforce.

This was conducted collaboratively with the Regional Workforce Steering Group, HSC Trust Human Resources, Finance and Operations Teams and the DoH Strategic Planning and

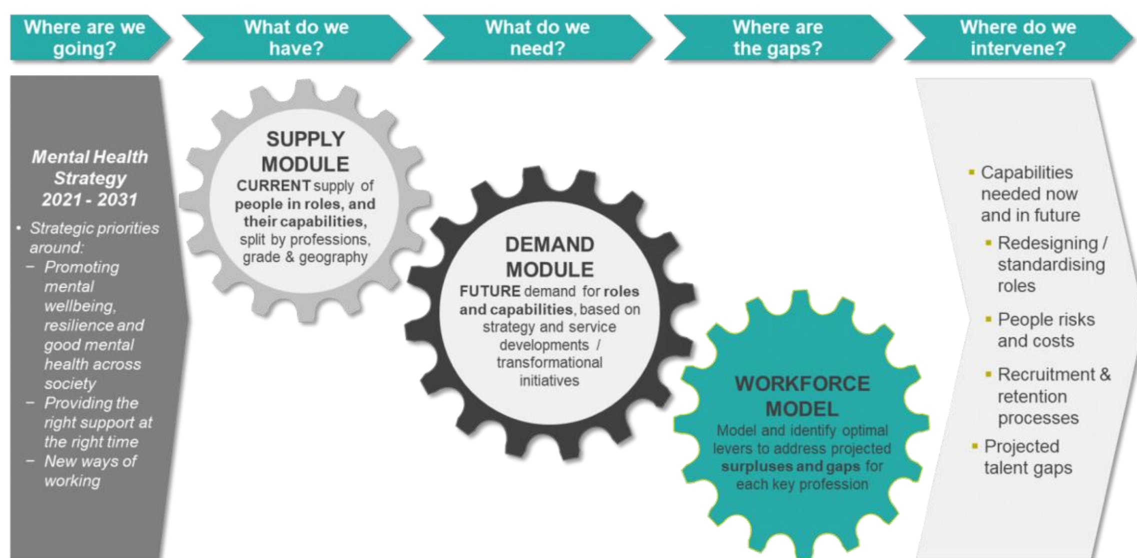
[16] Department of Health. (2015). *Regional HSC Workforce Planning Framework* [Online]. Available from: Regional-Workforce-Planning-Framework-March-2015.pdf (health-ni.gov.uk) [Accessed 07 May 2022].

Performance Group (SPPG) to ensure that the data returns were accurate and reflective of the current Mental Health Service.

Demand and Capacity Analysis: Demand for services was evaluated from activity and waitlist returns received from the SPPG. This demand was overlayed with prevalence, deprivation, and population trends to provide a realistic future demand profile.

To fully understand the current capacity across the region, HR data was collated and validated across all Trusts. An in-depth analysis across all Mental Health Services was completed for staff in post, split by Trust, profession, and grades. In addition, a review of vacancy rates was also conducted. Trends were collated to compare a pre-COVID-19 year (FY18/19) and COVID-19 year (FY21/22) to understand any changes in the workforce demographic.

Figure 2: Data Analysis Approach



Defining team service configurations for future Mental Health Services: Engagement with the Trusts and with the relevant professions was completed to agree the optimal team configuration required for all Mental Health Services. A single team configuration has been agreed which has been applied to all Trusts. This means each service, across all Trusts, has the same team composition per individual service to deliver a consistent delivery model across all Trusts. Consideration of best practice was also included where available, including National Institute for Health and Care Excellence (NICE) guidelines, standards, and recent in-depth reviews of specific Mental Health Services. Where systematic evidence for optimal team configurations for specific services was limited, the wealth of knowledge within the HSC system was utilised to develop a standardised approach to team configurations. The agreed configuration of the teams was incorporated with the demand and capacity model to provide the future workforce profile. This defined the team configuration by discipline type, band/level of seniority and quantity of resources required.

Understanding the future workforce: A comparison was completed between the current workforce and the proposed future workforce to understand what level of additional resource required to meet forecast demand across each profession. This included using attrition data, retirement age profile and length of training programmes, where applicable, to plan the level of recruitment that would be required to meet the future workforce profile.

As part of the interview processes, identified issues and challenges were collated in relation to retention, attraction, and training. These were evaluated to inform a set of recommendations and action plan to meet the additional resources outlined in this review.

Developing a set of recommendations and action plan to deliver the future workforce profile: To deliver the future workforce model, a set of recommendations and an action plan have been developed to support the delivery of the proposed future workforce model. Increasing capacity across services will support the objectives of the ambitious Mental Health Strategy 2021-2031.

2.5.2 Data Collection and Data Modelling

To inform the data analysis process and to build the demand and capacity model, data was collected from a range of sources as outlined below.

2.5.2.1 Data Collection

Data was collected from a range of sources and assimilated to inform the demand and capacity modelling approach as outlined in the following tables. All datasets were validated by each Trust. While all data was validated by the Trusts, it is acknowledged that there may be minor inaccuracies based on the staff coding within the HR systems.

Table 1: Workforce Capacity Data Sources

Capacity Data	Source	Key Information Used
HR Workforce	Human Resources Returns (HRPTS) Workforce Information & Systems	Headcount and Whole Time Equivalent (WTE)
Vacancy Data	Finance Team – Individual Trusts	Bank, agency, permanent, vacancies, total backfill
Absence Statistics	HRPTS Workforce Information & Systems	Absence estimates
Mental Health Order (MHO) Status	HSC Pension Service	Retirement estimates
Prison Healthcare	South Eastern Health and Social Care Trust (SEHSCT)	Forensic Mental Health (MH) workforce

Table 2: Workforce Demand Data Sources

Demand Data	Source	Key Information Used
Incorporated in the Data Analysis / Demand vs. Capacity Modelling		
Outpatient Activity	SPPG	New appointments, past trends, capacity, repeat vs. new appointments
Outpatient Waitlists	SPPG	March 2022 waitlist, past waitlist trends
Inpatient Data	SPPG	Admissions, discharges, length of stay, occupancy
Population	Northern Ireland Statistics and Research Agency (NISRA)	Population changes over the next 10 years
Prevalence	CAMHS: Youth Wellbeing Prevalence Survey 2020 AMH: Department of Health (DoH)	Prevalence estimates for CAMH and AMH
Unmet Need	N/A	Estimated
Considered but not explicitly incorporated in the Demand vs. Capacity Modelling. Incorporated within 7.5% unmet need applied to the model.		

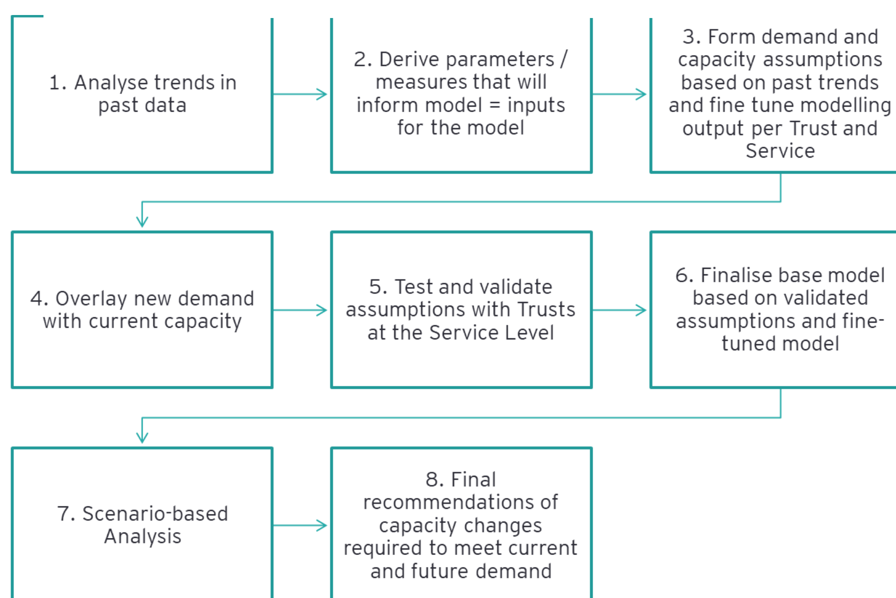
Deprivation	NISRA	Assumed approximately equal scatter of most and least deprived areas across all Trusts in NI
Substance Use	DoH	Prevalence estimates were incorporated
Paediatric Beds & Adult Mental Health (AMH) Bed Usage by CAMHS patients	Belfast Health and Social Care Trust (BHSCT)	No patient-level admission or discharge information available but acknowledged waitlists and pressure on CAMHS acute services
Primary Care MDT / Integrated Care Model	HSC NI	Derry early insights of 35-40% impact; further evaluation required

Table 3: Other Key Workforce Data Sources

Other Key Data	Source	Key Takeaways
National Health Service (NHS) Psych. Workforce Capacity	NHS/Canterbury University UK	Psychological therapists and psychological staff work
Approved Social Workers Workforce Planning 2020	Queen's University Belfast	Evidence based estimate of the number of Approved Social Workers (ASWs) required to fulfil duties under the MHO 1986.
Review of Demand & Capacity in Psychological Therapies	SPPG, DoH	SEHSCT Demand & Capacity Model - Gap Analysis
Substance Use Services	Service users, wait list and staff providing substance use services in the C&V sector	C&V sector

As part of the consultation process, other relevant data sources were included where necessary to adjust for any gaps within the datasets. The following is an overview of the Data Analysis Process:

Figure 3: Overview of Data Analysis Process



2.5.2.2 Data Modelling

The data modelling process involved assimilating data gathered from the various sources (as described above) and extracting key information required for the demand vs. capacity model. The data and modelling were broken down by Adult Mental Health Services (AMH) and Child and Adolescent Services (CAMHS) and split by Community (outpatients) vs. Acute services level. The community data provided was at the outpatient appointment-level while the acute service data provided was at the inpatient-level for CAMHS and inpatient monthly aggregated level for AMH. Therefore, outpatient and inpatient modelling were performed separately.

An analysis of the trends in the data was undertaken to examine past data to frame the model. The assumptions and model were fine-tuned per Trust and Service in AMH and CAMHS model separately. This approach was used as it was observed that each Trust and Service was unique and presented differently to each other. The assumptions were validated by each individual Trust and relevant adjustments completed based on Trust insights.

Once the validated assumptions were finalised (please refer to the Appendix iii for Trust/Service specific assumptions), these were fed back into the model for the final demand vs. capacity analysis. Demand for the model was based on past activity, current trends, as well as future projections.

Table 4: Factors to derive future demand

	Factors to derive future demand
Past and Current Activity	○ **Appointments -** average of new patients seen, repeat patients seen in each Trust and Service in Adult MH and CAMHS ○ **Prevalence** (assumed that the current activity and waitlists combined with unmet need, reflect the prevalence in the population) ○ **Waitlist change** in the past 5-year period excluding COVID year (2020-2021)
Future Trends	○ Population growth (10-year period from NISRA) ○ Unmet need

The above assumptions were different for each Service and Trust. Therefore, they were changed accordingly and validated by each Trust and Service. Please refer to Appendix iii for details on the methodology followed for Outpatients and the validated assumptions per Service and Trust.

A scenario-based analysis was then undertaken, in which the capacity levels were changed to test the influx of capacity that is required to meet the current and future demand.

- Scenario 0: This was the "do-nothing" scenario, where the impact on future waitlists is outlined if capacity is kept at the current levels.
- Scenario 1: This consisted of keeping the same assumptions and future demand as Scenario 0 but changing capacity (number of resources) such that waitlists reduce.

It was considered practical but also imperative that the first influx of capacity is by June 2023 and the second by June 2024, so that waitlists reduce to manageable numbers in the next 3-4 years for services such as Step 3 services, and to no waitlist for eating disorder and addiction services by or before June 2025. Both scenarios are included in Appendix iii.

The outputs of the data modelling projected an optimal level of resources based on current team configurations. The capacity and demand analysis provide an interpretation based on current service delivery and demand drivers only. Therefore, the outputs of the demand model were applied to the new team configurations, as developed within the working groups, and associated meetings, to accurately reflect the overall workforce profile. The incorporation of the proposed future service configurations encompasses best practice, national guidance and incorporates recent reviews to define the workforce profile needed to deliver best practice outcomes and transform services planned over the next ten years. To support the delivery of a single service that is working towards standardisation across all services within Trusts, it has been assumed that the service configurations are the same across all Trusts. The outputs of the modelling and the service configuration development have led to the future workforce profile outlined in section 5.

2.5.2.3 Data Quality and Caveats

Patient-level (anonymised) data is required for accurate demand and capacity modelling. For inpatients/acute services, patient-level data was available for CAMHS but not for AMH. This led to a reduction in accuracy of the model for inpatient AMH. For outpatients/community services, the data that was available was at the monthly appointment level and consisted of activity per Trust and Service. However, the quality and accuracy of the data varied per Trust.

Furthermore, the data did not consist of clinical pathway details (such as patient journey) and did not capture consultants seen, referrals, contacts, and length of patient MH journey in the system. While the data analysis is utilised to inform demand, incorporation of new models of care and team configurations has also been considered to arrive at the preferred workforce model to deliver best outcomes for all within Northern Ireland.

2.5.3 Governance

A robust governance approach was put in place to ensure appropriate levels of engagement and input from key stakeholders. The NI Mental Health Workforce Review Steering Group, co-chaired by the Directors of DoH Mental Health Directorate and Workforce Policy Directorate, consists of key stakeholders across DoH, Public Health Agency (PHA), Health and Social Care representatives, Universities, Trade Unions, and Service User and Representative Professional Groups to ensure a holistic review of Mental Health Services is completed. The Steering Group has met monthly to provide guidance and direction throughout the course of this review process. (See appendix i for list of membership).

2.5.4 Stakeholder Engagement

A key element of developing this workforce review was to engage widely across the HSC to gather data, insights, trends and best practice across all services and Trusts. A series of interviews was undertaken at the outset of the project to gather insights on the key challenges, opportunities and the future developments that would shape this workforce review. This included Trust representatives, Department of Health representatives, profession-specific representatives, and other key stakeholders such as the Community and Voluntary Sector.

In addition, AMH services and CAMHS groups were set up to contribute to the workforce review, inputting to service needs, validating assumptions, and agreeing future service models to meet demand across Northern Ireland.

Ongoing engagement continued throughout the project with key stakeholders sharing and validating information with colleagues to gather input and feedback, and ensure all perspectives were considered.

3. Understanding the Current Workforce

3.1. Current Service Provision

Across Northern Ireland there is a range of services delivered at Trust level with several regional services across CAMHS and Adult services. Services have evolved over time to meet the needs of their specific population. There is variance in the service delivery model and skill mix variations throughout teams due to different constraints within and across Trusts. The following are the current services delivered across Northern Ireland and evaluated within this review.

3.1.1 CAMHS

Children and Adolescents Mental Health Services (CAMHS)[17] focuses on delivering an integrated care pathway to provide compassionate care, using best practice research and published guidance to support the delivery of outcomes for children and young people e.g., National Institute of Clinical Excellence (NICE) guidelines and Quality Network for Community CAMHS (QNCC). As part of the workforce review, focus was placed on ''Working Together is at the heart of everything that we do'', through expansion of the multidisciplinary team ethos and holistic review of services to best meet the needs of the child and young person. The following is the list of services encompassed within CAMH services:

Table 5: Overview of CAMH services

CAMH Services	
Primary Mental Health Teams (Step 2)	Intellectual Disability CAMHS (ID CAMHS) *(Within SHSCT currently, to be expanded to all Trusts in future model)*
Core CAMHS (Step 3)	Crisis Resolution & Home Treatment
Drug and Alcohol Mental Health Services (DAMHS)	Regional Family Trauma Centre
Eating Disorders	Regional Inpatient Unit (Beechcroft)
Regional Deaf CAMHS	Youth Justice Pilot
Lifespan Gender Identity Service (accounted for within adult workforce numbers)	

[17] Family Support NI. (2018). Working Together: *A Pathway for Children and Young People Through CAMHS* [Online]. Available from: CAMHS-Pathway.pdf (familysupportni.gov.uk) [Accessed 07 May 2022]

3.1.2 Adults

Within adult services, there is variation in the naming and scope of services across Trusts, therefore, to evaluate services in a standardised approach the following were the services included within this review across each Trust. To compare current naming conventions to the conventions used for the purposes of this review, please see Appendix ii

Table 6: Overview of Adult services

Adult Services	
Community Assessment Teams	Day Services
Community Intervention Teams	Supported Living/Floating Support
Community Addictions	Mental Health & Deafness Service
Eating Disorder Service	Rehabilitation Service
Early Intervention Psychosis	Mental Health Liaison Services
Personality Disorder Service	Crisis Response & Home Treatment
Community Forensic Service	Multi-Agency Triage Team
Condition Management Service	Acute Inpatient Services (including Psychiatric Intensive Care Unit (PICU))
Lifeline Service	Inpatient Addiction Service
Lifespan Gender Identity Service	Medium Secure Service
Psychological Therapies Service	Primary Care MDT (Mental Health Practitioners Only)

3.2. Current Capacity

An understanding of current capacity is required to inform the level of intervention that can be provided and to understand where there may be deficits in resource capacity. In addition, understanding the age profile, workforce breakdown and vacancy rates provides an appreciation of the challenges that exist in the current system.

Current capacity of the workforce was provided as a metric of staff-in-post, with a breakdown by acute vs community services for AMH and CAMHS separately. These were collated by each Trust and aggregated by the Human Resources Pay and Travel System (HRPTS). The following summaries show an analysis of current headcount and age profile by profession. Trust finance data was used to understand the current gaps in permanent funded roles compared to staff-in-post and how Trusts are utilising different types of backfill to meet service demand. To deliver current services, a range of staff are in use across the Trusts, with staff-in-post and a range of agency, bank, overtime, and temporary staff.

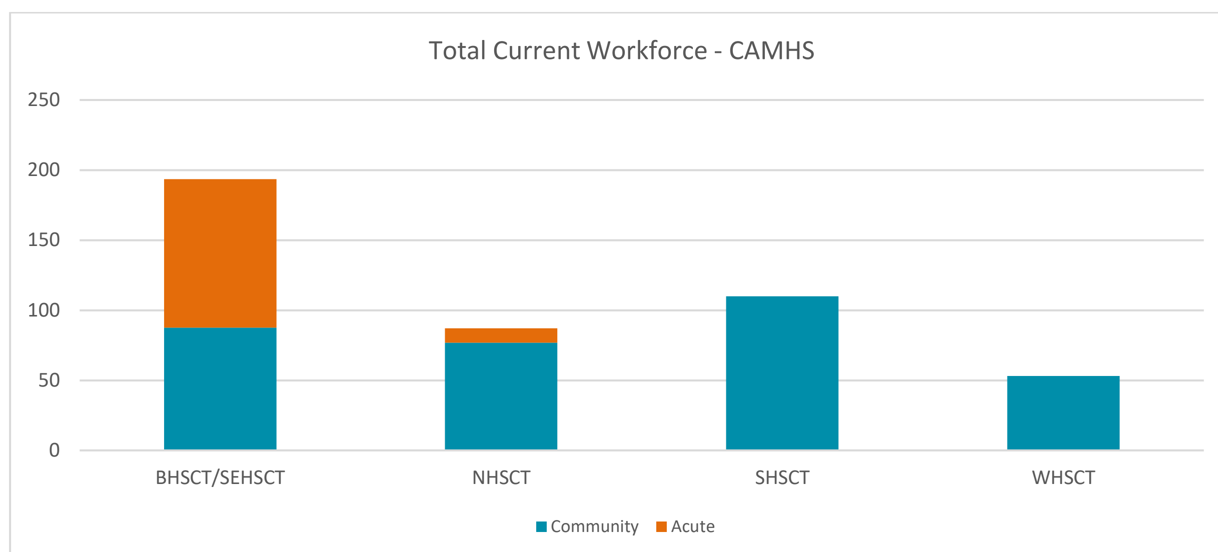
This section provides an appreciation of the challenges that are existing within services currently which will continue to need to be addressed going forward and is considered within this review.

3.2.1 Current WTE by Trust

CAMHS

The total current workforce for CAMHS is as follows:

Figure 4: Total Current WTE Workforce – CAMHS (March 2022)



Source: NI Workforce Analysis

Table 7: Current CAMHS WTE per Trust (March 2022)

	BHSCT/ SEHSCT	NHSCT	SHSCT	WHSCT
Community	101	77	110	49
Acute	106	10	-	-
Total	207	87	110	49
Total Population <18	77,506 (BHSCT) 81,712 (SEHSCT)	109,282	99,466	73,142
Ratio per 1,000 population	0.63*	0.80	1.11	0.67

Source: NI Workforce Analysis **Community only*

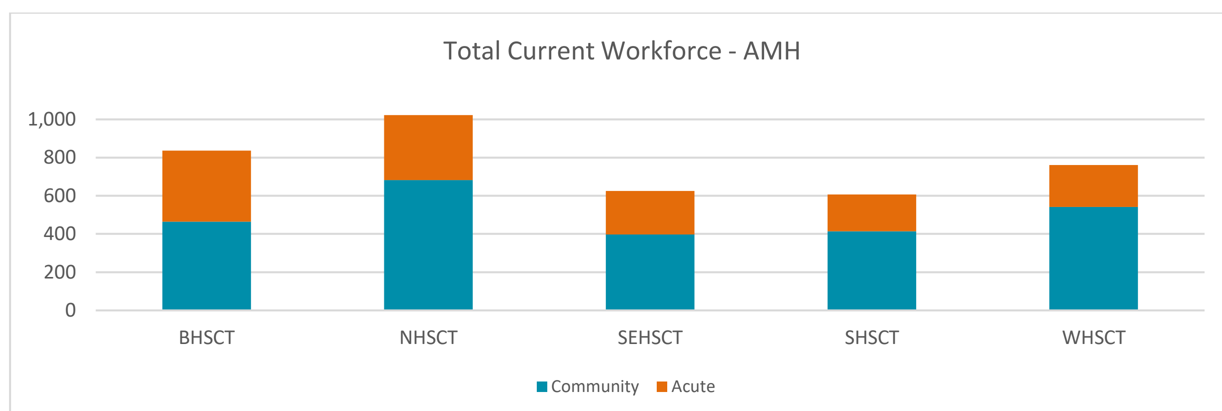
It is important to note that CAMHS services in Northern Ireland are below the median size for core CAMHS teams when compared to NHS Benchmark data per 100,000 population bases.[18] Feedback from a range of interviews highlighted the pressure teams are experiencing on the ground within different CAMHS services, impacting on the ability to keep pace with demand, leading to increases in waitlists.

[18] NHS Benchmarking Project Accessed by: 2019 Child and Adolescent Mental Health Services project – Results published — NHS Benchmarking Network

Adult

The total current workforce for Adult MH services is as follows:

Figure 5: Total Current WTE Workforce – AMH (March 2022)



Source: NI Workforce Analysis

Table 8: Current Adult WTE per Trust (March 2022)

	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
Community	476	649	391	393	535
Acute	359	341	235	202	213
Total	834	990	626	595	749
Current Population +18	281,724	370,912	282,479	289,222	230,065
Ratio per 1,000 population	2.96	2.67	2.22	2.06	3.26

Source: NI Workforce Analysis

Across both Adult and CAMHS, when comparing changes in workforce headcount pre-COVID-19 (2019) and 2022 there has been a modest increase in total growth overall. Substantial growth was noted in BHSCT and SHSCT CAMHS services, however, compared to NHS Benchmark Network data, total workforce is in the lower quartile[19].

Table 9: Growth in Mental Health Services; comparing 2019 and 2022

	BHSCT	NHSCT	SHSCT	SEHSCT	WHSCT
AMH Comm	12%	1%	4%	4%	8%
AMH Acute	-5%	7%	-3%	4%	8%
CAMHS	60%	-4%	25%	4%	8%

Source: NI Workforce Analysis

When reviewing the data, it was observed that on average approximately 95% of staff are working full time across all Trusts, except in SHSCT which has a slightly lower percentage of

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[19] *Children and Young People's Mental Health Services Workforce Report for Health Education England (2021) Health Education England.* *https://www.hee.nhs.uk/sites/default/files/documents/National%20HEE%20Children%20Young%20People%20Mental%20Health%20Service%20Report%20-%20Final%20%282.11.2021%29.pdf*

88% in adult services. This indicated that most staff are working full time, which minimises the total number of resources needed to meet the WTE identified in this report.

3.2.2 Workforce Supply

3.2.2.1 Permanent Vacancy Rates

The vacancy rate (calculated as a proportion of Permanent Vacancies in WTE and the Permanent Funded Posts in WTE) varied across Trusts. All vacancy rates are based on a point in time in March 2022. This analysis provides insight at the level of challenge within each profession, and how Trusts are employing different strategies to address their vacancy levels. It also highlights that there is a challenge recruiting into these funded posts across all Trusts.

Table 10: Vacancy Rate as a % of Total Funded Posts (March 2022)

BHSCT	NHSCT	SHSCT	SEHSCT	WHSCT
22.8%	19.8%	14.5%	14.5%	15.4%

Source: NI Workforce Analysis – Finance Returns

Broken down by profession, there is variability between Trusts on the vacancy rates across different disciplines.

Table 11: % Staff in Post against Permanent Funded Posts (March 2022)

	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
Admin	76%	78%	92%	94%	81%
Allied Health Professions	83%	95%	87%	88%	74%
Clinical Psychology	76%	70%	56%	68%	65%
Medical	N/A*	49%	N/A	52%	N/A
Nursing/Midwifery	80%	83%	85%	83%	86%
Social Care	74%	85%	92%	101%	89%

Source: NI Workforce Analysis *N/A indicates no data available*

To counteract the number of posts that are vacant, the Trusts are successful in filling roles with backfill resources, except for SEHSCT who continue to have a deficit of 12%. Different trends can be seen between Trusts and between disciplines. BHSCT, NHSCT and WHSCT have a challenge recruiting and maintaining administration staff in comparison to SHSCT and SEHSCT with lower vacancy rates. There is also a disparity in the vacancy level in SEHSCT for Clinical Psychology permanent staffed posts, with a 44% vacancy rate (representing 20 of 35 posts not filled), presenting an acute challenge for SEHSCT. Nurse staffing is challenging across all Trusts. In March 2022, BHSCT required 166 posts to have a full nursing workforce, with other Trusts had in the range of 100 vacant nurse post to fill to meet a full nursing staffing complement.

To continue to deliver services, each Trust employs a range of options to fill these vacant positions on a temporary basis. Trusts are using backfill to fill most vacant roles. It is noted that SEHSCT is operating their services 12% below their total funded level as their level of temporary resourcing remains low. This is due to several factors, including staff expressing burnout limiting use of bank. In addition, SHSCT are not using off-contract agencies at present due to the impact this could have to further demoralise staff and incentivise staff to move to agency work. This is limiting their ability to bring in backfill staff. This is under constant review.

All other Trusts are meeting their funded resource position with the use of different backfill strategies.

Table 12: % Deficit of Resourcing when utilising Backfill (March 2022)

BHSCT	NHSCT	SHSCT	SEHSCT	WHSCT
2%	0.8%	12.3%	3.8%	1.5%

Source: NI Workforce Analysis

Each Trust has utilised different options to reduce their resourcing deficit, which can be seen below. Each Trust has identified different challenges, which are managed locally to meet safe standards of staffing.

Table 13: Type of Backfill utilised per Trust (March 2022)

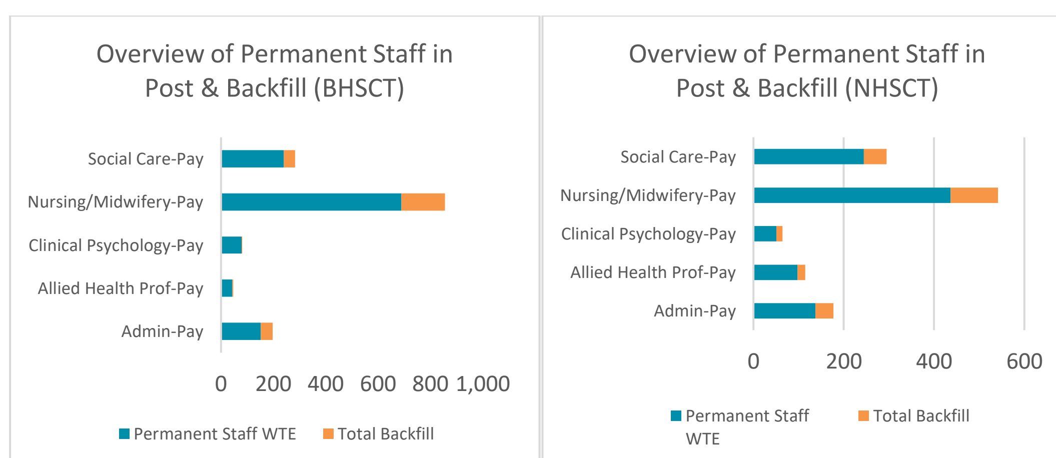
	Temporary Staff WTE	Agency WTE	Bank WTE	Add hrs	Overtime WTE	Total Backfill
BHSCT	0.1%	13.3%	6.1%	0.0%	0.8%	20.3%
NHSCT	4.3%	5.2%	8.4%	0.3%	0.8%	19.0%
SEHSCT	1.5%	0.3%	0.6%	0.0%	0.2%	2.6%
SHSCT	4.2%	8.7%	4.4%	0.2%	0.8%	18.3%
WHSCT	4.5%	1.0%	7.9%	0.0%	0.5%	13.9%

Source: NI Workforce Analysis – Financial Returns

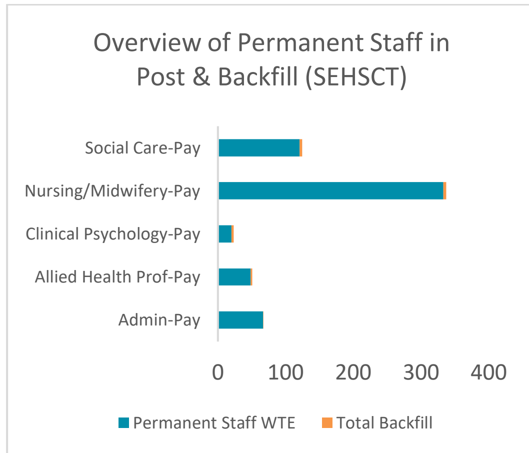
With respect to the type of backfill that Trusts rely on, BHSCT, NHSCT and WHSCT rely on bank staff to cover approximately 50% of their backfill staff. In contrast, SHSCT uses 47.5% of agency staff to cover their backfill. As noted, SEHSCT is a low user of temporary type staffing. However, with the need to meet safe staffing standards, this is under constant review.

Figure 6: Overview of Permanent Staff-in-Post and Backfill per Trust (March 2022)

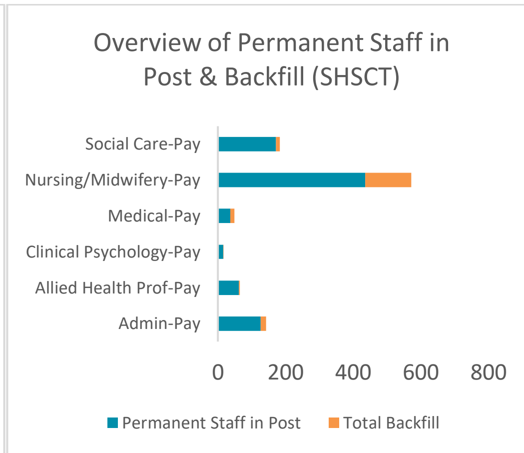
BHSCT **NHSCT**



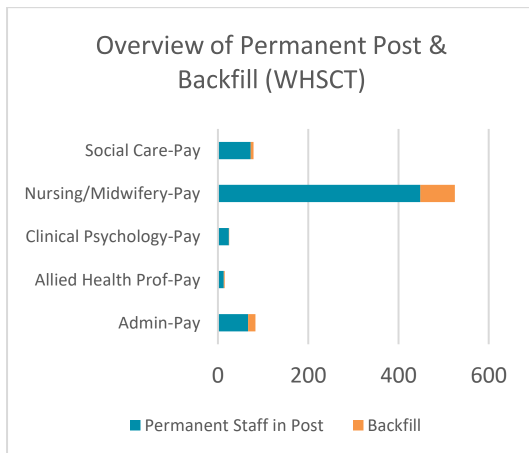
SEHSCT



SHSCT



WHSCT



Source: NI Workforce Analysis

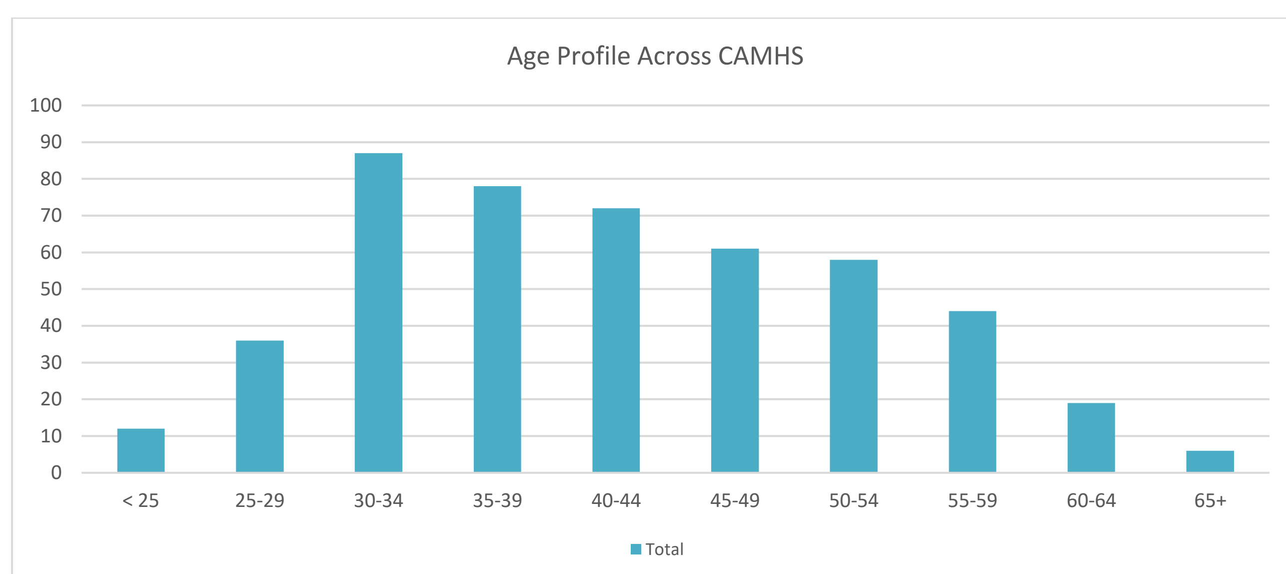
3.2.3 Age Profile

From the age profile of the current workforce by headcount, 28% of the workforce is aged over 50, with 13.9% of those over 55 who will be retiring within the next 10 years. There is also a small number of people with Mental Health Officer status that will also impact on level of retirements. This is a significant drain on skilled workforce that will need to be planned for appropriately. As can be seen from the graph below, there is a need to continue to have an adequate pipeline of new graduates and to attract the experienced clinicians into the workforce to ensure there are sufficient resources to replace retirees so services can continue to be built.

CAMHS

For CAMHS, 17.7% are aged over 50 years, with 8.3% over 55 years of age.

Figure 7: Age Profile Across CAMHS (March 2022)



Source: NI Workforce Analysis

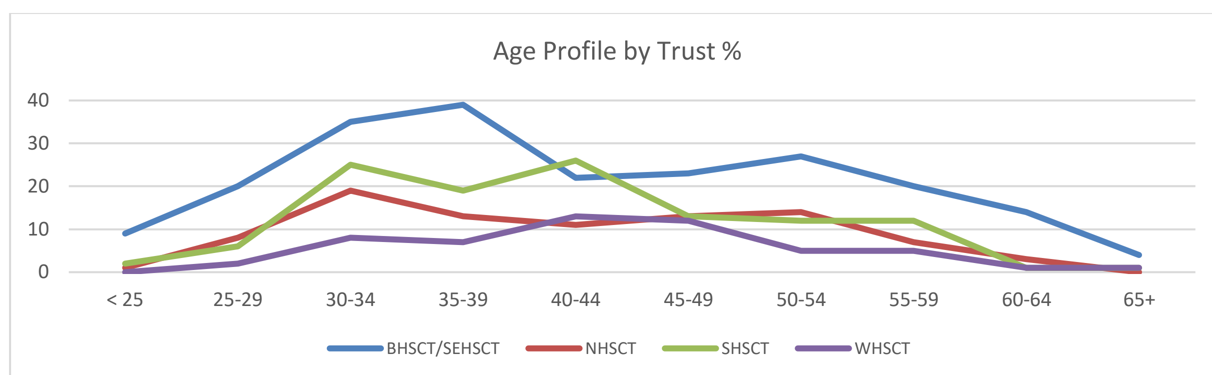
This retirement rate needs to be factored in future workforce numbers with standard attrition rates.

Table 14: Age Profile by Trust by Headcount – CAMHS (March 2022)

	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
BHSCT/SEHSCT	9	20	35	39	22	23	27	20	14	4
NHSCT	1	8	19	13	11	13	14	7	3	0
SHSCT	2	6	25	19	26	13	12	12	1	1
WHSCT	0	2	8	7	13	12	5	5	1	1
Total	**12**	**36**	**87**	**78**	**72**	**61**	**58**	**44**	**19**	**6**
% Breakdown	**3%**	**8%**	**18%**	**16%**	**15%**	**13%**	**12%**	**9%**	**4%**	**1%**

Source: NI Workforce Analysis

Figure 8: Age Profile by Trust by Headcount – CAMHS (March 2022)



Source: NI Workforce Analysis

Generally, the age profile is evenly dispersed through the 35 - 54 age categories. A similar distribution of the age profile is noted when comparing by discipline, as shown in the next table.

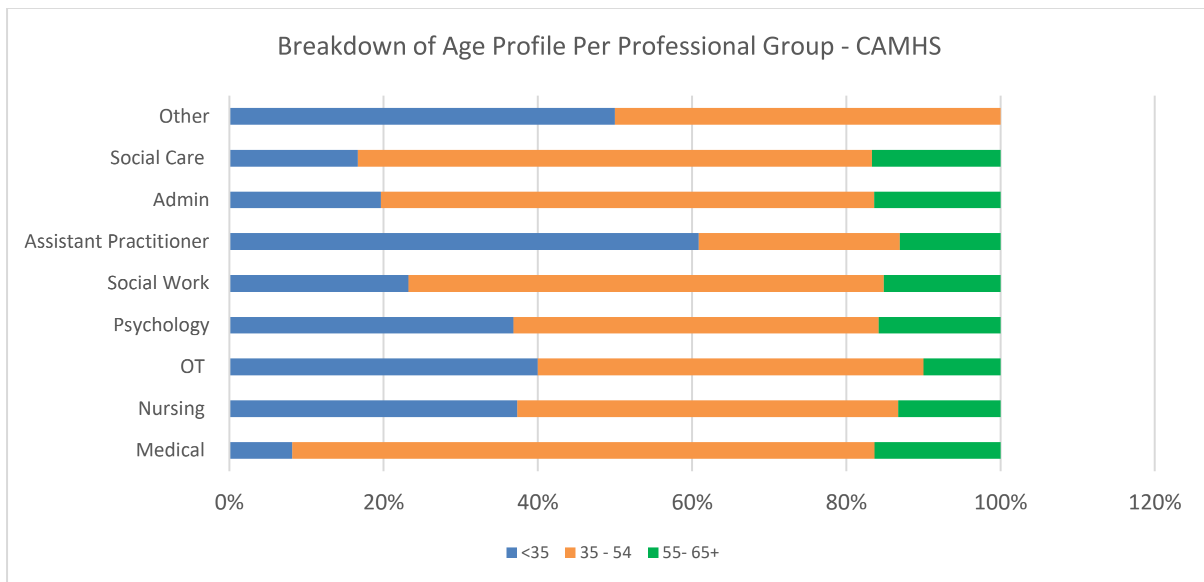
Table 15: Age Profile by Discipline – CAMHS (March 2022)

	< 35	35 - 54	55- 65+
Medical	8%	76%	16%
Nursing	37%	49%	13%
OT	40%	50%	10%
Psychology	37%	47%	16%
Social Work	23%	62%	15%
Assistant Practitioner	61%	26%	13%
Administration	20%	64%	16%
Social Care	17%	67%	17%
Other	50%	50%	0%
Total	**33%**	**55%**	**13%**

Source: NI Workforce Analysis

Social Care, Medical, Psychology, Social Work and Administration have the highest proportion of staff over 55 years. Given the anticipated increasing demand for Social Work and Medical staff in relation to regulatory requirements such as the Mental Capacity Act, succession planning must be put in place for standard and specialist roles.

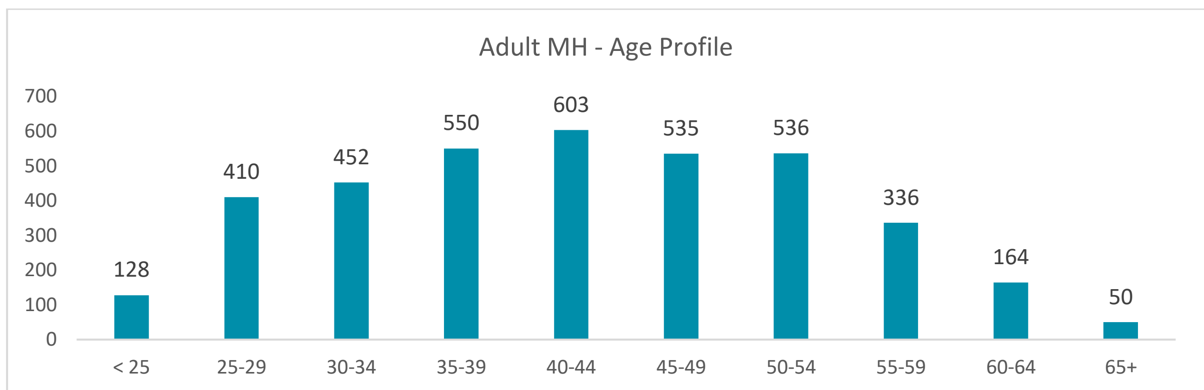
Figure 9: Breakdown of Age Profile by Discipline – CAMHS (March 2022)



Adult MH Services

Within Adult MH services, 29% of the workforce are over 50 years of age and 26% are under 35 years of age, with 45% between 35 and 49 years of age. At present, based on the curve profile, there is an even distribution of age profile indicating that managing the number entering the workforce must be maintained to mitigate against retirements. The level of retirements will be factored into future workforce numbers required, in section 5.2 with standard attrition rates, to help plan the recruitment and training places needed for Mental Health Services over the next 10 years.

Figure 10: Adult Mental Health by Headcount – Age Profile (March 2022)



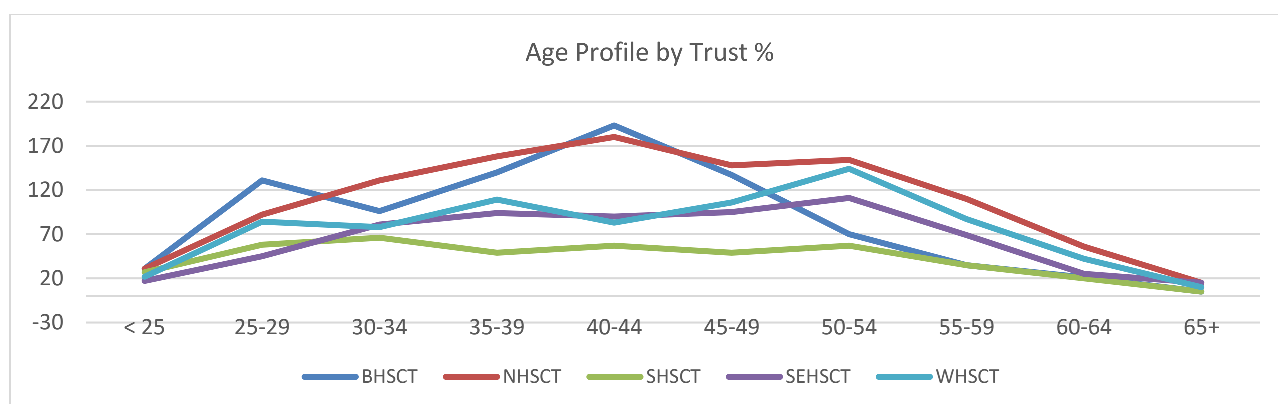
Source: NI Workforce Analysis

Table 16: Age Profile by Trust by Headcount – Adult (March 2022)

	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
BHSCT	31	131	96	140	193	137	70	35	21	5
NHSCT	31	92	131	158	180	148	154	110	56	15
SHSCT	27	58	66	49	57	49	57	35	20	5
SEHSCT	17	45	81	94	90	95	111	69	25	15
WHSCT	22	84	78	109	83	106	144	87	42	10
Total	128	410	452	550	603	535	536	336	164	50
% Breakdown	3%	11%	12%	15%	16%	14%	14%	9%	4%	1%

Source: NI Workforce Analysis

Figure 11: Age Profile by Trust by Headcount – Adult (March 2022)



Source: NI Workforce Analysis

Generally, the age profile is evenly dispersed through the 30 - 54 age categories. A similar distribution of the age profile is noted when comparing by discipline, with nursing, OT and other having a higher proportion of staff under 35, as shown in the next table.

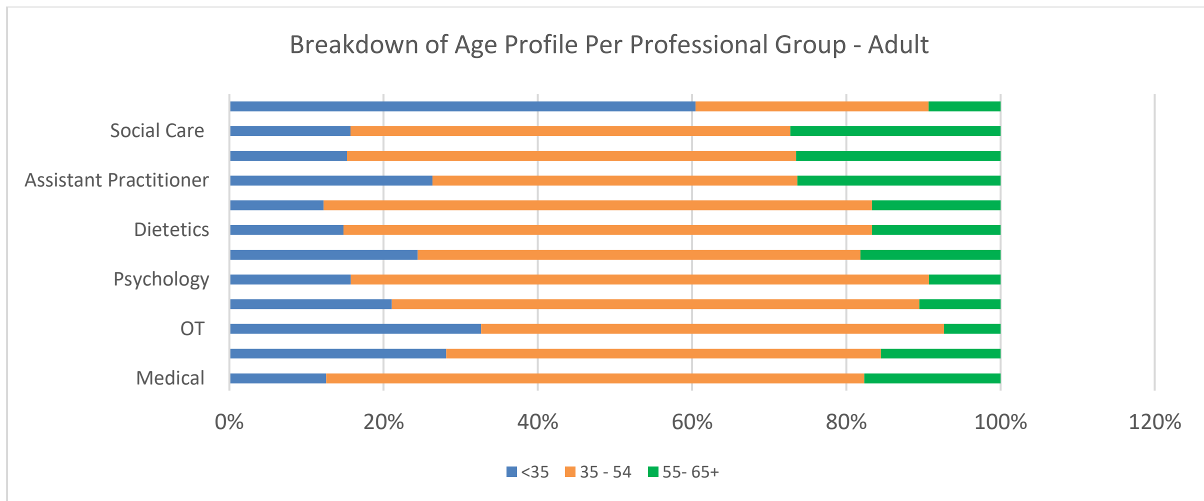
Table 17: Age Profile by Discipline – Adult (March 2022)

	< 35	35 - 54	55- 65+
Medical	13%	70%	18%
Nursing	28%	56%	16%
Occupational Therapist (OT)	33%	60%	7%
Physiotherapy	21%	68%	11%
Psychology	16%	75%	9%
Social Work	24%	57%	18%
Dietetics	15%	69%	17%
Psychotherapy (CBT) & Counsellor	12%	71%	17%
Assistant Practitioner	26%	47%	26%
Administration	15%	58%	27%
Social Care	16%	57%	27%
Other	59%	29%	12%

Source: NI Workforce Analysis

As seen above, Assistant Practitioner, Administration and Social Care have the highest proportion of staff due to retire in the next 10 years. There is a challenge to plan effectively to attract new staff and retain existing staff. Succession planning will be needed to limit the impact on services. In particular, for medical staff, succession planning needs to start now given the lead in time for consultant training. Medical, Nursing, Social Work and Dietetics should also prioritise to ensure continuity for specialist roles within these professions.

Figure 12: Breakdown of Age Profile by Discipline – Adult (March 2022)



Source: NI Workforce Analysis

As shown, the vacancy rates and retirement rates will need to be considered as part of future planning. To deliver the future model, existing permanent roles must be filled with detailed planning to expand access routes to training and development of recruitment initiatives to meet future demand outlined in section 5.

4. Defining the Future Workforce

To plan for the future workforce profile for Mental Health Services, demand drivers must be understood to forecast what capacity is needed. The commencement of new services and planned service developments must be evaluated to understand the implications for workforce profile.

4.1. Demand Drivers

Recent estimates and projections show that MH services in NI are continuing to experience rising demand that exceeds available capacity in both adult and children and adolescents' services. Anecdotal evidence from clinicians describes the added complexity of cases that are presenting, exacerbated by the COVID-19 pandemic and delayed time to present to services. Bed occupancy rates for inpatient MH services regularly exceed the 85% level recommended by the Royal College of Psychiatrists and indeed many Trusts hover at 100% occupancy regularly. While growing waitlists and increasing wait times are clear evidence that the service is falling short of meeting current demand, capacity provision and planning needs to not only meet current demand but also future demand. Therefore, several drivers of future demand have been considered in this forecasting analysis.

4.1.1 Prevalence

4.1.1.1 CAMHS Prevalence Estimates

The recently conducted Youth Wellbeing Survey shed light on recent (2020) prevalence estimates of mental health and mental illness in the child and adolescent population of NI. This survey was compiled by Ulster University, Queen's University Belfast, and the Mental Health Foundation over 18 months and collected data on over 3,000 young people aged 2-19 years. The table below lists a summary of the key findings:

Table 18: MH Disorder & Findings

	MH Disorder	Finding	Deprivation vs. Prevalence
Emotional & Behavioural Problems	Emotional difficulties	1 in 8	16.5% vs 7.8
	Conduct problems	1 in 10	13.3% vs 6.0%
	Hyperactivity	1 in 7	19.6% vs 9.9%
Oppositional Defiant & Conduct Disorders	Oppositional defiant disorder	1 in 10	no significant association
	Conduct disorder	1 in 20	no significant association
Mood & Anxiety Disorders	Mood or anxiety disorder	1 in 8	no significant association
Stress Related Disorders	Post-Traumatic Stress Disorder (PTSD)	4.90%	no significant association
Eating Disorders	Engaged in a pattern of disordered eating	1 in 6 or 16.2%	no significant association
Self-Injury & Suicidal	Thinking about or attempting suicide	1 in 10 or 9.4%	no significant association
	Thinking about or attempting suicide	1 in 8 or 12.1%	no significant association
Psychotic Disorders	reported six or more symptoms on a screening questionnaire	1 in 5 or 18.7%	no significant association
Adverse Childhood Experiences (ACEs)	experienced at least one ACE	47.5%	59.9% vs 36.0%

Bullying and Cyberbullying	traditional bullying	16.80%	no significant association
	cyber bullying	14.90%	no significant association
Use of Tobacco, Alcohol & Drugs	smoke	1 in 5 or 21.5%	no significant association
	problematic drinking	40.90%	no significant association
Social Media Use	problematic social media use	4.70%	no significant association
Parental Mental Health	parents or caregivers reported a previous diagnosis of any MH disorder	1 in 5 or 22%	31.9% vs. 17.2%

4.1.1.1 AMH Prevalence Estimates

The raw disease prevalence statistics in Northern Ireland 2021/2022 were used to estimate adult Mental Health prevalence in the NI population. This is based on administrative data recorded on General Practice Disease Registers on 31 March 2022. The raw prevalence rates include the 15 registers that count patients with specific conditions or diseases as covered by the Quality and Outcomes Framework for 2021/22[20].

4.1.2 Population Change

Population was another factor that was considered as a key demand driver in the future. The population projections were obtained from Northern Ireland Statistics and Research Agency (NISRA) estimates. A key fact to note here is the difference in population change for adults compared to children and adolescents in the next 10-year period. While the entire population should increase by 2.42%, this change is being driven mainly by the adult population and more specifically the 65+ age group (+26.26%). This will have an important effect on MH services for older people such as old age psychiatry. Due to a drop in the birth rate, the 0 to 17-year-olds are seeing a declining trend (-7.22%) in the 2022-2032 period.

Table 19: Estimated Change in NI Population 2022-2032 – Breakdown by Age[21]

Year / Age	0-17	18-39	40-64	>=65	Total
2022	444,375	524,447	615,133	334,526	1,918,481
2032	412,311	513,940	616,267	422,376	1,964,894
Percentage change (2022-2032)	-7.22%	-2.00%	0.18%	26.26%	2.42%

Source: 2018-based Population Projections for Areas within Northern Ireland

Table 20: Estimated Change in Total NI Population 2022-2032 – Breakdown by Trust [22](includes all age groups)

Year / Trust	BHSCT	NHSCT	SHSCT	SEHSCT	WHSCT	TOTAL
2022/23	362,062	483,581	397,844	369,740	305,254	1,918,481
2032/33	366,700	488,620	423,368	381,715	304,491	1,964,894
Percentage change (2022-2032)	1.28%	1.04%	6.42%	3.24%	-0.25%	2.42%

Source: Sub-National Population Projections | NISRA

[20] Department of Health. (2022). *Raw Disease Prevalence Data for Northern Ireland* [Online]. Available from: 2021/22 Raw Disease Prevalence Data for Northern Ireland (health-ni.gov.uk) [Accessed 07 May 2022].
[21] Northern Ireland Statistics and Research Agency. (2020). *2018-based Population Projections for Areas within Northern Ireland* [Online]. Available from: 2018-based Population Projections for Areas within Northern Ireland | Northern Ireland Statistics and Research Agency (nisra.gov.uk) [Accessed 07 May 2022].
[22] Northern Ireland Statistics and Research Agency. (2020). *Sub-National Population Projections* [Online]. Available from: Sub-National Population Projections | Northern Ireland Statistics and Research Agency (nisra.gov.uk) [Accessed 07 May 2022].

2022 - 2032 Adult Demographic Pressure (Age group: >=18-year olds[18])

An increase of 5.32% is projected in the adult population in the 5 Trusts between 2022 – 2032 as follows:

Table 21: Adult Demographic Change by Trust

Date	BHSCT	NHSCT	SHSCT	SEHSCT	WHSCT	Total
CHANGE	3.46%	4.06%	9.92%	6.30%	2.54%	5.32%

Source: Sub-National Population Projections | NISRA

2022 – 2032 CAMHS Demographic Pressure (Age Group <=17 years old)

A decrease of 6.76% is projected in those 6–17-year-olds that would access CAMHS, this has been incorporated within the workforce demand profile. Projections <5-year-old are excluded as put low demand on services and with reductions in population growth in this age category, it was disproportionately impacting on overall demand.

Table 22: 2022 - 2032 CAMHS Demographic Change by Trust[18]

Date	BHSCT	NHSCT	SHSCT	SEHSCT	WHSCT	Total
CHANGE	-5.76%	-9.23%	-3.20%	-7.92%	-7.69%	-6.76%

Source: Sub-National Population Projections | NISRA

4.1.3 COVID-19 Impact on Mental Health

The COVID-19 pandemic has left the Northern Ireland population more vulnerable to mental health issues. The prevalence of mental health in Northern Ireland is estimated to be 25% higher than the rest of the UK[23]. Those with pre-existing mental health issues, coupled with the reduction of access to Mental Health Services during the pandemic has impacted on the health of this population. At this point, the long-term effects of the COVID-19 lockdown and isolation on mental health are unknown. However, when similar quarantine measures were introduced in Ebola and other severe acute respiratory syndrome (SARS) outbreaks, it led to an increase in levels of anxiety, depression, and a myriad of other mental health conditions[24].

Evidence suggests that adolescence is a peak period for the onset of mental health issues. Mental health issues that are not adequately treated in younger years can lead to difficulties in adulthood. Pre-pandemic data suggests that an estimated 1 in 8 young people have a mental health condition such as depression or anxiety and 20% of young people suffer from significant mental health issues in Northern Ireland. Whilst general practice activity has been impacted during the pandemic, resulting in a fall in referrals to CAMHS, a significant increase in demand for these services is expected post pandemic. Educational services have seen a rise in the demand for psychological services, with additional supports planned for children and young people through the education system. Children and adolescents have been faced with extended school closures because of the pandemic, leaving many exposed to social isolation and loneliness. This is expected to have a knock-on impact on CAMHS services. Other factors considered in the modelling are shown in the following table:

[23] Department of Health. (2021). *Mental Health Strategy* [Online]. Available from: doh-mhs-strategy-2021-2031.pdf (health-ni.gov.uk) [Accessed 07 June 2022].
[24] Mulholland, C., Duffy, M. and Blaire, C. (2020). *The Mental Health Impact of the COVID-19 Pandemic in Northern Ireland: A Rapid Review* [Online]. Available from: The Mental Health Impact of the COVID-19 Pandemic in Northern Ireland - A Rapid Review - July 31 2020 | Department of Health (health-ni.gov.uk) [Accessed 27 May 2022]

Table 23: Environmental and Social Conditions & Impact of COVID-19

MH condition	Impact Of COVID-19: Estimated Mental Health Risk In NI
Isolation & Loneliness	A proportion of the adult population (n=921,000) => Perceived Social Isolation increases the risk of having suicidal thoughts by 21% and increases the risk of attempting suicide to 8.4% => approximately 3,868 are more at risk of having suicidal thoughts and **1,547** are more at risk of attempting suicide.
Alcohol Misuse	Alcohol sales have increased by 31.4%, this potentially increases risk of alcohol and/or drug misuse in at least 289,194 adults in NI. Alcohol misuse in turn also raises the risk of developing a co-morbid Mental Health disorder by 37% which could mean a further **n=107,002 adults** are at risk in Northern Ireland.
Domestic Violence	There are approximately 2, 642 domestic abuse incidents per month in NI. Based on the 49% increase in volume of calls to Domestic Abuse helplines, incidents in NI could rise by approximately n=1,295 per month. 75% of individuals requiring support are likely to present with PTSD which increases the Mental Health risk for an additional **n=971** since COVID-19 lockdown.
Economic Recession	A 0.79% rise in suicides due to unemployment through economic downturn.
Unemployment	Prior to COVID-19, 1 in 5 adults (n=184,200) had a Mental Health problem at any one time in NI. COVID-19 saw a 1% increase in unemployment rates in NI. Considering the average person is 2x more likely to develop MH problems if unemployed, an additional **n=8,990** are at a 2x greater risk of becoming psychologically unwell in NI after COVID-19.

4.1.4 Other factors

It is expected that displaced refugees fleeing conflict may have an impact on Mental Health Services demand; however, as demand was not quantifiable, it has not been accounted for as an independent contributing demand driver in the demand vs. capacity model.

While transgenerational trauma impacts on demand for Mental Health Services in NI, it has been assumed that this demand is reflected in the activity data provided, and therefore no specific transgenerational factor has been applied in the data modelling approach.

No efficiency has been factored in for technological enablement within Mental Health Services. There is limited evidence to suggest that virtual consultations have improved efficiencies in service delivery. Indeed, one of the recommendations from the Ten Thousand More Voices report, indicated whilst both approaches had received positive feedback, a blended approach is needed going forward based on service user choice[25]. While it is acknowledged that it does have a place within service delivery, anecdotal evidence is that patients require more contacts to attain the same outcomes if only using virtual appointments.

The proposed NI electronic healthcare record system, known as the Encompass programme, will put in place an electronic health record for all patients in NI. The time required to input to these systems will not create a reduction in administration time but will make access to information easier, enabling better decision-making capability with all relevant information

[25] You and Your Experience of Mental Health Services During COVID-19 Pandemic Ten Thousand More Voices report. 210222_PHA_Mental-Health-COVID-19-Report_FINAL.pdf (hscni.net)

sources available. There is also enabling technology solutions that will supplement care, which will support low intensity interventions, promoting focus on cases of higher complexity. Therefore, it has been assumed that no specific impact will be accounted for within this model.

As factors outlined above were not accounted for individually within the demand model, it is recognised that there will be an unmet need that should be accounted for. For this reason, an unmet demand factor of 7.5% has been applied to the demand model, which is a prudent approach to planning workforce demand.

4.2. Defining Service Developments

A core principle of defining service developments is to ensure standardisation across all services and Trusts. This would provide equitable resource allocations based on population and demand drivers specific to the service per Trust. Therefore, all workforce service configurations have been developed using best practice guidelines, benchmark information and specialist knowledge, where available and appropriate. Delivering on the Regional Mental Health Pathway[26] and the CAMHS Working Together; A Pathway for Children and Young People Through CAMHS[27] and the Mental Health Strategy, a review of all planned and proposed service developments was considered to understand the workforce implications.

4.2.1 Regional Service Developments

There are several key developments underway that will impact on the level of demand for Mental Health Services. The establishment of the Regional Mental Health Service[28] will include the introduction and/or expansion of Managed Care Networks, Care Networks, and Integrated Care Partnerships. This includes the fundamental change in the operation of secondary Mental Health care, moving away from models of more fragmented service delivery, towards joined up locality-based approaches centred upon populations in General Practitioners (GP) Federation areas. The roll out of Multidisciplinary Teams within the GP Federations is a key step in bolstering Primary Care. This will make a significant difference to how statutory services are delivered, with the expectation that increasing complexity will be managed within community and specialist Mental Health teams. One consideration that will need to be taken account of, is the draw of resources out of Mental Health Services to take up posts within the Primary Care MDT teams within the GP Federations. This is currently impacting on Mental Health Services and will continue until the teams are filled, approximately, an impact as they are drawing from the same resource pool.

A key aim of the integrated care model is to build capacity in Primary Care to manage patients close to home with signposting to the right specialist services the first time, to improve timelines of access and treatment, and prevent deterioration of presentations. This will mean that more acute cases will enter Step 3 services, within the Stepped Care Model. It will take time to embed these developments and measure their impact and benefit to the overall system.

Providing well-resourced community-based services is critical to minimising demand for acute inpatient services through diverting to specialist services that can manage varied complexity of care closer to home. This should prevent patients accessing acute services unless clinically indicated. Throughout this review, emphasis has been placed on augmenting core and specialist community services to deliver high quality, evidence-based care. This has been cited as a key enabler of better management of emergency care services for Mental Health [29].

The development and expansion of Crisis teams to better manage and prevent admissions will be a key enabler to reduce pressure on acute services; in addition, the focus on developing

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[26] Health and Social Care Board. (2014). *Regional Mental Health Pathway* [Online]. Available from: You-In-Mind-Regional-Mental-Health-Care-Pathway.pdf (hscboard.hscni.net)
[Accessed 10 June 2022].

[27] Family Support NI. (2018). *Working Together: A Pathway for Children and Young People Through CAMH*S [Online]. Available from: CAMHS-Pathway.pdf (familysupportni.gov.uk) [Accessed 07 May 2022]

[28] *Department of Health. (2021).* From Silos to Systems: Report of the Project for a Regional Mental Health Service for Northern Ireland

[29] Regulation and Quality Improvement Authority. (2019). *Review of Emergency Mental Health Service Provision across Northern Ireland* [Online]. *Available from: Regulation and Quality Improvement Authority. (2019). Review of Emergency Mental Health Service Provision across Northern Ireland (rqia.org.uk) [Accessed 07 April 2022]*

capacity and capability within community services to focus on prevention and early intervention will be transformational for all people with mental health needs. To deliver services that are equitable and accessible to all people, a key part of the development of the workforce plan is to ensure a standardised approach to service development and workforce profile across all services that are delivered at Trust level.

4.2.2 Approach to Service Developments and Workforce Profiling

Across Mental Health Services, there is variation in the scope and delivery models across Trusts. To plan for future workforce demand, a high-level standardisation exercise was completed to align the scope of similar services across Trusts with a common naming convention. This allowed the future workforce profile to be developed to each service in a standardised approach. It is acknowledged that work is underway to align services, and this work will continue over time.

A blended approach was used to understand the optimal future workforce profile per service. This was replicated across each Trust. The demand and capacity model were overlayed with forecast demand to develop a total workforce profile with adequate capacity for all services. This was consolidated to provide a summary of the total workforce needed across CAMHS and Adult Services.

For some services, proposals have been prepared that will require further evaluation and relevant business case approvals. This review, where possible, has included services that have a clear plan, although in recognition that detailed care pathway design would be required. This may impact the configuration of the teams and should be adapted accordingly. Where adequate information on a service development proposal was not available due to the early stage of planning, these have been documented as potential additional developments, outlined in the next section, but have not been accounted within this workforce review.

CAMHS

Aligned to the Step Care Model, services from Step 2 and above have been reviewed to develop the optimal team configurations to meet the need of the NI child and adolescent population. The following describes any key changes planned or in planning across CAMHS.

- Step 2 – Primary Mental Health Team

Primary Mental Care Teams will continue to provide assessment and intervention for children and young people experiencing mild/moderate developmental, behavioural, mental health and emotional difficulties. The model is well established, and a review of the team configurations indicated that broadening the multidisciplinary professions would positively impact on quality of care. The team would consist of medical, nursing, social work, psychology, OT, SLT, Music, Art and Drama Therapies, Assistant Practitioners.

- Step 3 & 4 – Specialist Intervention Mental Health Services

These teams will continue to provide specialist intervention for children and young people experiencing moderate/severe mental health and emotional difficulties which are having a significant impact on daily life. The model is well established, and a review of the team configurations indicated the broadening of the multidisciplinary team would positively impact on quality of care. In addition, for disciplines that may not have dedicated resources in specialist teams, it has been agreed that certain roles will sit in the Specialist Intervention Teams but be accessible by other specialist services. This will enable these professions to embed in a single CAMHS team, enabling co-location with other colleagues to aid assess to professional support and reduce feelings of professional isolation.

The multidisciplinary team will consist of Medical, Nursing, Social Work, Psychology, OT, SLT, Physiotherapy, Dietetics, Music, Art and Drama Therapies, Pharmacy, Child and Adolescent Psychotherapy, Transition Workers and Assistant Practitioners. This will include Profession Lead roles who will be responsible for developing the individual role of their profession across CAMHS services and provide the professional leadership and supervision required by their profession.

- Drugs, Alcohol and Addition Services

These services are experiencing consistent demand. Highest demand is experienced in BHSCT, which also covers SEHSCT, due to the demographic for the area. A team including Consultant input, Nurse Prescribers and Social Work have been included to meet demand.

- Eating Disorders Service

Eating disorders have seen high demand, exacerbated by the COVID-19 pandemic. It is acknowledged that experienced community-based teams are required to manage this complex cohort, to help divert from acute admissions. With challenges accessing acute beds, and the focus on providing care close to home, the teams have been expanded to include Consultant, Social Work, Psychology, Dietetics and Physiotherapy input to better respond to complex needs of this cohort.

- ID CAMHS

Whilst currently ID CAMHS is only available in the SHSCT, in other Trusts services for this cohort of patients are embedded in Children's or Learning Disability Services. The direction of travel for ID CAMHS services is to have dedicated teams that support those with complex mental health presentations, whilst children and young people with a mild ID may continue to access general services, as deemed most appropriate as part of the assessment process. This will build on the recommendations from the Bamford review. These teams should be integrated within the wider CAMHS structures to build well established ways of working, referral, and coordination across all patient needs. The teams have been configured to provide a multidisciplinary team approach to management which include Consultant, Nursing, Social Work, Psychology, Dietetics, OT, Physiotherapy, SLT, Music, Art and Drama Therapies and Assistant Practitioners. This is a senior team due to the complexity of the need. Where a dedicated resource has not been provided this can be accessed through the Step 3 – Specialist Intervention Mental Health Services.

- Crisis and Home Treatment Services

Focus has been placed on prevention and de-escalation away from acute services to provide crisis intervention and intensive services designed to manage the needs of those children and young people who are at immediate risk or who need intensive therapeutic care to prevent hospital admission. Whilst all Trusts operate differently at present, the aim is to strengthen crisis and home treatment services, as per the NI Review of Crisis Services. This has been reflected in the team configuration.

- Regional Family Trauma

The Family Trauma centre is a regional resource, hosted by BHSCT. The Family Trauma Centre would continue to be the main resource for helping children who have experienced a trauma. The workforce profile has been updated to reflect service knowledge and demand.

- Youth Justice Pilot

Within Youth Justice Services, in collaboration with the Department of Justice, for children aged 16-25 years, a pilot is being completed presently to evaluate the benefit of supporting this cohort to access Mental Health Services. A small allocation of resources (one Youth Justice Band 7 per Trust) has been included in this review, but additional planning and evaluation is needed to refine the delivery model and test outcomes for this service into the future which may impact on the resource profile needed in the future.

- Regional Deaf CAMHS

A dedicated team for a Regional Deaf service has been proposed to work collaboratively with the other CAMHs teams as required.

- Gender Identity Service

In recent years, the Gender Identity service has been significantly depleted, a new lifespan model has been proposed. For purposes of this review, this has been included within the adult workforce numbers.

- Forensic CAMHS

Forensic CAMHS is a regional specialist service for young people involved in dangerous, high-risk behaviours towards others. These young people will be presenting with severe disorders of conduct and emotion, neurodevelopmental or serious mental health problems or where there are legitimate concerns about the existence of such disorders. The service delivers a graded model of intervention – advice, formal consultation, assessment, and intervention. This regional service will provide out-reach to each Trust to support a graded model of intervention. This team will enable the re-establishment of all levels of the service as per the Service Specification.

- Regional CAMHS Inpatient Service

Beechcroft is the only dedicated inpatient mental health service for children and young people. As seen from the demand analysis, demand outstrips beds and at times has led to children being placed in general beds within children's inpatient services, or in the case of older teens, within adult inpatient beds. There is a recognition in the system that there is a need to bolster community services to better manage children to decrease demand for inpatient beds and to provide better quality services to children and young people in the community. Therefore, within the review, focus was given to developing community and crisis services to support the patient to stay at home with support from specialist teams.

The current team configuration has been aligned with Delivering Care 5A for the nursing profile and the current team has been augmented with dedicated Pharmacy, OT, SLT, Dietetics and Music, Art, and Drama Therapies, Child and Adolescent Psychotherapy input.

Adult Community Mental Health Services

Adult Mental Health Services are broad and range from Community Assessment and Intervention through to Regional Specialist Services. The following describes any key changes planned across Adult Mental Health Services that are within scope and have a workforce profile included within this review. It should be noted that, while naming conventions may vary between Trusts, common terminology has been used to maintain standardisation for workforce profiling. See Appendix ii for further information.

Within adult services, the following have been included within the review:

- Community Assessment

All Trusts operate slightly differently, so for the purposes of this review, community assessment includes assessment centres and single point of referral management. The future teams will consist of medical, nursing, psychology, social work, and occupational therapy as an access point to other mental services based on need.

- Community Intervention

Similar to above, there is significant variation in how Trusts operate different services throughout community services. For the purposes of this review, community intervention teams consist of Primary Mental Health Teams, Recovery Focussed Treatment & Care and Physical Health Monitoring (including Clozapine & Lithium Service).

This team consists of a strong multidisciplinary team ethos with an expansion of roles throughout these teams. In each team, medical, nursing, social work, psychology, and Occupational Therapy is included. This team has been expanded to include Dietetics, Physiotherapy, Pharmacy, Adult Psychotherapy, Art, Music, and Drama Therapists. The introduction of nurse prescribers and pharmacists as part of the core team will lead to better management of patients and overall health outcomes in line with standards.

This broad range of professionals has been included to enable access to professionals where specialist services have not been provided with a dedicated health professional. Where this is the case, these teams will be able to access professionals via the community intervention teams. This is a change to current operations that will need to be considered as part of introducing these new roles to these teams. This will allow access to a range of professions and for emerging professions to build competence across a range of Mental Health Services.

- Eating Disorder services

Eating disorder services have seen a significant increase in demand within NI and internationally, and a new NI model has been devised to meet emerging needs. The DoH Mental Health Action Plan (2020) set the foundations for the longer term, strategic improvements that are described in the new Mental Health Strategy 2021-31. Two key actions in the Mental Health Action Plan were to develop an options paper for eating disorder services by March 2021, and to review eating disorder services to provide a new service model for specialist eating disorder Mental Health Services by July 2021. Both actions have been completed. NICE guidelines (NG69, May 2017)[30] underpinned this work and these apply to all settings in which health care is provided, including settings in which eating disorders might be identified. A business case for a new eating disorder service is currently being finalised by DoH SPPG. The proposed workforce profile from this work has been standardised and incorporated into this review.

In addition, a pilot project for a day service for eating disorder patients within BHSCT is currently under evaluation. The outpatient and day service models have been incorporated as part of this review to deliver targeted intervention to this complex cohort. This team consists of senior clinicians, reflecting the complexity of management of cases within the community and liaison with acute services. The team includes medical, nursing, social work, psychology, OT, Speech and Language Therapy (SLT), Dietetics, Physiotherapy, Art and Drama therapy, and Assistant Practitioners.

[30] National Institute of Health and Care Excellence. (2018). *Eating Disorders* [Online]. Available from: Eating disorders | Topic | NICE [Accessed on 07 April 2022]

- Community Addictions (Drugs and Alcohol)

Across NI, addiction (alcohol and drugs) services, including opiate substitution treatment teams continue to see steady demand, with significant need for services. Teams are seeing significant co-morbidity with people presenting with Substance use and mental health issues. The team has been strengthened to increase access to all required professionals. Dedicated Nurse Prescribers and Pharmacy have been allocated to this team for a better-quality service and to reduce impact on medical workforce going forward.

- Early Intervention

At present, BHSCT are the only Trust with this team, and evidence suggests that low threshold high intensity intervention has a profound impact on their mental health journey. Therefore, an Early Intervention Psychosis team has been planned for each Trust. This will include Medical, Nursing, Social Work, Psychology, OT, Pharmacy, Art Therapy, Peer Support Workers.

- Personality Disorders

A proposed model has been co-produced with service user input and carer representation, alongside the clinical members of the HSCB Personality Disorder Networks involving both statutory and community & voluntary organisations. The treatment and services proposed are underpinned by the available evidence and statements from respected organisations e.g., NICE, RCPsych, and Personality Disorder Consensus Statement. The model is structured based on a tiered service approach with associated resources at each Tier. While this service is subject to formal business case procedure currently being taken forward by DoH SPPG, the workforce profile has been included within this report[31].

- Condition Management

Condition management model will remain unchanged from what is currently delivered within Trusts, with additional AHP input to support the demands of this patient cohort included.

- Day Services and Recovery Colleges

All services are unique to each Trust and local area. Alignment with day care standards[32] and the planned recommendations of the Social Care Review, which is due for completion by end of 2022, have been included within this review. One of the key recommendations of the Social Care Review is focused on registered social care provision to reduce demand on nursing and optimise resource configurations. This has been incorporated within the profile which should be implemented soon.

- Supported Living and Community Support

As above, all services are unique across the Trusts, therefore consultation was held with each Trust to identify their needs. Alignment to standards above have been followed and adjusted, based on the current trajectory of travel with the Social Care Review.

- Mental Health Liaison Services

An augmented Mental Health Liaison Service has been included in the review to better meet demand observed within the hospital setting, aligned to the review of Mental Health Crisis Services in NI.[29] This will enable the main General Hospitals in NI to have a discrete onsite Mental Health Liaison Service with an enhanced 24-hour Model. This would ensure that there

[31] Department of Health. (2021). *Future Personality Disorders Draft*

[32] Department of Health, Social Services and Public Safety. (2012). *Day Care Settings, Minimum Standards* [Online]. Available from: Microsoft Word - Adult Day Care Standards - Final Version - January 2012 (rqia.org.uk) [Accessed on 07 April 2022]

are staff available 24 hours a day to provide mental health assessments in line with NICE Guidelines.

- Crisis Response and Home Treatment

A review of Mental Health Crisis Services in NI was conducted in April 2021[33] by an independent review team, supported by the Department of Health, with specific recommendations to improve service delivery. Key recommendations include the development of an integrated Regional Mental Health Crisis Service. Significant investment and cross departmental collaboration are required to maximise benefit for patients in crisis.

As part of crisis response, the Multi-Agency Triage Team delivers an important service. This is a joint service between HSC, the Police Service of Northern Ireland (PSNI) and NI Ambulance Service (NIAS). Currently this service is operational in two Trusts, with SEHSCT operating a 7-day service and BHSCT operating a 3-day service. There are challenges with the delivery of the current model due to resourcing pressures in NIAS. Within the SPPG, options are under evaluation to agree the future model for this service, however for the purposes of this review, a workforce profile has been included based on a single regional team providing 7-night cover. This may be revised once options have been fully evaluated.

Coordinating with this, Crisis Resolution Home Treatment Teams would concentrate their resources to provide effective and safe alternatives to inpatient care for those in mental health crisis. Additional resources have been added to better meet demand

- Rehabilitation Teams

A proposal to develop two inpatient rehabilitation units and three community teams, on a sub-regional basis, is being finalised and subject to business case approval; this will provide step down/up services for a specific cohort of patients who require intensive intervention. The current level of investment in rehabilitation services in Northern Ireland is limited and therefore a phased approach to the development of a 'fit for purpose' infrastructure is necessary. Such a configuration will include a mix of hospital and community provision.

It is proposed that the development of these high intensity inpatient rehabilitation services is founded upon the existing availability of appropriate hospital estate in which to locate a sufficient number of inpatient beds. Therefore, the size and scope of these units may vary, depending on environmental factors. It is envisaged that in the first phase of development, two Trusts will each provide a high intensity unit with each containing 10-14 beds. These wards will deliver rehabilitation services on a sub-regional basis.

In the other three Trusts, community units will be established each comprising of 8 beds. The community rehabilitation service will in-reach into these units to support the rehabilitation programme for people with complex mental health needs who require more intensive treatment and care than can be provided in supported living accommodation. It is expected that the length of stay for such complex cases will be in the region of 12-18 months.

Each Trust will be supported to develop its community rehabilitation infrastructure. Their key aim will be to support patients who are living in more independent circumstances to maintain their independence through applying a biopsychosocial model in providing person-centred treatment and care to meet the needs of people with complex psychosis who are at risk of being unable to achieve or sustain successful community living. The proposed workforce profile has been included within the review.

[33] Bateson, C., Allen, A., Cunningham, T., Davidson, G., McFeely, E., McGarry, P. and O'Connor, R. (2021). *Review of Mental Health Crisis Services in Northern Ireland* [Online]. Available from: *Microsoft Word - Annex B - Review of Mental Health crisis services in Northern Ireland (health-ni.gov.uk)* [Accessed: 26 August 2022]

- Lifeline

Lifeline services are a regional service, commissioned by the PHA as a crisis service. No change to the service model is planned so the resource requirement has been aligned to demand.

- Lifespan Gender Identity

In recent years, the Gender Identity service has been significantly depleted with the loss of local skillsets. A review has been completed and plans have been created to deliver a lifespan approach to service delivery, a single service across all age categories. The new model has proposed that it will encompass a multidisciplinary team approach to delivery between Mental Health and Endocrinology, based on best practice and current system challenges across NI. The mental health resources of the proposed model have been included in this review, pending business case approval.

- Mental Health and Deafness

The Mental Health and Deafness team will continue, with a strengthening of resourcing based on demand and population change and continue to work in conjunction with local community teams.

- Medium Secure Facility and Community Forensic Services

As part of the Forensic Managed Care Network hub and spoke model, the medium secure facility has been augmented to meet demand, including aligning the Delivering Care 5A for nursing inpatient ratios. In addition, Community Forensics has been uplifted to provide additional medical and multidisciplinary support. Early planning is underway to provide low secure facilities for NI; these have been discussed in the future developments in the next section.

- Regional Trauma Network

The Regional Trauma Network is a unique network bringing statutory and community and voluntary sectors together. Implementation of the new network is taking a phased approach, with Phase 1 anticipated to be publicly launched in early 2023. Detailed planning has been completed on the resource profile for this network which has been encompassed in this review, additional phases of development have been excluded until Phase 1 has been evaluated. The resource profile may change once the Network has been fully tested and evaluated.

- Primary Care MDT within GP Federations

A key development in the strengthening of Primary Care services is the creation of the Primary Care MDT teams, in particular the role of the Mental Health Practitioner role as a key member of the team. The MHP workforce have been included within this review.

Adult Inpatient Services

- Acute Inpatients and Inpatient Addictions

A key theme of the Mental Health Strategy is to enable patients to access community services in a timely manner and to easily navigate the services they require, reducing the reliance on crisis services and hospital admissions. While it is acknowledged that inpatient admissions will always be required, with strengthening of community and specialist services, this should have a knock-on effect on inpatient admissions and length of stay. The workforce profile for these services is based on staff required per bed. Delivering Care 5A has been utilised to plan nursing complement with the addition of a broad multidisciplinary support.

Inpatient Addictions service is delivered by three Trusts, NHSCT, SEHSCT, WHSCT. The workforce profile has been reviewed to reflect the current presenting needs of patients. Community addictions has also been reviewed to provide additional support to this cohort of patients, to reduce reliance on inpatient admissions and to support the patients' post-discharge.

4.2.3 Proposed Future Developments

There are several services that are currently at a very early planning stage and are undefined at the time of this review. A workforce profile has not been defined for these potential developments at this time but should be considered as part of a broader overview of the potential future developments in Mental Health Services. These may need to be subsequently incorporated into this review once additional analysis and planning has been completed. These potential future developments include:

- The introduction and full adoption of the **Mental Capacity Act** (NI) 2016 has been partially commenced and currently provides a new statutory framework in relation to deprivation of liberty. The first Phase of the Act came into operation in two stages - research provisions commenced on 1 October 2019 and provisions in relation to deprivation of liberty and money & valuables in hospitals and residential care and nursing homes commenced on 2 December 2019. At present, disaggregated Mental Capacity Act (MCA) activity data by programme of care has not been calculated, therefore a full review should be completed across all Programmes of Care to understand the activity demand from this statutory requirement that will have a direct impact on mental health demand. As a requirement for Mental Health Services, funding availability must be considered alongside this review.

- The **Student Mental Health Services** pilot in Belfast between Queens University, Ulster University, and Belfast HSCT has been trialled for a period of three years, with a plan to extend the trial period to the end of the 2023/24 academic year. Initial results indicate that services have been successful in identifying students with emerging mental health issues earlier, supporting a preventative model. Further evaluations are underway to optimise the model; if positive results are evaluated this may be rolled out regionally, in conjunction with the Department of Health.

- Planning is underway in relation to additional **Mental Health Inpatient beds** that should come on stream in the coming years. Business cases are under development for WHSCT and SEHSCT, with NHSCT in design phase for a new Mental Health facility. As these are in the early stages of planning, the workforce profile for these new beds have not been included in this review.

- As part of the Forensic Managed Care Network, forensic services are in planning stages to evaluate options for **regional low secure inpatient beds**. However, in the absence of a clear service model and the requirement for capital infrastructure for this new facility, a workforce plan has not been included at this point but may be considered in the future (early estimates indicate this could be in place by 2026).

- Re-development of **a neuropsychiatry service** for Northern Ireland that would provide neuropsychiatry input as a regional service has been recommended by the Royal College of Psychiatry. The absence of this service is due to the retirement of the Consultant Psychiatrist and an inability to have a succession plan. This service needs to be reinstated following best practice guidance. Neuropsychiatry services could be delivered on a hub and spoke model, aligned to the Neuroscience Centre. This will need to be explored in conjunction with the Neurology Review, to agree the most

appropriate service model, management, the inpatient service/ beds provision, and workforce profile for this service. The Regional Review of Neurology Services is tasked with developing new models of care for outpatient, unscheduled and community care for people with neurological conditions. Initial discussions have commenced with the Neurology Lead and this service will be progressed through the Neurology Review.

- Adult safeguarding legislation is due to be passed in the near future, this will have a significant impact on the Social Work workforce. As details of requirements at not available at this point in time, this will form part of future service delivery.

4.3. Data-based Demand and Capacity Outputs

Based on the assimilation of historical data and the application of demand drivers, a forecast model was derived to apply to the new service configurations developed across each service for the next 10 years. New service configurations are the proposed workforce profiles, agreed with stakeholders, for each Mental Health Service. These have been agreed based on best practice guidelines, service reviews and specialist knowledge.

Due to the impact of COVID-19 on demand, each service within each Trust had specific assumptions applied to develop a forecast demand for the future. Each assumption was validated by the Trusts to ensure accuracy of the assumptions. In the following section the outputs of the analysis are outlined as a % change in demand that has been applied to the new service configurations for both AMH and CAMH services. This % change was applied to Scenario 0 (do nothing) and Scenario 1 (new team configurations). Scenario 0 is the base scenario where no change to capacity or services is planned. Scenario 1 considers the service developments planned and the new team configurations proposed.

A detailed breakdown of the assumptions underpinning the demand profile have been included within Appendix iii

4.3.1 Community (Outpatient) Modelling

The data-based approach led to the following recommended change in capacity required to meet the current and future demand at the community setting. The tables below project the estimated increase in capacity required to meet current and future demand in CAMHS and AMH services. For example, in Table 23, within CAMHS a 15% increase in capacity is recommended in Step 2 services to have waitlists at a stable/declining level in the next 3-4 years. This is linked to the ability to onboard staff in a timely manner. This increase is based on the current capacity levels and incorporates past data trends, demand drivers, assumptions, and capacity estimations. These capacity recommendations are based on the key assumption that the first influx of capacity is by June 2023 and the second by June 2024, so that waitlists reduce to manageable numbers in the next 3-4 years for services such as Step 2, Step 3 services, and to no waitlist for Eating Disorder and Addiction Services by or before June 2025.

Table 24: CAMHS Community (Outpatient) Modelling Outputs

Trust/ Service	Step 2	Step 3	Eating Disorders	Addictions	Crisis/ Home Tx	Gender Identity	Regional Trauma
BHSCT	15%	4%	45%	25%	0%	35%	20%
NHSCT	15%	15%	27%	0%	0%	N/A	N/A
SHSCT	11%	10%	14%	N/A*	N/A	N/A	N/A
SEHSCT	34%	22%	N/A	N/A	N/A	N/A	N/A
WHSCT	30%	12%	15%	0%	7%	N/A	N/A

**No waitlist information available*

Table 25: Adult MH Community (Outpatient) Modelling Outputs

Trust/ Service	Comm MH	Forensic	Eating Disorder	Comm MH Older	Addiction	Personality Disorder	PC MH
BHSCT	9%	8%	14%	10%	8%	0%	2%
NHSCT	8%	8%	10%	9%	20%	0%	N/A
SHSCT	2%	0%	18%	8%	20%	11%	8%
SEHSCT	4%	N/A	N/A	10%	10%	6%	2%
WHSCT	11%	0%	13%	0%	19%	0%	11%

4.3.2 Inpatient Modelling

Aligned to the principles of delivering care at the right place at the right time, the aim of the Mental Health Strategy is to focus on prevention and management. This will support diversion from emergency and inpatient services to community services where possible. With the proposed future team configuration, this skilled workforce will be better placed to respond to demand within the community. In line with this, analysis was completed on the change that is required to reduce demand on inpatient services to maintain a recommended occupancy level of 85% in all inpatient facilities. While it is a systemic shift that is needed for this to occur, it was deemed an appropriate approach as it will take time to deliver on plans to add additional beds to support demand. However, plans are in place to commission rehabilitation and low secure beds as key actions in the MH Strategy, with the intention of therefore increasing the capacity of acute mental health beds.

The data-based approach led to the following recommended decrease in length of stay (LOS) required to meet the current and future demand at the inpatient setting. This recommendation is based on a key assumption that additional beds/infrastructural changes are not possible in

the near future and thus, with an improved service configuration and uplift in capacity at the community level, will enable better management in the community to reduce the frequency of patients presenting. As noted in the previous section, there are future plans to add additional beds; this will help to support demand in the long term.

Caveats (please refer to the appendix ii for more details)

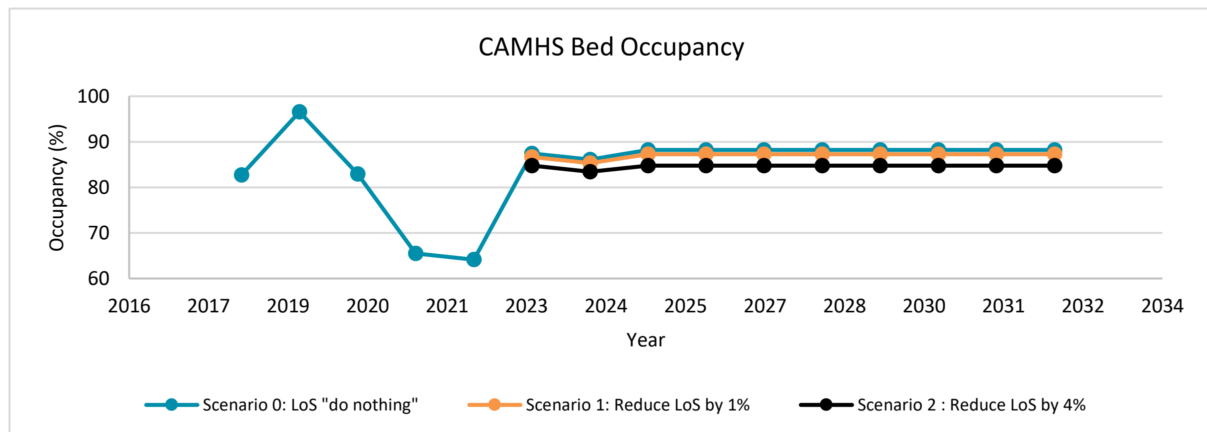
- CAMHS patients waiting at other sites in paediatric/adult beds are not considered explicitly in the model due to a lack of patient-level data (admission/discharge information). However, expansion of specialist teams such as Eating Disorder Services will be able to better monitor, manage and treat these patients.
- AMH data was not available at the patient-level and consisted of monthly aggregates, reducing accuracy in the model.

CAMHS Inpatient Modelling

A constant bed capacity of 29, which includes 4 PICU beds, is assumed to calculate the % occupancy during the inpatient demand vs. capacity modelling. The average occupancy pre-COVID-19 has been approximately 98.8%. However, this is due to rolling bed closures to maintain safe staffing levels. The plot below shows the modelled occupancy based on past data (COVID-19 period excluded due to a drop in occupancy during COVID-19).

In Scenario 0, the do-nothing scenario, there is no change in Length of Stay (LOS) over the next 10 years. Scenarios 1 and 2 relate to a 1% and 4% reduction in LOS respectively. This in turn affects the occupancy % as shown below. A reduction of 4% – 4.5% will reduce occupancy to below 85% with the current forecast (when including an unmet need of 7.5% in the demand). Therefore, within the workforce model, relevant standards have been incorporated to meet the needs of a fully staffed Beechcroft at full occupancy ~85%.

Figure 13: CAMHS Inpatient LOS based on increased capacity in Community Services

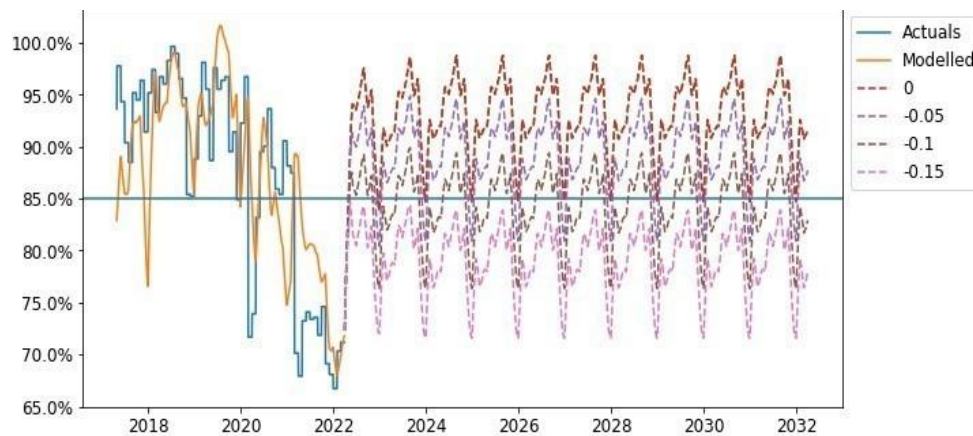


Adult MH Inpatient Modelling

The plot below outlines the actual vs. modelled occupancy rates (in %) for Adult MH inpatient acute services from 2018 to 2022. In 2022, only the forecasted occupancy has been shown. This is depicted by the red dotted line which is the base model scenario (scenario 0), i.e., if there is no change in LOS from the current state. The other dotted lines depict the % reduction in LOS of 5%, 10% and 15% respectively to test the effect this would have on the occupancy %. The high-level analysis outlines that, based on forecast demand, community services, and in particular the expansion of Crisis and Home Treatment, will support the reduction in demand for acute beds. A reduction of 15% on LOS will reduce occupancy to below 85% with the current forecast (including unmet need of 7.5% in demand).

A 15% reduction in LOS is a significant undertaking, even with significant investment in community and crisis services. Therefore, there is a risk that demand will continue to be above the recommended 85% occupancy standard. This is reviewed on an ongoing basis and a detailed evaluation of bed levels should be undertaken. The potential for future beds to come on stream in the coming years will help to manage demand in the longer term.

Figure 14: Forecast Adult Inpatient Occupancy Levels



5. Future Workforce Profile

Developing a future workforce profile is complex, with many factors shaping the staff types and experience required to deliver future service models. In developing the future workforce model, demand drivers as outlined previously provide a snapshot of what demand forecasts may look like based on current modes of delivery.

The future workforce model is shaped with added layers of insight which include benchmark information, clinical guidelines, service and discipline reviews and insight from services on emerging areas of new practices. This has informed the workforce profile to deliver a blend of resources that will meet the direction that Mental Health Services is moving towards.

5.1. Summary Overview

As part of the review, focus was placed on the roles required to deliver specific services. This has focused the workforce profile based on a multidisciplinary team approach with an emphasis on the core competencies and functions required to deliver these services. Several key assumptions have been included to derive the proposed workforce profile.

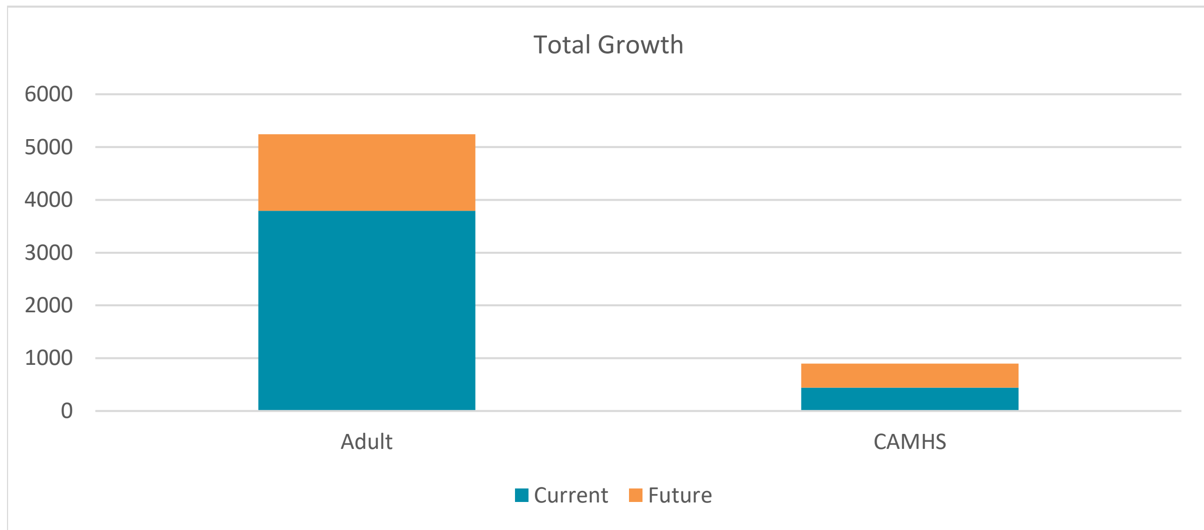
- For each service, a team configuration was agreed that would meet best practice standards. This team configuration has been applied across each Trust; this provides a consistent workforce profile for each team in each Trust.
- All emerging, new, absent, or severely limited professions have been considered within all services. This includes professions that are well established in other jurisdiction but may not be well represented within NI Mental Health Services at present. For disciplines, where evidence is lacking to support the inclusion within specific teams; additional resource has been included within Step 3 community services that will be accessible by specialist services.
- It is assumed that all therapeutic modalities would be delivered within the professions in the teams, and the therapeutic modalities delivered would be based on demand for services and the skill mix within the teams. It is assumed that the specific breakdown between core functional duties and delivery of interventions will be devised by the services based on service needs. These modalities may include, but are not restricted to Cognitive Behavioural Therapists (CBT), Eye Movement Desensitisation Reprogramming (EDMR) therapy etc. Specific modalities have not been named in the review. An exception to this is in two specific services where dedicated resources are identified; Counsellors within the Lifeline service and CBT within the Psychological Therapeutic services, who provide specific distinct roles.
- Aligned to the point above, the role of the Mental Health Practitioner has been removed and reconstituted within the core professions with an assumption that therapeutic intervention would be delivered within the team by those core and supplementary professions. The role of the Mental Health Practitioner has been retained within the GP Federations only within this review, as this is the agreed delivery model going forward.

The following is an overview of proposed future workforce across Adults and CAMHS. Adult services have a proposed a 38.1% increase in workforce with CAMHS showing an uplift of 100.7%. A significant driver of this growth in CAMHS is the inclusion of a dedicated ID CAMHS integrated into overall CAMH services of each of the five Trusts with equates to 26% of the total uplift of resources.

Table 26: Proposed Future Workforce WTE across Adults and CAMHS

	Current	Future	% Change
Adult	3794	5245	38.2%
CAMHS	443	895	102.1%

Figure 15: Total Workforce Growth (WTE)

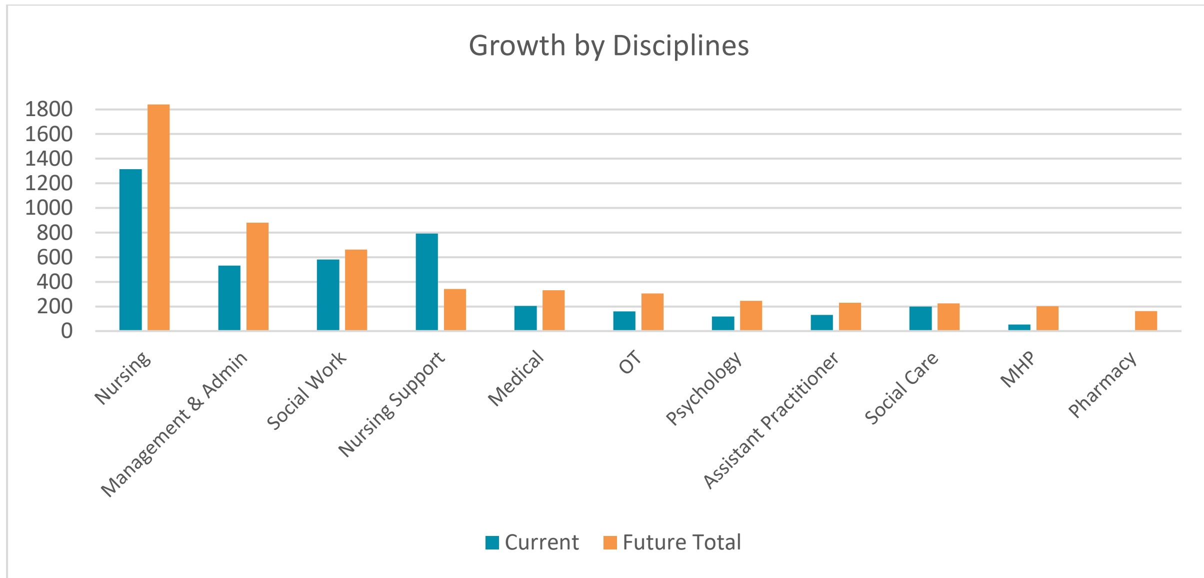


Source: NI Workforce Analysis

5.2. Workforce Profile by Disciplines

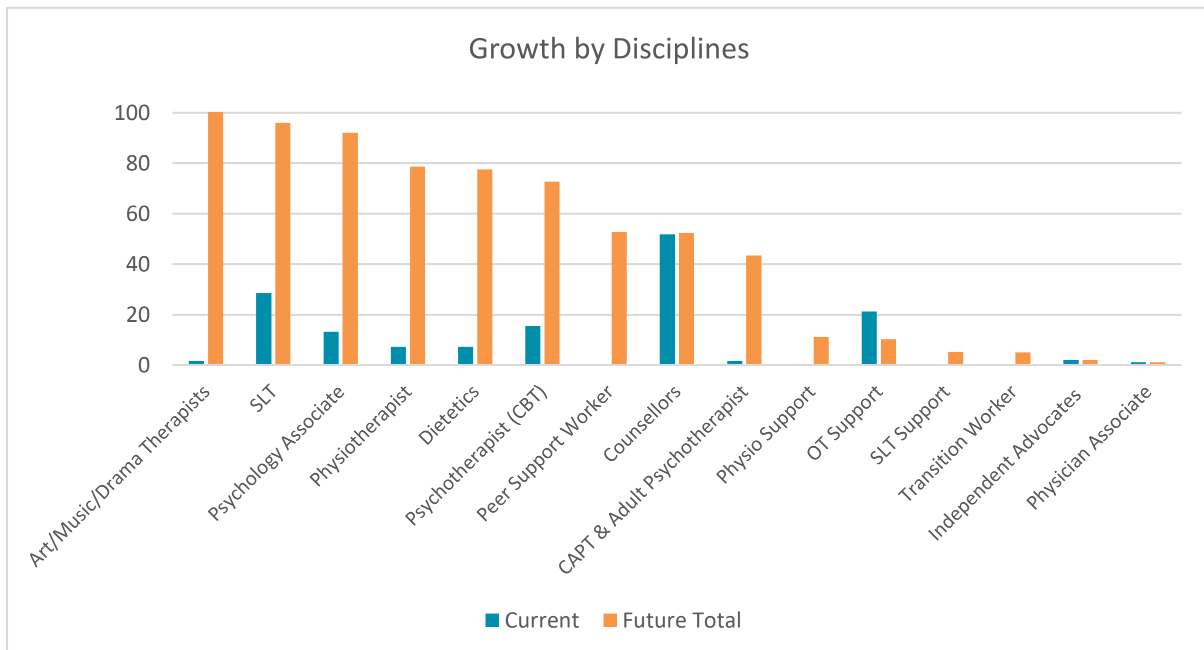
Based on outputs from the demand and capacity model and a review of all service team configurations, the following is the proposed workforce profile broken down by profession. This provides an overview of the growth in the range of professions that are planned for Mental Health Services. Further detail on the total profile per profession has been included within the next section.

Figure 16: Total Growth by Discipline (WTE)



Source: NI Workforce Analysis

Figure 17: Total Growth by Discipline Continued (WTE)

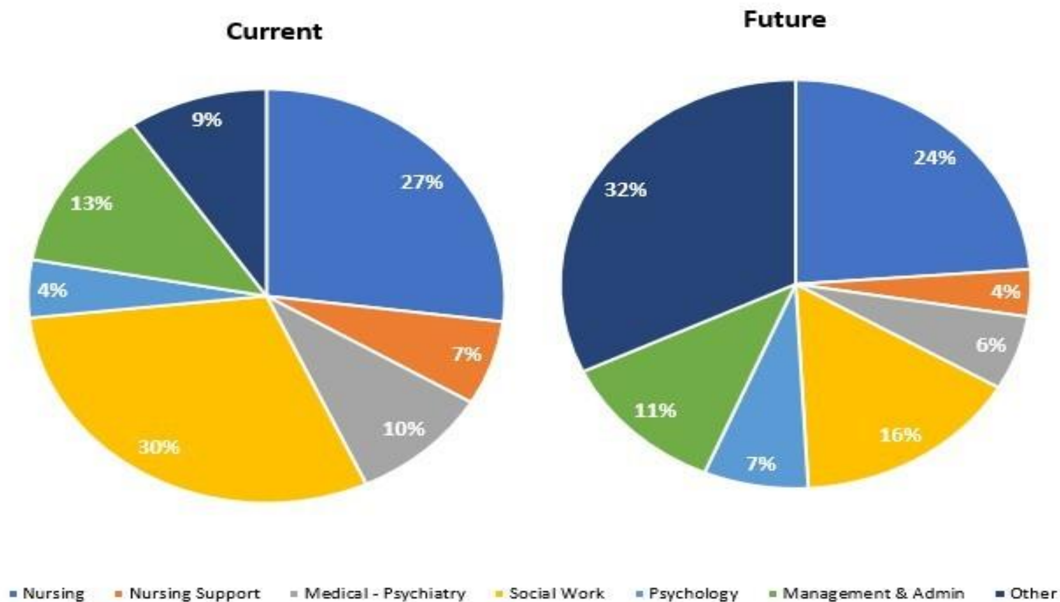


Source: NI Workforce Analysis

The following is the breakdown of professions across all current and future proposed CAMHS services. It highlights the move to a broader multidisciplinary team approach, which will deliver a blend of care functions and therapeutic intervention to meet the needs of the caseload within services.

To demonstrate the move to a more diverse workforce, a comparison is shown below of the change from current workforce breakdown (% discipline/ total workforce) compared to the future workforce breakdown. In the next section, the actual resource numbers are outlined.

Figure 18: Current and Future CAMHS Services Workforce



Source: NI Workforce Analysis

Table 27: Breakdown of 'Other' Category within CAMHS (Pie Chart)

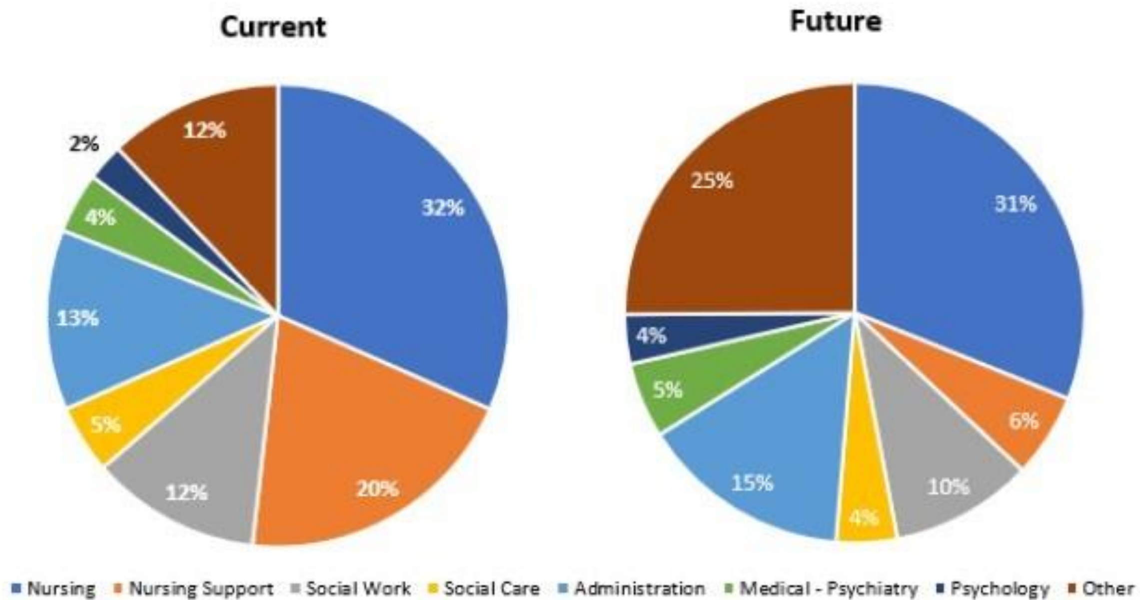
Other Category	Current	Future
Psychology Associate	1%	2%
Counsellors	1%	0%
CAPT	0%	3%
OT	2%	4%
OT Support	0%	0%
SLT	0%	4%
Other therapies	0%	4%
Physician Associate	0%	0%
Physiotherapist	0%	3%
Dietetics	0%	4%
AHP Lead	0%	1%

Pharmacy	0%	1%
MHP	1%	0%
Support Worker	0%	6%
Transition Worker	0%	1%
Independent Advocates	0%	0%

Source: NI Workforce Analysis

For Adult Mental Health Services, which is a more mature service, there is less change in the configuration of the new model, however there is a significant change in the Nursing profile with the introduction of the Delivering Care 5A, which has uplifted the inpatient nursing complement. There is also a significant change in the Nursing Support, as NHSCT have a heavy reliance on Nursing Support and the move to the Social Care Model for Supported Living and Day Services has been incorporated.

Figure 19:Current and Future Adult Services Workforce



Source: NI Workforce Analysis

Table 28: Breakdown of 'Other' Category within Adult Services (Pie Chart)

Other Category	Current	Future
Psychology Associate	0%	1%
Psychotherapist (CBT)	0%	1%
Counsellor	1%	1%
OT	4%	5%
OT Support	1%	0%
SLT	1%	1%
SLT Support	0%	0%
Other therapies	0%	1%
Physician Associate	0%	0%
Physiotherapist	0%	1%
Physio Support	0%	0%
Dietetics	0%	1%
Pharmacy	0%	3%
MHP	1%	4%
Assistant Practitioner	3%	3%
Independent Advocate	0%	0%

Source: NI Workforce Analysis

As discussed as part of the demand and capacity analysis, based on population need, prevalence factors and demand (waitlists), the following is an overview of proposed total future workforce across Adults and CAMHS reflected per Trust.

Table 29: Total Future Workforce by Trust (WTE)

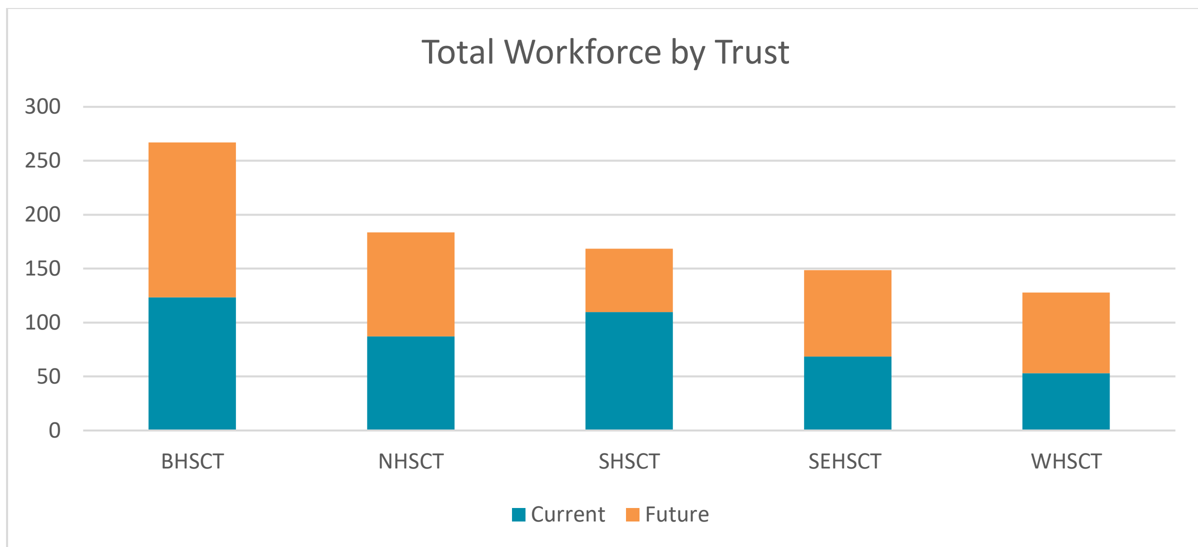
	BHSCT	NHSCT	SHSCT	SEHSCT	WHSCT
Adult*	1221	1198	917	870	863
CAMHS	267	184	168	149	128

Source: NI Workforce Analysis

*The proposed future Rehabilitation service resources (total 175 WTE) are as of yet unassigned to Trusts.

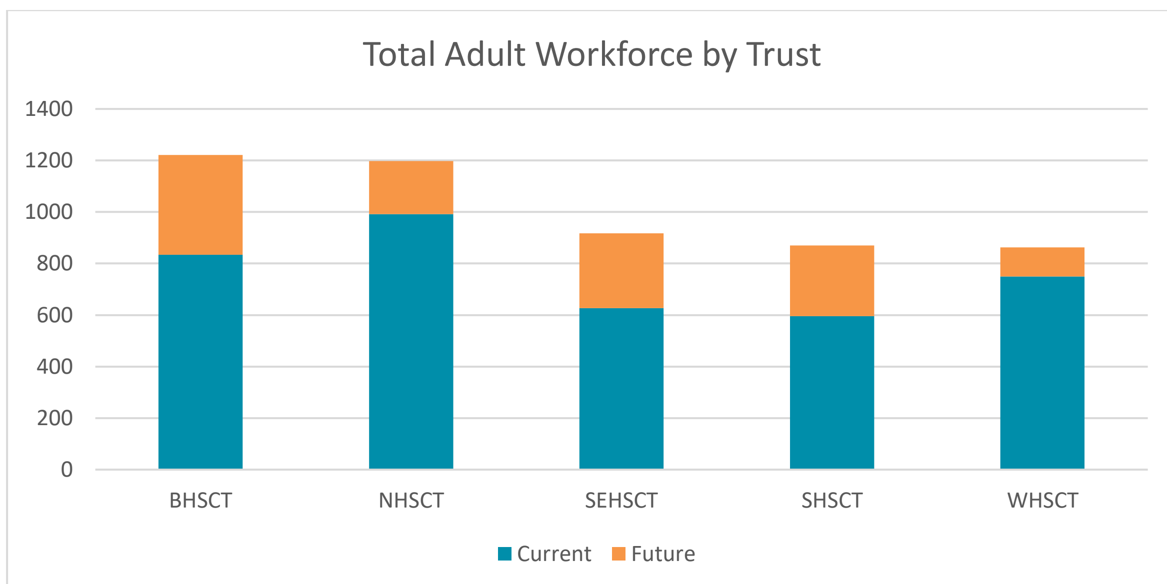
For CAMHS, growth in workforce numbers is aligned to the population differences across Trusts. While SEHSCT resources have been calculated separately, BHSCT are currently delivering CAMHS on behalf of SEHSCT. Therefore, the current workforce has been split based on an estimated, but the total figures are representative of the total workforce required for each Trust.

Figure 20: Total CAMHS Workforce by Trust (WTE)



For adult services, growth in NHSCT is high compared to other Trusts, based on their population base. In addition, BHSCT has additional demand for some services and provides some regional services, and this therefore has necessitated an uplift in resource above the others for adult services.

Figure 21: Total Adult Workforce by Trust (WTE)



5.3. Future Workforce Profile by Discipline

The following provides the future workforce profile by discipline. For disciplines that have a limited or no footprint in current services, the % changes are significant; however, the total numbers are small in comparison to other more established professions.

Total Workforce Changes

The following provides an overview of the total workforce changes across both CAMHS and Adult services and the combined % change from the current workforce.

Table 30: % Change between current and future model by discipline

Profession	Total Current CAMHS & Adult Combined WTE	Total Future CAMHS & Adults Combined WTE	% Change from current workforce (CAMHS & Adult combined)
Nursing	1316	1842	40%
Medical - Psychiatry	203	331	63%
Social Work	582	663	14%
Psychology	118	246	108%
Occupational Therapy	159	307	93%
Physiotherapist	7	79	985%
SLT	28	96	238%
Dietetics	7	78	973%
CAPT & Adult Psychotherapist	2	43	2613%
Psychotherapist (CBT)	16	73	369%
Pharmacy	2	162	7979%
Art/Music/Drama Therapists	2	100	6586%
Mental Health Practitioner	52	202	285%
Social Care	199	224	13%
Counsellors	52	52	1%
Management & Admin	533	891	67%
Nursing Support	791	343	-57%
Psychology Associate	13	92	598%
OT Support	21	10	-52%

SLT Support	0	5	N/A
Physiotherapy Support	0	11	2697%
Physician Associate	1	1	0%
Assistant Practitioner	131	230	76%
Peer Support Worker	0	53	N/A
Independent Advocates	2	2	0%
Transition Worker	0	5	N/A
Total	**4237**	**6140**	**45%**

Source: NI Workforce Analysis

* Includes Band 6 trainee roles

** N/A as no comparison is available as the role is not within the current workforce.

As depicted above, there are some service model changes that have altered the workforce profile. For instance, Nursing support has seen a reduction due to a shift towards the Social Care model within day services and supported living. A move towards a general Assistant Practitioner role instead of discipline specific support roles has impacted on growth in OT supports. The addition of the Transition workers within CAMHS, one per Trust, to support young people to transition smoothly to adult services was deemed an important role to deliver a better experience to patients.

CAMHS

Based on outputs from the demand and capacity model and a review of all service team configurations, the following is the workforce profile broken down by profession. This has led to an expansion of the roles throughout CAMHS, focused on an integrated multidisciplinary team delivery. This review has enabled the inclusion of disciplines that may be new to NI CAMHS services but are embedded within CAMHS services in other jurisdictions e.g., NHS. The new roles within CAMHS are Physiotherapy, SLT, Child and Adolescent Psychotherapy, Pharmacy, Assistant Practitioner and Transition Worker roles. In line with NHS and other emerging research, additional roles have been included within the Step 3 CAMHS and within specialist services. This is in line with other jurisdictions and based on emerging needs observed within the Trusts.

In comparison with the NHS, a comparison of roles was conducted, with the future model demonstrating 177 WTE per 100,000 population in comparison to a mean of 98 WTE within a comparable NHS Trust. Although, with a range of between the mean of 98 to the highest resourced team of 280 per 100,000, the NI CAMHS workforce profile is placed in approximately the 80th percentile against peers per 100,000, indicating that while this workforce profile will see growth in numbers, it is within norms when compared to NHS Trusts.

The following is an overview of the change between current workforce profile and future workforce profile, including the % change.

Table 31: CAMHS Workforce profile by profession (WTE)

Profession	Current	Future	Change
Nursing	119.5	212	77%
Medical - Psychiatry	42	53	24%
Social Work	134	140	4%
Psychology	20	64	215%
OT	9	35	308%
Physiotherapist	0	23	N/A
SLT	0	33	N/A
Dietetics	1	33	3247%
Child & Adolescent Psychotherapist	2	24	1403%
Psychotherapist (CBT)	0	0	N/A
Pharmacy	0	13	N/A
Art/Music/Drama Therapists	2	35	2261%
MHP	3	0	-100%
Social Care	17	0	-100%
Counsellors	3	0	-100%
Management & Admin	56	114	104%
Nursing Support	29	33	13%
Psychology Associate	3	19	566%
OT Support	1	1	0%
SLT Support	0	0	N/A
Physiotherapy Support	0	0	N/A
Physician Associate	0	0	N/A
Assistant Practitioner	0	57	N/A
Peer Support Worker	0	0	N/A
Independent Advocates	2	2	0%
Transition Worker	0	5	N/A
Total	**443**	**895**	**102.1%**

Source: NI Workforce Analysis

*includes Band 6 trainee roles

** N/A as no comparison is available as the role is not within the current workforce.

Of note, the number of Social Workers looks to have reduced in the new model; this is due to a high proportion of Social Workers taking on Early Intervention Specialist and Mental Health Practitioner posts within NHSCT. Currently within NHSCT, Social Work accounts for 40% of all CAMHS resources; based on the agreed team configurations per service, this has been realigned with other Trusts.

Mental Health Practitioners have been converted to discipline specific roles within this workforce model and there was no need identified for Social Care workers. As mentioned earlier, there is a move from AHP specific supports to a more generalised role as an Assistant Practitioner. This will provide better support to all members of the teams. A Transition Worker per Trust has been appointed to provide support to those transitioning to adult services as a pilot. This may be expanded upon pending outcomes from the initial pilot.

Multidisciplinary Team Delivery within CAMHS teams

Presently, with the evolution of CAMHS, several professions are well established and deliver the relevant core competencies and functions, including risk assessment and Key Worker functions required to meet patient outcomes. At present, this includes Medical, Nursing, Social Work, Psychology and OT professions. In the future model these professions account for 56% (n=483) of resources who can currently perform these core duties, this will expand with the broadening of the disciplines within the multidisciplinary teams.

For professions that grow in the future model, it is expected that, over time, this group will expand to broaden the number of professions available to deliver core competencies and functions[34]. There is an additional 13% (n=113) of the workforce that could deliver on the core competences and functions, pending a review of competencies and/or upskilling as required. As some professions have been limited or absent until now, this is an opportunity to include professions with established core competencies to support overall delivery of CAMHS core functions. These include SLT, Physio, Dietetics and Child and Adolescent Psychotherapy. This provides the CAMHS workforce with adequate capability to meet demand throughout CAMHS and adapt to the changing needs of the population.

In addition, there are additional roles, who provide complementary roles to deliver more holistic input to the multidisciplinary CAMHS team, enriching the delivery care model and ultimately positive patient outcomes. These encompass 19% of roles which include Creative Therapies, Pharmacy, and a range of support roles (Nursing Support, Assistant Practitioner), and 12% are administration roles. This expansion of roles will deliver better quality outcomes.

Adult Services

Based on outputs from the demand and capacity model and a review of all service team configurations, the following is the workforce profile broken down by profession.

Professions which are absent in Adult Services but are well-established in other jurisdictions i.e., Adult Psychotherapist as well as expanding roles for Art/Music/Drama Therapists, SLT and Peer Support Workers. Further detail on the profile per profession has been included within this section.

[34] *NHS Education for Scotland. A Roth, F Calder, S Pilling. (2011). A competence framework for Child and Adolescent Mental Health Services* [Online]. Available from: www.ucl.ac.uk/CORE [Accessed on 03 September 2022]

Table 32: Workforce Profile by Profession (WTE)

Profession	Current	Future	Change
Nursing	1196.6	1630	36%
Medical - Psychiatry	161	278	73%
Social Work	448	525	17%
Psychology	98	182	85%
Occupational Therapy	150	272	81%
Physiotherapist	7	56	673%
SLT	28	63	123%
Dietetics	6	44	608%
Adult Psychotherapist	0	19	N/A
Psychotherapist (CBT)	16	73	369%
Pharmacy	2	149	7329%
Art/Music/Drama Therapists	0	65	N/A
GP Federation MHP	49	202	311%
Social Care Workers	182	224	23%
Counsellors	48	52	8%
Management & Admin	477	776	63%
Nursing Support	762	310	-59%
Psychology Associate	10	73	606%
OT Support	20	9	-55%
SLT Support	0	5	N/A
Physiotherapy Support	0.4	11	608%
Physician Associate	1	1	0%
Assistant Practitioner	131	173	32%
Peer Support Worker	0	53	N/A
Independent Advocates	0	0	N/A
Transition Worker	0	0	N/A
Total	**3794**	**5245**	**38.2%**

Source: NI Workforce Analysis

** N/A as no comparison is available as the role is not within the current workforce.

While most disciplines have seen an uplift, a reduction in nursing support has been observed, due to a high reliance in NHSCT and WHSCT. A move to a Social Care model for day services and supported living facilities in the future has also impacted on this change of profile. OT support have also seen a reduction as a transition is planned to an Assistant Practitioner role that will provide generic support to all professionals, so that support staff can utilised for a broader range of activities. OT and nursing support has been retained in the acute setting.

5.4. Discipline Level Workforce Profile

The following is a breakdown of each key discipline for CAMHS and Adult Services.

5.4.1 Medical Staff

Views were sought from the Royal College of Psychiatry and service managers within Trusts to identify medical input required for services. Where available (e.g., Quality Network Inpatient CAMHS) suggested standards were followed.

Table 33: Future model - Medical Workforce WTE

Band	Profession	CAMHS	Adults	Total
	Psychiatrist	31.5	172.2	203.9
	SAS Doctors	21.0	106.1	127.1
	Total			**331.0**

Source: NI Workforce Analysis

The role of SAS Doctors was expanded across Mental Health Services, which will provide a key role in delivering medical services. A more flexible system for those who want to become Consultants through the certificate of eligibility for specialist registration (CESR) process should be considered to attract more clinicians down this career path.

In addition, the role of Specialist Doctor is evolving. Although restricted access to substantive funding at present has limited its adoption, it is expected that this new clinical role will enable better career pathways for SAS Doctors. This will need to be considered as part of the future medical model as a breakdown for this emerging role was not agreed as part of this review.

Of note, the Mental Capacity Act in Northern Ireland is restricted to the Consultant post signing specific forms which is having, and will continue to have, a significant impact on demand on finite resources. This is unlike England and Wales which allow additional clinical staff to sign these forms. The impact of this restriction needs to be fully evaluated to understand the capacity required to discharge these duties in full.

As was noted as part of the review of current age profiles, there is an urgency for medical staff to adequately plan for additional psychiatry places to meet future demand. It is also noted that at Consultant level many clinicians work less than full time which will impact on the total WTE required to meet demand. Specific interventions for geographical areas e.g., WHSCT, who have failed to attract Consultants, needs to be further considered.

Further, monitoring of current and anticipated medical posts involving the Northern Ireland Medical and Dental Training Agency (NIMDTA), DoH, and the Trusts could better inform the number of training places required in Core and Higher training each year, given the significant time required to train additional resources.

5.4.2 Nursing

Proposed nursing levels have been aligned to Delivering Care 5A standards for inpatient services, and it is recognised that the proposed community workforce will need to be evaluated against Delivering Care 5B on its publication. Banding and WTE provision within each service has been evaluated across each service. This includes Nurse Prescriber roles within Community Intervention and Addictions teams and the extension of ANP roles, with the emerging roles of the Consultant Nurse and Lead Nurse roles to support ongoing development of the nursing profession across Mental Health Services.

Table 34: Future model - Nursing Workforce WTE

Band	Profession	CAMHS	Adults	Total
Band 5	Mental Health Nurses*	32.0	544.9	576.9
Band 6	Mental Health Nurses*	66.0	607.7	673.7
Band 7	Mental Health Nurses*	86.4	431.8	518.2
Band 8A	Advanced Nurse Practitioners (ANP)	17.6	35.1	52.7
Band 8B	Consultant Nurse	5.0	5.0	10.0
Band 8B	Lead Nurse	5.0	5.0	10.0
	Total			**1,841.5**

Source: NI Workforce Analysis **This will include RNLD for ID CAMHS services*

As outlined in earlier sections, vacancy rates are currently high, leading to dependence on agency and bank to supplement services. This is a system wide challenge across nursing, which the Nursing and Midwifery Taskforce are working on. They cross four themes of safe staffing, valuing staff, leadership, and good work conditions. A key focus of the Nursing and Midwifery taskforce is to recruit and retain the current and future workforce to make services more sustainable. This will, in turn, reduce pressure on existing staff, delivering safe staffing, enable better work conditions (for example to take breaks and leave on time), and provide leadership opportunities. This should also include access to CPD, including leadership and/or preceptorship programmes to make nursing an attractive profession again.

Key actions that have been proposed as part of this review that could support this aim, to attract and retain, to use retention premia for ‘hard to fill’ vacancies, with regional and locally focused recruitment, including focus campaigns for hard to fill vacancies. Providing clear communications across Mental Health Services of perks (such as flexible working, training and career pathways into clinical specialist roles or management) is important to make MH nursing an attractive option going forward. Further information is available in section 6.

5.4.3 Social Work

Social Work provision was informed by the Mental Health Social Work review produced by Queens University Belfast (QUB), which provided guidance on overall need for SW within the workforce and number of Approved Social Workers required to meet the UK baseline. The recommendations were further examined by both Trusts and professional representatives and aligned with demand modelling.

Table 35: Future model - Social Work Workforce WTE

Band	Profession	CAMHS	Adults	Total
Band 5	Social Workers	0.0	31.6	31.6
Band 6	Social Workers	53.9	283.6	337.5
Band 7	Social Workers	80.6	188.4	269.0
Band 8A	Social Workers Lead	5	10.0	15
Band 8B	Lead Social Worker	0	10.0	10
	Total			**663.1**

Source: NI Workforce Analysis

Social Work has an important role across services, which was recognised, and numbers were adjusted based on their competence and skill contribution to the multidisciplinary team. For Social Work, it is recognised that a proportion of Mental Health Social Workers move into Team Leader and Senior Manager roles. This is an important contribution to Mental Health Services but also has implications for the number of Mental Health Social Workers that need to be recruited. The Team level data further illustrates the variation in the structure, job titles and composition of Teams within and between Trusts. It should be noted that the Trust and Team level data provide a good overview of the relevant structures, roles and issues but do not provide a complete picture of all relevant teams and services across sectors.

In addition to the Mental Health Strategy 2021-2031, there are several other important developments which directly influence the workforce planning for Mental Health Social Work. The first is the estimated need for an additional 380 Social Workers in Primary Care multi-disciplinary teams by 2030. A proportion of the 380 would be in Mental Health and, based on NISCC's current figure of 10% of Trust Social Workers working in Mental Health, this would mean an additional 38 Mental Health Social Workers in Primary Care MDTs within GP Federations. In addition to those Mental Health Social Workers in Primary Care MDTs, based on current recruitment figures, 50% of staff in Mental Health Practitioner posts in MDTs will be Social Workers. This would translate into the need for an additional 93 social workers for those Primary Care posts by 2030. There is a risk that Social Workers within MH services may choose roles in Primary Care, impacting on MH service delivery.

The impact of the Mental Capacity Act in Northern Ireland is not fully understood. It needs to be fully evaluated to understand the capacity required to discharge these duties in full. This will have a material impact on Social Work and, once evaluated, will need to be updated in the workforce profile.

In addition, Adult Safeguarding legislation is under development, this will have a significant impact on the Social Work workforce. As requirements are unclear at this point, no estimations

have been included in this review. However, it is expected that this will have an impact on the duties of the Social Work workforce in the longer term.

5.4.4 Psychological Professions

When developing a clinically-trained psychological workforce, the recommendations of Higher Education England's "Psychological Professions Workforce Plan for England"[35] and British Psychological Society's "Clinical and applied psychologists in Child and Adolescent Mental Health Services"[36] were consulted to guide proposed staffing levels. These figures were then further evaluated by Trusts and professional representatives.

As outlined in the assumptions, in the main, single modality intervention roles have not been included, as these roles are delivered by specific disciplines. It is assumed that the specific breakdown between core functional duties and delivery of interventions will be devised by the services based on service needs. The only variance in this review is the inclusion of counsellors in the Lifeline service and Cognitive Behavioural Therapists within the Psychological Therapeutic services, which provides a specific distinct role. The delivery of therapeutic modalities will continue to require adequate supervision, coaching and mentoring to ensure a high standard of therapeutic delivery as outlined by their relevant Professional bodies.

Clinical Psychology

It is acknowledged that Clinical Psychologists, including Forensic Psychologists, will represent only a fraction of psychologically qualified staff across services and that staff from all professions input to the delivery of psychotherapeutic interventions (e.g., CBT, behavioural therapy). Other Mental Health Clinicians with post graduate training will provide specific interventions; this should be defined by the service based on need.

Table 36: Future model - Clinical Psychology Workforce WTE

Band	Profession	CAMHS	Adults	Total
Band 7	Psychologists	28.5	40.8	69.3
Band 8A	Psychologists	25.6	113.7	139.3
Band 8C	Consultant Psychologist	9.8	27.5	37.3
	Total			**245.9**

[35] *Higher Education England's "Psychological Professions Workforce Plan for England":* NHS Health Education England Psychological Professions Workforce Plan for England 2020/21 to 2023/24
[36] *British Psychological Society's "Clinical and applied psychologists in child and adolescent Mental Health Services"*

Child & Adolescent Psychotherapists and Adult Psychotherapist

Similar to Clinical Psychologists, the recommendations of Health Education England's "Psychological Professions Workforce Plan for England"[37] were considered when defining this workforce.

Child and Adolescent Psychotherapy (CAPT) have been included in both community and inpatient settings. A challenge for this cohort is lack of training places within Northern Ireland, with the proposed growth in this cohort of professions; this will need to be considered to ensure a pipeline of therapists are available. Similarly, the development of Assistant Child & Adolescent Psychotherapy posts is underway between the HEE and the Association of Child Psychotherapists in England, this will present opportunities for NI to provide a clear career pathway and an adjunct supply of professions to deliver therapy under the supervision of CAPT therapists.

Adult Psychotherapists have not yet been employed in NI and provision has been included that allows for progression within MH services. Accredited training is available in Northern Ireland from the British Psychoanalytic Council.

As part of their role across both Adult and CAMHS, it is envisaged that psychoanalytic informed reflective practice for mental health staff will form part of the role of CAPT and Adult Psychotherapists to broaden and deepen understanding of the complex dynamics with which they are working.

Table 37: Future Model – Adult and Child & Adolescent Psychotherapists Workforce WTE

Band	Profession	CAMHS	Adults	Total
Band 7	Psychotherapist	8.8	5.5	14.3
Band 8A	Psychotherapist	6.4	8.3	14.7
Band 8C	Psychotherapist	4.4	5.5	9.9
	Total			**38.9**

Source: NI Workforce Analysis

Psychotherapists (CBT)

Within this review, Psychotherapist roles have been included for the Psychological Therapies Service only. As articulated within the assumptions, as the majority of resources that deliver advanced psychological therapy are coded by their professional discipline, accurate information was unavailable to inform a clear demand for these professions. It is recognised that delivery of psychological intervention is integral to delivering patient outcomes within all services. Therefore, in the future model, across all team configurations, it has been assumed that a proportion of each team will deliver psychological therapies. This would be defined by the needs of the team. Therefore, the total number of resources outlined below would not be representative of the total Psychological Therapies workforce; only those dedicated to the Psychological Therapies Service.

[37] *Health Education England's "Psychological Professions Workforce Plan for England"*[Psychological-Profession-Workforce-Plan-for-England.pdf (hee.nhs.uk)]

It is acknowledged that staff trained in CBT have high competency skill levels that must be maintained and meet the standards of their relevant professional body, British Association of Behavioural and Cognitive Psychotherapy (BABCP) the all-Ireland branch the Irish Association of Behavioural and Cognitive Psychotherapy (IABCP). All clinicians must be meet these standards to maintain high quality evidence-based care.

Table 38: Future Model – Psychotherapist (CBT) Workforce

Band	Profession	CAMHS	Adults	Total
Band 7	Psychotherapist (CBT)	0	72.7	72.7
	Total			**72.7**

Source: NI Workforce Analysis

An evaluation across all Mental Health Services is recommended to understand the status of resources with advanced training to include all psychological therapies. It is important to understand both the availability of these skilled resources and how best to utilise this workforce whilst maintaining core services. This will inform where additional training places are needed to meet service demand and re-allocate resources where surplus advance trained resources are required but not fully utilised.

Counsellors

Counsellors in Lifeline Service were adjusted to match increases in population and estimated increases in prevalence.

Table 39: Future Model – Counsellor Workforce

Band	Profession	CAMHS	Adults	Total
	Counsellors	0.0	52.4	52.4
	Total			**52.4**

Source: NI Workforce Analysis

Similar to services in wider UK an emerging psychology graduate workforce is becoming available. This includes roles such as the Primary Wellbeing Practitioner (PWP) in England and the Clinical Assistant Psychologist (CAP), using a preceptorship model, in Scotland. The PWP course is available in University of Ulster and a new Psychology Post-graduate Certificate is being delivered collaboratively between Queen's University Belfast and Ulster University. With this in mind, it is likely that current psychology posts, across Band 5 – 7, and posts offering psychological therapies from other disciplines may be re-profiled over the next 10 years to accommodate these new roles and skill sets.

To ensure access to the right type of psychological intervention is available in each MH service, it is recommended that a review of all post-graduate psychological trained clinicians is documented and assessed on whether these skills are maximised within teams, and to identify and plan for any gaps in skills required to meet patient outcomes. This should inform a holistic view of training plans required in the future.

Further to the strategic development of Psychological Professions, there is no Psychological Therapies Framework in Northern Ireland. A holistic approach to all psychological professions would be beneficial to have a common understanding of the taxonomy, the relevant Registration Bodies (statutory or non-statutory) and a holistic career pathway for all Psychological Professions to attract untapped resources that may in the future become part

of Mental Health Services. This will support the adherence to best practice and delivery of high-quality therapeutic intervention from these professions.

5.4.5 Allied Health Professionals

For all Allied Health Professionals providing a clear structure and career path was deemed essential to attract professionals to Mental Health Services. This would ensure leadership and mentoring is accessible and the opportunity to develop emerging practice of care would be an attractive prospect for individuals. Therefore, the appointment from a Band 8A and clinicians down to a Band 5 will provide the necessary platform to develop clinical competence and grow through Mental Health Services. In addition, as some of these roles are emerging, placing clinicians together within the core teams, in the main, will ensure a sense of team is built to promote a positive professional community, maximising retention.

Occupational Therapists

Occupational Therapy provision in Mental Health Services was evaluated with Trusts and the Royal College of Occupational Therapy. Defined roles for Occupational Therapy to perform their core skills, and clear career progression were highlighted as crucial to attracting and retaining OTs to Mental Health Services.

Table 40: Future model - Occupational Therapist Workforce WTE

Band	Profession	CAMHS	Adults	Total
Band 5	Occupational Therapist	4.4	31.8	36.2
Band 6	Occupational Therapist	10.8	111.1	121.9
Band 7	Occupational Therapist	14.5	119.1	133.6
Band 8A	OT Lead	5.0	5.0	10.0
Band 8A	OT Governance	0.0	5.0	5.0
	Total			**306.7**

Source: NI Workforce Analysis

Physiotherapists

The role of physiotherapy in MH services in Northern Ireland has been limited to this point. However, it's efficacy has been shown by pilot programmes (NHS Tayside, Scotland) and in academic literature[38][39]. As with other AHP professions, its inclusion in services has been based on ensuring it provides therapeutic benefit and allowing for a more complete multidisciplinary team across MH services, while allowing clear career progression and proper governance to help attract and retain physiotherapists to Mental Health Services.

[38] R. Carney, J. Firth (2021*) Exercise interventions in child and adolescent mental health care: An overview of the evidence and recommendations for implementation. [Online]. Available from:*acamh.onlinelibrary.wiley.com

[39] K. Kozlowska, N Gray , S Scher, B Savage Blanche (2020 *Psychologically informed physiotherapy as part of a multidisciplinary rehabilitation program for children and adolescents with functional neurological disorder: Physical and mental health outcomes. [Online]. Available from:* onlinelibrary.wiley.com

Table 41: Future model - Physiotherapist Workforce WTE

Band	Profession	CAMHS	Adults	Total
Band 5	Physiotherapist	4.4	0	4.4
Band 6	Physiotherapist	8.8	31.8	40.6
Band 7	Physiotherapist	4.4	19.2	23.6
Band 8A	Physiotherapist Lead	5.0	5.0	10.0
	Total			**78.6**

Source: NI Workforce Analysis

Speech & Language Therapists (SLT)

The proposed increase in SLT resources in MH services is a result of consultation with Trusts and professional representatives, alongside comparisons to SLT provision elsewhere in the NHS. The North-East England SLT service has shown the demand for SLT within Mental Health Services and was used as a comparator for the proposed SLT provision recommended by this review. As with other AHPs, the need for career progression within MH services, and proper governance were highlighted as necessary for retaining SLT resources in Mental Health Services.

Table 42: Future Model - Speech & Language Therapist Workforce WTE

Band	Profession	CAMHS	Adults	Total
Band 5	Speech & Language Therapist	0	15.9	15.9
Band 6	Speech & Language Therapist	13.5	16.2	29.7
Band 7	Speech & Language Therapist	14.2	26.3	40.5
Band 8A	Speech & Language Therapist	5.0	5.0	10.0
	Total			**96.1**

Source: NI Workforce Analysis

Dietetics

The role for dedicated dietetics resources has been highlighted by Trusts in several services throughout the review. With increasing prevalence of eating disorder and prescription of medications with physical side-effects, the requirement for specialist dietetics input in services has been noted. The proposed dietetic input to services has been suggested through consultation with Trusts and professional representatives. Given the specialist nature of the work, it was deemed important to be Band 7 level, however, there is recognition that, in order to ensure succession planning and skill acquisition, rotation options or shadowing will need to be considered.

Table 43: Future model - Dietetics Workforce WTE

Band	Profession	CAMHS	Adults	Total
Band 6	Dietitian	9.8	11.6	21.4
Band 7	Dietitian	18.6	27.5	46.1
Band 8A	Dietician Lead	5.0	5.0	10.0
	Total			**77.5**

Source: NI Workforce Analysis

Art/Drama/Music Therapists

The Combine Workforce Review Report (Art, Drama and Music Therapy), submitted to DoH in June 2010, recommends the following: "The development of an Arts Therapies strategy for Northern Ireland by carrying out a review of Arts Therapies services, in collaboration with the Department of Health, Health and Social Care Board and five HSC Trusts, in order to support the transformation agenda with the development and improvement of services across the region". The role of Music, Art, and Drama Therapies in psychologically informed care in Mental Health Services has been recognised by NICE guidelines[40]. The expansion of Music, Art and Drama therapist roles in NI is proposed to allow for proper governance and career progression within MH services.

Table 44: Future Model - Art/Drama/Music Therapists Workforce WTE

Band	Profession	CAMHS	Adults	Total
Band 6	Art/Drama/Music Therapists	4.4	21.6	26.0
Band 7	Art/Drama/Music Therapists	26.0	25.8	51.8
Band 8A	Art/Drama/Music Therapists	0.0	12.5	12.5
Band 8A	A/D/M Therapist Lead	5.0	5.0	10.0
	Total			**100.3**

Source: NI Workforce Analysis

5.4.6 Pharmacy

Throughout the review process, a significant increase in dedicated Pharmacy resources was highlighted as crucial to future service provision, to alleviate some of the requirements of medical staff. Over the next 5 years, all Pharmacy graduates will be able to prescribe as well as advise on medications, which will provide an essential support to teams going forward. The proposed level of Pharmacy resources was informed through consultation with Trusts and the Regional Mental Health Pharmacist group and aligned to the Pharmacy workforce review.[41]

[40] NICE (2013) Psychosis and schizophrenia in children and young people: recognition and management. [Online] Available from: *Psychosis and schizophrenia in children and young people: recognition and management (nice.org.uk)*

[41] Regional Mental Health Pharmacist Group (2022) Pharmacy Mental Health Workforce 2022

Table 45: Future Model – Pharmacy Workforce WTE

Band	Profession	CAMHS	Adults	Total
Band 4	Pharmacy Technician	1.0	16.7	17.7
Band 5	Pharmacy Technician	0.0	10.7	10.7
Band 6	Pharmacist	0.0	13.5	13.5
Band 7	Pharmacist	6.0	55.4	61.4
Band 8A	Pharmacist (Advanced)	6.0	37.1	43.1
Band 8B	Pharmacist (Lead/Specialist)	0.0	5.5	5.5
Band 8C	Pharmacist (Consultant)	0.0	2.0	2
	Total			**153.9**

Source: NI Workforce Analysis

5.4.7 Mental Health Practitioners

The following are the total number of Mental Health Practitioner required for the MDT within GP Federations.

Table 46: Future Model – Mental Health Practitioner Workforce WTE

Band	Profession	CAMHS	Adults	Total
Band 7	Mental Health Practitioner	0.0	202	202
	Total			**202**

Source: NI Workforce Analysis

5.4.8 Support Roles

There are a range of support roles that have been included within this review to augment services. To devise the workforce for this cohort, insight from the Trusts and standards where available were used to input to workforce profile.

Non-registered nursing roles have been aligned to Delivering Care 5A standards for inpatient settings. Community based nursing support roles were based on consultation with nursing professions and Trust input and incorporated into the assistant practitioner role.

The role of the Assistant Practitioners in community-based teams has been proposed to allow multiple professions of the multidisciplinary team share support resources. In community settings, this has replaced single discipline support roles to optimise the level of support available to all Professions. Dedicated support for each profession has been maintained in inpatient settings.

The inclusion of a Transition Worker in each Trust has been proposed, as a critical development to support the smooth transition of patients from CAMHS to Adult Services, as

this has been identified as a challenge in current provision of services. This pilot service will be evaluated and expanded if deemed a successful model.

The development of the Social Care workforce has been informed by the Social Care Strategy that is due for completion at the end of 2022 and this report has aligned where possible. Further review will be required once the strategy is complete.

Peer support workers are very effective across services and this support has been included as part of the future model.

Table 47: Future Model Support Roles Workforce

Band	Profession	CAMHS	Adults	Total
Band 3	Mental Health Nurse Support (Non-registered)	33.0	309.9	342.9
Band 4	Social Care Worker	0.0	216.3	216.3
Band 5	Social Care Worker	0.0	7.9	7.9
Band 5	Psychology Associate	18.6	73.5	92.1
Band 6	Child & Adolescent Psychotherapist Trainee	4.4	0	4.4
Band 4	Occupational Therapist Support	1.0	9.2	10.2
Band 4	Speech and Language Therapist Support	0.0	5.2	5.2
	Physician Associates	0.0	1.0	1.0
Band 4	Physiotherapist Support	0.0	11.2	11.2
Band 2	Pharmacy Technician	0.0	7.8	7.8
Band 4	Assistant Practitioners	57.3	122.6	179.9
Band 3	Assistant Practitioners	0.0	50.1	50.1
Band 5	Peer Support Worker	0.0	51.7	51.7
Band 4	Peer Support Worker	0.0	1.1	1.1
	Independent Advocates	2.0	0.0	2.0
	Transition Worker	5.0	0.0	5.0
	Total			**988.8**

Source: NI Workforce Analysis

5.4.9 Administration & Management

Administration input to services was increased to match standard levels across HSC services[42]. The governance structures for management across each Trust have not been changed, current management structures have been included in the workforce review.

The inclusion of performance and business support roles dedicated to Mental Health Services was deemed important to be able to develop structure in data collection and analysis to be able to aid decision making with respect to services.

Table 48: Future Workforce - Administration & Management Workforce

Band	Profession	CAMHS	Adults	Total
	Director of MH & LD	5.0	5.0	10.0
	Asst Director of MH	0.0	10.0	10.0
Band 8B	Service Manager*	0.0	26.0	26.0
Band 8A	Assistant/Clinical Service Manager*	0.0	61.0	61.0
Band 8B	AHP Lead	5.0	5.0	10.0
Band 7	Service Manager/Team Lead	5.0	82.7	87.7
Band 7	Registered Manager (Day/Supported Living)	0.0	18.0	18.0
Band 4	Administrative staff	42.7	306.5	349.2
Band 3	Administrative staff	50.7	222.3	273.0
Band 8A	Dedicated bed management manager	1.0	5.0	6.0
Band 7	Service User Consultant	0.0	5.0	5.0
Band 8A	Service Improvement Manager	0.0	5.0	5.0
Band 8A	Towards Zero Suicide (TZS) Service Improvement Manager	0.0	5.0	5.0
Band 7	Practice Educator (Nursing)	0.0	5.0	5.0
Band 7	Performance & Bus Support Manager	0.0	5.0	5.0
Band 6	Information Analyst	0.0	5.0	5.0
Band 5	Information Analyst	0.0	5.0	5.0
Band 7	Youth Justice Worker	5.0	0.0	5.0
		Total		**890.9**

Source: NI Workforce Analysis *CAMHS roles included in adult figures

5.5. Future Workforce Profile Development

[42] *Department of Health. (2022). Northern Ireland Health and Social Care Workforce Census March 2022 [Online]. Available from: Northern Ireland Health and Social Care Workforce Census March 2022 (health-ni.gov.uk) [Accessed on 02 May 2022]*

To understand the rate of recruitment required, it is necessary to understand the rate of attrition[43], rate of retirements anticipated (see section 3), and the rate of growth required (see section 4), across the disciplines. This will support planning for recruitment, training places and training programmes for Mental Health Services. The following is the recruitment profile based on factors above, including training time required for a student to join the workforce.

To see the full recruitment profile for each disciple please see Appendix iv. This includes the total new WTE required per year.

Total Workforce by Discipline

5.5.1 Medical Staff

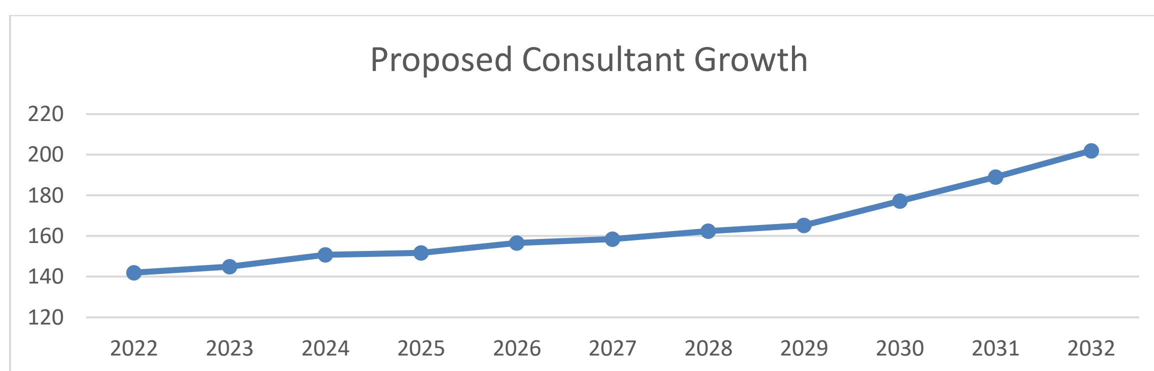
In response to different trends seen across disciplines (lead time to train resources, attrition, retirements) several factors must be considered when projecting growth within each discipline.

With 48 resources due to retire in the next 10 years and growth to meet the workforce required in 2032; the following is a proposed growth of medical resources required:

Table 49: Total Workforce by Discipline

Medical	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
Consultant											
CAMHS	26	26	27	27	28	28	28	29	29	30	30
Adult	116	119	124	125	129	131	134	137	148	160	172
Total	**142**	**145**	**151**	**152**	**157**	**159**	**162**	**165**	**177**	**189**	**202**
SAS Doctor											
CAMHS	10	10	10	10	11	12	14	16	17	19	21
Adult	54	56	57	59	63	68	75	83	90	98	106
Total	**64**	**65**	**67**	**69**	**74**	**80**	**89**	**98**	**107**	**117**	**127**

Figure 22: Proposed Consultant Growth based on projected demand



[43] Department of Health. (2022). *Northern Ireland Health and Social Care Workforce Census March 2022* [Online]. Available from: Northern Ireland Health and Social Care Workforce Census March 2022 (health-ni.gov.uk) [Accessed on 02 May 2022]

The growth proposed allows for the number of trainees expected to complete training each year per a recent medical review (under consideration by DoH) until 2027 and an increase in training places to meet the forecast demand who will complete higher training from 2028.

5.5.2 Nursing

Based on an observed attrition rate of 5%, with 299 resources due to retire in the next 10 years (per HRPTS data) and growth to meet the workforce required in 2032, the following is the proposed growth of nursing resources required:

Table 50: Nursing Recruitment Profile

Nursing	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
CAMHS	120	130	140	149	160	170	179	188	197	204	212
Adult	1,197	1,253	1,306	1,356	1,403	1,447	1,488	1,527	1,563	1,598	1,630
Total	**1,316**	**1,383**	**1,446**	**1,505**	**1,563**	**1,617**	**1,668**	**1,715**	**1,760**	**1,802**	**1,841**

Following the announcement that NI Executive funding has been secured for an additional 50 places each year bringing the total to 195 from 2022/23[44], this has provided a strong pipeline of nursing graduates in the coming years. The workforce plan will require ~175 new WTE each year to meet the forecast. It is acknowledged that new graduates may join the C&V sector or primary care which will also place demand on new graduate availability. Any attrition from graduates within NI or resources joining the workforce in positions less than full-time will need to be met with local or international recruitment.

5.5.3 Social Work

Based on an observed attrition rate of 3%, with 113 resources due to retire in the next 10 years (per HRPTS data) and growth to meet the workforce required in 2032, the following is the proposed growth of social work resources required:

Table 51: Social Work Recruitment Profile

Social Work	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
CAMHS	134	133	133	132	133	134	134	135	137	138	140
Adult	425	432	442	451	460	472	483	493	504	514	524
Total	**559**	**566**	**575**	**583**	**593**	**605**	**617**	**629**	**641**	**652**	**663**

[44] Funding secured for 300 additional nursing and midwifery undergraduate places | Department of Health (health-ni.gov.uk)

5.5.4 Psychological Professions

Clinical Psychology

Based on an observed attrition rate of 3%, with 15 resources due to retire in the next 10 years (per HRPTS data) and growth to meet the workforce required in 2032, the following is a proposed growth of clinical psychologist resources required:

Table 52: Psychology Recruitment Profile

Psychology	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
CAMHS	20	23	26	30	34	38	41	45	51	57	64
Adult	98	104	110	115	120	126	138	149	161	172	182
Total	**118**	**127**	**136**	**145**	**154**	**163**	**179**	**194**	**212**	**229**	**246**

CAPT and Adult Psychotherapy

Based on an observed attrition rate of 3%, with 0 resources due to retire in the next 10 years (per HRPTS data) and growth to meet the workforce required in 2032, the following is the proposed growth of psychodynamic psychotherapy resources required:

Table 53: CAPT and Psychotherapy Recruitment Profile

Psychotherapy	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
CAPT	1	5	9	13	15	18	20	23	23	23	24
Adult	0	4	8	11	13	16	17	19	19	20	20
Total	**1**	**9**	**17**	**23**	**29**	**34**	**38**	**42**	**42**	**43**	**44**

5.5.5 Allied Health Professionals

Occupational Therapy

Based on an observed attrition rate of 3%, with 12 resources due to retire in the next 10 years (per HRPTS data) and growth to meet the workforce required in 2032, the following is a proposed growth of OT resources required:

Table 54: OT Recruitment Profile

OT	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
CAMHS	9	13	16	20	23	25	27	29	31	33	35
Adult	150	164	178	191	204	217	229	241	252	263	272
Total	**159**	**177**	**194**	**211**	**227**	**242**	**256**	**270**	**284**	**297**	**307**

Physiotherapy, SLT, Dietetics and Art/Music and Drama Therapy

Based on an observed attrition rate of 3%, with 13 resources due to retire in the next 10 years (per HRPTS data) and growth to meet the workforce required in 2032, the following is the proposed growth of AHP (Physiotherapy, SLT, Dietetics and Art/Music/Drama Therapists excluding OT) resources required:

Table 55: AHP Recruitment Profile

AHP	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
CAMHS	3	11	26	40	54	67	80	92	103	114	124
Adult	42	59	75	90	104	126	147	166	185	204	223
Total	**45**	**70**	**101**	**130**	**159**	**193**	**226**	**258**	**288**	**318**	**347**

5.5.6 Pharmacy

Based on an observed attrition rate of 3%, with no resources due to retire in the next 10 years and growth to meet the workforce required in 2032, the following is a proposed growth of pharmacy resources required:

Table 56: Pharmacy Recruitment Profile

Pharmacy	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
CAMHS	0	6	10	12	12	12	12	13	13	13	13
Adult	2	22	41	60	78	96	113	125	136	147	149
Total	**2**	**28**	**51**	**72**	**90**	**108**	**125**	**138**	**149**	**160**	**162**

5.5.7 Administration & Management

Based on an observed attrition rate of 6%, with 163 resources due to retire in the next 10 years (per HRPTS data) and growth to meet the workforce required in 2032, the following is a proposed growth of admin & management resources required:

Table 57: Admin & Management Recruitment Profile

	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
CAMHS	56	62	67	72	77	82	87	91	95	99	102
Adult	477	518	557	595	630	664	696	721	740	758	775
Total	**533**	**580**	**624**	**667**	**707**	**746**	**782**	**812**	**835**	**857**	**878**

Suggested growth projections have been provided only for the largest disciplines in the proposed workforce and those with significant training requirements.

5.6. Attraction, Retention & Training

A key challenge for Mental Health Services, and indeed across the HSC, is the attraction, retention, and training of a suitably skilled workforce. Overall workforce growth in Mental Health Services has averaged at 2.2% over several years, ranging from 3.1% growth in SEHSCT down to c.1% in NHSCT and 1.8% in BHSCT. Vacant funded positions range from 14.5 – 20.3%, indicating the magnitude of the challenge to meet the workforce profile outlined in this review. Following consultation across Mental Health Services and informed by various reviews completed across disciplines within the scope of this review, several common themes emerged.

5.6.1 Attracting workforce to Mental Health Services

Attracting workforce both from graduate entry through to experienced recruitment continues to be an ongoing challenge across Mental Health Services and the broader HSC. There are several factors contributing to this that require continued innovation to make Mental Health Services an attractive place to work and build your career.

- Individual Trusts are competing for the same finite resources with geographical location playing a large factor in employee choice. With the development of the Mental Health Practitioner role within the Primary Care MDT teams within the GP Federations, there is a significant challenge the balance of expertise across all services. While bolstering community services will help Mental Health Services overall, Trusts and Community services will need to work hand in hand to manage the movement of talent across services.
- Remuneration is standard across Trusts, aligned to the Agenda for Change, and there are known challenges to incentivise staff to areas where there are significant deficits, leading to challenges in attracting staff to certain services and geographical areas. This is leading to a sub-optimal service delivery, poor patient experience due to limited access to services locally and reliance on locums and agency staff to deliver minimum standards. Whilst there is a lot of innovation happening within the Trusts to tackle this, it presents an ongoing challenge to sustainability of services.
- Some Trusts, WHSCT and SHSCT, are challenged by better pay and conditions for some professionals close to the border where renumeration is more favourable within the Republic of Ireland. This is impacting on the availability of resources and reliance on less sustainable options

In addition, there are challenges with the number of graduates available:

- As outlined in several reviews e.g., OT[45], SLT[46], Physio, training spaces in University and Specialist schemes are often insufficient to meet demand. They have cited the need to expand training numbers to meet forecast demand. Even with expansion of training places, attracting candidates to more remote areas may continue to persist.
- Some Undergraduate programmes do not have dedicated Mental Health modules or specific placements to get exposure to the array of career opportunities across Mental Health Services. Incorporating specific Mental Health exposure will begin to make Mental Health service more visible to undergraduates.

[45] Department of Health. (2022). *Workforce Planning: Occupational Therapy* [Online]. Available from: Occupational Therapy Workforce Review 2019 – 2029 | Department of Health (health-ni.gov.uk) [Accessed on 02 May 2022]

[46] Department of Health. (2020). *Workforce Planning: Speech Language Therapy* [Online]. Available from: Speech and Language Therapy Workforce Review 2019 – 2029 | Department of Health (health-ni.gov.uk) [Accessed on 02 May 2022]

- In some disciplines with limited resources within services, there is a perceived lack of career progression which is a barrier to attracting workforce, in conjunction with reduced exposure within undergraduate programmes.
- Nursing specifically is looking at avenues to reduce the amount of non-core activities that they are required to undertake by developing Further Education courses to increase the competences within Nursing Support to reduce pressure on Nursing staff.

Several solutions have been proposed for consideration:

Visibility and understanding of Mental Health roles: To improve the brand of Mental Health Services, skills per service need to be clarified and standardised across Trusts to ensure a consistent language and terminologies are used. This will help with raising Mental Health Services profile.

Incentivisation: Whilst challenging for the HSC, development of incentive package options may garner employee loyalty and attract people to services. Options for consideration from the outset of the recruitment process include, for example, discussing flexible working, car parking, alternative working hours, working conditions and environment, access to training programmes and mentoring programmes. Indeed, for retaining staff, providing flexibility is a fine balance between balancing operations and meeting employee expectations, however additional flexibility, and innovation to meet the expectations of the employee and service is essential with such choice available to the employee. The use of a retention premia should be used where appropriate to increase retention rates in at risk services. Equity and fairness will need to be applied to minimise any downstream implications in other areas.

Indeed, within Nursing, the Nursing and Midwifery Taskforce identified four themes to deliver across all specialties to improve retention and attract more nurses to the HSC; these include safe staffing, valuing staff, leadership, and good work conditions.

Improving Mental Health awareness in Education: In the next section, several proposals have been set out that may help increase awareness and attract candidates to Mental Health Services.

5.6.1.1 Retaining the Workforce

As can be seen from section 3, there are significant challenges to overcome in relation to current deficits across disciplines, prior to meeting the future workforce profile outlined in this review. With all Trusts, augmenting their workforce with backfill staff ranging from 2% to 19% is having a knock-on effect on sustainability of services, and therefore impeding development and expansion of services. With significant impacts in the workforce due to retirements, it is imperative that a strong pipeline is developed to attract and retain the workforce required to deliver Mental Health Services. From a series of interviews, there are several factors that are impacting on the retention of professions. This includes:

- **Staff wellbeing and burnout**: Sustained increased demand being placed on all professions in Mental Health Services due to the added complexity of cases. Ongoing staffing challenges due to COVID-19 are impacting on isolation requirements and illness requires ongoing management and minimum staff levels. Providing additional hours for extended periods to support understaffed services due to sick leave, COVID-19 restrictions and general attrition is additionally leading to burnout.

- **Remuneration:** Disparity of wages for permanent versus agency wages continues to bring discontent amongst staff. While this is not a new issue, there is a recognition that the additional burden permanent staff are experiencing for long periods is taking its toll. It is acknowledged that younger staff members are not as interested in permanent

roles and the flexibility agency provides suits their lifestyle with better rates of renumeration.

- **Career Development:** Within some professions there is a lack of career pathways, thereby impacting professionals entering and being retained within Mental Health Services. This is affecting professions that are emerging or developing within Mental Health Services such as OT, SLT and dietetics[47]. Pathways need to be clearly defined for this cohort of professionals to showcase the careers that are available. The introduction of the Consultant level roles across nursing, AHP, pharmacy and other professions will be important to demonstrate careers available and the specialties that can be developed through emerging research.

- **Training:** Accessing specialist training can be challenging and dependent on the specific profession and approved funding bodies. Going forward, it is recommended that all specific training requirements per service should be consolidated with a single funding stream. There is an opportunity to streamline the commissioning of post graduate courses, between commissioning bodies, to allow a broader range of multidisciplinary team professionals the option to apply for training based on a standardised framework. This will enable the training to be applied to specific needs identified in services and lead to transparency in the skill gaps in services, training programmes required, professions eligible to apply; and a clear path for professionals to apply for specific courses. In addition, some staff with specialist training may be limited in how they use their new skill dependent on their core role, with many unable to fully utilise their new competency. This brings an employee dissatisfaction and, from a service perspective, means the HSC are not utilising that resource to the full extent of their professional license. Where a specific skill is identified within a service, it is recommended that this skill is ringfenced to deliver that modality, to get a return on investment in the training and deliver better outcomes for patients.

- **Development of discipline agnostic courses** should be considered for competencies in demand of services to provide options to different clinicians to diversify and expand their skillsets; this will help to bolster established professions that are in too much demand.

- **Transformation Posts** have been developed to allow Trusts to deliver new services or roles with definitive period of funding. However, to attract candidates into the post, many must be made permanent. This leads to unfunded posts in the system and poor ability to plan services with finite funding arrangements.

5.6.1.2 Training Programme Analysis

From an analysis of the programmes, there are several common themes that have emerged:

For several Undergraduate degrees, there are no dedicated spaces for Mental Health specific professions, and no specific modules or placement opportunities related to Mental Health Services. Mental Health Services are at a distinct disadvantage attracting new graduates as they are not exposed during their Undergraduate programmes e.g., speech and language therapy and physiotherapy. It is recommended that all curriculums should include exposure to Mental Health Services as a minimum requirement. Optimally, a dedicated module and

[47] Department of Health. (2022). *Workforce Planning: Dietetics Workforce Review* [Online]. Available from: Dietetics Workforce Review 2019 – 2029 | Department of Health (health-ni.gov.uk) [Accessed on 02 May 2022]

placement should be considered. In addition, training should be provided to give a whole system wide understanding i.e., learning how the entire Mental Health sector/service works and the parts linked together, to expose them to the options that are available for specialisation through their chosen career pathway.

For AHPs, there is an opportunity to increase training places as it has been demonstrated that there is clear demand for these professions within their respective reviews. A key challenge is the ability to provide training placements as part of their Undergraduate training and have open roles at Band 5 to begin their careers. Continued collaboration between the Universities and the Trusts to identify ways to increase placement positions and provide adequate exposure to Mental Health settings in advance of graduating will help to attract all disciplines to Mental Health Services. Providing clarity on the career pathways in Mental Health needs to be well articulated.

Consideration of providing an avenue to ensure a proportionate representation from certain geographical areas should be considered as individuals based in those locations are most likely to want to work there.

In addition, at the outset of professional careers, there is a varied approach to providing rotational opportunities into Mental Health Services which has impacted on attracting professions to Mental Health Services. Incorporation of rotations through Mental Health Services to increase exposure will provide more visibility of Mental Health Services as a career of choice. In addition, provision of more multidisciplinary based training will provide an understanding of the ethos in Mental Health Services, which in turn will provide added attraction to new graduates to focus on Mental Health competencies.

There is an opportunity to provide pathways for support roles, such as Assistant Practitioner, nursing support and others, to be able to apply to complete professional training which could allow candidates continue to work whilst training to gain a professional qualification. This could build competence in staff to take on additional responsibility and/or become fully qualified in a professional role. This would require specific planning with regards to eligibility, management of the process and delivery of training to minimise disruption to services. This could attract a large cohort of candidates who may have been precluded from university at an earlier stage in their career, to provide an opportunity to upskill and advance their career. This could include an agreed contract to work within the HSC once the course is completed while ensuring a supply of workforce for a minimum period. Research from other jurisdictions have confirmed that retention levels for these staff are higher than other staff grades. Across several reviews and from successful user cases, it is recommended that an evaluation is completed to understand how this would impact on retention and workforce numbers.

In recent years, additional roles have become available which will provide alternative options to supplement gaps in certain professions. There is an opportunity to diversify roles with the right level of clinical governance and supervision that can support meeting the workforce numbers in this report e.g., Psychological Wellbeing Practitioner. A single taskforce for Mental Health Services should explore this together to share knowledge and insights that will meet the needs of services agnostic of discipline. Due to necessity WHSCT have had some success in this regard with an opportunity to be more innovative on how to deliver care.

Within Appendix iv, an overview of training across NI and challenges presented by individual professions to meet demand across all programmes of care is available.

5.6.1.3 Other Levers – Community & Voluntary Sector

While this review has focused on the services delivered by the HSC, a critical part of overall Mental Health Service delivery partnerships with the Community and Voluntary sectors. They are integral to service delivery and provide a range of valuable services across the Trusts at both local and regional levels. Given the challenge of securing a full workforce, new partnerships and models of delivery can be explored to augment HSC services. Several themes have come up through the review which have included:

- Resourcing: The C&V sector are challenged to attract resources. Due to COVID-19 and the opportunity to work virtually, there is an opportunity for resources to take on roles outside of Northern Ireland. There is a reluctance to return to full face-to-face delivery models due to the time commitment and additional cost it incurs, and, in some cases, it does not pay as well as contracts offered in other jurisdictions. In addition, for some services, the HSC and the C&V sector are in direct competition with each other for resources which is putting an additional strain on services.

- Funding and Procurement: Processes are often arduous, and limit innovation and agile delivery of services. It is acknowledged that relevant quality and risk assurance must be to the forefront, but processes could be improved. Funding needs to be long term to be able to build and deliver sustainable services. This will positively impact on retaining resources for longer term or permanent contracts. This will enable the C&V sector to take on additional roles to support delivery of Mental Health Services.

- Opportunities: C&V sector are rich in experience and play an important key role as part of the Mental Health Strategy; levering their ability to innovate quickly, test pilots prior to a regional roll out should be considered alongside HSC services. Aligned to current engagement between DoH and the C&V sector to work more closely together, there is an opportunity to have a more joined up approach to development of pilot programmes and delivery of programmes that will meet patient needs. Improving communication channels to respond to emerging needs earlier will allow Mental Health Services to be more agile in prioritising services.

5.6.1.4 Other Levers – Technology Enablement

Digitisation of health services are underway, underpinned by the Digital Strategy 2022-2030[48], which aims to bring digital to the fore of all service developments. A part of this and a wider government agenda, is to increase collaboration between departments. Mental Health Services have started on this journey working with the Department of Justice and Department of Communities to solve wider systemic issues that permeate the NI population. Current examples are Crisis Services working with local PSNI and NIAS colleagues. However, there is an opportunity over the coming years to plan innovative solutions to complex problems that will bring sustainable outcomes to patients.

The Digital Innovation Strategy 2022- 2026[49] is a potential lever to pilot and test new delivery models prior to scaling to test whether solutions will benefit Mental Health Services. It is

[48] Department of Health. (2022). *Northern Ireland Health and Social Care Workforce Census March 2022* (Online). Available from: Northern Ireland Health and Social Care Workforce Census March 2022 (health-ni.gov.uk) [Accessed 02 May 2022]
[49] Department of Health. (2022). *Digital Innovation Strategy: HSC Northern Ireland 2022 - 2026* (Online). Available from: PowerPoint Presentation (health-ni.gov.uk) [Accessed on 02 May 2022]

recommended that focus on innovation is encompassed in future service development to support the delivery of care outcomes and to do more with less resources.

In addition, the Data Strategy Vision is ''to make HSC a data and insight driven organisation that improves people's lives with data''. The ability to use data effectively will enable insights to be gathered to inform service development and focus funding to the right areas. The availability of standardised information is challenging to collate and interpret. At present, focus is on waiting lists, activity, and performance metrics. A move to collating and analysing outcomes will benefit the patient and better inform decisions for services. The development of the Outcomes Framework as outlined in the Mental Health Strategy will be instrumental in providing insights on the outcomes of specific services, helping to identify best practice and standardise services across the region. Mental Health Services should, as part of one service approach, apply the same methodology to the collection and monitoring of data across the region.

Whilst face to face intervention cannot be replaced, technology enablement can provide an opportunity in other areas also:

- Reduce administration tasks, such as scheduling, repetitive work tasks, and report writing, with packages that can automate activities. In terms of scheduling this can reduce admin time whilst providing patients with additional choice of appointment times to ease the need for manual interfaces at all points of the patient journey.
- Provide easy access to patient records and test results. The Encompass programme will transform the availability of patient information and provide a level of analytics that will support service level decision making. This will support services to make informed decisions.
- Use of programmes will augment current service delivery and provide adequate intervention to low intensity need; freeing up resources to deliver care.

As part of the development of the Regional Electronic Health Record (EHR), being delivered through the Encompass programme, this system will help to standardise processes and workflows that will enable Mental Health Services to have a better understanding of their service from a single source. This EHR will be instrumental in supporting the evaluation of patient outcomes and delivering effective services and will be rolling out to Trusts on a phased basis from next year. Other programmes such as the Equip programme and other local projects will help to effective use resources to have the best impact for the population of Northern Ireland.

Over the life of the Mental Health Strategy, digitisation and technology will have a significant role to play. As part of service developments, digital needs to be considered as part of how services could be delivered differently with the same or better outcomes.

6. Recommendations and Action Plan

6.1. Key Recommendations

The following are the key recommendations to support the delivery of this ambitious Mental Health Workforce Review.

Workforce Capacity & Profile:

Funding and Resourcing this Workforce Review: The future workforce profile outlined in section 5 demonstrates a significant increase in resources compared to current capacity. As such, the funding required to meet the additional resources identified will also be significant. It will therefore be necessary to plan the prioritisation of service developments and resource profiles needed based on availability of funding.

Recommendation 1: The cost of this future workforce profile should be evaluated to inform the requests for additional funding and to plan the phased delivery of this workforce review.

Recruitment: With known challenges of recruiting and attracting candidates, prioritisation of service developments should be planned in a co-ordinated manner based on critical service delivery requirements to focus resources accordingly. As noted above, prioritisation of service developments will also be influenced by funding availability. With workforce growth across several services identified, key appointments should be put in place in the first instance to establish services for success and attract candidates to the services.

Recommendation 2: A task and finish group should be established to complete a prioritisation of service developments, and to plan the recruitment of key appointments and other team members. This should include agreement on the number of pre-registration training places and number of posts per discipline to be recruited through normal recruitment processes. Recruitment should start with appointing key personnel who will lead on the development of the service.

Maximise the contribution of the Community and Voluntary Sector in the delivery of Mental Health Services: The breadth of capability, capacity and knowledge within the C&V sector is integral to the delivery of Mental Health Services. Whilst this review was restricted to the statutory sector, in order to meet the needs of the population as envisaged in the Mental Health Strategy, the role of the C&V sector needs to be fully and comprehensively considered. This has the potential to enable innovation within Mental Health Services, test services and further promote maintenance and management in the community.

Recommendation 3: Assess the capacity and capability available within the Community and Voluntary Sector to inform optimisation of existing structures and ways of working to co-deliver the full range of Mental Health services required.

Workforce Capability:

Developing workforce capability and expanding the workforce will be a key focus over the next 10 years to meet the demands within Mental Health Services.

Re-defining and standardising roles: As mentioned earlier within the review, there is variability across the Trusts in the delivery of services and in the roles of team members. Creating standardised job profiles, including banding, that are common across all Trusts will support the delivery of a Regional Mental Health Service and facilitate recruitment processes.

Recommendation 4: A job profile standardisation exercise should be completed to clearly define and standardise each job profile per profession within specialist teams.

Measuring the Benefit of New and Emerging Roles: With the expansion of roles within Mental Health Services in NI, such as Pharmacy, Child and Adolescent Psychotherapy, AHP roles including Creative Therapies, and Assistant Practitioner roles, there is an opportunity to measure the impact of these professional roles through monitoring quality outcomes for patients. In addition to existing evidence base, this will help to clearly articulate the benefit of these blended teams and advocate for additional funding. Going forward, it will also ensure that priority is given to the right services/resource which have the maximum impact on patient outcomes based on a clear evidence base.

Recommendation 5: A task and finish group should agree a structured approach to evaluating the benefit of new and emerging roles prior to full roll out of the full workforce profile outlined in this review.

Advanced Training Review: This review has outlined the workforce required by discipline, as the availability of information in relation to advanced training skills is disparate and not readily available. An evaluation across all Mental Health Services is recommended to understand the status of resources with advanced training, such as psychological interventions. It has been anecdotally noted that there are skilled resources that are unable to use their advanced training due to reasons such as demand for their current role, or unprotected time by the service to deliver specific therapeutic intervention. It is important to understand both the availability of these skilled resources and how best to utilise this workforce whilst maintaining core services. A review is currently underway within NHSCT to understand available advanced training skills and which skills are needed to best align with service demands. This should be coordinated by the Workforce Policy Directorate (WPD) and completed by all Trusts to identify where additional training places are needed to meet service demand and re-allocate resources where surplus advance trained resources are required.

Recommendation 6: Complete analysis of all resources with advanced training qualifications across all Mental Health Services within each Trust to understand the status of those trained and practicing to the top of their license.

Psychological Therapies Framework: Within NHS Health Education England, Psychological Therapies have experienced significant advancements in recent years, with the expansion of different therapeutic modalities with significant growth planned for the coming years. NI has also expanded the therapeutic modalities available but would benefit from a structured framework to underpin further development. It is recommended that a Psychological Therapies Framework is agreed that will encompass all Psychological Professions and Professionals delivering psychological therapies. This should include a taxonomy of all Psychological Professions, confirmation of registration bodies for Northern Ireland, defined career pathways and access routes to training programmes. This framework should support

the development, evaluation, and expansion of the range of professions that can deliver therapeutic intervention as part of Mental Health Services in Northern Ireland. This aligns to Action 19 of the Mental Health Strategy to 'Embed psychological services into mainstream mental health services and ensure psychological therapies are available across all steps of care'.

Recommendation 7: A Psychological Therapies Framework should be developed for NI which should include a taxonomy of all psychological professions, defined career pathways and access routes to training programmes for existing and emerging psychological professions.

Pathways into the workforce

Developing clear pathways into Mental Health Services, spanning pre-registration through to recruitment of experienced staff, is a fundamental need if workforce numbers are to be increased in the coming years.

Undergraduate Training: For professions that do not have dedicated Mental Health modules as part of their curriculum, consideration should be given to the inclusion of a mandatory module or lectures for Mental Health Services, with the potential to include a Mental Health placement where appropriate and applicable. This will increase awareness of Mental Health Services as a career of choice.

Recommendation 8: For undergraduate programmes of professions that are expanding significantly in this workforce review e.g., SLT and Dietetics, liaison with the University Institutions is required to agree ways to improve awareness of mental health services e.g., through dedicated lectures and/or modules

Supported training roles: Across all disciplines, there is an opportunity to provide a pathway for Assistant/Support resources to access additional training to further their career into a professional discipline. This could be through apprenticeships and supported re-training. It is recommended that a task group is convened to review a single pathway for supported training programmes across key disciplines to understand the implications, funding and planning required to put these training structures in place.

Recommendation 9: A task and finish group should evaluate and develop an implementation plan for a single pathway for supported training programmes across key disciplines.

Diversifying the workforce: There is an opportunity to diversify roles with the right level of clinical governance and supervision that can help to meet the workforce numbers in this review. It is recommended that a task and finish group should explore what has worked well for other professions e.g., Practitioner Assistant, Psychological Wellbeing Practitioner, Physician Associate. This should aim to identify the skills required, not aligned to specific profession, in order to develop a wider pool of resources to meet the demands seen in Mental Health Services. Input from the Universities, Training Colleges, SPPG, HSC Trusts and DoH would be required in order to evaluate safe and effective models prior to an extensive roll out.

Recommendation 10: A task and finish group should explore the development of new Professions that can be 'profession agnostic' which will allow access to a wider pool of resources e.g. psychology graduates training to be Psychological Wellbeing Practitioners.

Workforce Recruitment and Retention

Education and Training: A key driver of staff satisfaction is the opportunities available to further their career. There is an opportunity to develop more transparent processes for all Mental Health Services staff to be able to access specialised training to align service needs and personal professional aspirations. It is recommended that a single consolidated pathway is developed of all training programmes, current and future training programmes, across all commissioning bodies. This should include a review of funding allocations to move towards training requirements per service needs rather than allocation through disciplines.

Recommendation 11: Define training needs and develop a single process to apply for all advanced training programmes across all commissioning bodies based on service need.

Specified Training Places for Critical Skills: Several Trusts have specific challenges attracting different disciplines due to their geographical location. It is recommended, in consultation with the Universities and Professional Bodies, that several training places be ringfenced for specific critical skill gaps in specific geographical areas. This would require specific requirements to be stipulated to maximise retention into the specific services post qualification. This could provide a sustainable workforce into specific geographical areas that have failed to recruit through normal recruitment channels. This could support recommendation 8 to develop a pipeline of supported training roles within Trusts.

Recommendation 12: Evaluate, with HR Trust Directors, Universities and Professional Bodies, the ability to ringfence training places under specific conditions to address critical skill shortages.

Incentive Packages: As part of the Agenda for Change and other HR initiatives, there are many benefits available to all staff in the HSC. It is recommended that all incentive initiatives are collated, and a targeted communication plan is put in place to increase awareness of these benefits for internal staff and to attract prospective candidates. e.g., flexible working, career pathways, availability of premium payments and staff wellbeing initiatives etc. In areas where there are specific deficits in resources, packages must be tailored to attract more candidates.

Recommendation 13: Create and implement a communication plan to increase staff and external candidates' awareness of the benefits and incentives of working in the HSC.

Recruitment Campaigns: Regional recruitment campaigns are underway in several professions which are effective. Alongside these, targeted localised campaigns are recommended to attract candidates to critical areas.

Recommendation 14: Agree targeted localised recruitment campaigns per Trust that can leverage regional campaigns.

Scope of Mental Health Workforce Review

Evaluation of Mental Capacity Act (2016) on Mental Health Workforce Demand**:** With the full implementation of the Mental Capacity Act legislation underway, a review of activity pertaining to the MCA legislation is required to adequately plan the resource demand for Mental Health Services. It is recommended that this review is completed to understand the full remit and activity across all Programmes of Care which upon evaluation, Mental Health Services demand should be extrapolated to inform the inclusion within this workforce review. In addition, it is recommended that a data reporting structure is maintained to evaluate workforce demand on an ongoing basis as the new legislation embeds into services.

Recommendation 15: Complete a review of all activity required to meet MCA legislation requirements across all Programmes of Care, to identify specific Mental Health resources required to meet future demand.

Incorporation of Mental Health demand from Learning Disability, Dementia, Attention Deficit Hyperactivity Disorder (ADHD) and Autism Reviews**:** For these specific cohorts that have been excluded from this review, it is imperative that coordination and collaboration are maintained and strengthened with the respective reviews, to ensure that all Mental Health aspects of services are adequately evaluated within these reviews.

Recommendation 16: To ensure a joined-up approach to all relevant reviews outside the scope of the Mental Health workforce review, identify Mental Health representation to evaluate the mental health demand and associated resources required to meet the needs of these cohorts of patients.

Other:

Standard Service Terminology and Scope: The current landscape of Mental Health Services is varied across the Trusts and at times there is variability in delivery of services within Trusts. For this workforce review, a standardised approach has been applied to build the workforce profile per service per Trust. Aligned to the complementary work underway within the Encompass Programme, further work is required going forward to review current services, agree common care pathways to agree a standardised delivery model and naming convention across the region. This will make it easier for patients to understand and access services and will be a key characteristic of the Regional Mental Health Service.

Recommendation 17: Aligned to the vision for a Regional Mental Health Service, review and align scope of all current services and naming conventions to have single definitions per service across Mental Health Services.

Data Quality, Collection and Analytics: Development of services should be supported by quantitative data inputs that can demonstrate the impact of services. These should include healthcare outcomes as well as activity-based insights to inform decisions. It is acknowledged that development and standardisation of datasets is ongoing, however, basic information about the structure of services, and the composition of teams is not easily accessible, which impacts the ability to compare and evaluate services regionally. It is recommended that a regional standardisation of datasets, including clinical and operational outcome measures and key performance indicators, should be agreed across all services. This should align to Action 34 in the Mental Health Strategy to develop an Outcomes Framework to underpin and drive service delivery.

Recommendation 18: Aligned to the Encompass Programme and other work underway, a regional standardisation of datasets including clinical, activity and operational outcome measures and key performance indicators should be agreed across all services to monitor benefit and to underpin future service improvements plans. This should align to Action 34 in the Mental Health Strategy to develop an Outcomes Framework to underpin and drive service delivery.

6.2. Key Actions

Once recommendations are accepted, the proposed actions outlined below should be progressed to ensure delivery of recommendations. The commencement timeline is indicative only and will be subject to funding and resource allocations. Further detailed planning will be required for several recommendations that should feed into the development of a Mental Health Workforce Implementation Plan.

Theme	Recommendation	No.	Action	Start Date & Owner
Workforce Capacity & Profile				
Funding and Resourcing this Workforce Review	The cost of this future workforce profile should be evaluated to inform the requests for additional funding to plan the phased delivery of this workforce review.	1A	Complete analysis of recurrent funding required to meet the future workforce profile.	Q2 2023
		1B	Confirm funding availability for the workforce outlined in this report.	DoH
	A task and finish group should be established to complete a prioritisation of service developments, and to plan the recruitment of key appointments and other team members. This should include agreement on the number pre-registration training places and number of posts to be recruited through normal recruitment processes. Recruitment should start with appointing key personnel who will lead on the development of the service and support successful team onboarding.	2A	Prioritise planned service developments based on funding availability.	Q2 2023
		2B	Agree key appointments for prioritised services and commence recruitment process.	DoH Task & Finish Group
		2C	Agree recruitment plan per discipline specific to mental health services with each discipline group.	
		2D	Consult on the development of additional training places for specific disciplines, where required.	

Maximise the contribution of the Community and Voluntary Sector in the delivery of Mental Health Services	Assess the capacity and capability available within the Community and Voluntary Sector to inform optimisation of existing structures and ways of working to co-deliver the full range of Mental Health services required.	3A	Undertake assessment of current capacity and capability across the C&V sector.	Q2 2023
		3B	Consult with C&V sector to understand key challenges and opportunities to enable additional collaboration with DoH.	Q2 2023
		3C	Develop prioritisation of services that could provide additional workforce to meet some of the demand outlined in this review.	Q3 2023
Workforce Capability				
Re-defining and standardising roles	A job profile standardisation exercise should be completed to clearly define and standardise each job profile per profession within specialist teams.	4	Complete job profile standardisation exercise per profession E.g., OT in Mental Health Services. Agree standardised specific requirements per specialist team.	Q3 2023
Measuring the Benefit of New and Emerging Roles	A task and finish group should agree a structured approach to evaluating the benefit of new and emerging roles prior to full roll out of the full workforce profile outlined in this review.	5A	Develop a structured approach with a common benefits framework to evaluate new and emerging roles throughout services.	Q3 2023 DoH Task & Finish Group
		5B	In collaboration with Universities and other Innovation partners, develop a research and innovation framework to evaluate new and/or emerging Professions in services to measure quality outcomes to inform future workforce decisions.	Q4 2023
Advanced Training Review	Complete analysis of all resources with advanced training qualifications across all Mental Health Services within each Trust to understand the status of those trained and practicing to the top of their license.	6A	Complete evaluation of resources with advanced training skills and evaluation of utilisation of advanced training across Trusts.	Q3 2023 HSC Trusts
		6B	Agree process to re-align resources to where specific advanced skillsets are required within Trusts .	Q4 2023 DoH

Psychological Therapies Framework	A Psychological Therapies Framework should be developed for NI which should include a taxonomy of all Psychological Professions, defined career pathways and access routes to training programmes for existing and emerging psychological professions.	7	Development of Psychological Therapies Framework to outline the taxonomy of the professions, registration of professions, access to training programmes and career pathway structures for all Psychological Professions.	Q3 2023 DoH
Pathways into the Workforce				
Undergraduate Training	For undergraduate programmes of professions that are expanding significantly in this workforce review e.g., SLT and Dietetics, liaison with the University Institutions is required to agree ways to improve awareness of mental health services e.g., through dedicated lectures, modules and/or placements	8A	Discuss with university and training bodies the inclusion of a Mental Health lectures/modules in all undergraduate healthcare professional's curriculum.	Q2 2023 DoH
		8B	Test the feasibility of providing additional placements/internships to undergraduate students across Mental Health Services (short- and longer-term options) across disciplines.	Q3 2023
		8C	To consult with the Training Bodies to discuss the potential to ringfence training places for critical workforce deficits and agree parameters and processes required to implement.	Q3 2023
Supported training roles	A task and finish group should evaluate and develop an implementation plan for a single pathway for supported training programmes across key disciplines.	9	A task group should be set up to plan how supported training programmes could be delivered and rolled out across all disciplines in a consistent manner.	Q2 2023 DoH

Diversifying the workforce	A task and finish group should explore the development of new Professions that can be Profession agnostic which will allow access to a wider pool of resources e.g. psychology graduates training to be Psychological Wellbeing Practitioners.	10	A single taskforce should explore the options available to develop new professions that can support service delivery that are not discipline specific.	Q2 2023 DoH
Workforce Recruitment and Retention				
Education and Training	Define training needs and develop a single process to apply for all advanced training programmes across all commissioning bodies based on service need.	11A	Complete a review of the number of staff with advanced training within Mental Health Services and the proportion that are actively using these skills	Q3 2023 DoH
		11B	Complete consultation process to plan how to configure resources to maximise skillsets and operate at the top of their license.	Q4 2023 DoH
		11C	Evaluate the development of a single pathway to access training opportunities for all disciplines should be explored. This should include a review of commissioning streams and funding allocations.	Q4 2023 DoH
Specified Training Places for Critical Skills	Evaluate, with HR Trust Directors, Universities and Professional Bodies, the ability to ringfence training places under specific conditions to address critical skill shortages.	12	Evaluate ringfencing several training places for critical skills. Agree conditions and parameters to maximise return on investment in critical areas.	Q3 2023 HRD Group
Incentive Packages	Create and implement a communication plan to increase staff and external candidates' awareness of the benefits and incentives of working in the HSC.	13	Develop a communication plan targeted for internal Mental Health employees and externally for prospective candidates.	Q2 2023 HRD Group
Targeted Recruitment Campaigns	Agree targeted localised recruitment campaigns per Trust; that can leverage regional campaigns.	14	Collate critical roles across Trusts and plan targeted campaigns for most critical skill gaps.	Q2 2023 HRD Group

Scope of Mental Health Review				
Evaluation of Mental Capacity Act on Mental Health Workforce Demand	Complete a review of all activity required to meet MCA legislation requirements across all Programmes of Care, to identify specific Mental Health resources required to meet demand.	15A	To complete a review of all MCA activity broken down by all Programmes of Care. Define associated workforce demand for Mental Health Services.	Q2 2023 DoH
		15B	Develop reporting structure to track activity levels across Mental Health Services over time.	Q3 2023
Incorporation of Mental Health demand from other reviews	Ensure joined up approach to all relevant Reviews, to have Mental Health representation to evaluate the mental health demand and associated resources required to meet the needs of these cohorts of patients.	16A	Agree approach to collaborate with the Learning Disability Review to input on behalf of MH services.	Q2 2023 DoH
		16B	Agree approach to collaborate with the Dementia Review to input on behalf of MH services.	
		16C	Agree approach to collaborate with the ADHD and Autism Reviews to input on behalf of MH services.	
		16D	Confirm mechanism to allocate funding for MH resources identified from the reviews above.	Q2 2023 DoH

Other				
Standard Service Terminology and Scope	Aligned to the vision for a Regional Mental Health Service, review and align scope of all current services and naming conventions to have single definitions per service across Mental Health Services.	17	Evaluate where common terminology can be used for services and agree a plan to review common care pathways to develop a standardised delivery model and naming convention across the Region.	Q3 2023 DoH
Data Quality, Collection and Analytics	Aligned to the Encompass Programme and other work underway, regional standardisation of datasets including clinical, activity and operational outcome measures and key performance indicators should be agreed across all services to monitor benefit and to underpin future service improvements plans. This should align to Action 34 in the Mental Health Strategy to develop an Outcomes Framework to underpin and drive service delivery.	18A	Liaise with the Encompass Programme to understand progress to date and agree how best to align and build on the work completed to date.	Q2 2023 DoH
		18B	Aligned to the development of an Outcomes Framework, complete a review of current datasets and future regional data requirements. A phased implementation plan should be agreed subsequently to develop standard datasets and collection methods.	Q3 2023 DoH Q1 2024
		18C	Input to the Outcomes Framework workstream should be prioritised for the inclusion of fit for purpose metrics to support future service development planning.	Immediate DoH

7. Conclusion

Following the publication of the Mental Health Strategy 2021-2031, a key enabler of the strategy is the development of a workforce plan that is fit for purpose, recognising increasing demand within Mental Health Services, more complexity in presentation, and recruitment and retention challenges.

This workforce review has established current demand drivers and planned a future focused workforce profile based on best available evidence and knowledge throughout the system. It has focused on blended multidisciplinary team configurations that will meet the complexity of presentations seen within services. This is a living document, which is providing a clear direction for the next 10 years, however, it should flex to the needs of services where appropriate if trends change over time.

This workforce review has expanded the range of multidisciplinary roles in Mental Health Services. For some professions this is providing an opportunity to align to best practice in other jurisdictions and for other emerging roles such as Creative Therapies, it provides an opportunity to pilot and embed into services. These include an expansion of AHP roles, Pharmacy, Child and Adolescent Psychotherapy, Assistant Practitioner roles. There is an expectation and opportunity for new roles to emerge in the coming years, to fulfil roles that the HSC are unable to recruit to and provide additional options to deliver services.

Whilst attracting and retaining the workforce is an ongoing challenge within Mental Health Services and the broader HSC, some practical recommendations have been provided to support development of clear career pathways for professions, improve undergraduate access to Mental Health training and providing supportive career pathways for support workers to further develop their skills. It is accepted that the recruitment of this workforce will take time, however, making Mental Health Services more attractive will help to smooth the path.

The pace at which this review can be delivered will largely be determined by the extent to which additional funding is made available. That being said, the ambition of the Mental Health Strategy, and the delivery of the recommendations set out in this workforce review, have the potential to transform Mental Health Services to improve outcomes for all people within Northern Ireland, by ensuring an effective future workforce model which can provide better access to care within the context of a single Regional Mental Health Service.

8. APPENDIX

8.1. Appendix i: Stakeholder List

The Steering Group was established to oversee the work of this review. This included to review and to support strategic workforce planning within the HSC and across all sectors that have responsibility for the provision of care/support for Mental Health services.

The Steering Group was co-chaired by Department of Health Workforce Policy Director, Philip Rodgers and Department of Health Mental Health Director, Peter Toogood.

The following are the Steering Group Representatives:

NI Mental Health Workforce Review Steering Group	
Philip Rodgers	DoH WPD Director – Co-Chair
Peter Toogood	DoH MH Director – Co-Chair
Gary Comiskey	External Review Team representation
Michelle Mulcahy	External Review Team representation
Tim Sheedy	External Review Team representation
Shruti Narasimham	External Review Team representation
Fiona McCausland	DoH Head of AMHU
Gavin Quinn	DoH Head of CAMHU
Siobhan Rogan	DoH Professional Officers – Nursing & PHA Mental Health Representative
Ian McMaster	DoH Professional Officers - Psychiatrist
Darren Strawbridge	DoH Professional Officers – Social Work
Cathy Harrison	DoH Professional Officer - Pharmacy
Alison Dunwoody	Representative from Information and Analysis Directorate, DoH
Moira Kearney	Belfast Trust Interim Director of Mental Health
Petra Corr	Northern Trust Director of Mental Health
Jan McGall	Southern Trust Director of Mental Health
Margaret O'Kane	South-Eastern Trust Director of Mental Health
Karen O'Brien	Western Trust Director of Mental Health
Lorna Conn	DoH SPPG Mental Health representative
Jacqui Reid	Trust HR representative
Kevin McAdam	Trade Union Representative - Unite
Terry Thomas	Trade Union Representative - NIPSA
Michael Doherty	Royal College of Psychiatrists Policy Lead
Loretta Gribben	Royal College of Nursing Mental Health Representatives
Ruth Sedgewick	Royal College of Speech & Language Therapists Mental Health Representative
Kate Lesslar	Royal College of Occupational Therapists Mental Health Representative
Laurence Dorman	Royal College of General Practitioners Mental Health Representative
Rodney Morton	PHA and Representative from Allied Health Professions
Mary Emerson	Representative from Allied Health Professions
Nichola Rooney	Representative from BPS
Caroline Ewart	Representative from BASW NI

Deirdre Meehan	Representative for Association of Child Psychotherapists
Carole McKenna	Representative from NIPEC
Gillian McAuley	Representative from NISCC
Nichola Topping	Education Representative
Gavin Davidson	Representative Queen's University
Dominic McSherry	Ulster University Representative
Aidan Daly	Representative from Community & Voluntary/ Independent sector
Jayne Wright	Representative from Community & Voluntary/ Independent sector
Alex Bunting	Representative from Community & Voluntary/ Independent sector
Ruth Barry	Representative from Patient and Client Council

Throughout the course of the review, the following Professional Organisations were consulting with as part of the development of the review:

Professional Organisations/Groups
Department of Health Strategic Planning and Performance Group representatives
Health and Social Care Trust representative
Public Health Authority
Patient Client Council (also the conduit for service user involvement)
Royal College of Psychiatrists
British Psychological Society
The Royal College of Nursing
Royal College of Speech and Language Therapists
Royal College of Occupational Therapists
Royal College of General Practitioners
British Association of Social Workers NI
Association of Clinical Psychologists
Northern Ireland Social Care Council
Northern Ireland Practice and Education Council for Nursing and Midwifery
The Pharmaceutical Society of Northern Ireland
Trade Unions
GP Federations
Representatives from Universities
Independent Sector
Regional Workforce Wellbeing Network
Association of Child Psychotherapists
Regional Mental Health Pharmacist Group
Northern Ireland Public Service Alliance

Throughout the engagement the following professions were consulted with through workshops, interviews, and group sessions to input to the review.

Representation from Trust Professions/Disciplines
Psychiatrists
Mental Health Nurses
Social Care Workers
Social Workers including Approved Social Workers
Assistant, Associate and Clinical and other Practitioner Psychologists
Counsellors
Child and Adolescent and Adult Psychotherapists
Occupational Therapists
Dieticians
Orthoptists
Physiotherapy
Speech and language Therapists
Pharmacists
Support Workers
GPs
Physician Associates
Peer Support Workers
Independent Advocates
Other therapists e.g., Art/ Music Therapists
Supporting Administrative/Clerical staff

8.2. Appendix ii: Listing of current services and naming conventions

The following is the alignment of current naming conventions per Trust with the naming conventions used in this review.

<table>
<tr><th></th><th>BHSCT</th><th>NHSCT</th><th>SHSCT</th><th>WHSCT</th><th>SEHSCT</th></tr>
<tr><td rowspan="2">Community Assessment</td><td>Single Point of Referral Management &Triage Service</td><td rowspan="2">Community Mental Health Teams</td><td rowspan="2">Single point of referral management and triage</td><td rowspan="2">Primary Care Liaison Service</td><td rowspan="2">Mental Health Assessment Centre, North Down/ Ards, Lisburn, Downpatrick</td></tr>
<tr><td>Two Assessment Centres</td></tr>
</table>

<table>
<tr><th></th><th>BHSCT</th><th>NHSCT</th><th>SHSCT</th><th>WHSCT</th><th>SEHSCT</th></tr>
<tr><td rowspan="5">Community Intervention</td><td>Two primary Mental Health Teams</td><td rowspan="5">Community Mental Health Teams</td><td>Primary Mental Health Care Team</td><td>Primary Care Liaison Service</td><td rowspan="2">Community Mental Health Teams</td></tr>
<tr><td>Recovery CMHT</td><td rowspan="3">Support and Recovery Community Mental Health Team</td><td rowspan="4">Multi-Disciplinary Community Recovery Teams</td></tr>
<tr><td>Care Management Team</td><td>Adult Mental health Personalised Care Management Team</td></tr>
<tr><td>Clozapine and Lithium team</td><td rowspan="2">Physical Health Monitoring</td></tr>
<tr><td>High dose antipsychotic Physical Health Monitoring</td><td>Antipsychotic Physical Healthcare monitoring</td></tr>
</table>

	BHSCT	NHSCT	SHSCT	WHSCT	SEHSCT
Community Addictions	Community Addictions Team Substitute Prescribing Team Drug Outreach Team	Community Addictions Team	Community Addictions Service	Community Addiction Teams	Community Addictions Team

	BHSCT	NHSCT	SHSCT	WHSCT	SEHSCT
Adult Eating Disorders Service	Adult Eating Disorder Service	Adult Eating Disorder Service	Adult Eating Disorder Service	Adult Eating Disorder Service	Adult Eating Disorder Service

	BHSCT	NHSCT	SHSCT	WHSCT	SEHSCT
Early Intervention Team/first Episode Psychosis	Early Intervention MH Service	STEPS Team (Psychosis prevention)	No current equivalent Service	No current equivalent Service	No current equivalent Service

	BHSCT	NHSCT	SHSCT	WHSCT	SEHSCT
Personality disorder service	Self-harm and Personality disorder service	Personality Disorder Service	Personality Disorder Service	Personality Disorder Service	Dialectical Behavioural Therapy

	BHSCT	NHSCT	SHSCT	WHSCT	SEHSCT
Community Forensic Service	Community Forensic Mental Health Service (delivered with SEHSCT)	Community Forensic Mental Health team	Community Forensic Mental Health team	Forensic Mental Health Team	Community Forensic Mental Health Service (delivered with BHSCT)

	BHSCT	NHSCT	SHSCT	WHSCT	SEHSCT
Condition Management Service (CMP)	Conditions Management Team	Conditions Management Team	Condition Management Service (CMP)	Conditions Management Programme	Conditions Management Programme

	BHSCT	NHSCT	SHSCT	WHSCT	SEHSCT
Psychological Therapies Service	Cognitive Behavioural Therapy Team The Centre for Psychotherapy	Psychological Therapies Service	Cognitive Behavioural Therapy Service Psychological Therapies	Adult Psychological Therapy Service	Clinical Psychology and Psychological Therapies Service

	BHSCT	NHSCT	SHSCT	WHSCT	SEHSCT
Mental Health Liaison Service	Mental Health Liaison Service	Mental Health Liaison Service	Integrated Liaison Service	Mental Health Liaison Service Substance Misuse Liaison	Mental Health Assessment Centre & Mental Health at Night Service Liaison/SMLT

8.3. Appendix iii: Data Modelling Approach

8.3.1 Outpatients / Community Services Modelling

8.3.1.1 Methodology Summary

Both CAMHS and AMH data modelling was undertaken at the Trust and Service level based on available outpatient activity level datasets. These datasets were at the appointment level and consisted of the past five-year history from 2018 up until March 2022.

As described previously, the outpatient modelling consisted of analysing the data, extracting key trends from the data, forming assumptions based on past trends (specific to each Trust and Service) and using these assumptions as inputs to the model for the model to predict new demand. The new demand was then overlaid with current capacity estimates to evaluate the gap that exists and will continue to exist if the capacity is not changed. This was the foundation of scenario 0 or the "do-nothing" scenario. Scenario 1 then consisted of keeping the previous assumptions but changing (increasing in this case) capacity such that waitlists reduce. It was considered practical but also imperative that the first influx of capacity is by June 2023 and the second by June 2024, so that waitlists reduce to manageable numbers in the next 3-4 years for services such as Step 2 and Step 3 services and to 0 for Eating Disorder and Addiction Services by or before June 2025.

8.3.1.2 Assumptions

During the modelling phase, to calculate future demand of appointments and capacity in terms of contacts per month possible, several modelled parameters (secondary parameters) formed part of the analysis as described below:

Table 58: Assumptions

Modelled Parameters (Future)	Inputs
New appointments demand / month	Average new patients / month, population growth, waitlist change / month
Repeat appointments demand / month	Predicted new patients seen / month, ratio of new vs. repeat appointments
Predicted new patients seen / month	Predicted patients seen / month, repeat appointments / month, repeat appointment backlog or waitlist / month
Predicted total demand / month	New appointments demand / month, total backlog, or waitlist / month, repeat appointment demand / month
Predicted appointments / month (contacts seen)	Capacity / month, predicted total demand / month
Repeat appointments backlog / month (Model output)	Waitlist in March-2022 (to load the model initially), Repeat appointments demand / month, Predicted appointments / month

A primary set of parameters (from past data) informed the secondary parameters (modelled / future patterns). Both the primary and secondary parameters were crucial to predicting future demand and current capacity. To attribute values to each of these parameters, past trends in data were analysed and led to the formation of assumptions for the primary parameters listed below:

1. Average new patients seen / month
2. Ratio for new vs. repeat appointments

3. Waitlist in March 2022 (not assumed but taken from most recent data available)
4. Capacity / month (new and review contacts seen / month)
5. Waiting list change / month

The main assumptions were 1) the way in which each of the values for these parameters were calculated (as shown in the below table) and 2) the period of the average considered from past data.

Table 59: Derived Parameters

Derived Parameters (Past Data)	Inputs	Calculation Used
Ratio for new vs. repeat appointments	Past new appointments / month Past repeat appointments / month	Each month's ratio = That month's repeat appointments / Sum of past 12 months' new appointments followed by an average
Average new patients seen / month	Past new appointments / month	Average
Capacity / month (new and review contacts seen / month)	New appointments / month Repeat appointments / month	Sum of new and repeat appointments / month followed by an average
Waiting list change / month	March 2018 to March 2022 waitlist yearly snapshots	Average of annual change in waitlist for pre-COVID-19 years and 2021-22 (due to a general increase in waitlists between 2021-22 observed across services, exception: 2021 to 2022 waitlist reduction in some services/Trusts).

Since an analysis of past data shed light on the differences in activity not only in each Trust but also in each Service, the decision was taken to fine tune the assumptions (i.e., the period considered for the average) per Trust and per Service. This led to different averages being considered for each Trust and Service for each of the above primary parameter values (please refer to the example given below). The period of the average considered was the only difference across each Trust and Service, all other calculations were kept the same. Once parameters were populated with values based on these assumptions and averages, they were sent to each Trust and Service for validation.

Table 60: CAMHS

Parameter	BHSCT Step 2	BHSCT Step 3	BHSCT Eating Disorder	BHSCT Crisis	BHSCT Addictions	BHSCT KOI
Ratio for Repeat Appointments	0.62	1.55	3.29	0.37	3.45	0.88
Average New Patients / month	35	51	6	92	2	2

Waitlist Mar-22	101	137	17	0	2	44
Capacity / month (Scenario 0)	281	1126	243	550	80	25
Waiting List / month Change	0.750	3.722	0.056	0.000	0.028	0.250

Parameter	BHSCT Regional Trauma	NHSCT Step 2	NHSCT Step 3	NHSCT Eating Disorder	NHSCT Crisis	NHSCT Addictions
Ratio for Repeat Appointments	0.78	0.49	1.00	1.73	0.13	0.38
Average New Patients / month	14	110	53	12	36	4
Waitlist Mar-22	43	466	200	7	0	0
Capacity / month (Scenario 0)	166	744	645	237	161	25
Waiting List / month Change	0.139	7.806	1.750	-0.028	0.000	-0.250

Table 61: AMH

Trust	BSHCT					
Service	Comm MH	Forensic	ED	Comm MH Older	Addiction	PD	PC MH
Ratio for Repeat Appointments	2.76	11.05	2.25	0.58	.89	5.11	0.28
Average New Patients / month	116	2	12	155	133	3	359
Waitlist Mar-22	355	1	12	37	148	0	766
Capacity / month (Scenario 0)	4006	253	313	1163	1487	204	1439
Waiting List / month Change	3.56	-0.19	0.19	2.75	-5.00	0.00	-5.53

Trust	NHSCT					
Service	Comm MH	Forensic	ED	Comm MH Older	Addiction	PD
Ratio for Repeat Appointments	1.54	3.86	2.02	0.81	0.70	3.00
Average New Patients / month	348	1	8	52	98	6
Waitlist Mar-22	384	0	9	50	385	0
Capacity / month (Scenario 0)	6454	50	184	518	901	193
Waiting List / month Change	-0.14	0.00	0.00	-0.11	5.22	-0.17

Trust	SHSCT						
Service	Comm MH	Forensic	ED	Comm MH Older	Addiction	PD	PC MH
Ratio for Repeat Appointments	3.52	4.06	3.11	2.07	0.88	0.86	0.60
Average New Patients / month	96	2	12	32	78	3	198
Waitlist Mar-22	29	0	24	1	331	0	1067
Capacity / month (Scenario 0)	3897	120	404	807	908	51	1508
Waiting List / month Change	-0.67	0.06	0.08	-0.19	7.56	-0.71	2.78

Trust	SEHSCT				
Service	Comm MH	Comm MH Older	Addiction	PD	PC MH
Ratio for Repeat Appointments	1.79	0.59	1.28	0.96	0.07
Average New Patients / month	181	188	74	20	476
Waitlist Mar-22	651	0	172	0	0
Capacity / month (Scenario 0)	3932	1492	1126	262	960
Waiting List / month Change	11.50	0.00	0.03	0.00	0.00

Trust	WHSCT						
Service	**Comm MH**	**Forensic**	**ED**	**Comm MH Older**	**Addiction**	**PD**	**PC MH**
Ratio for Repeat Appointments	3.13	1.27	0.34	0.58	1.12	0.99	0.22
Average New Patients / month	96	4	18	71	60	6	328
Waitlist Mar-22	0	3	25	47	240	0	399
Capacity / month (Scenario 0)	3514	85	85	592	815	150	1100
Waiting List / month Change	0.00	0.19	-0.14	0.64	0.78	0.00	2.42

Table 62: Example of different averages per Trust and Service considered and validated

Metric	Period considered for average for BHSCT Addictions	Period considered for average for WHSCT Addictions
Ratio for repeat appointments	Pre-COVID-19 and last 1 year data	Pre-COVID-19 and past 6 months' data Oct-21 to Mar-22
Average new patients / month	**2**, which is the average from Mar-18 to Feb-20 and Oct-21 to Mar-22.	**3**, last 1 year data Mar-21 to Mar-22
Capacity / month **(total contacts)**	Last 1-year average Mar 21 – Dec 21 **(80)**	Jan-21 to Dec-21 data **(33)**
Current Waiting list (Mar-22)	**2**	**2**
Waitlist change	0.33 = **~0 patient**, average of the change between (Mar 2018-19, Mar 2019-20, and Mar 2021-22)	0.33 = **~0 patients** average of the change between (Mar 2018-19, Mar 2019-20, and Mar 2021-22)

8.3.2 Scenario-based Analysis for Capacity

Once the above assumptions were tested and validated by each Trust for each Service, they were not altered for the next stage, i.e., the Scenario-based analysis. This stage involved changing capacity from the base/current level (Scenario 0 – "do nothing") to an increase in capacity (Scenario 1 – "increase capacity to stabilize/decrease waitlists). Since the output of the model was in the form of waitlists over the next 10 years, an influx in capacity / month was factored into the analysis to observe the behaviour of waitlists.

8.3.3 Population Change Assumptions

The following population change scenarios were applied to understand the impact over the next 10 years.

2022 - 2032 Adult Demographic Pressure (Age group: >=18-year-olds[50])

The projected increase of 5.4% of the adult population in the 5 Trusts in NI which shows a year on year growth .

Table 63: Adult Demographic Pressure

Date	BHSCT	NHSCT	SHSCT	SEHSCT	WHSCT	Total
Mar-22	283,494	374,594	296,560	287,529	231,929	1,474,106
Mar-23	284,102	376,093	299,211	289,354	232,324	1,481,084
Mar-24	284,864	377,614	301,979	291,151	232,881	1,488,489
Mar-25	285,668	379,229	304,885	293,221	233,482	1,496,485
Mar-26	286,771	381,104	308,011	295,367	234,237	1,505,490
Mar-27	287,962	382,894	311,094	297,323	234,977	1,514,250
Mar-28	289,026	384,453	314,176	299,112	235,648	1,522,415
Mar-29	290,176	386,024	317,178	300,914	236,341	1,530,633
Mar-30	291,385	387,492	320,228	302,721	237,037	1,538,863
Mar-31	292,354	388,761	323,174	304,274	237,463	1,546,026
Mar-32	293,308	389,819	325,988	305,654	237,814	1,552,583
CHANGE	**3.46%**	**4.06%**	**9.92%**	**6.30%**	**2.54%**	**5.32%**

Source: Sub-National Population Projections | NISRA

2022 - 2032 CAMHS Demographic Pressure[51] (6 – 17 year olds were included as may access services over the next 10 years. The 0 – 5 year olds were disproportionally impacting on demand and would be unlikely to be access services)

Table 64: CAMHS Demographic Pressure

Date	BHSCT	NHSCT	SHSCT	SEHSCT	WHSCT	Total
Mar-22	52,816	75,809	69,180	57,369	50,348	305,522
Mar-23	53,389	75,958	69,973	57,579	50,669	307,568
Mar-24	53,615	75,836	70,500	57,581	50,793	308,325
Mar-25	53,530	75,348	70,562	57,151	50,694	307,285
Mar-26	53,215	74,440	70,257	56,533	50,236	304,681
Mar-27	52,737	73,521	69,842	55,968	49,698	301,766
Mar-28	52,258	72,651	69,357	55,435	49,114	298,815
Mar-29	51,652	71,650	68,820	54,767	48,412	295,301
Mar-30	50,922	70,629	68,175	53,994	47,638	291,358
Mar-31	50,356	69,680	67,555	53,383	47,060	288,034
Mar-32	49,773	68,811	66,969	52,826	46,478	284,857
CHANGE	**-5.76%**	**-9.23%**	**-3.20%**	**-7.92%**	**-7.69%**	**-6.76%**

[50] Northern Ireland Statistics and Research Agency. (2020). *Sub-National Population Projections* [Online]. Available from: Sub-National Population Projections | Northern Ireland Statistics and Research Agency (nisra.gov.uk) [Accessed 07 June 2022]
[51] Northern Ireland Statistics and Research Agency. (2020). *Sub-National Population Projections* [Online]. Available from: Sub-National Population Projections | Northern Ireland Statistics and Research Agency (nisra.gov.uk) [Accessed 07 June2022]

8.3.4 Inpatient / Acute Services Modelling

A proportions-based model was used for both AMH and CAMHS inpatient modelling.

The sources of data for both models were:

- CAMHS: De-identified patient-level Beechcroft data from was used for the modelling.
- AMH: Monthly aggregated Trust and Site data was used for the modelling.

8.3.5 CAMHS

8.3.5.1 Inputs and Assumptions

During the modelling phase, to calculate future occupancy rates based on a constant capacity (29 beds in case of CAMHS), several modelled parameters (secondary parameters) formed part of the analysis as described below:

Table 65: CAMHS Inputs & Assumptions

Modelled Parameters	Inputs / Calculation
Length of Stay (LOS)^	Date of admission, date of discharge
Proportions*	The proportion of patients that belong to each LOS bucket
Arrival Schedule^^	The number of patients grouped by date of admission
Model of Care (MOC)**	The LOS for each LOS bucket is stored in the MOC table. Each LOS are set to be the median of their respective bucket.

^LOS: Each patient is then categorised into an LOS bracket based on their LOS.

- 0 to 7 days
- 8 to 21 days
- 22 to 28 days
- 29 to 48 days
- 49 to 90 days
- 91 to 365 days

*Proportions: T*he data related to COVID-19 periods was filtered out as it was deemed to not reflect the norm. This was done by filtering out patients with a DATE OF ADMISSION between 2019-04-30 and 2021-03-31. Any patient that could not be categorised into a LOS bucket (No discharge date) was also filtered out.*

LOS BUCKET	PROPORTION
0 to 7 days	0.2008197
22 to 28 days	0.0655738
29 to 48 days	0.1311475
49 to 90 days	0.1311475
8 to 21 days	0.2786885
91 to 365 days	0.1762295
>365 days	0.0163934

^^Arrival Schedule: The arrival schedule is based off the arrivals into Beechcroft. This excludes patients waiting in different Trusts/sites for space in Belfast. Patient-level admission

and discharge data was unavailable for CAMHS patients using paediatric/AMH beds at other sites, while waiting for a bed at Beechcroft.

**Model of Care (MOC): Each LOS are set to be the median of their respective bucket. This is rounded to the nearest whole number in the model. The LOS for the bucket “>365 days” is assumed to be 3 years. Note: the actual average LOS per bucket was tried, but this reduced the occupancy which was not reflective of actual demand.

LENGTH OF TIME	LOS
0 to 7 days	3.5
22 to 28 days	25
29 to 48 days	38.5
49 to 90 days	69.5
8 to 21 days	14.5
91 to 365 days	228
>365 days	1095

The scenarios are based off reducing the LOS by a percentage[52].

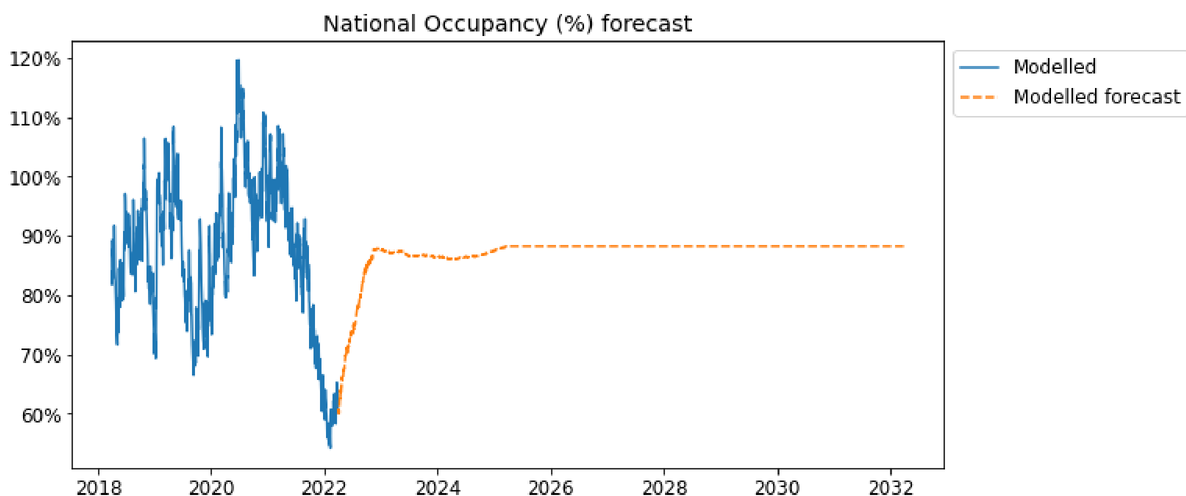
8.3.5.2 Model approach

First, a cartesian product between the arrival schedule and the proportions is taken. Then, the arrivals are multiplied by the proportions. This leaves the number of arrivals per day per LOS bucket. The MOC is then combined, joining on the Date and LOS columns. This provides the length of time that admission proportion will be staying. This allows us to get the discharge date for each admission proportion. This is used to then calculate the occupancy per day when patients both enter and leave the system.

8.3.5.3 Outputs

The plot below shows the modelled occupancy based on past data (2018 – 2022) and the forecasted occupancy (2022 – 2032). Please note that a constant bed capacity of 29 is assumed to calculate the % occupancy.

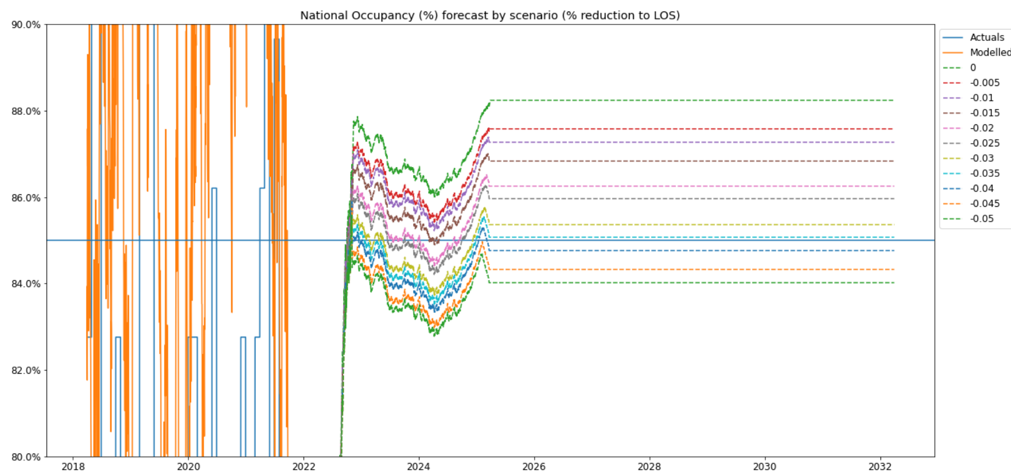
Figure 23: National Occupancy Forecast (%)



[52] *Note: that the LOS is rounded to the nearest whole number so reducing by a percentage may not reduce low numbers by much as they may then be rounded up.*

Once the base model was finalized and accurate, the model was then run again with different LOS values between 0% and 5% to consider different scenarios under which the occupancy rates could reduce. The plot below shows the modelled occupancy % on the y-axis and the years (2018 – 2032) on the x-axis.

Figure 24: Scenarios LOS



Reduction by 0%, 0.5%, 1%, 1.5%, 2%, 2.5%, 3%, 3.5%, 4%, 4.5%, 5%

Source: EY Inpatient Demand and Capacity Model

As can be seen from the graph a reduction of 4% – 4.5% will reduce the model's occupancy to below 85% with the current forecast, which should be attainable with robust community and crisis services in situ.

8.3.6 AMH

8.3.6.1 Inputs, Assumptions, Model Approach

A similar approach was followed for AMH acute services as for CAMHS described above. The only difference was the data available which was at a monthly aggregate level for AMH patients vs. patient-level for CAMHS patients. The "Forensic Psych LOS", "Mental Illness LOS" and "Old Age Psych LOS" data was used and consisted of:

- Average available beds by Trust/site
- Average occupied beds by Trust/site
- Proportions by Trust/site
- Average LOS
- Admissions (aggregated, no patient-level data available)
- Discharges (aggregated, no patient-level data available)

To get the proportions for this model i.e., the proportion of patients that belong to Trust/Site, the "Forensic Psych LOS", "Mental Illness LOS", "Old Age Psych LOS" data was used.

Table 66: AMH Modelled Parameters

Modelled Parameters	Inputs
Average Length of Stay (LOS)^	DoH data
Proportions	The proportion of patients that belong to each LOS bucket
Arrival Schedule	Total admissions per month
Model of Care (MOC)	The LOS for each LOS bucket is stored in the MOC table. Each LOS are set to be the median of their respective bucket.

^The average LOS was obtained from the DoH data. The "Average Length of Stay" was aggregated across all 3 tabs, with a weighted average being taken if a Trust/site appeared in more than one tab. This is rounded to the nearest whole number in the model.

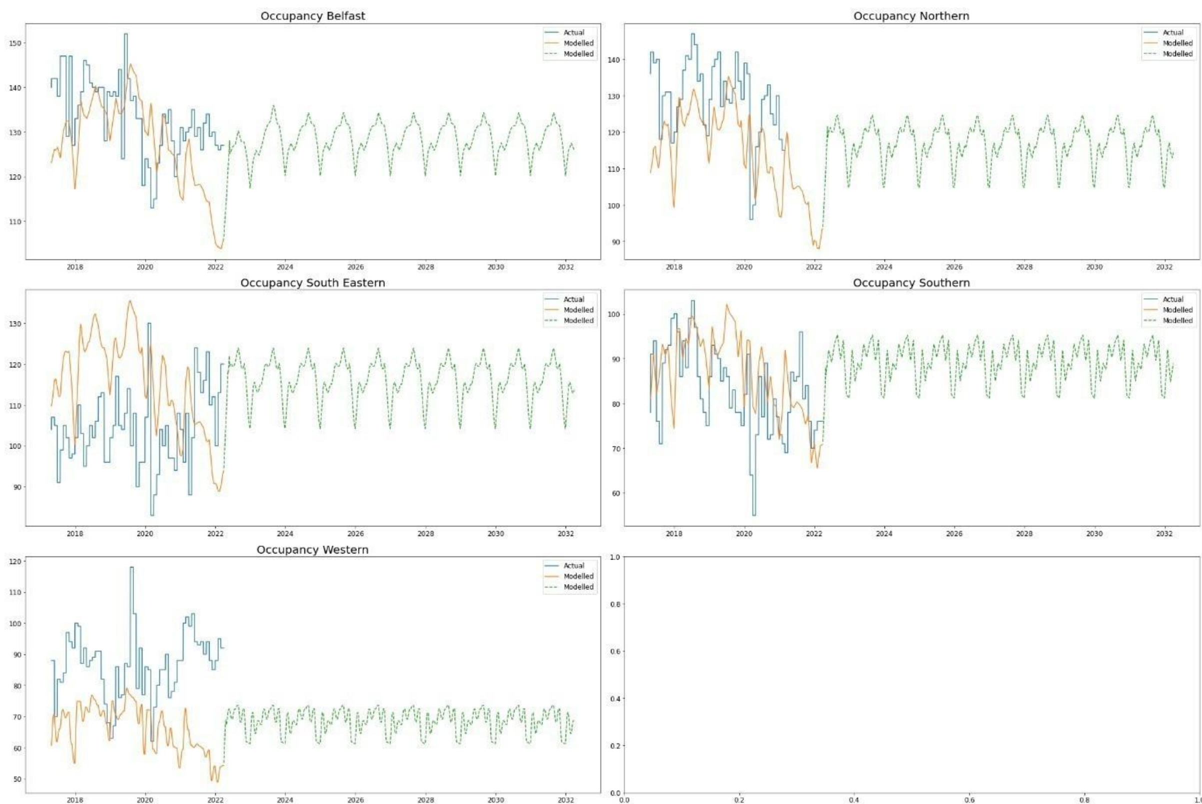
Figure 25: Average LOS Adult Inpatient Facilities

TRUST	SITE	LOS
Belfast	Acute Mental Health inpatient centre	63.91194332
Belfast	Knockbracken	559.6666667
Northern	Holywell	52.31666667
Northern	Ross Thomson	50.5751634
SE	Downshire	61.57559682
SE	Lagan valley	44.74584718
SE	Ulster	48.46388889
Southern	Bluestone	33.29391892
Southern	St Luke's	190.9230769
Western	Grangewood	14.29370629
Western	Tyrone & Fermanagh	22.17847411

8.3.6.2 Outputs

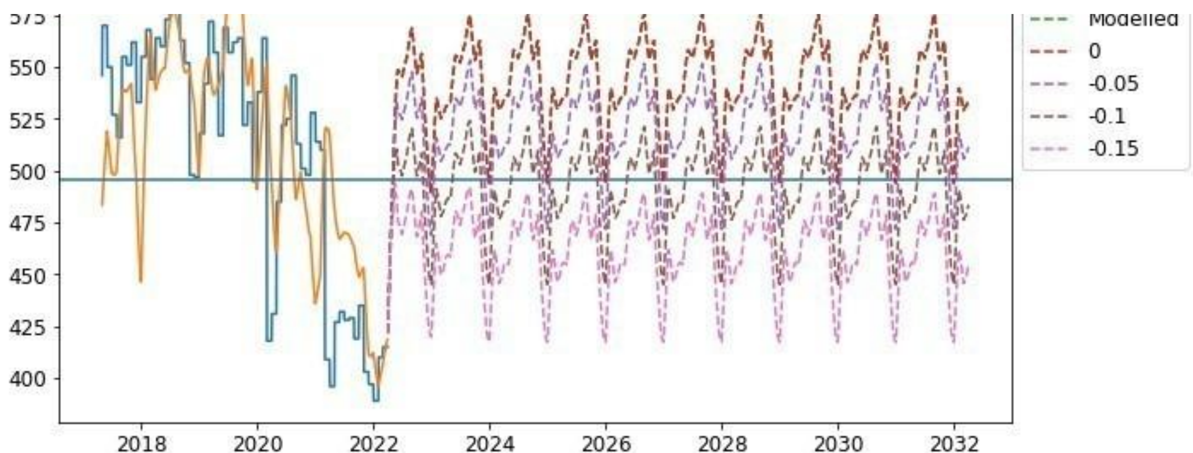
The plots below show the actual vs. modelled occupancy from 2018 to 2022 and the forecasted occupancy (based on past data) from 2022 – 2032. It can be seen that forecast predicts occupancy to exceed 85% most of the time.

Figure 26: Actual vs Modelled Occupancy



To find the % reduction in LOS that would lead to occupancy being below 85%, different values of 5%, 10% and 15% for % reduction in LOS were tried and tested.

Figure 27: National Occupancy Forecast



As can be seen from the graph **a reduction of 15% on LOS** will reduce the model's occupancy to below 85% with the current forecast

8.3.6.3 Working assumptions

AMH

No recent data for NHSCT inpatient AMH admissions. Latest data available from 28 Feb 2021. Assuming this as bed capacity / beds available = 136.

Admissions are assumed to be spread uniformly over the month as patient-level admission and discharge dates unavailable.

CAMHS

Constant bed capacity of 29.

Length of Time buckets: Patients categorised into the following buckets and their LOS assumed to be halfway through interval – should calculate the average and test – might be causing a reduction in LOS.

Table 67: LOS LOH

	Length of Time	LOS
0	0 to 7 days	3.5
1	22 to 28 days	25.0
2	29 to 48 days	38.5
3	49 to 90 days	69.5
4	8 to 21 days	14.5
5	91 to 365 days	228.0
6	>365 days	1095.0

This LOS is rounded in the model is at day level so for example 3.5 is rounded to 4.

Preloaded for 4 years with constant average admissions

Forecast for 10 years with constant average admissions (excluding between 2019-04-30 and 2021-03-31. The admissions are then increased by 7.5% to account for unmet demand.

The arrival schedule is based off the arrivals into Belfast. This means patients that are waiting in different Trusts/sites to be admitted to Beechcroft cannot be allowed for.

Currently scenarios are based off reducing LOS by a % (before rounding to nearest day).

Proportions are excluding arrival dates between 2019-04-30 and 2021-03-31 inclusive.

Whilst analysis was limited by the data available, patient level data would be required to provide more specific modelling analysis. Discrete event simulation could be used instead of a proportions-based model. Using simple averages may underestimate occupancy as in reality the system is more complex.

8.4. Appendix iv: Training

The following is an overview of training available across NI and challenges presented by individual professions to meet demand across all programmes of care.

Allied Health Professionals

Occupational Therapy undergraduate courses available in Northern Ireland, accredited by the Royal College of Occupational Therapists and approved by the Health and Care Professions Council. At present there are approximately 500 applications for only 60 Occupational Therapy training places per annum. The number of places has decreased since 2010, with the current supply of graduates insufficient to meet the needs of the NI population for now and the next decade. Within their current review an additional 33 places have been identified. With the planned OT increase in MH services, this number should be reviewed.

As recommended within the OT and this MH Workforce review, exploration of alternative routes such as access courses, postgraduate courses and degree apprenticeships should be considered as well as dedicated mental health modules and placements within the curriculum.

Speech and Language Therapy undergraduate courses are available in Northern Ireland and recognised by the Royal College of Speech and Language Therapists and approved by the Health and Social Care Professions Council. The number of undergraduate places has continually fallen from 32 places in 2009 to 28 places in 2021 which has resulted in 15% of all SLT posts being vacant (84% of these vacancies are for permanent posts). As a result of this there is a planned increase on a phased basis of 40 places by 2024.

As outlined in the review, SLT are exploring alternative routes such as accelerated postgraduate MSc and degree apprenticeships; both options should be explored to support attracting entry level staff and delivering key skills that have been identified for specialist MH services.

Physiotherapy undergraduate courses are accredited by the Charted Society of Physiotherapy and approved by the Health and Care Professions Council. An additional 36 undergraduate places have been put forward annually to address the annual shortfall of 85 physiotherapists. There is nine times as many undergraduate applicants as there are places.

As outlined in the review, development of an accelerated MSc with Ulster University (UU) and the Department of Health Northern Ireland (DOHNI) & professional body to scope Open University Physiotherapy degree or a degree apprenticeship to accelerate training of new graduates is being considered.

In addition, consideration to additional exposure to mental health within undergraduate courses will help to increase awareness of Mental Health Services.

Dietetics undergraduate and pre-registration masters' courses are available in Northern Ireland, accredited by the British Dietetic Association and approved by the Health and Care Professions Council. Across NI, the average vacancy rate of 7.42% in Dietetic posts in NI (2020) & 57% of the workforce works on a part time basis. Retention rate of undergraduate dieticians joining HSC following graduation was 57% and 20% at master's level with serious difficulties in creating a sustainable workforce across all services (2017/18). To meet demand for services, HSC requires 455 graduates over the next 10 years.

Further development of roles has been identified that will build a career pathway to retain dietitians, these include:

- Supplementary prescribing status for dieticians to reduce delays in obtaining prescriptions and eliminate the need for hospital visits by resolving issues with diet and medication at an earlier stage

- Consider alternative routes such as access courses and degree apprenticeships
- A need to develop consultant, research, and clinical academic roles to support the progression of dieticians as post-registration accredited courses are currently unavailable.

Art, Drama and Music Therapists: A master's in art psychotherapy course is accredited by the British Association Art Therapists and Health and Care Professionals Council (HCPC) and is available in NI. Currently there is no Drama or Music therapy postgraduate courses in NI that are approved by the HCPC and British Association of Drama Therapists and British Association of Music Therapists respectfully.

Further evaluation on the need for an accredited drama and music therapy course should be considered to support the development of the professions.

Table 68: Allied Health Professional Training Places

<table>
<tr><th>Courses</th><th>Current Training Places (2021/22)</th><th>Planned Training Places (2022/23) *</th><th>Projected Training Places (Total)</th></tr>
<tr><td>BSc Occupational Therapy (UU)</td><td>55</td><td>65</td><td>83 by 2023</td></tr>
<tr><td>BSc Speech and Language Therapy (UU)</td><td>28</td><td>33</td><td>40 by 2024</td></tr>
<tr><td>BSc Physiotherapy (UU)</td><td>80</td><td>90</td><td>126 by 2023</td></tr>
<tr><td>BSc Dietetics (UU)</td><td></td><td>24</td><td rowspan="2">455 graduates for 2019-2029</td></tr>
<tr><td>MSc Dietetics (UU) – pre-registration</td><td>10</td><td>7</td></tr>
<tr><td>MSc Art Psychotherapy (UU)</td><td>40*</td><td></td><td></td></tr>
</table>

Pharmacy

Pharmacy undergraduate courses are available in Northern Ireland through both UU and QUB, accredited by the General Pharmaceutical Council and the Pharmaceutical Society of Northern Ireland. The MSc Advanced Pharmacy Practice with Independent Prescribing at QUB encompasses the Northern Ireland Centre for Pharmacy Learning and Development (NICPLD) non-medical prescribing course and the NICPLD Advanced Practice Development modules. An additional 50 places in the MPharm course will be available by 2024, this will need to be stress tested to plan for the uplift in Mental Health Services.

From 2023 once legislation has been passed, all newly registered pharmacists would qualify to register as independent prescribers following completion of foundation training.[53] This will complement and support better decision making for effective medicinal management, optimisation and reduce time for other professions such as medical staff.

Table 69: Pharmacy Undergraduate/Postgraduate Courses

Courses	Current Training Places (2021/22)	Planned Training Places (2022/23)	Projected Training Places
Undergraduate			
MPharm Pharmacy (UU)	74 Number of Level 1 students who have currently enrolled in 2022-23: 160	Up to 120	Additional 50 by 2024 within NI
MPharm Pharmacy (QUB)	Approx.150 students into Year 1	Number of Level 1 students who have currently enrolled in 2022-23: 160	
Postgraduate			
MSc Advanced Practice Development with Independent Prescribing (QUB)	30 [19 students enrolled]	30	30
MSc Advanced Pharmacy Practice (UU)	11	Up to 19	

This is not an exhaustive list other post graduate avenues are available

[53] *NI Workforce Review Report –** DoH Ni Pharmacy Workforce Review 2020 & Royal Pharmaceutical Society (RPS) Advanced Pharmacy Framework + RPS Roadmap to Advanced Practice:* pharmacy-workforce-review-published (gov.uk)

Psychology [54]

Psychological Professions encompass a broad range of professions, some are more well established in Northern Ireland than others. There is no single Psychological Therapies Framework available in Northern Ireland unlike England, Scotland, and Wales. This has led to challenges with career progression throughout the whole psychology profession. The Psychological Professions would benefit from a holistic approach to all Psychological Professions to develop a cohesive strategic direction to build a sustainable pipeline of professions at low and high-intensity levels. There are approximately 500 psychology graduates in NI per annum who compete for a small number of places on some post-graduate courses. These are a potential workforce for emerging roles within the Psychological Profession.

The following are the Psychological Professions that are part of MH services:

Clinical psychology: This group is HCPC registered and are the most established group in MH services. The requirement for additional clinical psychologists has been identified across most of workforce strategies e.g., cancer / LD etc

The QUB Doctorate in Clinical Psychology is fully funded by DoH[55]; places have increased 75% from 2018 where there were 11 in total. These are now in line with the rest of the UK with 21 funded places, with 300 applicants for this small number of places.

Following undergraduate a proportion will gain relevant work experience as Band 4-5 prequalification psychology assistants and associates. They also often complete additional relevant masters or PhD and the professional qualification (DClinPsych).

Forensic psychology does not have a direct course in NI; Forensics can train via British Psychological Society (BPS) independent route in staged approach.

For **Cognitive Behavioural Therapy**, a relevant undergraduate degree is needed e.g., MH nursing, psychology, social work, and OT. The Cognitive Behavioural Therapist (CBT) postgraduate diploma and certificate is run by QUB which is adult focused and less geared to severe and enduring MH conditions such as psychosis and more focused on anxiety and depression.

An MSc in Trauma and CBT is also available. There are no child specific courses available. There are specific commissioned nursing & social workplaces with some places ring-fenced for wider MH workforce. This can limit accessibility for some professions.

Within **Family Therapy** there are 3 levels of training: Postgraduate Cert (1 year), Postgraduate Diploma (1 year) & MSc Systemic Psychotherapy (2 years). A relevant undergraduate degree is required. There are a small number of training places ringfenced and funded specifically for MH services in Northern Ireland.

Child and Adolescent Psychotherapy and Adult Psychotherapy

At present, there is no accredited training available within Northern Ireland for the Child and Adolescent Psychotherapy profession. However, for the past 13 years, a pre-clinical training requirement for eligibility to apply for CAPT clinical training is commissioned by PHA and SPPG and is accredited by Tavistock and Portman Foundation Trust and University of Essex. This provides a ready pool of prospective CAPT trainees. Aligned to the growth seen in the UK, to meet the growing demand for Child and Adolescent Psychotherapy a proposal has

[54] *Clinical Psychology Workforce Project – Division of Clinical Psychology UK 2015 QUB Doctorate in Clinical Psychology – Selection Procedures: September 2022 Entry*

[55] Queen's University Belfast (2022). *Doctorate in Clinical Psychology: Course Regulations and Academic Modules 2016-2017 [*Online]. Available from: *Filetoupload,732618,en.pdf (qub.ac.uk) [Accessed on 02 May 2022]*

been put forward to the Department of Health to support the development of a training course in NI that would improve access for potential candidates and build the profession within NI.

For Adult Psychotherapy, an Adult Psychotherapy Training programme with the Northern Ireland Psychoanalytic Society, accredited by the International Psychoanalytic Association and the British Psychoanalytic Council is readily available in Northern Ireland.

Given the breadth of Psychological Therapies available, it is recommended that a common Framework is put in place to provide clarity on career paths, registration requirements and options for advanced training programmes.

Emerging Psychology Roles

There are a significant number of students who graduate with an undergraduate psychology degree, thus with good grounding in psychological theories, developmental psychology, and clinical modules. Given the workforce needs there is more recent work being undertaken to explore increasing psychology graduates as part of a MH workforce particularly in the delivery of psychological therapies.

There has been ongoing challenge of removing core staff and roles from Nursing, Social Work and AHPs and reconstituting as psychological therapists. This has a two-fold impact as it impacts on core professional role availability, or patchy delivery of psychological therapies as dedicated time is unavailable.

A multiagency group across the Universities (QUB/UU/Open Uni) with Heads of Psychological services and the British psychological Society have been completing joint work around development of this workforce. This is aiming at a Band 4 – Band 6 workforce, thus allowing skill mix and career development within the delivery of psychological therapies as a primary focus of roles. This is in the early stages of development.

Social Work[56]

Social Work undergraduate and postgraduate courses are available in Northern Ireland and are accredited by the Northern Ireland Social Care Council and Northern Ireland Post-Qualifying Education and Training Partnership

For Social Work, the Post Graduate Dip/ MSc in Mental Health and Mental Health Capacity at QUB provides the necessary training for social workers to undertake the role of Approved Social Worker under the Mental Health (Northern Ireland) Order 1986 and the Mental Capacity Act (Northern Ireland) 2016.This will support the most significant delegated statutory function for social workers.

The Social Work Workforce Review recommends increasing the number of social workplaces in university by 60. There are currently not enough social workers to act as Domestic Abuse Protection Order under the new policy and will have further implications with the introduction of the Adult Safeguarding Bill currently under review. Social Workers will have more statutory responsibilities across all programmes of care not only MH which will place additional demand on the Social Work workforce. This will need to be considered in the future.

In addition, within Queens University's widening participation programme, a Pathway Programme is expected to extend to the Bachelor of Social Work Degree in 2023 which will support school leavers from underserved communities.

[56] Department of Health. (2022). *Social Work: Workforce Review Northern Ireland 2022 [*Online]. Available from: *Social Work Workforce Review Northern Ireland 2022 | Department of Health (health-ni.gov.uk) [Accessed on 02 May 2022]*

Table 70: Social Work Undergraduate Courses

<table>
<tr><th>Courses</th><th>Current Training Places (2021/22) *</th><th>Planned Training Places (2022/23)</th><th>Projected Training Places*</th></tr>
<tr><td><u>Undergraduate</u></td><td></td><td></td><td></td></tr>
<tr><td>BSW Social Work (QUB)</td><td>72</td><td></td><td rowspan="7">Additional 60 places for the next 5 years</td></tr>
<tr><td>BSW Social Work Degree Entry (QUB)</td><td>40</td><td></td></tr>
<tr><td>BSc Social Work (UU)</td><td>63</td><td></td></tr>
<tr><td>BSc Social Work Degree Entry (UU)</td><td>40</td><td></td></tr>
<tr><td>BSc Social Work (Belfast Met College)</td><td>30</td><td></td></tr>
<tr><td>BSc Social Work (South West College)</td><td>15</td><td></td></tr>
<tr><td>BA Social Work (Open University)</td><td>15</td><td></td></tr>
<tr><td><u>Postgraduate</u></td><td></td><td></td><td></td></tr>
<tr><td>Pg. Dip/MSc Mental Health and Mental Capacity Law</td><td></td><td>55</td><td></td></tr>
</table>

Additional postgraduate courses available are the MSc Social Work with Children, Young People and Families (QUB) and MA in Social Work (Open University).

Medical

Developing a sustainable pipeline of medical staff is a challenge across all Specialties. Significant effort is required to attract and retain medical staff into Mental Health Services. In particular, the WHSCT has had significant issues with attracting Consultant Posts, with heavy reliance on sessional or locum support.

Queens University Belfast and University of Ulster are the two medical training schools within NI, all others are trained in the UK and ROI. For instance, statistics show that of doctors registered with a license to practice living in NI, 74.7% of trainees, 67% of specialists & 57.7& of non-consultant career grade doctors (NCCG) graduated from QUB; demonstrating the importance of locally educated medical students. Of the NI domiciles who complete foundation training in NI and subsequently start specialty training, 95-97% remain in NI for training. There is concern that NI domiciles who study graduate medicine in Great Britain will remain; only

25% return to NI for foundation training. Providing additional places in the graduate medicine course could aid in retaining Northern Irish medical graduates in NI.[57]

Several challenges were outlined by the RCPsych, these included the transition from Specialist Doctor to Consultant is erroneous and could be rationalised to make this process more attractive. In addition, locally employed doctors are not eligible to use their experience to attain specialist doctor level. It is recommended that a mechanism to provide training to become accredited would enable a larger pipeline of medical staff to transition into specialty roles.

A review of psychiatry training in Northern Ireland was carried out by the Northern Ireland Medical and Dental Training Agency in 2021[58], key findings included:

- 57% of core psychiatry trainees reports that the magnitude of vacant rota slots had impacted greatly on their training – sizeable increase from the review carried out in 2019 where the figure was 24%
- 70% of trainees received the mandated 1 hour of protected clinical supervision per week which is below the target of 100%
- A third of trainees reported that psychotherapy training is regularly missed
- Attrition rate of 29% from psychiatry training in NI; this should be explored to understand the rationale for this to help reduce the attrition rate
- 74% of the psychiatry trainees/specialist graduated from QUB, illustrates how crucial QUB medical graduates are to the psychiatry workforce in NI.

In addition, within the Medical Workforce Plan 2022-2031[59], recommendations to assist in the development of training places needed to meet demand across all specialities has been proposed. Given the time to train within the medical profession, early implementation of these recommendations will support the needs of the Medical Mental Health Workforce.

To support medical workforce, the role of the Physician Associate is expected to become a regulated profession by summer 2023 by the General Medical Council if government legislation is approved. On appointment, the Physician Associate and supervising Consultant will continue to build the scope of practice that can be modified over time with increasing competence and knowledge[60]

In addition, Health Education England have approved a doctor degree apprenticeship for delivery from September 2023 by the Institute for Apprenticeships and Technical Education. A funding band of up to £27k has been awarded for the apprenticeship; any additional training expenses above this is to be met by the employer. This has been developed to widen access to medicine by easing the financial strain associated with the traditional route[61] Once evaluated this should be considered for Northern Ireland.

Nursing

Nursing undergraduate and postgraduate courses are available in Northern Ireland through UU, QUB and OU with statutory registration through the Nursing and Midwifery Council. All three universities provide under-graduate training. As part of New Decade, New Approach a

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[57] *Northern Ireland Medical School Places Review 2018 – early actions of the HSC Workforce Strategy: Delivering for our people by DoH*

[58] *NIMDTA (2018) Psychiatry Training – Placement Quality Review Regional Resurvey Results [Online]. Available from: Northern Ireland Medical School Places Review 2018 – early actions of the HSC Workforce Strategy: Delivering for our people by DoH*

[59] *Prof P Woods (2021) Mental Health Workforce 2022-2031 (draft). Department of Health*

[60] Faculty of Physician Associates at the Royal College of Physicians (2022). Physician Associate Update. [Online]. Available from: *Faculty of Physician Associates - quality health care across the NHS (fparcp.co.uk)*

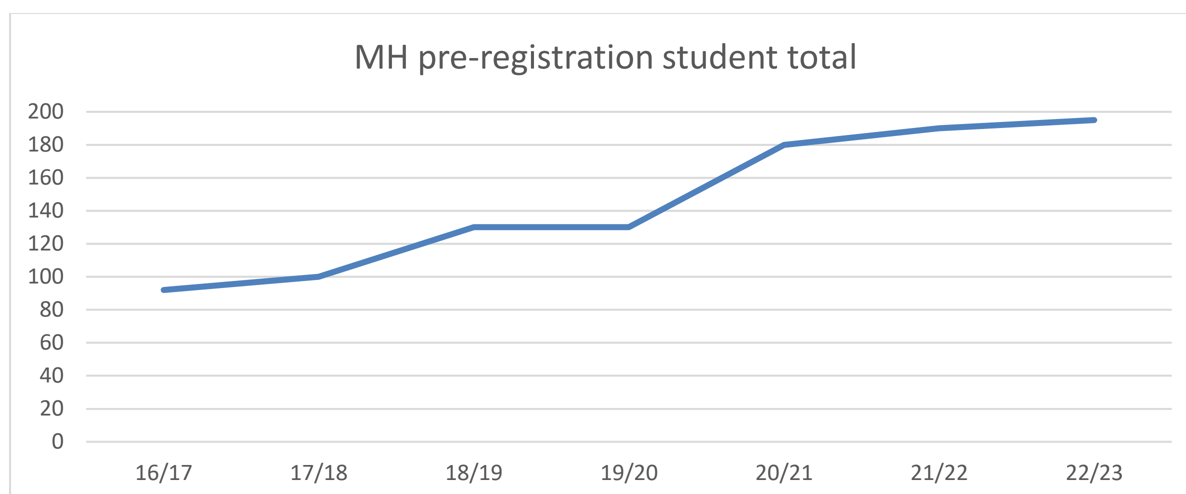
[61] Health Education England (2018). *Apprenticeship Standards [Online]. Available from: Standards - HASO (skillsforhealth.org.uk)*
Health Education England (2022) *Medical Doctor (Degree) apprenticeship implementation resource pack. [Online]. Available from: Report template (skillsforhealth.org.uk)*

key priority was set out to increase pre-registration nursing and midwifery training places over a 3-year period, commencing in 2020/21 and previously set out in the Workforce Plan for Nursing and Midwifery 2015-2025[62]. This has led to an uplift in Mental Health places as per below:

Table 71: Mental Health Nursing Pre-Registration Places

Academic Year	16/17	17/18	18/19	19/20	20/21	21/22	22/23
MH pre-registration student total	92	100	130	130	180	190	195

Figure 28: Growth in Mental Health Nursing Pre-Registration Places



The Graduate Entry Master's programme (GEM) (2-year course) has been running at QUB since 2021/22. Included within the numbers above are 20 places that have been secured on the GEMs programme for the incoming academic year (2022/23), the same number as the 2021/22 academic year.

As part of the expansion of the Nursing role within Mental Health Services there are several post-graduate courses available:

- MSc in Advanced Professional and Clinical Practice (Nursing)
- MSc in Professional Nursing (Mental Health)
- PgDip in Cognitive Behavioural Psychotherapy
- PgCert in Nurse and Midwifery Prescribing
- PgDip in Specialist Nursing (with Pathways)

As outlined in the Nursing and Midwifery Taskforce Review[63], over the last ten years the core postgraduate education budget in nursing and midwifery has progressively decreased from £10.8 million to £7.3 million across all areas. With the expansion of the Nursing role, with the introduction of the Nurse Consultant role and advanced roles such as the Advanced Nurse Practitioner, Nurse Prescriber and advanced training in psychological therapies, training places will be required to develop these advanced skills. As recommended, in the next steps framework, with funding through New Decade, New Approach, there are clear plans to

[62] *A Workforce Plan for Nursing and Midwifery in Northern Ireland (2015 – 2025).* DHSSPS Workforce Plan for Nursing Midwifery 2015-2025 May 2016 (qub.ac.uk)
[63] Nursing And Midwifery Task Group (NMTG) *Report and Recommendations. [Online]. Available from:* NMTG-report-and-recommendations.pdf (health-ni.gov.uk)

prioritise advanced training within Strategic Theme 2. Within Strategic Theme 2: Invest recurrently in nursing & midwifery post graduate education at a level commensurate with both the size of the workforce and the transformation agenda, the following are key to further establishing the MH Nursing Workforce of the Future.

- To build & resource a new career framework so that within ten years there are Consultant Midwives & Advanced Nurses across all branches & across nursing specialities. With an outcome to enable growth in specialist nurse training in line with HSC Transformation rising from £7.3M to £11.3M
- To increase the number of clinical academic roles in midwifery & all branches of nursing. The targeted outcome is 120 WTE ANP in primary & community / secondary care 25 WTE Nurse/Midwifery Consultants. 25 WTE Clinical Academic posts, which will include dedicated Mental Health nursing roles[64]

[64] *Nursing And Midwifery Task Group (NMTG) Next Steps Framework [Online]. Available from: NMTG-implementation-framework.pdf (health-ni.gov.uk)*

8.5. Appendix vi: Attrition, Retirement & Growth by Discipline

The following set of tables provide a breakdown of the total new WTEs required to meet the forecast additional resources needed to meet future demand. This takes account of average attrition rates and retirements expected over the next 10 years. It also takes into consideration the time required to train new graduates to build a sustainable workforce.

Table 72: Attrition, Retirement & Growth by Discipline (Psychiatry CAMHS)

CAMHS	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
New WTE		1	1	1	1	1	1	1	1	1	1
Attrition %	0%	0	0	0	0	0	0	0	0	0	0
Retirement		0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6
Growth %		2%	2%	1%	1%	1%	1%	1%	1%	1%	1%
	26	**26**	**27**	**27**	**28**	**28**	**28**	**29**	**29**	**30**	**30**

Table 73: Attrition, Retirement & Growth by Discipline (Psychiatry Adult)

Adult	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
New WTE		5	8	3	7	4	6	5	14	14	15
Attrition %	0%	0	0	0	0	0	0	0	0	0	0
Retirement		2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5
Growth %		2%	5%	0%	4%	1%	3%	2%	8%	8%	8%
	116	**119**	**124**	**125**	**129**	**131**	**134**	**137**	**148**	**160**	**172**

Table 74: Attrition, Retirement & Growth by Discipline (SAS CAMHS)

CAMHS	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
New WTE		0	0	1	1	1	2	2	2	2	2
Attrition %	0%	0	0	0	0	0	0	0	0	0	0
Retirement		0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Growth %		-2%	-2%	8%	8%	7%	15%	13%	12%	10%	9%
	10	**10**	**10**	**10**	**11**	**12**	**14**	**16**	**17**	**19**	**21**

Table 75: Attrition, Retirement & Growth by Discipline (SAS Adult)

Adult	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
New WTE		3	3	3	6	6	9	9	9	9	10
Attrition %	0%	0	0	0	0	0	0	0	0	0	0
Retirement		1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
Growth %		3%	3%	3%	8%	7%	11%	10%	9%	8%	9%
	54	**56**	**57**	**59**	**63**	**68**	**75**	**83**	**90**	**98**	**106**

Table 76: Attrition, Retirement & Growth by Discipline (Nursing CAMHS)

CAMHS	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
New WTE		20	20	20	22	22	22	22	22	22	22
Attrition %	6%	7	8	9	9	10	10	11	11	12	12
Retirement		2	2	2	2	2	2	2	2	2	2
Growth %		9%	8%	7%	7%	6%	6%	5%	4%	4%	4%
	120	**130**	**140**	**150**	**160**	**170**	**180**	**189**	**197**	**205**	**212**

Table 77: Attrition, Retirement & Growth by Discipline (Nursing Adult)

Adult	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
New WTE		157	157	157	157	157	157	157	157	157	157
Attrition %	6%	73	77	80	83	86	88	91	93	95	98
Retirement		28	28	28	28	28	28	28	28	28	28
Growth %		5%	4%	4%	3%	3%	3%	3%	2%	2%	2%
	1,198	**1,254**	**1,307**	**1,357**	**1,404**	**1,448**	**1,489**	**1,528**	**1,564**	**1,598**	**1,630**

Table 78: Attrition, Retirement & Growth by Discipline (Social Work CAMHS)

CAMHS	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
New WTE		5	5	5	6	6	6	7	7	7	7
Attrition %	3%	4	4	4	4	4	4	4	4	4	4
Retirement		1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
Growth %		0%	0%	0%	0%	0%	0%	1%	1%	1%	1%
	134	**133**	**133**	**132**	**133**	**134**	**134**	**135**	**137**	**138**	**140**

Table 79: Attrition, Retirement & Growth by Discipline (Social Work Adult)

Adult	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
New WTE		30	32	32	33	35	35	35	35	35	35
Attrition %	3%	13	13	13	14	14	14	14	15	15	15
Retirement		9.8	9.8	9.8	9.8	9.8	9.8	9.8	9.8	9.8	9.8
Growth %		2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
	425	**432**	**442**	**451**	**460**	**472**	**483**	**493**	**504**	**514**	**524**

Table 80: Attrition, Retirement & Growth by Discipline (Psychology CAMHS)

CAMHS	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
New WTE		3	3	5	5	5	5	5	8	8	8
Attrition %	3%	1	1	1	1	1	1	1	1	1	2
Retirement		0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Growth %		11%	9%	17%	14%	12%	10%	9%	15%	13%	11%
	20	**22**	**24**	**28**	**32**	**36**	**40**	**43**	**50**	**56**	**62**

Table 81: Attrition, Retirement & Growth by Discipline (Psychology Adult)

Adult	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
New WTE		10	10	10	10	10	17	17	17	17	17
Attrition %	3%	3	3	3	3	4	4	4	4	5	5
Retirement		1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2
Growth %		6%	5%	5%	5%	4%	10%	8%	8%	7%	6%
	98	**104**	**110**	**115**	**120**	**126**	**138**	**149**	**161**	**172**	**182**

Table 82: Attrition, Retirement & Growth by Discipline (CAPT CAMHS)

CAMHS	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
New WTE		4	4	4	3	3	3	3	1	1	1
Attrition %	0%	0	0	0	0	0	1	1	1	1	1
Retirement		0	0	0	0	0	0	0	0	0	0
Growth %		0%	0%	0%	400%	100%	50%	33%	25%	20%	12%
	1	**5**	**9**	**13**	**15**	**18**	**20**	**23**	**23**	**23**	**24**

Table 83: Attrition, Retirement & Growth by Discipline (Adult Psychotherapist)

Adult	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
New WTE		4	4	3	3	3	2	2	1	1	1
Attrition %	0%	0	0	0	0	0	0	1	1	1	1
Retirement		0	0	0	0	0	0	0	0	0	0
Growth %		0%	0%	0%	0%	100%	50%	30%	20%	18%	15%
	0	**4**	**8**	**11**	**13**	**16**	**17**	**19**	**19**	**20**	**20**

Table 84: Attrition, Retirement & Growth by Discipline (Occupational Therapy CAMHS)

CAMHS	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
New WTE		4	4	4	4	3	3	3	3	3	3
Attrition %	3%	0	0	0	1	1	1	1	1	1	1
Retirement		0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Growth %		40%	28%	21%	17%	10%	9%	8%	7%	6%	6%
	9	**13**	**16**	**20**	**23**	**25**	**27**	**29**	**31**	**33**	**35**

Table 85: Attrition, Retirement & Growth by Discipline (Occupational Therapy Adult)

Adult	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
New WTE		20	20	20	20	20	20	20	20	20	18
Attrition %	3%	5	5	5	6	6	7	7	7	8	8
Retirement		1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3
Growth %		9%	8%	8%	7%	6%	6%	5%	5%	4%	3%
	150	**164**	**178**	**191**	**204**	**217**	**229**	**241**	**252**	**263**	**272**

Table 86: Attrition, Retirement & Growth by Discipline (Pharmacy CAMHS)

CAMHS	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
New WTE		6	4	2	1	0	1	1	0	1	0
Attrition %	3%	0	0	0	0	0	0	0	0	0	0
Retirement		0	0	0	0	0	0	0	0	0	0
Growth %		NEW	64%	17%	6%	-3%	5%	5%	-3%	5%	-3%
	0	**6**	**10**	**12**	**12**	**12**	**12**	**13**	**13**	**13**	**13**

Table 87: Attrition, Retirement & Growth by Discipline (Pharmacy Adult)

Adult	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
New WTE		20	20	20	20	20	20	15	15	15	7
Attrition %	3%	0	1	1	2	2	3	3	4	4	4
Retirement		0	0	0	0	0	0	0	0	0	0
Growth %		997%	88%	45%	30%	23%	18%	10%	9%	8%	2%
	2	**22**	**41**	**60**	**78**	**96**	**113**	**125**	**136**	**147**	**149**

Excludes Pharmacy Technicians

Table 88: Attrition, Retirement & Growth by Discipline (Physiotherapy, SLT, Dietetics & Art/Music/Drama Therapists CAMHS)

CAMHS	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
New WTE		8	16	16	16	16	16	16	16	16	16
Attrition %	3%	0	1	1	2	3	3	4	5	5	6
Retirement		0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Growth %		257%	143%	56%	34%	24%	18%	15%	12%	10%	9%
	3	**11**	**26**	**40**	**54**	**67**	**80**	**92**	**103**	**114**	**124**

Table 89: Attrition, Retirement & Growth by Discipline (Physiotherapy, SLT, Dietetics & Art/Music/Drama Therapists Adult)

Adult	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
New WTE		20	20	20	20	28	28	28	28	30	30
Attrition %	3%	2	3	4	4	5	6	7	8	9	10
Retirement		1	1	1	1	1	1	1	1	1	1
Growth %		40%	27%	20%	16%	21%	16%	13%	11%	11%	9%
	42	**59**	**75**	**90**	**104**	**126**	**147**	**166**	**185**	**204**	**223**

Table 90: Attrition, Retirement & Growth by Discipline (Admin & Management CAMHS)

CAMHS	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
New WTE		10	10	10	10	10	10	10	10	10	10
Attrition %	6%	3	3	3	4	4	4	4	5	5	5
Retirement		1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4
Growth %		10%	9%	8%	7%	6%	5%	5%	4%	4%	4%
	56	**62**	**67**	**72**	**77**	**82**	**87**	**91**	**95**	**99**	**102**

Table 91: Attrition, Retirement & Growth by Discipline (Admin & Management Adult)

Adult	Y0	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
New WTE		80	80	80	80	80	80	75	70	70	70
Attrition %	6%	24	26	28	30	32	33	35	36	37	38
Retirement		14.9	14.9	14.9	14.9	14.9	14.9	14.9	14.9	14.9	14.9
Growth %		9%	8%	7%	6%	5%	5%	4%	3%	2%	2%
	477	**518**	**557**	**595**	**630**	**664**	**696**	**721**	**740**	**758**	**775**

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