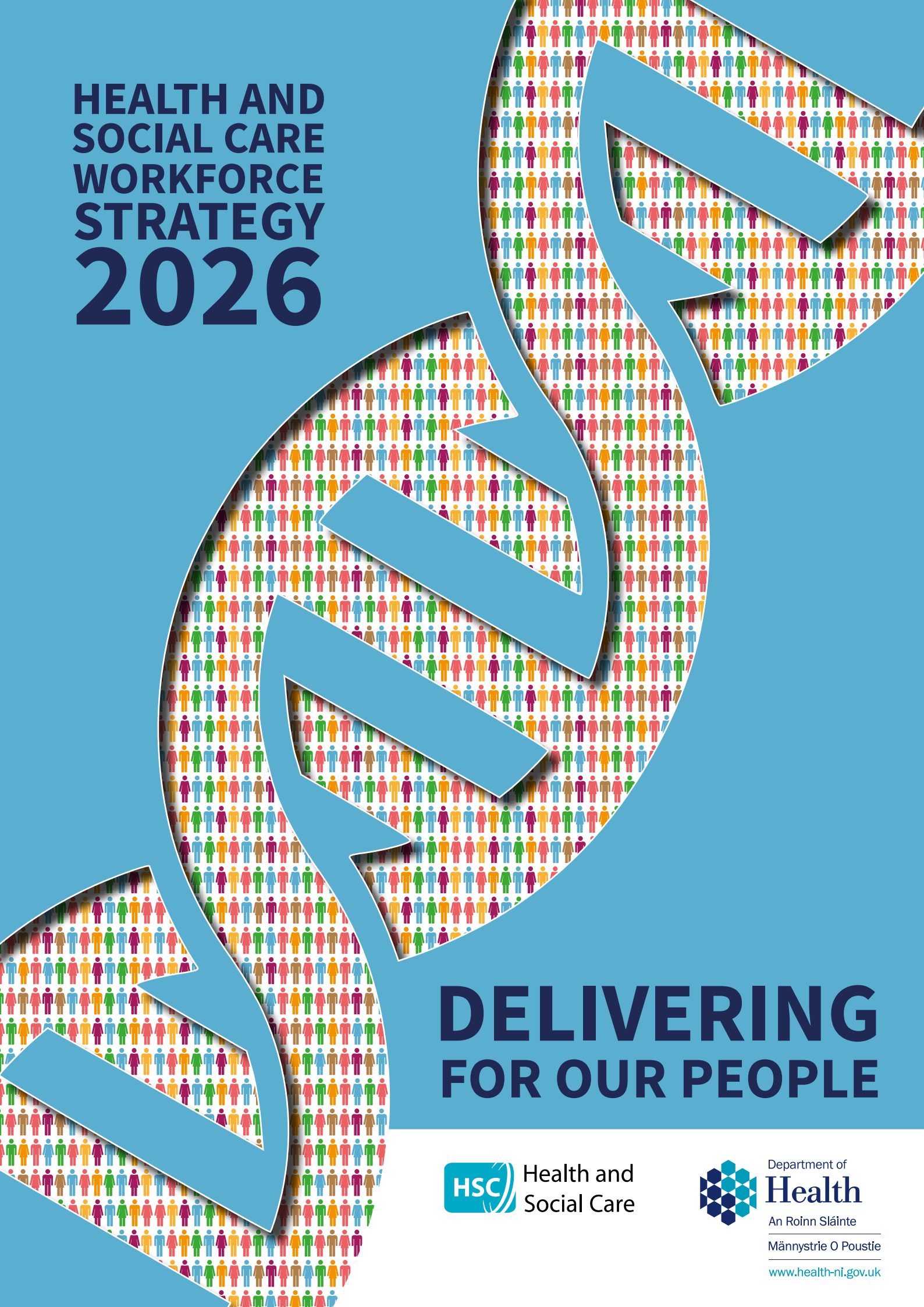
# HEALTH AND SOCIAL CARE WORKFORCE STRATEGY 2026



# DELIVERING FOR OUR PEOPLE

HSC Health and Social Care

Department of Health
An Roinn Sláinte
Männystrie O Poustie

www.health-ni.gov.uk


Nurse

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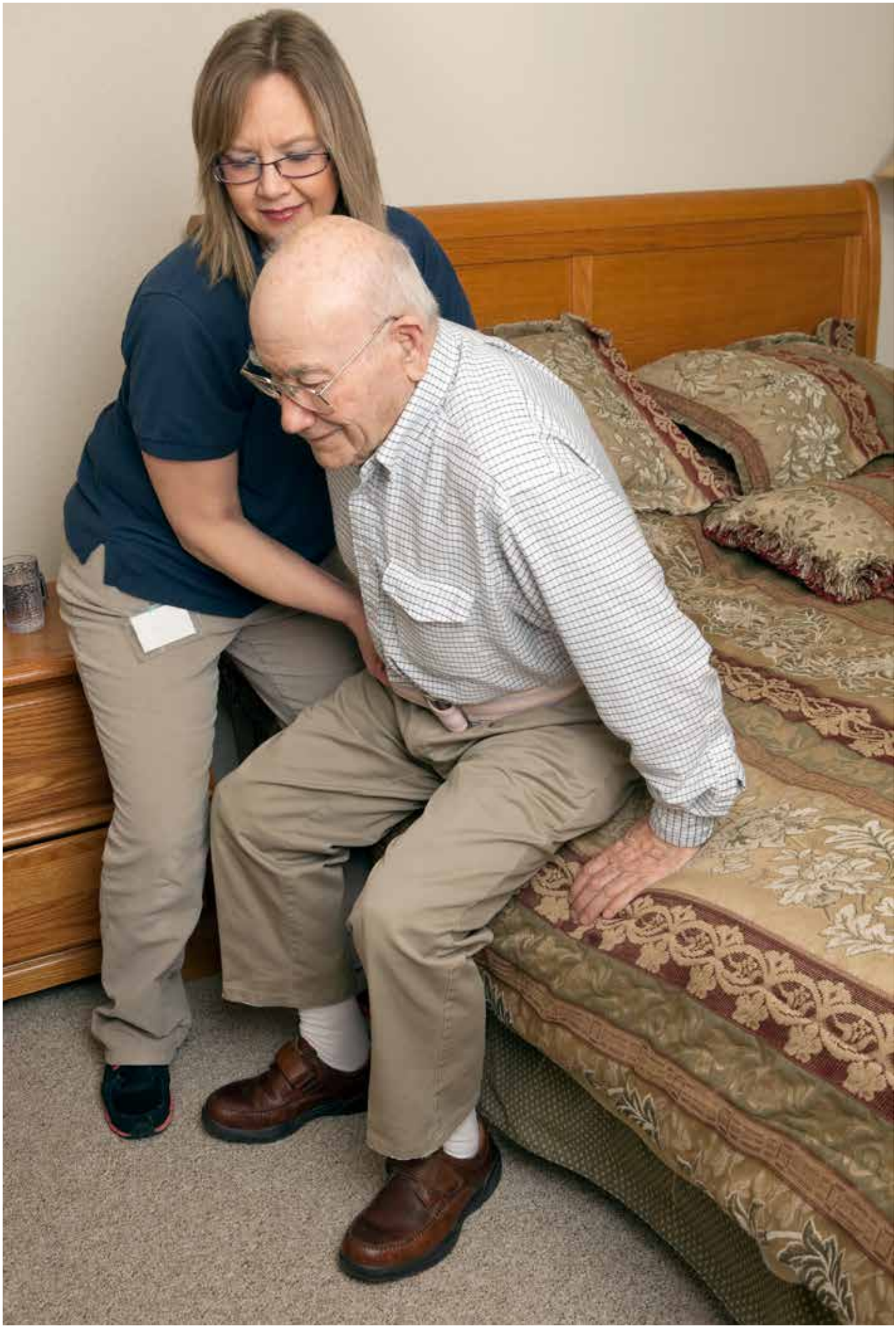


***Health and Wellbeing 2026 – Delivering Together***, was the outworking of the recommendations of the Expert Panel on transforming health and social care, chaired by Professor Rafael Bengoa. It acknowledged that our health and social care services were designed to meet the needs of the 20th century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

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

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 But recruiting additional people alone to prop up outdated service models is not the answer.

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

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

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

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

**The Transformation Implementation Group**

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

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

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

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

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

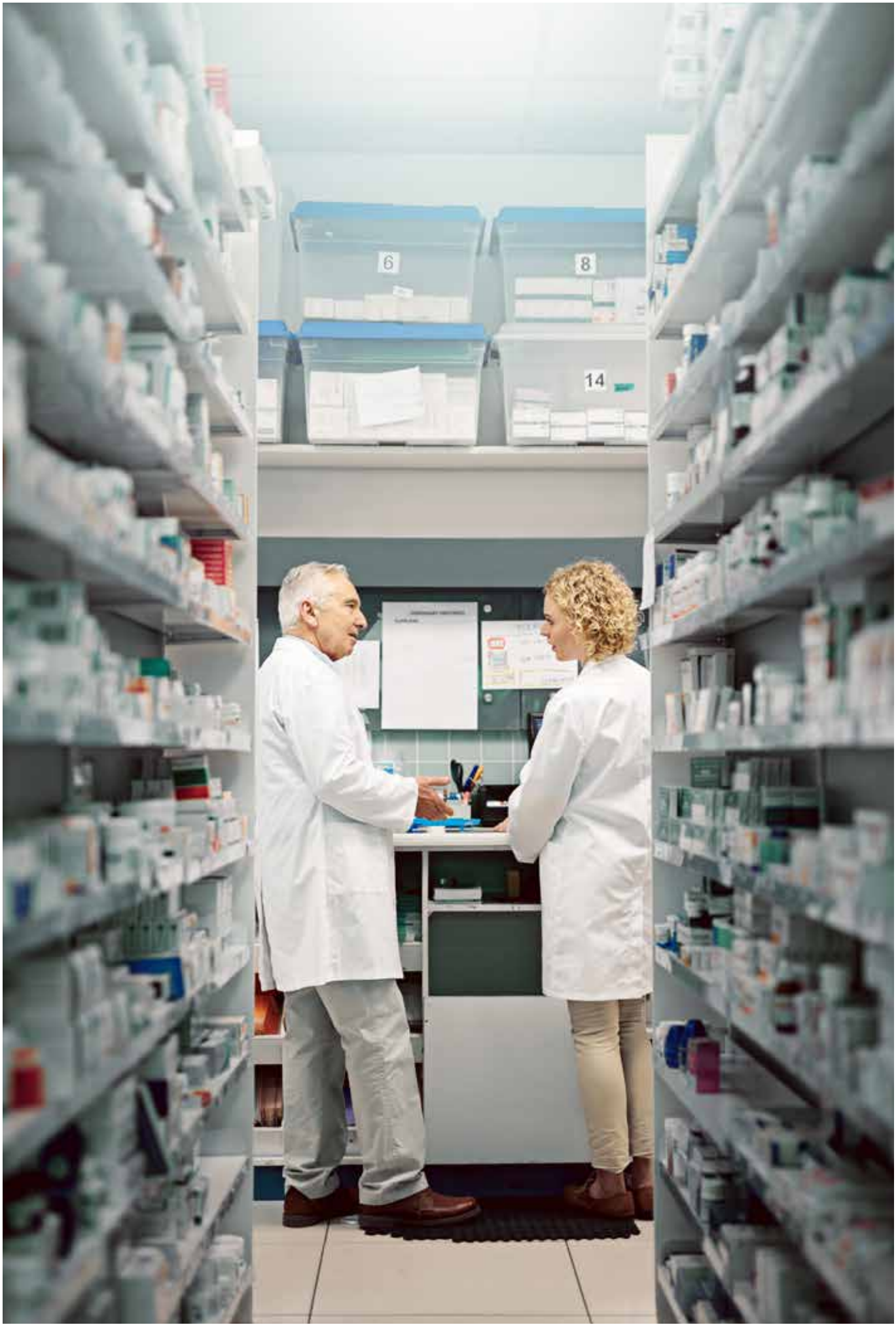
**Ultimately, our aim is, by 2026, to meet our workforce needs – and the needs of our workforce.**

In this document, we set out details about:

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

We are also publishing alongside this document:

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

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

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

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

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

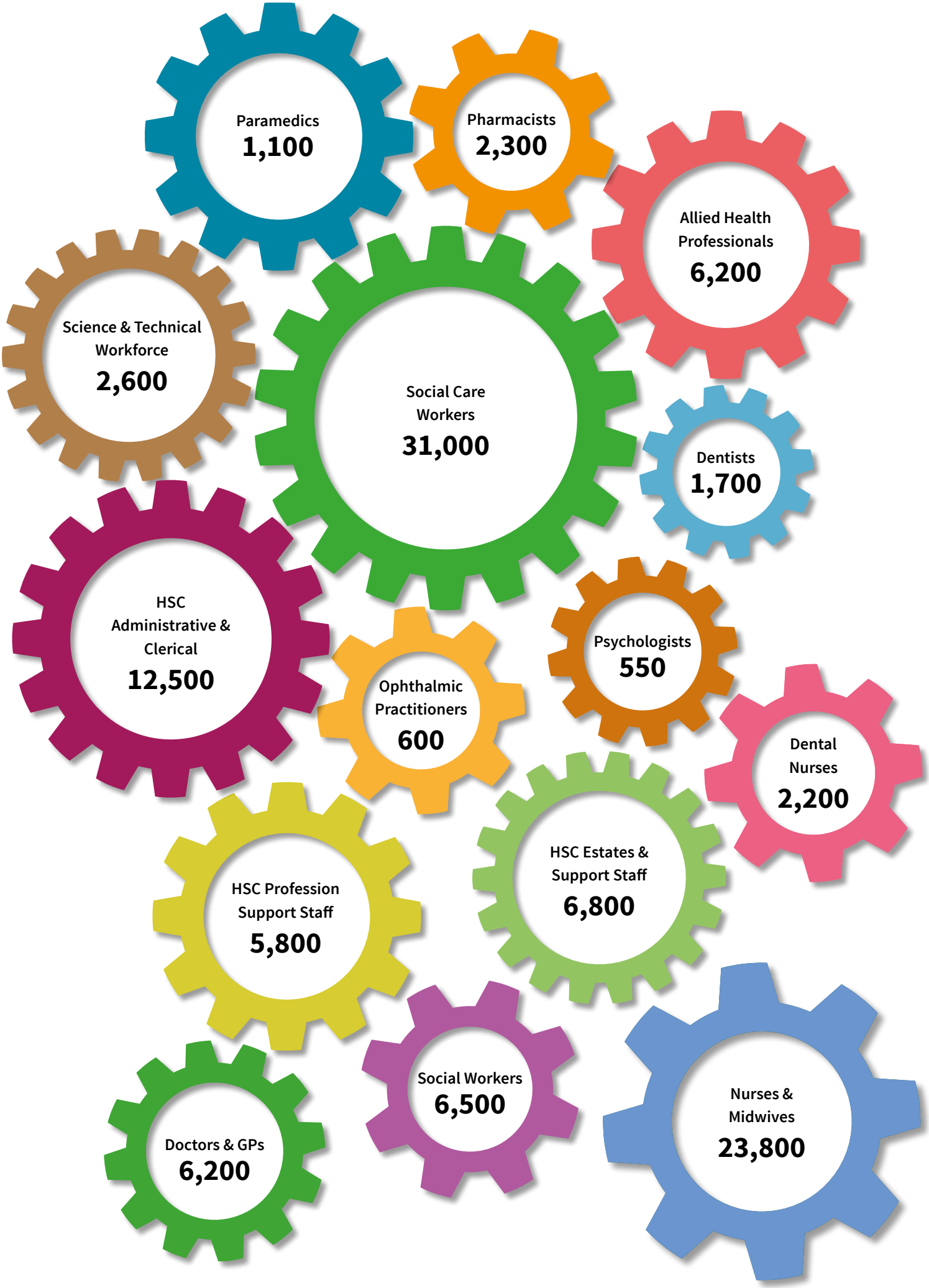
Further information about each organisation can be found at https://www.health-ni.gov.uk/

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

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

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

1. Quarterly Employment Survey March 2017.


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

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

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

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

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

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

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

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

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

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

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

## Brief profile of the workforce

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

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

## Expenditure

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

## Areas of pressure

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

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

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

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


AMBULANCE

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

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

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

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

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

## Strategic issues in Northern Ireland

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

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

## The future

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

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

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

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

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

## Technology

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

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

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

## Policy and planning

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

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

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

## Other reports and strategies

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

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

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

## Early intervention

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

3. Kindig and Stoddart 2003

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

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

## Mental health

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

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

## Social care

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

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

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

## Brexit

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

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

## What the workforce thinks

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

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

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

## Other issues raised

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

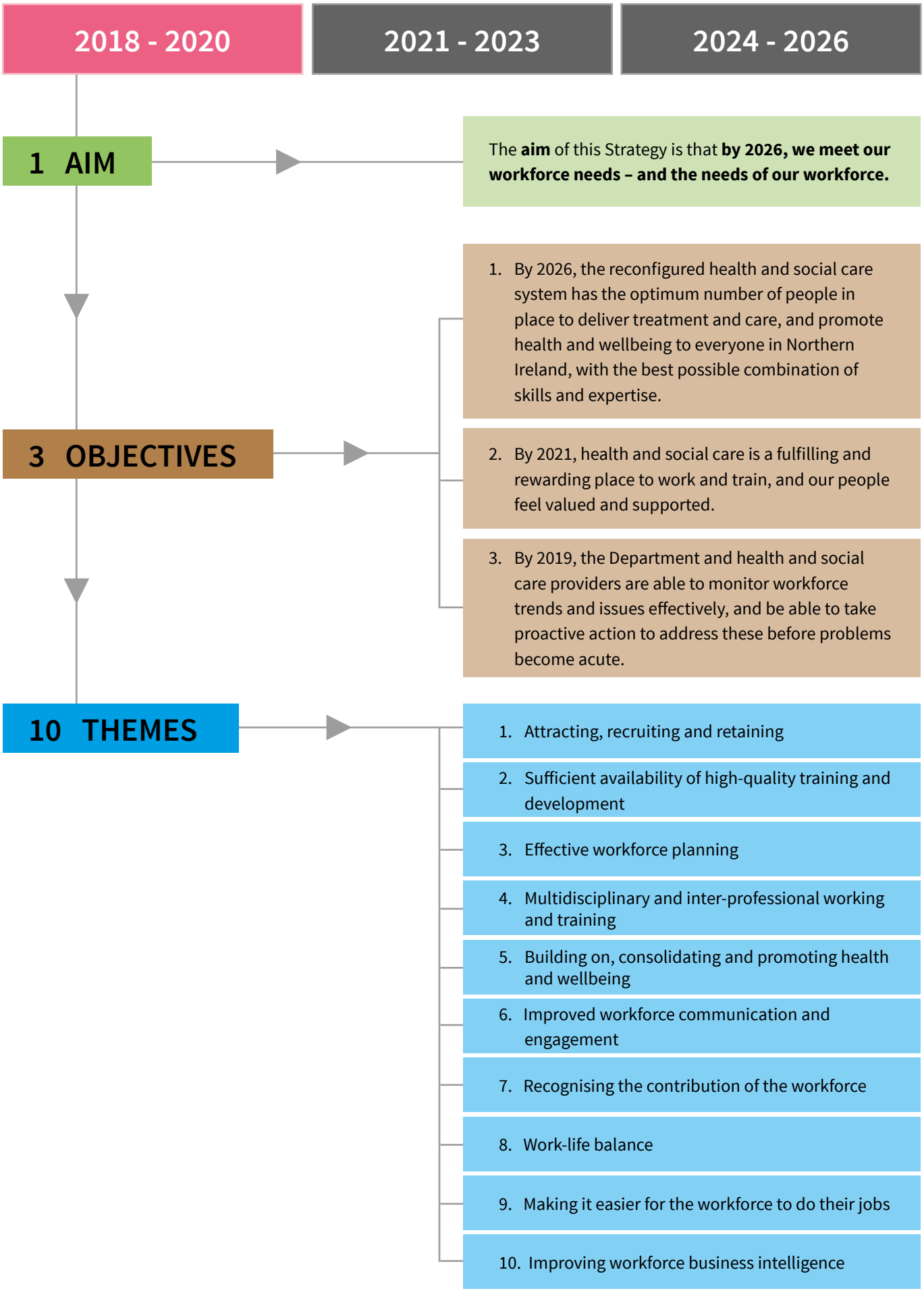
8. **Work-life balance**
   - Recognising that people have different needs and obligations outside of work, whilst balancing service needs.
   - Responding to the changing needs and expectations of the workforce over time.

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

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

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

# Action Plans



## Action plans

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

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

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

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

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

## Oversight and accountability

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

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

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

## Measuring success

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

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

AMBULANCE

## OBJECTIVE 1

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

### THEME 1

### Attracting, recruiting and retaining

#### ACTION 1

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

#### WHY?

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

#### OUTPUT
**By 31/12/2020**

**Regional Health and Social Care careers service established.**

#### ACTION 2

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

#### WHY?

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

#### OUTPUT
**By 31/12/2020**

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

## THEME 2

### Sufficient availability of high-quality training and development

### ACTION 3

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

### ACTION 4

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

### WHY?

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

### OUTPUT

**By 31/12/2020**

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

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

**Multidisciplinary working and training to be a key principle.**

**Align to Leadership Strategy.**

## THEME 3

## Effective workforce planning

### ACTION 5

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

### WHY?

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

### OUTPUT
**By 31/12/2020**

**Review of required medical training places completed by June 2018.**

**Progression of all recommendations arising from workforce planning reviews.**

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

### ACTION 6

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

### WHY?

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

### OUTPUT
**By 31/12/2020**

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

## THEME 3

### Effective workforce planning

**ACTION 7**

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

**WHY?**

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

**OUTPUT**
**By 31/12/2020**

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

**Regular meetings in 2018-19.**

## THEME 4

### Multidisciplinary and inter-professional working and training

**ACTION 8**

**Planning for and introducing new roles.**

**WHY?**

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

**OUTPUT**
**By 31/12/2020**

**Needs analysis of new roles required.**

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

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

**Assess actions for other potential new roles.**

## THEME 4

### Multidisciplinary and inter-professional working and training

### ACTION 9

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

### WHY?

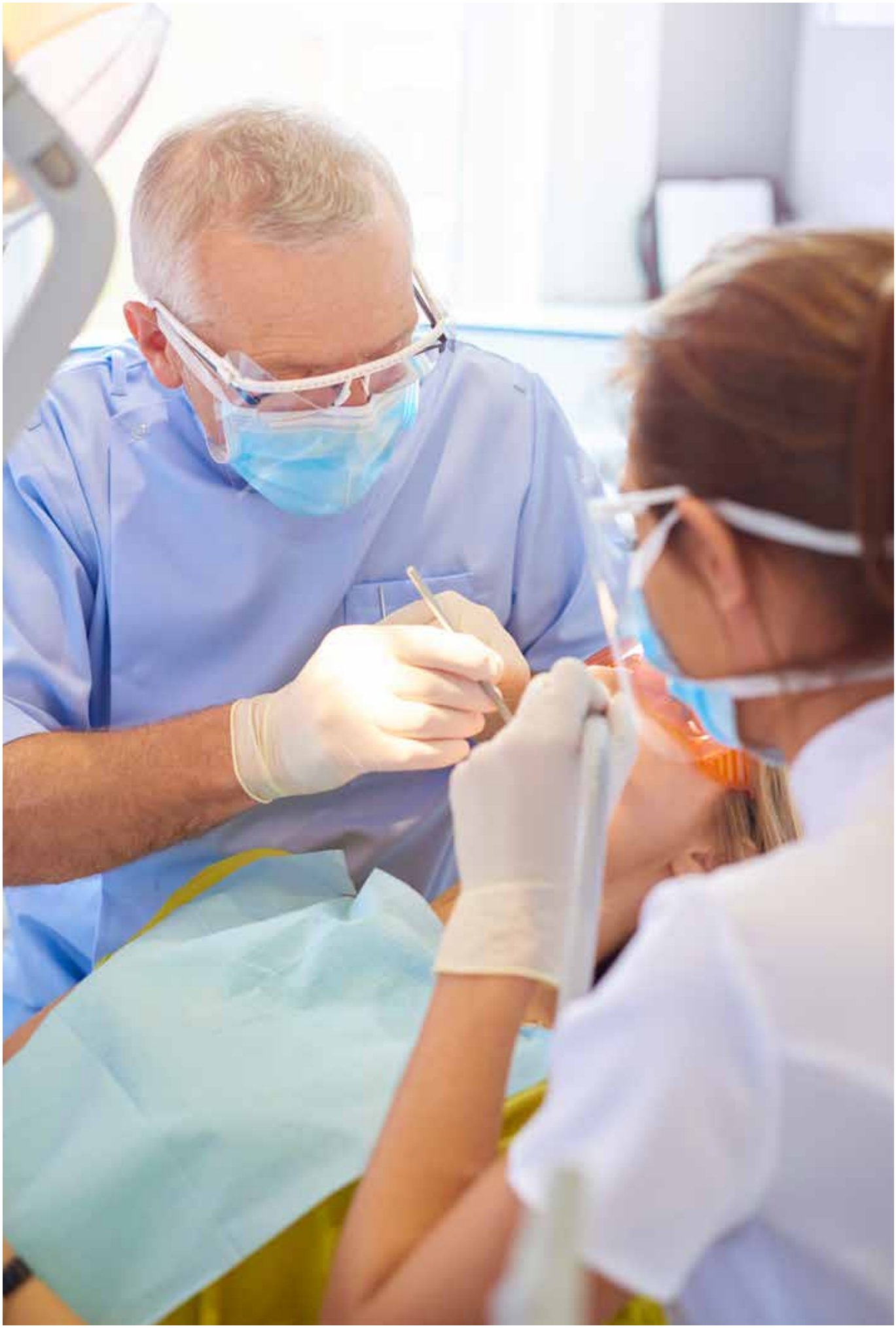
- Effectively utilising skills and resources.
- Streamlining care pathways across locations and teams.
- Addressing increasing incidence of co-morbidities in an ageing population.
- Need to ensure that role of multidisciplinary teams in transformation of delivery of health and social care services is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

### OUTPUT

**By 31/12/2020**

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

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



## OBJECTIVE 2

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

### THEME 5

### Building on, consolidating and promoting health and wellbeing

#### ACTION 10

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

**WHY?**

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

**OUTPUT**
**By 31/12/2020**

**Audit of existing services and procedures.**

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

#### ACTION 11

**Commissioning and establishment of sustainable occupational health services.**

**WHY?**

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

**OUTPUT**
**By 31/12/2020**

**Audit of existing services.**

**Completion and implementation of multidisciplinary occupational health workforce plan.**

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

## THEME 6

## Improved workforce communication and engagement

### ACTION 12

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

### WHY?

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

### OUTPUT
**By 31/12/2020**

**Audit of existing services.**

**Processes and procedures co-produced and fully embedded.**

### ACTION 13

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

### WHY?

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

### OUTPUT
**By 31/12/2020**

**Audit of existing services.**

**Completion and rollout of project and recommendations.**

## THEME 6

## Improved workforce communication and engagement

### ACTION 14

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

**WHY?**

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

**OUTPUT**
**By 31/12/2020**

**Audit of existing services.**

**Completion and rollout of agreed co-produced policy.**

### ACTION 15

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

**WHY?**

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

**OUTPUT**
**By 31/12/2020**

**Agreed and updated HSC staff facility policy.**

**Recognising the contribution of staff**

## THEME 7

### ACTION 16

### Recognising the contribution of the workforce

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

**WHY?**

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

**OUTPUT**
**By 31/12/2020**

Policy published by 31 December 2018.

## THEME 8

### ACTION 17

### Work-life balance

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

**WHY?**

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

**OUTPUT**
**By 31/12/2020**

Regional policy design group established and work under way.

## THEME 9

## Making it easier for the workforce to do their jobs

### ACTION 18

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

**WHY?**

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

**OUTPUT**
**By 31/12/2020**

**Completion of lead employer project for doctors in training.**

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

### ACTION 19

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

**WHY?**

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

**OUTPUT**
**By 31/12/2020**

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

### ACTION 20

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

**WHY?**

- Eradicate unnecessary delays in filling vacancies

**OUTPUT**
**By 31/12/2020**

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

## OBJECTIVE 3

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

### THEME 10

### Improving workforce business intelligence

#### ACTION 21

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

**WHY?**

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

**OUTPUT**
**By 31/12/2020**

**This objective to be achieved by 31 Dec 2019.**

#### ACTION 22

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

**WHY?**

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

**OUTPUT**
**By 31/12/2020**

**This objective to be achieved by 31 Dec 2019.**

## THEME 10

### Improving workforce business intelligence

#### ACTION 23

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

**WHY?**

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

**OUTPUT**
**By 31/12/2020**

**This objective to be achieved by 31 Dec 2019.**

#### ACTION 24

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

**WHY?**

- We need better business intelligence.

**OUTPUT**
**By 31/12/2020**

**This objective to be achieved by 31 Dec 2019.**


CAUTION
WET FLOOR

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

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

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

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

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

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

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

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

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

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

# APPENDIX

## CURRENT PROBLEMS AND FUTURE CHALLENGES

## SOCIAL CARE

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

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

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

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

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

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

## SOCIAL WORK

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

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

## MEDICAL WORKFORCE

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

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

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

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

### *Medical vacancies*

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

### *Postgraduate training*

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

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

5. HSC/NIMDTA Valued Strategy 2016

### *Specialty and associate specialty (SAS)*

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

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

### *Consultants*

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

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

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

### *General Practice*

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

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

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

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

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

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

## PHARMACY

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

### *Medicines*

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

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

### *Challenges*

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

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

### *Future developments*

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

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

## DENTAL WORKFORCE

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

### *Dental nurses*

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

### *Community dental service*

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

### *Dental hospital/school*

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

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

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

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

The ongoing Dental Services Workforce Review is considering these issues.

## CLINICAL PSYCHOLOGY

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

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

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

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

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

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

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

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

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

## NURSING AND MIDWIFERY

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

### *Challenges and opportunities*

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

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

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

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

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

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

### *Recruitment and growth in demand*

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

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

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

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

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

### *Children's nursing*

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

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

### *Mental Health nursing*

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

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

### *Learning Disability nursing*

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

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

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

### *Nursing Assistants*

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

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

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

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

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

### *Midwifery*

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

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

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

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

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

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

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

## ALLIED HEALTH PROFESSIONALS[6]

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

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

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

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

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

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

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

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

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

## SCIENTIFIC SPECIALISMS

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

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

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

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

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

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

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

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

## OPHTHALMIC SERVICES

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

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

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

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

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

## AMBULANCE SERVICE

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

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

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

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

### *Paramedics*

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

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

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

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

### *Workforce Review*

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

### *Ambulance response times*

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

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

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

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

## HSC ADMINISTRATIVE AND CLERICAL WORKFORCE

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

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

## HSC ESTATES AND SUPPORT SERVICES

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

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

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