Workforce Planning – Mental Health

ASSESSING SUPPLY AND DEMAND

October 2018

Contents

1. Acknowledgements

This report relates to all staff working across the Mental Health Services (MHS) nationally and the profile and location of the different staff types. The data provided is essential in ensuring that information on our current workforce can be used to analyse trends and plan for future workforce requirements. It is also a very valuable tool in allowing scarce resources to be allocated to areas of greatest need whilst balancing against the supply of staff entering into MHS.

Acknowledgements and thanks are due to the members of the Mental Health Services Workforce Planning Steering Group and Mental Health Services Workforce Planning Advisory Group for their input, guidance and advice in the preparation of this report.

The work of the National Human Resources (HR) Directorate Workforce Planning, Analytics & Informatics and the Planning and Business Information (PBI) Unit of the Deputy Director General's Office for supporting the service in the production of the Report is also noted with thanks.

Yvonne O'Neill

Head of Planning, Performance and Programme Management

Mental Health Services

1.1. Membership of the Mental Health Services Workforce Planning Steering Group

Name	Organisation	Current Title and Position
Yvonne O'Neill (Chair)	Community Operations	Head of Planning, Performance and Programme Management
John Brehony	Human Resources	Head of HR Midlands Louth Meath CHO
Liz Clausen	Health Business Services	HR/Payroll Systems & Analytics Health Business Services
Leo Kinsella	Mental Health Services	Head of Mental Health Services, CHO 1
Phillipa Withero	National Human Resources	Assistant National Director Strategic Workforce Planning and Intelligence
Finola Doran	National Recruitment Services	National Recruitment Services Campaign Manager
Theresa Heller	Mental Health Services	Human Resources Lead, National Mental Health Services
Philip Flanagan	Mental Health Services	Service Improvement Lead, Data Analytics Project Manager
Patricia O'Neill	Mental Health Services	Service Improvement Lead, Workforce Planning Project Manager
Priscilla Crombie	Strategic Portfolio and Programme Management Office	Programme Manager

Karen O'Mahony	Strategic Portfolio and Programme Management Office	Programme Manager

1.2. Membership of the Mental Health Services Workforce Planning Advisory Group

Name	Current Title and Position	Representative
Yvonne O'Neill	Head of Planning, Performance and Programme Management	Chair
Dr Philip Dodd	National Clinical Director	Medical
Ned Kelly	Area Director of Nursing, Cork Mental Health Services	Nursing
Daniel Flynn	Principal Psychology Manager	Psychology
Karen Murphy	Principal Social Worker	Social Work
Ruth Power	Occupational Therapy Manager	Occupational Therapy
Leo Kinsella	Head of Mental Health Services, CHO 1	Service Manager

2. Executive Summary

In 2016, the Mental Health Service set out to design a workforce planning process to proactively manage staffing types and levels according to demand for services arising from current and future models of care. This report has been designed to assess and address staffing challenges on an on-going basis and is aligned to the Department of Health's National Strategic Framework for Health and Social Care Workforce Planning (2017). The document looks at two aspects of the workforce: (i) current supply and demand, and (ii) future supply requirements in accordance with emerging population and health service needs.

Current supply and demand information relied on data collection and validation within existing mechanisms. This was then looked at through confirmation of target staffing levels based on "A Vision for Change" (VfC), and other sources for areas not covered in VfC but known in relation to new models of care. The workforce profile was examined in the context of the current workforce characteristics including, current WTE, headcount, location/distribution, age, discipline, planned and unplanned absence, staff grade mix, and flexible working arrangements.

The future staffing requirements by discipline and region were then determined by cataloguing all current and planned Service Improvement Programmes within the Strategic Portfolio and Programme Management Office in Mental Health Services, and the Clinical Strategy & Programmes Division respectively. The workforce supply was determined by looking at future workforce entry either through the graduate schemes, or anticipated entry based on previous recruitment data which was then offset by staff attrition/ turnover through leavers and retirees. It is important to note that data quality was recorded at an average of 85% accuracy. Multiple data sources were used to validate the position for non-community staff whereas within community only one data source (Qlikview) was used as it was deemed to be a reliable source post validation activity.

The findings and recommendations are covered in more detail under Section 13 of this report and were defined under 4 main categories: (i) Data Collection and Quality; (ii) Resource and Deployment; (iii) Building Capacity; and (iv) Continuation and development of the workforce planning process.

Main data findings indicate that community staff only accounts for 27% of the overall workforce within Mental Health. Also, the Voluntary Non Acute Agencies submit their data by discipline only and not by age profile or programme of work, i.e. Child and Adolescent Mental Health Services (CAMHS), General Adults, Psychiatry of Later Life (POLL), etc. There is potential that some mental health staff working in non-psychiatric settings (e.g. Liaison Services) are not being recorded as part of this analysis.

Under resource and deployment we note that currently Mental Health has a workforce which is at 76% of VfC recommended levels with 23% of our total workforce aged over 55 years. In addition, 73% of the overall workforce is female, of which 29% are under the age of 40 who are most likely to avail of maternity leave. The national staff turnover rate (all leavers including retirements and excluding absences) is 6.4% and within Mental Health, planned and unplanned absence such as sick leave, maternity leave, is 8%.

In order to build capacity we need to match workforce supply with health service demand and this will require on-going liaison with our educational providers, as well as exploring both domestic and international markets.

The future of workforce planning within Mental Health depends on the commitment of each CHO to take ownership of their own data and this is reflected throughout the organisation. Looking towards the future, to enable robust service planning, this project has unveiled the requirement for consideration on how improvements in data management can be made across both Non-Governmental Organisations (NGOs) and Voluntary Non-Acute agencies. A contingency sum of 8% (4% absence leave plus 4% maternity leave) should be factored in to all future posts to ensure an adequate workforce at all times.

Through the key findings in this review, it is recognised that there is a current shortage of trained mental health staff nationally and evidence would suggest that this trend is not unique to Ireland, but is reflected within the European context [Deloitte, 2017]. Notwithstanding these challenges, the findings and recommendations [view recommendation DEV.3] from this document should be used to inform future workforce planning at a local and national level.

3. Introduction

3.1. Definition

Work Force Planning (WFP) is 'a core process of HRM (Human Resource Management) which is shaped by the organisational strategy and ensures the right number of people with the right skills, in the right place, at the right time to deliver short- and long-term organisation objectives'. [Department of Health, 2017]

3.2. Objectives

The objectives of the WFP report are:

a) To identify and provide, through working with service managers, human resource managers and staff representatives:
   - Current staffing levels by discipline and region;
   - Staff grade mix;
   - Current stated demand from VfC and other known demand areas not covered in VfC, e.g. Forensic Hospital, Acute Units, etc.; and
   - Gap Analysis to compare staffing to current and future needs.

b) To identify future supply initiatives which will:
   - Assess and detail all current initiatives by discipline:
     - in recruitment for roles within the Mental Health Services including currently posted vacancies,
     - in graduate supply, education and practice placements for roles within the service,
     - in any other initiatives to supply staff within the service; and
   - Identify resource needs by discipline required for service improvement initiatives and clinical programmes.

c) To propose recommendations to address the report findings.

3.3. Mental Health Workforce Planning Report

The Mental Health Services Workforce Planning (WFP) report was developed to support the HSE Corporate Plan 2015-2017, HSE National Service Plan 2018, HSE Health Services People Strategy 2015 - 2018, and Community Healthcare Operational Plan 2018. It will continue to support mental health operational planning from 2018 onwards. The WFP report has sought and will continue to seek guidance through the HSE strategic workforce planning and intelligence unit, currently in establishment subsequent to the publication of the National Strategic Framework for Health and Social Care Workforce Planning by the Department of Health (November 2017). This document has used the approach as set out in that framework report.

The WFP report has considered the collective opinion of key senior leaders and staff within the mental health services and the wider HSE organisation. The WFP report also represents the current and future challenges posed to all Mental Health services. The key challenges which need to be considered for future impact on the Mental Health Workforce include, but are not limited to, possible additional budgetary constraints, changing population demography bringing about the potential for increased workload and intensity, rising cost of living potentially affecting workforce distribution, employee recruitment and retention affected by labour market forces and the international labour market, changes in technology, changes in care delivery models, and the transfer of organisational knowledge.

More specifically, the Mental Health WFP report provides us with:

- A framework for making staffing decisions linked to the Mental Health Services (MHS) mission, goals, and objectives;
- A means of assisting in the alignment of fiscal, technological, and human resources to meet the service needs;
- A resource to inform the analysis and presentation of the mental health services budget and resource needs;
- A resource to proactively manage staffing types and levels according to the demand for services arising from current and future models of care;
- A resource to highlight staffing challenges on an ongoing basis; and
- A resource to assist decision making at local and national operational level.

3.4. Workforce Planning Cycle

The workforce planning cycle illustrated in figure 2.1. below sets out the continuum for this project. The WFP document in Mental Health Services has aligned to the National Strategy for Health and Social Care Work Force Planning (2017 DoH). The Mental Health Services WFP document to date has focused on three of the five stages within the planning cycle. The remaining two stages will require collaboration with the Department of Health National Workforce Planning Unit.

- Stage 1: Analyse external and internal environments
- Stage 2: Assess / forecast workforce demand and supply
- Stage 3: Identify possible HR and / or policy solutions to address workforce shortfall

The future workforce needed will be informed by (i) new service and clinical developments, (ii)workforce skills and skills mix required to deliver a largely community-based model, and (iii) the availability of the required workforce. In closing the workforce gaps a number of potential strategies must be considered which include:

- reconfiguration of services,
- redeployment of staff to where services are required,
- strategic upskilling of the existing workforce,
- change to workforce skills and potentially role expansion, e.g. nurse prescribing and Advanced Nurse Practitioners
- increase in the available workforce,
- increase in the number of undergraduate and postgraduate training options, and
- the use of scalable technology based solutions especially at the level of prevention and early intervention.

To ensure successful implementation of any of the above potential strategies, key stakeholders (such as Medical, Nursing, Health & Social Care Professionals, Other Patient & Client Care, General Support Staff and Management & Admin) must be consulted in adopting an inter-disciplinary approach to implementing the workforce actions/ recommendations.

Figure 3.1: National Strategic Framework for Health & Social Care Workforce Planning 2017 – (Department of Health, 2017)

3.5. In Scope and Out of Scope

The aim of the project was to provide the baseline information which would be required when entering into a Mental Health Services Workforce Planning process. A number of tasks within the areas of (i) current supply and demand, and (ii) future supply were looked at and specifically are mentioned in the In Scope section below.

3.5.1 In Scope

Current Supply and Demand:

- To map the current workforce in Mental Health Services for all staff disciplines of Nursing, Medical, Occupational Therapy, Social Care Workers, Speech and Language Therapy, Social Workers, Psychology and Management/Administration;
- To identify agreed target staffing levels as outlined in VfC for all staff disciplines of Nursing, Medical, Occupational Therapy, Social Care Workers, Speech & Language Therapy, Social Workers, Psychology and Management/Administration;
- To highlight the staff grading within each discipline where available;
- To identify current staffing demands through a gap analysis based on VfC recommendations; and
- To identify characteristics of supply relating to the current workforce, e.g. outflows relating to retirement/maternity leave, resignations, etc.

Future Supply and Demand:

- To catalogue all current and planned initiatives to procure resources in all disciplines;
- To identify areas where existing initiatives do not address the staff demand highlighted in the Gap Analysis;
- To provide a prioritisation of unmet need per discipline and CHO; and
- To identify opportunity for skill mix, e.g. within acute units and high support residences, within community mental health teams, etc.

3.5.2 Out of Scope

Further work was identified which was deemed to be out of scope of the project. This included:

- Creating and implementing the future workforce planning process and framework;
- Establishing available skill sets within staff roles;
- Providing future demographic projections based on age and social environment of population;
- Addressing team redistribution according to “A Vision for Change” numbers;
- Identifying staff roles and responsibilities;
- Adjusting demand according to demographic intelligence;
- Achieving skill mix as determined in the workforce plan;
- Providing staff training requirements in workforce planning;
- Addressing attrition, retention and recruitment issues;
- Staff not specifically working in the disciplines as outlined in “in scope” section above e.g. Corporate, Quality, etc.
- Achieving resolution of Industrial Relations issues that could impact on the Workforce Plan; and
- Mapping of mental health posts within Primary Care, Social Care and Acute Services.

The last point above is recognised as a known risk to accuracy of mental health data, and it is recommended that further work take place to address this issue.

4. Background to Mental Health Workforce

4.1. National HR Directorate

Staffing levels in mental health are recorded through the National HR Directorate and gathered through the Health Business Services SAP & Uni-pay payroll systems, along with a staffing statement from Voluntary Non-Acute Agencies of St. John of God Hospital in Community Health Organisation (CHO) 6 and St. Vincent's Hospital, Fairview, CHO 9, on a monthly basis. In June 2017, the number of Whole Time Equivalent (WTE) numbers was recorded in the CHOs at 9,331.47 with a further 358.49 in Corporate & Forensics functions, giving a total of 9,690 WTE. The WTE figures takes into account the actual numbers in position at a point in time (June 2017) as opposed to the headcount figure of 11,331 (including voluntary agencies) during that same period.

4.2. Data validity

Staffing is recorded by discipline and location of cost centre. However, the person specific level detail below this is not recorded, i.e. a nurse could be recorded as working in Mayo Psychiatric Services but the community team that nurse works on is not recorded. In addition, if an employee works across more than one team the facility to record this is currently unavailable. In some cases employees are recorded under the programme of work they are assigned to, i.e. Child and Adolescent Mental Health Services (CAMHS), Community, Acute or Mental Health Intellectual Disability (MHID).

The Voluntary Non-Acute Agencies only submit their data by discipline and discipline count and not by programme of work assigned making it impossible to differentiate between CAMHS & Community, etc. [View recommendation DCQ.4]

In addition, transfer data recorded on the payroll systems is not updated regularly thus resulting in WTEs working in one location but being recorded as working elsewhere. It is also noted that the same discipline can sometimes appear on the payroll systems named differently, e.g. Staff Nurse (General) or Staff Nurse (Psychiatric). [View recommendations DCQ.5 and DCQ.6]

Despite the above anomalies a comparison of the 2017 Payroll data versus a staff census which was carried out in 2016 highlighted very high accuracy levels (85% accepted tolerance level) of the data.

4.3. Qlikview

As a result of the issues outlined above [view recommendation DCQ.3], the national centre needed to have clear sight of the number of actual WTEs on the Community Mental Health Teams to compare how near to "A Vision for Change" (VfC) they were. As the payroll HR systems were not currently capable of providing this level of WTE breakdown, the division, as part of the performance activity data cycle, requested individual community teams to return their WTE numbers alongside their patient activity data. This data set was designed to capture the number of staff in post at the end of the month based on the prescribed disciplines as set out in VfC.

This data is collected each month by the community teams via excel templates submitted to the Planning, Business Information unit (PBI) and is available through the Qlikview platform for internal reporting purposes only. This data is not used in the National monthly performance reports as current systems would not allow data to be reliably validated each month.

Data from the four CAMHS inpatient units, the four CAMHS Day services and the three CAMHS liaison services are also captured periodically by the submission of an excel template to the services concerned for completion.

4.4. An overview of data collection sources

Not all specialist services have been accounted for in VfC. The table below outlines where data is available, how data will be sourced in the future and highlights any areas where work is required to close the data gaps.

Figure 4.1: Data Collection Sources

	Workforce recommendation in VfC?	Do we have a current data collection process?	How do we plan in the future to collect this data?	Do we have a data gap?
Community				
Child & Adolescence Mental Health Services	Yes	Yes	Transition fully to SAP	No
General Adult Mental Health Services	Yes	Yes	Transition fully to SAP	No
Psychiatry of Later Life	Yes	Yes	Transition fully to SAP	No
MHID	Partial	Partial	Transition fully to SAP	No
Inpatient				
Child & Adolescence Mental Health Services	Partial	Partial	Transition fully to SAP	No
General Adult Mental Health Services	Partial	Partial	Transition fully to SAP	No
Psychiatry of Later Life	Partial	Partial	Transition fully to SAP	No
Emergency Department	No	No	Action required	Yes
Recovery and Rehabilitation				
24 hour staffed community residences	Partial	Partial	Transition fully to SAP	No
non 24 hour staffed community residences	Partial	Partial	Transition fully to SAP	No

Specialised Rehabilitation Units	No	No	SLA arrangements	No
Forensics	Partial	Partial	Transition fully to SAP	No
Specialist Services				
Homelessness	Partial	Partial	Transition fully to SAP	No
Clinical Programmes, e.g. Eating Disorders, Self-Harm	Partial	No	Transition fully to SAP	No

4.5. Mental Health Provision of Services

A request was made by Health Business Services (HBS) for the purpose of the National Integrated Staff Records and Pay (NiSRP) Program to design the actual service types against each programme of work within MHS. [View Recommendation DCQ.1 and DCQ.2] A visual representation of all service provisions within Mental Health Services can be viewed here. As result of this exercise, HBS are designing their system to align to the same structure as prescribed in the visual.

5. Assumptions and Standards

As part of the WFP project an exercise was undertaken to verify how reliable the manually-collected data (Qlikview) was versus the payroll data in respect of WTE figures and Head Count (or Staff Count[1]). Whilst the data does not match exactly, there is enough evidence to suggest that the teams returning data are accurately reflecting the picture on the ground. [View recommendation DCQ.8] Therefore with this information the project team were able to confirm with a degree of accuracy (85% acceptable tolerance level) the VFC staffing levels in each Community service from the Qlikview data.

As Qlikview data only records approximately 27% (2,616) of the 9,690 WTE staff, a further exercise was required to understand the variation from the HR / Payroll systems. It would appear that there is a large cohort of staff in acute approved centres or staffed community residences. The following data sources were used to understand the position of staff in these non-community settings:

- Qlikview staffing extract as at 30th June 2017;
- SAP payroll extract as at 30th June 2017;
- CHO 4 & 5 Uni-pay payroll extract as at 30th June 2017;
- Discipline data collected as part of a validation extract completed during the period of 2016 to 2017.

Replacement factor for leave, planned and unplanned, was not included as part of Vision for Change recommendations.

[1] *Staff count equates to the number of actual persons employed by the service. Whole time equivalent (WTE) is a unit that indicates the workload of an employed person in a way that makes workloads or class loads comparable across various contexts. This is calculated by hours worked divided by contracted hours for the staff category. For example 1 staff member on a 40 hour contract 5 days a week (8 hours per day) who regularly works reduced hours at 32 hours per week is calculated 32/40=0.8 Therefore the staff count is 1 but WTE is 0.8.*

6. A Vision for Change 2006 (VfC)

'A Vision for Change' is a strategy document which sets out the direction for Mental Health Services in Ireland. It describes a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness. This policy was developed by an expert group which combined the expertise of different professional disciplines, health service managers, researchers, representatives of voluntary organisations, and service user groups.

A Vision for Change builds on the approaches to mental health service provision proposed in previous policy documents. It proposes a holistic view of mental health and recommends an integrated multidisciplinary approach to addressing the biological, psychological and social factors that contribute to mental health problems. It proposes a person-centred treatment approach which addresses each of these elements through an integrated care plan, reflecting best practice, and agreed with service users and their carers. Special emphasis is given to the need to involve service users, their families and carers at every level of service provision. Interventions should be aimed at maximising recovery from mental illness, and building on the resources within service users and within their immediate social networks to allow them to achieve meaningful integration and participation in community life.

6.1. Vision for Change Staffing Recommendations

A Vision for Change prescribes that the new workforce would comprise of close to 11,000 staff. Based on the increasing population this would equate to 12,354 in 2016 and if the population was to increase at 3% every 5 years (0.6% per year), by 2026 Mental Health would require over 13,000 staff to implement A Vision for Change alone without any other new programmes of work being introduced.

Figure 6.1: VfC staffing recommendation against population growth

	2006	2011	2016	2021	2026
Population	4,239,848	4,588,252	4,761,865	4,904,721	5,051,863
VfC recommendation	11,000	11,904	12,354	12,725	13,107

Vision for Change recommendations have been based on Whole Time Equivalent (WTE) figures rather than Head Count values

6.2. Child and Adolescent Mental Health Services (CAMHS) Workforce

A Vision for Change (2006) recommends that there should be two Child and Adolescent Community Mental Health teams for every 100,000 population with individual Child and Adolescent Community Mental Health Teams made up of the following:

- One consultant psychiatrist,
- One doctor in training,
- Two mental health nurses,
- Two clinical psychologists,
- Two social workers,
- One occupational therapist,
- One speech and language therapist,
- One child care worker, and
- Two administrative staff.

The composition of each Child and Adolescent Community Mental Health Team should ensure that an appropriate mix of skills is available to provide a range of best-practice therapeutic interventions. The staff complement for two CAMHS teams, as recommended in *A Vision for Change (2006)* is 26 per 100,000 head of population, comprising 22 clinical and 4 administrative staff.

6.3. Community General Adult Mental Health Team Workforce

Vision for Change (2006) recommends that there should be one General Adult Community Mental Health Team for each sector of 50,000 population with each individual General Adult Community Mental Health Team comprised of the following:

- Two consultant psychiatrists,
- Two doctors in training,
- Two psychologists,
- Two psychiatric social workers,
- Eight mental health nurses,
- Two occupational therapists,
- One addiction counsellors/psychotherapists,
- Two mental health support workers, and
- Two administrative staff.

The staff complement for a General Adult Community Mental Health Team, as recommended in *A Vision for Change (2006),* is 23 per 50,000 head of population, comprised of 21 clinical and 2 administrative staff.

6.4. Psychiatry of Later Life (POLL) Services Workforce

A *Vision for Change (2006)* recommends that there should be one Psychiatry of Later Life service team for each sector of 100,000 population. The staff complement for a Psychiatry of Later Life team is 12 per 100,000 head of population, (11 clinical and 1 administrative support staff) and is made up of:

- One consultant psychiatrist (with specialist expertise in later life psychiatry),
- One doctor in training,
- One senior nurse manager,
- Three mental health nurses,
- One clinical psychologist,
- One social worker,
- One occupational therapist,
- Two mental health support workers/care assistants, and
- One administrative staff.

Figure 6.2 below demonstrates the total adult population of 4.7 million by Community Health Organisation as per the 2016 census. 25% of the population are under the age of 18 and 13% are over the age of 65 years.

Based on the Vision for Change recommendations we can show that 33% of the staffing recommendations are in the three speciality community Mental Health teams with the remaining 67% being non community based, i.e. acute inpatients units, residential units, liaison and day services, etc.

Figure 6.2: Populations per CHO (2016 Census)

Population Levels	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National	Percentage
Population Total	394,333	453,109	384,998	690,575	510,333	445,590	645,293	616,229	621,405	4,761,865	100%
CAMHS Population 0- <18	103,778	111,880	96,266	168,542	131,522	116,264	144,296	172,373	145,581	1,190,502	25%
Adult Population 18-64	230,492	272,671	232,797	423,156	304,509	278,504	418,006	369,598	404,063	2,933,796	62%
POLL Population 65 +	60,063	68,558	55,935	98,877	74,302	50,822	82,991	74,258	71,761	637,567	13%
Staffing Levels	**CHO 1**	**CHO 2**	**CHO 3**	**CHO 4**	**CHO 5**	**CHO 6**	**CHO 7**	**CHO 8**	**CHO 9**	**National**	**Percentage**
Adult Community VfC[1]	181	208	177	318	235	205	297	283	286	2,190	***18%***
CAMHS Community VfC[1]	108	116	100	175	137	121	150	179	151	1,238	***10%***
POLL Community VfC[1]	54	61	50	89	67	46	74	66	64	571	***5%***
Non Community[2]	680	789	672	1,210	886	785	1,153	1,069	1,111	8,355	***67%***
VfC Recommendation total[3]	1,023	1,176	999	1,792	1,324	1,156	1,674	1,599	1,612	12,354	

[1] Community Staff refers to staff directly employed within the Community CHO, excluding Inpatient Services, e.g. Acute Units, High Support Hostels, CAMHS Inpatient Units, etc.

[2] Contains a number of acute and community staff not defined in A Vision for Change, e.g. Liaison, Day Services, Rehab & Recovery, MHID, etc.

[3] This relates to recommended figures, not ACTUAL figures, and is based on VfC uplifted figures to cater for current population (2016 census)

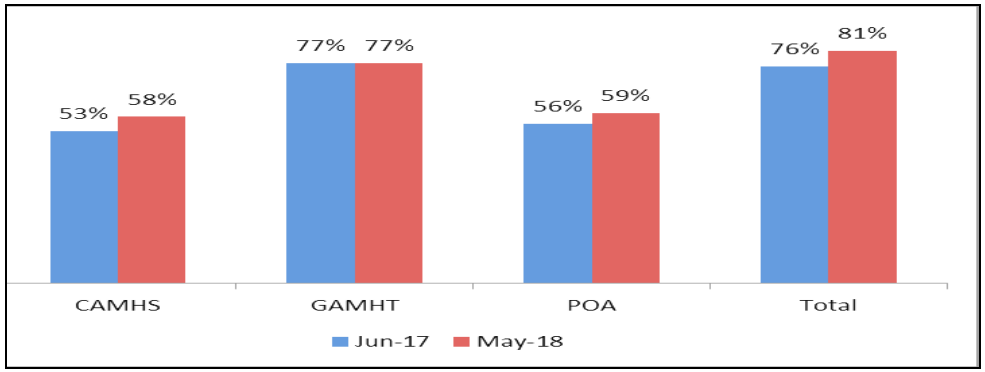
Currently the Mental Health service has 76% of the staffing levels prescribed by Vision for Change (see figure 6.3).

- Community Child & Adolescent Mental Health services have 53% of the staffing level with a range from 46% to 60%
- Community General Adult Mental Health services have 77% of the staffing level with a range from 48% to 97%
- Psychiatry of Later Life services has 56% of the staffing level with a range from 21% to 88%

Figure 6.3: Actual staffing levels against VFC recommendations per CHO area

	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
Adult Community Actual[1]	97%	91%	74%	88%	79%	48%	76%	71%	67%	77%
CAMHS Community Actual[1]	53%	57%	52%	48%	46%	55%	49%	57%	60%	53%
POLL Actual[1]	75%	79%	51%	21%	56%	73%	35%	88%	44%	56%
Non Community Actual[2]	96%	124%	84%	85%	102%	46%	47%	68%	81%	80%
Total Actual	90%	109%	78%	79%	90%	49%	52%	68%	75%	**76%**

The graph shows the increase in staffing resources as at May 2018 compared to the extracted data used in the validation process (June 2017). Community data extracted from Qlikview shows CAMHS increased to 58% and POLL increased to 59% whist General Adult remained static. Overall staff census data shows an increase from 76% to 81% (10,008 WTEs).



It is worth pointing out that even though some areas appear overprescribed they can in fact be under prescribed due to the volume of bed numbers and specialists services located in a particular CHO. A good example of this is CHO 2 which has a 20 bed CAMHS inpatient unit compared to other CHOs bordering it which do not have one of these centres and who therefore avail of the CHO 2 facility. Figure 6.4 below shows the ratio of staff to bed numbers (staff numbers exclude Community CAMHS, General Adult, & POLL)

[1] Community Staff refers to staff directly employed within the Community CHO excluding Inpatient Services, e.g. Acute Units, High Support Hostels, CAMHS Inpatient Units, etc.

[2] Contains a number of community staff not defined in A Vision for Change, e.g. Liaison, Day Services, Rehab & Recovery, MHID, etc.

Figure 6.4: Ratio of staff to bed numbers per CHO area

	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
Non Community Actual[1]	652	981	566	1,034	907	364	540	731	903	6,678
CAMHS IP Beds	0	20	0	20	0	0	22	0	12	74
Adult Acute Beds	89	99	89	171	88	91	142	112	137	1,018
Residential units Beds	137	101	110	219	244	53	101	138	211	1,314
Bed Total	*226*	*220*	*199*	*410*	*332*	*144*	*265*	*250*	*360*	*2,406*
Bed proportion	*9%*	*9%*	*8%*	*17%*	*14%*	*6%*	*11%*	*10%*	*15%*	*100%*
Staff to Bed ratio	2.88	4.46	2.84	2.52	2.73	2.53	2.04	2.92	2.51	2.78

[1] ***Contains Acute staff and a number of community staff not defined in A Vision for Change, e.g. Liaison, Day Services, Rehab & Recovery, MHID, etc.***

The Area Directors of Nursing were requested to identify the required staffing levels (including skill mix) for a 50 bed acute mental health unit (2 configurations) and a 10 bed 24-hour residential unit based upon the best evidence available. [View recommendation RD.1] The staffing levels recommended in the Framework report uses nurse-to-service user ratios, and it appears to be based on a mix of the New South Wales ratios and the professional judgement of the Workforce Planning nursing subgroup. Staffing levels for the Psychiatry of Later Life assessment sub-unit of 8 beds are also included based on professional judgement. While this report is still subject to final sign off, the WFP group acknowledges that this is a reference framework for Nursing WFP and recognises that there will always be local working arrangements.

7. Community Staffing Levels versus *A Vision for Change* recommendations

Using the 2016 population census data, the community services should have the following staffing levels as recommended in VfC based on the cohort of their populations.

The monthly data collection from the community specialities allowed the project team to draw comparisons against "in post" positions and VfC recommendations. The tables in this section illustrate the VfC recommendations for each cohort (Child and Adolescent, General Adult, and Later Life) of the actual staff numbers in post and the unmet need for these Community Mental Health specialities.

7.1. Child and Adolescent Mental Health Services (CAMHS)

Figure 7.1 highlights the number and grading of staff on these teams in place, along with the whole time equivalent (WTE) gap required to have the Vision for Change staffing recommendations at full complement. Figure 7.2 displays the unmet need percentage by grade type as a proportion of the total unmet need for each speciality.

Figure 7.3 demonstrates the VfC recommendation position by the grade type by Community Health Organisation (CHO).
It is also worthy to note that some grades may be oversubscribed for one of two reasons:

- Grade was not defined in A Vision for Change and may have been historically part of that individual service;
- As services will never precisely align to the 50,000 population model prescribed in Vision for Change this will cause some overstaffing levels.

Figure 7.1: Number of recommended teams versus actual teams in CAMHS

Child & Adolescent Mental Health Services	Vision for Change 2006	No. of recommended teams	Teams in place	Rec. Staff	Staffing levels at June 2017
Staff Community MHTs	1 : 50,000[1]	79[2]	66	1,238	656.86
Adolescent Day Services	1 : 300,000	16	4		26.43
Hospital Liaison MHTs	1 : 300,000	16	3	208	31.63
Total	1 : 42,900	111	71	1,446	714.92
Inpatient Services			**4 Units**		**199.30**
			Total Staff		**914.22**

[1] ***Equates to 1: 12,500 under 18 year old population (based on 2016 census) as 25% of population are aged under 18.***

[2] ***Child and adolescent mental health services should be provided by multidisciplinary CMHTs. Two teams should be provided for each sector of approximately 100,000 population. These teams should serve all children and adolescents in the sector population, providing multidisciplinary assessment and a comprehensive range of interventions in a variety of settings such as home, outpatient and day hospital settings as appropriate. The teams should cover the child and adolescent day hospital in the catchment area. One additional team per catchment area of 300,000 population should also be provided, to provide liaison cover to paediatric wards, general hospitals and maternity units in their area***

Figure 7.2: Percentage unmet need by discipline in CAMHS (National View)

WTE Staff	Population 0 - 18	Actual Clinical WTE	Total Actual WTE(clinical + admin)	Consultant Psychiatrist	NCHD (Senior Registrar & Registrar/ SHO)	Nurse	Social Worker	Clinical Psychologist	Speech & Language Therapist	Occupational Therapist	Child/Social Care Worker	Administrative Support Staff
CAMHS VfC recommendation	**1,190,502**	**1047.6**	**1238.1**	**95.2**	**95.2**	**190.5**	**190.5**	**190.5**	**95.2**	**95.2**	**95.2**	**190.5**
CAMHS in Post		**560**	**645.3[1]**	**71.9**	**83.5**	**106.5**	**81.6**	**72.5**	**51.0**	**56.6**	**36.4**	**85.3**
Unmet need		**487.7**	**592.9**	**23.3**	**11.7**	**84.0**	**108.9**	**118.0**	**44.3**	**38.7**	**58.9**	**105.2**
Percentage of overall unmet need				**4%**	**2%**	**14%**	**18%**	**20%**	**7%**	**7%**	**10%**	**18%**

[1] ***There is a small number of additional staff included in these totals. These staff would include staff not prescribed in VFC but remain on a team due to historic legacy issues or relevant to current needs. Examples of these staff can be dieticians or other therapy grades***

Currently there is an unmet need for an additional 581 WTEs to achieve the VFC recommendation for Community CAMHS. 20% of these posts would be specific to Clinical Psychologists followed closely by Social Workers (19%) and then finally Administration (18%).

Figure 7.3: VFC recommendation by grade type by Community Health Organisation in CAMHS (CHO view).

CAMHS WTE Staff	Population 0 - 18	Actual Clinical WTE	% VfC	Total Actual WTE(clinical + admin)	% VfC	Consultant Psychiatrist	NCHD (Senior Registrar & Registrar/SHO)	Nurse	Social Worker	Clinical Psychologist	Speech & Language Therapist	Occupational Therapist	Child/Social Care Worker	Admin Support Staff
CHO 1	**103,778**	49.1	53.8%	56.84	52.7%	75.3%	72.3%	72.6 %	56.0%	21.1%	48.2%	48.2%	48.7%	46.4%
CHO 2	**111,880**	55.4	56.3%	65.93	56.7%	87.1%	105.0%	49.2 %	56.4%	29.6%	49.2%	52.5%	34.0%	58.7%
CHO 3	**96,266**	50.3	59.4%	52.30	52.2%	75.3%	77.9%	71.4 %	63.0%	44.1%	64.9%	39.0%	39.0%	13.0%
CHO 4	**168,542**	72.0	48.6%	84.31	48.1%	52.6%	54.9%	32.9 %	50.1%	46.6%	47.7%	65.1%	43.7%	45.5%
CHO 5	**131,522**	53.9	46.6%	63.57	46.5%	72.2%	57.0%	57.5 %	31.6%	28.5%	42.8%	62.7%	26.6%	45.9%
CHO 6	**116,264**	54.6	53.4%	66.52	55.0%	69.9%	91.4%	59.1 %	29.6%	43.8%	75.3%	55.6%	30.1%	64.0%
CHO 7	**144,296**	63.6	50.1%	73.24	48.8%	76.2%	78.0%	41.6 %	34.4%	29.7%	59.8%	47.6%	76.2%	41.8%
CHO 8	**172,373**	89.6	59.1%	103.00	57.5%	74.8%	125.7%	80.5 %	27.6%	34.8%	23.6%	60.2%	43.5%	48.5%
CHO 9	**145,581**	83.0	64.7%	91.15	60.2%	101.1%	119.3%	46.8 %	48.6%	58.8%	81.6%	90.2%	0.0%	35.2%
Total	**1,190,502**	571.6	54.6%	656.86	53.1%	75.5%	87.7%	55.9 %	42.9%	38.0%	53.5%	59.4%	38.2%	44.8%
VfC Gap		45.4%		46.9%		24.5%	12.3%	44.1 %	57.1%	62.0%	46.5%	40.6%	61.8%	55.2%

7.2. Community General Adult Mental Health Teams (GAMHT)

A Vision for Change (2006) recommends the following for Community General Adult Mental Health Services:

Figure 7.4: VfC team / staffing recommendation in GAMHT

Community General Adult Mental Health Services	Vision for Change 2006	No. of recommended teams	Teams In place	Rec. Staff	Staffing levels in 2016
Staff Community MHTs	1 : 50,000	95	114[2]	2,191	1,680

Currently there is a need for an additional 510 WTEs to achieve the VfC recommendation for Community General Adult Mental Health Services. 35% of these posts would be specific to Mental Health Support workers, followed by Nurses (29%) and finally Occupational Therapists (14%). NCHD posts are in fact in excess by 11%.

Figure 7.5: VFC recommendation versus actual by discipline in GAMHT (National View)

WTE Staff	Population	Actual Clinical WTE	Total Actual WTE(clinical + admin)	Consultant Psychiatrist	NCHD (Senior Registrar & Registrar/SHO)	Nurse	Social Worker	Clinical Psychologist	Mental Health support worker	Occupational Therapist	Addiction Counsellor	Administrative Support Staff
Gen Adult VfC	**4,761,865**	**2000.0**	**2190.5**	**190.5**	**190.5**	**761.9**	**190.5**	**190.5**	**190.5**	**190.5**	**95.2**	**190.5**
Gen Adult in Post		**1463.1**	**1625.0[1]**	**160.2**	**247.8**	**614.7**	**139.4**	**132.2**	**9.5**	**119.9**	**39.5**	**161.9**
Unmet need		**536.8**	**565.5**	**30.2**	**-57.4**	**147.2**	**51.1**	**58.3**	**181.0**	**70.6**	**55.8**	**28.6**
Percentage of overall unmet need				**5%**	**-10%**	**26%**	**9%**	**10%**	**32%**	**12%**	**10%**	**5%**

[1] ***There are a small number of additional staff included in totals. These staff would include staff not prescribed in VfC but who remain on a team due to historical legacy issues or relevant to current needs. Examples of these staff include dietitians or other therapy grades***

[2] ***Currently there are 114 Community Mental Health Teams which are in a phase to reconfigure to the recommended VfC number of teams***

Figure 7.6: VfC recommendation by grade type by Community Health Organisation in GAMHT (CHO view)

General Adult WTE Staff	Population	Total Actual WTE(clinical+ admin)	% VfC	Consultant Psychiatrist	NCHD	Nurse	Social Worker	Clinical Psychologist	Mental Health support worker	Occupational Therapist	Addiction Counsellor	Administrative Support Staff
CHO 1	394,333	176.23	97.2%	90.7%	125.5%	121.4%	72.9%	58.3%	12.7%	64.0%	86.2%	143.6%
CHO 2	453,109	189.63	91.0%	88.3%	163.3%	89.1%	80.6%	76.1%	24.8%	74.5%	133.5%	96.9%
CHO 3	384,998	130.85	73.9%	82.5%	142.9%	72.5%	76.6%	50.6%	0.0%	66.9%	39.0%	89.1%
CHO 4	690,575	278.07	87.5%	75.7%	125.4%	111.8%	83.0%	95.6%	0.0%	69.9%	6.5%	73.5%
CHO 5	510,333	186.52	79.5%	82.1%	94.7%	89.6%	78.1%	74.3%	4.9%	62.5%	64.6%	81.1%
CHO 6	445,590	99.22	48.4%	77.5%	129.0%	31.4%	72.9%	62.8%	0.0%	39.3%	0.0%	32.5%
CHO 7	645,293	226.50	76.3%	92.2%	133.7%	84.7%	67.8%	69.7%	0.0%	70.9%	0.0%	85.2%
CHO 8	616,229	202.06	71.3%	77.1%	109.5%	69.9%	51.7%	62.1%	0.0%	48.7%	73.6%	93.2%
CHO 9	621,405	191.00	66.8%	92.3%	152.9%	53.8%	77.8%	61.6%	8.0%	66.8%	8.0%	81.7%
Total	4,761,865	1680.08	76.7%	84.1%	130.1%	80.7%	73.2%	69.4%	5.0%	62.9%	41.4%	85.0%
VFC GAP		23.3%		15.9%	-30.1%	19.3%	26.8%	30.6%	95%	37.1%	58.6%	15.0%

Figure 7.6 highlights an over-prescription in some areas of certain disciplines based on VfC requirements. However, the workforce requirement within Mental Health Services should not only be driven by policy requirements but also by service user needs and models of care. [See recommendation RD.2]

7.3. Psychiatry of Later Life

A Vision for Change (2006) recommends the following for Psychiatry of Later Life Mental Health Services

Figure 7.7: VfC team / staffing recommendation in POLL

Psychiatry of Later Life Mental Health Services	Vision for Change 2006	No. of recommended teams	Teams In place	Rec. Staff	Staffing levels in 2016
Staff POLL service	1 : 100,000[1]	48	30	571	316.5

[1] ***Equates to 1: 13,400 over 65 year old population (based on 2016 census) as 13.4% of population are aged over 65***

Currently there is a need for an additional 254 WTEs to achieve the VfC recommendation for Psychiatry of Later Life Mental Health Services. 37% of these posts would be Mental Health Support Workers, followed by Clinical Psychologists at 10% and finally Nurses, Social workers & Occupational Therapists at 9% each. Medical requires the least numbers with Consultant Psychiatrists and NCHDs at 4% and 1% respectively.

Figure 7.8: VfC recommendation versus actual by discipline in POLL (National View)

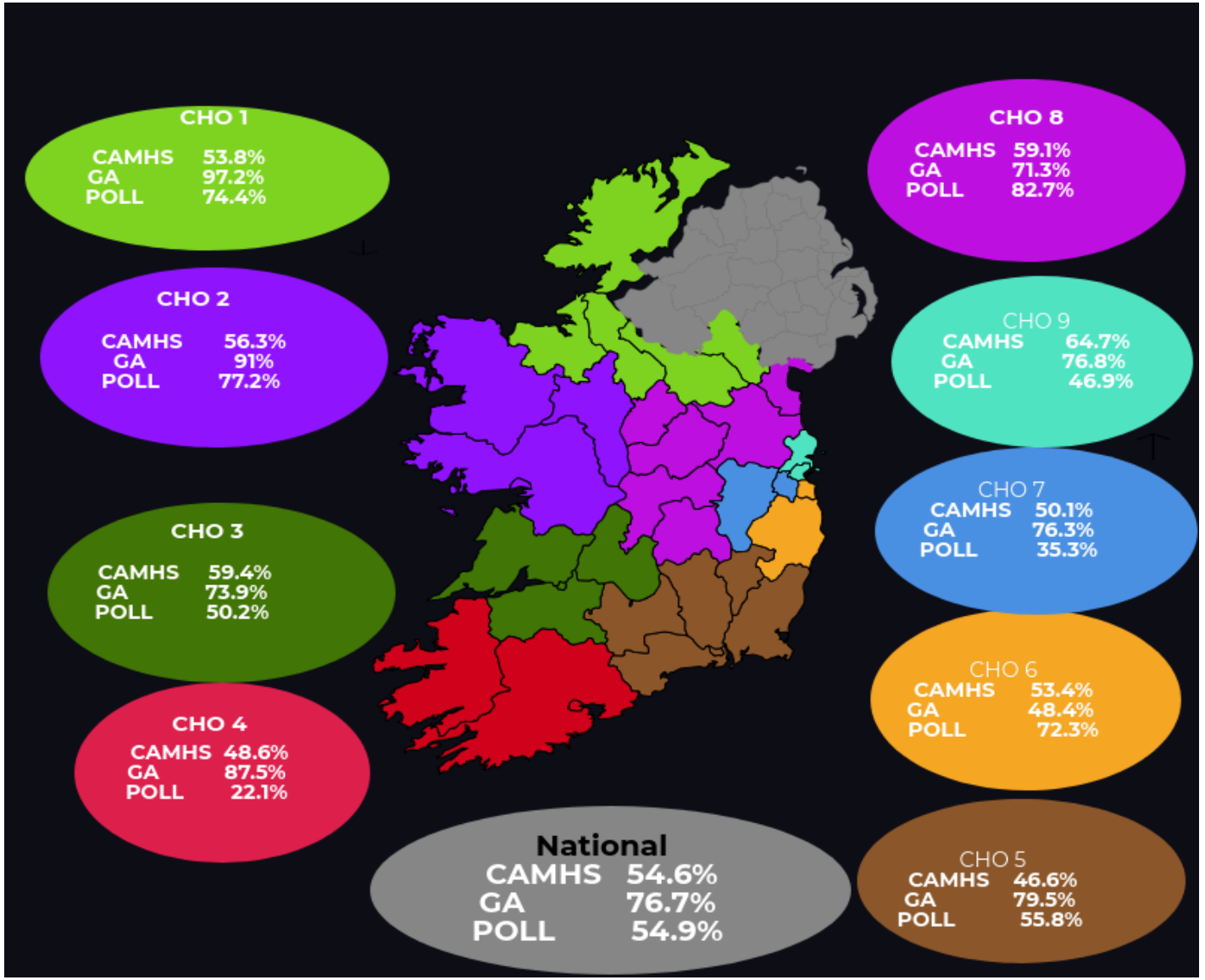
WTE Staff	Population > 65 years	Actual Clinical WTE	Total Actual WTE(clinical + admin)	Consultant Psychiatrist	NCHD (Senior Registrar & Registrar/SHO)	Nurse	Social Worker	Clinical Psychologist	Mental Health support worker	Occupational Therapist	Administrative Support Staff
POLL VfC	**637,567**	**475.8**	**523.4**	**47.6**	**47.6**	**142.7**	**47.6**	**47.6**	**95.2**	**47.6**	**47.6**
POLL in Post		**276.1**	**308.6[1]**	**37.8**	**45.4**	**120.7**	**24.3**	**22.1**	**1.9**	**23.9**	**32.5**
Unmet need		**199.8**	**214.8**	**9.8**	**2.3**	**22.0**	**23.2**	**25.5**	**93.2**	**23.7**	**15.1**
Percentage of overall unmet need				**5%**	**1%**	**10%**	**11%**	**12%**	**43%**	**11%**	**7%**

[1] ***There are a small number of additional staff included in these totals. These staff would include staff not prescribed in VfC but who remain on a team due to historical legacy issues or relevant to current needs. Examples of these staff include dietitians or other therapy grades***

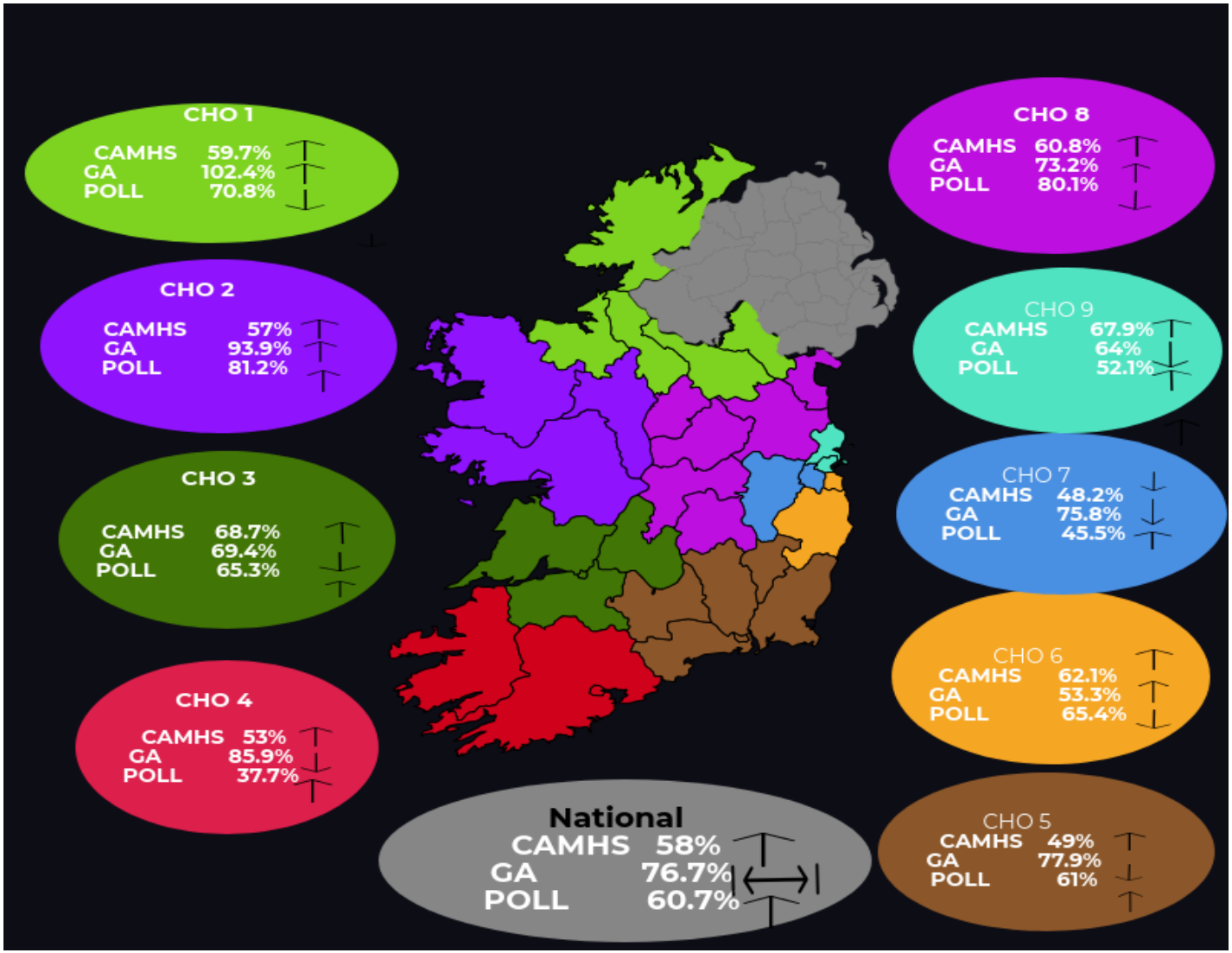
Table 7.9: VfC recommendation by grade type by Community Health Organisation in POLL (CHO view)

POLL WTE Staff	Population > 65 year	Actual Clinical WTE	% VfC	Total Actual WTE (clinical+ admin)	% VfC	Consultant Psychiatrist	NCHD (Senior Registrar & Registrar/SHO)	Nurse	Social Worker	Clinical Psychologist	Mental Health support worker	Occupational Therapist	Administrative Support Staff
CHO 1	**60,063**	35.9	74.4%	40.50	77.0%	78.1%	111.5%	119.0%	98.2%	44.6%	11.2%	44.6%	102.6%
CHO 2	**68,558**	42.5	77.2%	48.78	81.2%	97.7%	166.1%	114.3%	70.4%	67.4%	0.0%	78.2%	123.1%
CHO 3	**55,935**	22.6	50.2%	25.56	52.2%	71.9%	95.8%	79.9%	24.0%	47.9%	0.0%	47.9%	71.9%
CHO 4	**98,877**	17.6	22.1%	18.56	21.4%	27.1%	40.7%	30.7%	18.0%	32.5%	0.0%	20.3%	13.6%
CHO 5	**74,302**	33.3	55.8%	37.27	57.3%	90.2%	86.6%	91.1%	39.7%	50.5%	8.3%	43.1%	72.1%
CHO 6	**50,822**	29.5	72.3%	33.00	74.1%	105.5%	105.5%	109.9%	65.9%	79.1%	0.0%	92.3%	92.3%
CHO 7	**82,991**	23.5	35.3%	26.00	35.8%	64.6%	64.6%	59.2%	40.4%	0.0%	0.0%	16.1%	32.3%
CHO 8	**74,258**	49.3	82.7%	58.84	90.5%	108.3%	126.3%	131.9%	104.7%	72.2%	0.0%	72.2%	128.3%
CHO 9	**71,761**	27.0	46.9%	28.00	44.5%	99.0%	93.4%	61.0%	18.7%	44.8%	0.0%	65.4%	18.7%
Total	**637,567**	281.1	54.9%	316.51	56.7%	79.4%	95.2%	84.6%	51.1%	46.3%	2.0%	50.2%	68.3%
VfC GAP		54.1%		43.3%		18.8%	2.7%	13.5%	47.7%	52.6%	97.9%	48.7%	30.1%

7.4. Community Clinical staffing levels versus VfC recommendations at June 2017



7.5. Community Clinical staffing levels versus VfC recommendations at May 2018[2] (incorporates % +/- since 2017)



[2] The arrows represent the fluctuations in staffing levels within the different programmes of work. The 2018 position is based on un-validated workforce data.

Recommendation

Continual Quality Assurance of Workforce level data protocols at Team level

Adherence and validation of HR processes at CHO level

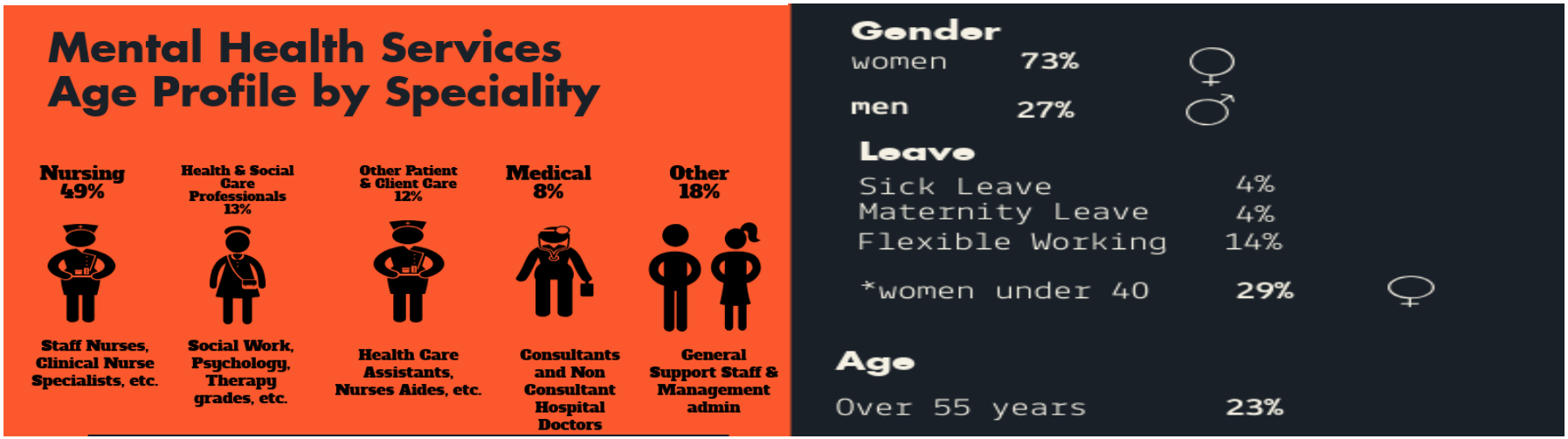
HBS Health Business Services
The business division of the HSE

Data anomalies to be addressed within SAP HR payroll system

8. Workforce Profile

Based on the validated data, the following findings were made:

- ✓ Nursing grades make up the largest proportion of the mental health workforce at 48% followed by Health & Social Care professionals at 13%
- ✓ Women make up 73% of the overall workforce in Mental Health, with 29% of those under the age of 40 years
- ✓ 23% of the Mental Health Workforce is aged over 55 years
- ✓ 14% of the Mental Health Workforce is currently availing of flexible working arrangements which are dealt with in more detail in Section 9



8.1. Age Profile

Further analysis of the data shows us the age of our workforce and the numbers nearing retirement over 5 year increments. We can also estimate the numbers expected to be on sick leave and maternity leave and the grade categories most likely to be impacted by maternity leave.

The usual retirement age in contracts of employment is 65. Many have provisions for early retirement from age 60, or in some cases from age 55, and most have provision for early retirement on health grounds. In some cases, there is a statutory retirement age. These retirement ages arise in jobs that are established by law and the law sets out the maximum age of staff.

Normal retirement

For nurses/midwives who entered the Public Sector pre-April 1, 2004, normal retirement age is 60. For nurses/midwives who entered post April 1, 2004, it is 65.

There have been no changes to the rules regarding the retirement of mental health nurses - those employed pre-April 2004, covered under Section 66 of the 1945 Mental Treatment Act, can retire from age 55 onwards. Those employed post-April 2004 have a retirement age of 65 with no doubling of service applying.

As we can see almost 23% of the mental health workforce are aged over 55 and 38% are aged over 50. The tables below show the age profiles and numbers that will be in the "eligible to retire" age bracket over the next 9 years.

Figure 8.1: Age profile of current work force

Age Profile	2017	
60-65 years	936	9%
55-59 years	1,489	14%
50-54 years	1,624	15%
40-49 years	2,650	25%
30-39 years	2,875	27%
< 30 years	1,191	11%

Figure 8.2: Age profile of workforce up to 2026

Age Profile	2017	2021	2026
60-65 years	936	1,489	1,624
55-59 years	1,489	1,624	2,650
50-54 years	1,624	2,650	2,875
40-49 years	2,650	2,875	1,191
30-39 years	2,875	1,191	
< 30 years	1,191		

It can be seen from the graph and Figure 8.3 below that 38% of the Mental Health workforce is under the age of 40. 39% are in the 40 to 54 year old age range and 23% are over 55 years of age.

Of this age range 9% are over 60 but this ranges from 7% to 11% across the CHOs. Whilst 23% are over the age of 55, it is worth noting that the variance between each CHO with CHO 2 having the highest number of over 55 year olds at 29% compared to the lowest in CHO 7 with 17%.Likewise CHO 3 has the highest number under 40 year olds at 45% compared to CHO 6 at 29%.

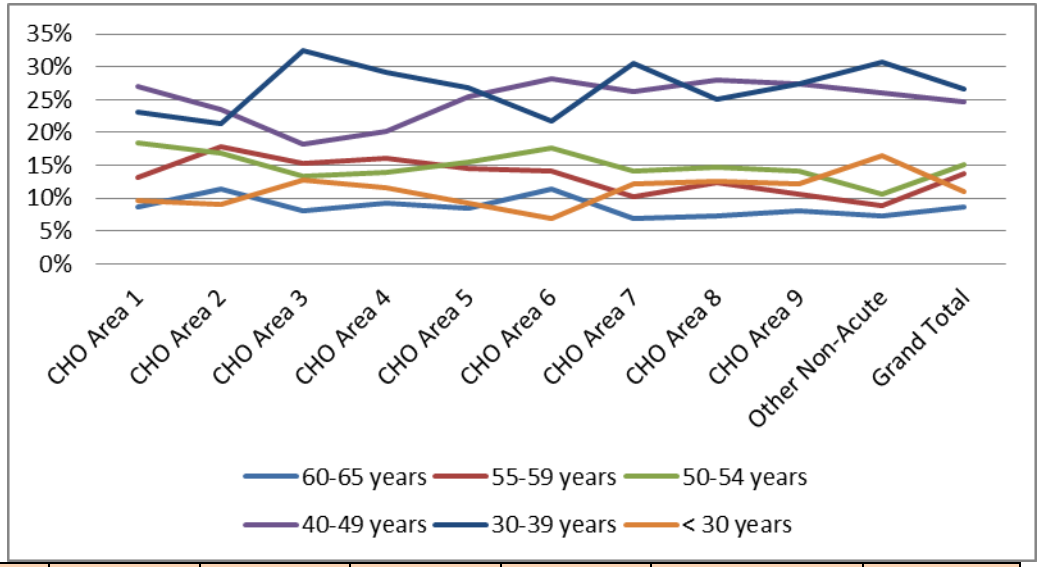


Figure 8.3: Workforce age profile by CHO Area

Age Profile	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	Other Non-Acute	Grand Total
60-65 years[1]	9%	11%	8%	9%	8%	11%	7%	7%	8%	7%	9%
55-59 years	13%	18%	15%	16%	14%	14%	10%	12%	11%	9%	14%
50-54 years	18%	17%	13%	14%	15%	18%	14%	15%	14%	11%	15%
40-49 years	27%	24%	18%	20%	25%	28%	26%	28%	28%	26%	24%
30-39 years	23%	21%	33%	29%	27%	22%	30%	25%	27%	31%	27%
< 30 years	10%	9%	13%	12%	9%	7%	12%	13%	12%	16%	11%

[1] 79.46 WTE are over the age of 65 years which equates to 0.8% of the overall Workforce Staffing Level

The highest age rate per staff category is in General Support staff discipline with almost 49% over the 55 year age band; this is followed by Other Patient & Client Care at 36% and Management/Admin at 26%. These figures are in the context of 23% of the Mental Health workforce being over 55 years of age.

Health & Social Care Professionals have the highest number of under 40 year olds at 53% with only 9% of these under 30 years of age; this is followed by Medical 46% & Nursing 43%. General Support & Management/ Admin have the fewest number of under 30 year olds with 3% & 2% respectively.

Figure 8.4: Staff Discipline by age

Age Profile	General Support Staff	Health & Social Care Professionals	Management/ Admin	Medical	Nursing	Other Patient & Client Care	Grand Total
60-65 years	24%	5%	10%	7%	5%	17%	9%
55-59 years	25%	7%	16%	9%	13%	19%	14%
50-54 years	17%	10%	17%	14%	15%	19%	15%
40-49 years	22%	25%	33%	25%	24%	25%	25%
30-39 years	10%	44%	22%	33%	28%	14%	27%
< 30 years	3%	9%	2%	13%	15%	6%	11%
Total	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***

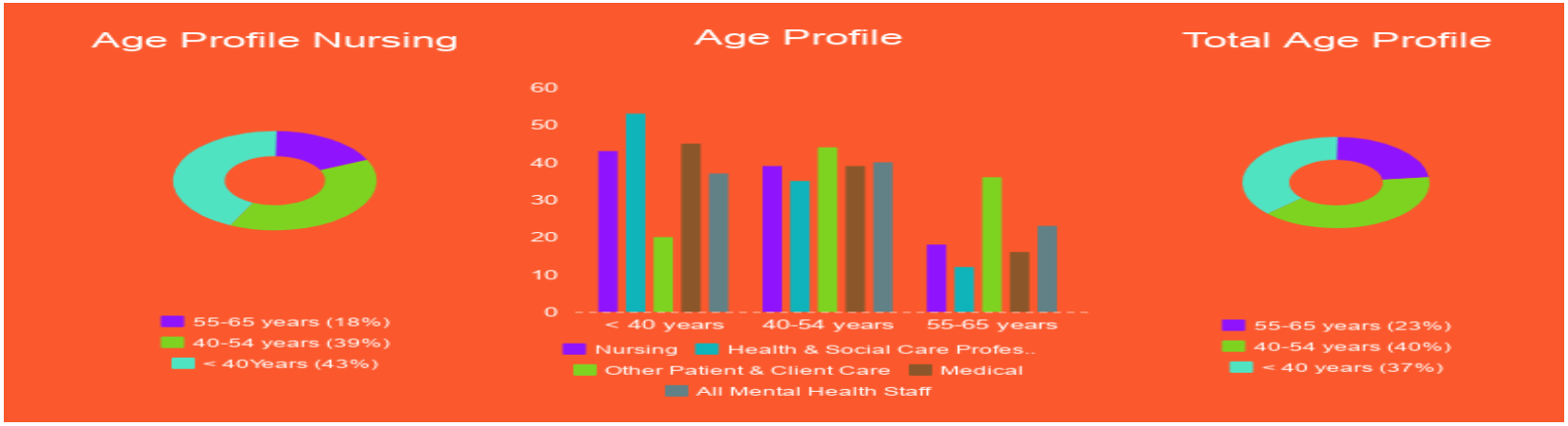


Figure 8.5 shows that the highest staff category by age is nursing with 27% of those over the 60 year age band followed by Other Patient & Client Care at 25%. These figures are within the context of 49% of the Mental Health workforce being nursing and 12% Other Patient & Client Care.

Figure 8.5: Percentage of staff category by age

Age Profile	General Support Staff	Health & Social Care Professionals	Management/ Admin	Medical	Nursing	Other Patient & Client Care	Grand Total
60-65 years	23%	8%	11%	6%	27%	25%	***100%***
55-59 years	15%	7%	11%	5%	45%	17%	***100%***
50-54 years	9%	9%	10%	7%	49%	15%	***100%***
40-49 years	7%	14%	12%	8%	47%	13%	***100%***
30-39 years	3%	22%	7%	10%	51%	6%	***100%***
< 30 years	2%	11%	2%	10%	68%	7%	***100%***
Total	8%	13%	9%	8%	49%	12%	***100%***

Note: the age profile of staff is only available for HSE employees

8.2. Staff Grade Mix

In any review of workforce it is important to ensure that there is an appropriate grade and skill mix within the workforce that strikes the balance between availability of senior decision makers, alongside opportunities for professional development in the context of support and development of the next generation of the healthcare professionals. When deciding upon the optimum mix of skills and grades, the factors for consideration should include at a minimum: (i) the service needs, e.g. availability of senior decision makers/autonomous practitioners and patient safety; (ii) the availability of professional development through supervision arrangements to enable a positive clinical learning environment for the development of the next generation of the mental health workforce; and (iii) the provision of a positive work environment whereby there is opportunity for career progression through enhanced development of skills and grades that will equally provide for attractive careers that lends itself to recruitment and retention.

Figure 8.6 below presents the current mix of grades across mental health staff groups. It should be noted that this is based on the current available data, and is not a recommended mix but rather reflects the 'as is' picture of grade mix, across the staff groups and regions in mental health.

Figure 8.6: Percentage of Staff excluding Senior Grades

CHO	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	Other	Total
General Support Staff	94%	89%	92%	93%	96%	96%	97%	93%	96%	93%	94%
Health & Social Care Professionals – includes OT, SW, S&LT, etc.	57%	36%	86%	60%	53%	53%	53%	52%	52%	65%	56%
Management Grades 8 +/ Admin Grades 3 - 7	90%	90%	84%	93%	89%	63%	84%	90%	93%	40%	86%
Medical	57%	63%	55%	61%	53%	48%	52%	57%	67%	44%	58%
Nursing – all staff nurse grades	65%	66%	69%	77%	69%	66%	64%	68%	64%	71%	69%
Other Patient & Client Care	98%	98%	100%	100%	99%	100%	71%	100%	100%	100%	96%
National	**72%**	**73%**	**77%**	**78%**	**74%**	**71%**	**65%**	**74%**	**72%**	**68%**	**73%**

Note: the above figures exclude Voluntary Agencies

8.3. Planned and Unplanned Absence

From a range of data sources it can be calculated that each month over 5.4% (or approximately 580 staff) from the Mental Health workforce are absent. These absence rates can be divided into two main categories - sick leave or maternity leave.

8.3.1. Sick Leave

The National HR Directorate collates monthly sickness absence data across the Health Service Executive (HSE) and reports this through the monthly performance process. The tables below show Mental Health Services Absenteeism rates as per the September 2017 performance report.

It can be seen that almost 90% of these absences are certified by a medical doctor, which is in line with rates from other services across the HSE. The remaining 10% is an accumulation of uncertified sick leave and unexplained absences.

Figure 8.7: National view of absenteeism by staff discipline

	Medical	Nursing	Health & Social Care	Management / Admin	General Support	Patient & Client Care	Overall	Certified
Mental Health	2.4%	4.8%	3.4%	3.4%	6.0%	4.8%	4.4%	89.8%
National	1.15%	4.68%	3.25%	3.95%	5.44%	5.8%	4.33%	89.26%

Figure 8.8: CHO view of absenteeism by staff discipline

Discipline Type	Overall	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
Medical / Dental	2.4%	0.9%	2.9%	3.6%	2.6%	2.0%	1.3%	1.9%	3.1%	2.7%
Nursing	4.8%	5.4%	3.8%	7.9%	3.8%	4.8%	5.4%	4.8%	4.9%	4.0%
Health & Social Care Professionals	3.4%	4.1%	3.5%	4.2%	1.8%	2.8%	3.7%	3.0%	4.6%	2.7%
Management / Admin	3.4%	3.7%	3.4%	3.4%	2.0%	5.5%	2.9%	8.0%	3.5%	2.5%
General Support Staff	6.0%	5.9%	5.9%	4.3%	3.4%	7.2%	4.4%	11.1%	8.8%	5.4%
Other Patient & Client Care	4.8%	7.2%	3.1%	8.6%	2.3%	5.4%	4.1%	5.3%	6.2%	5.6%
Total	**4.4%**	**5.0%**	**3.6%**	**6.4%**	**3.2%**	**5.0%**	**4.0%**	**4.2%**	**5.0%**	**4.2%**
Certified	*89.8%*	*91.5%*	*92.8%*	*94.1%*	*86.6%*	*89.5%*	*78.8%*	*89.4%*	*89.3%*	*88.6%*

Based on the percentages outlined above, it can be expected that 457 people would be certified absent each month. The table below highlights the number of certified absences per discipline per CHO area.

Figure 8.9: Number of certified absences per CHO area

Discipline Type	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	Total
Medical/ Dental	1	3	2	4	2	0	2	3	4	21
Nursing	29	24	33	35	37	11	21	28	20	239
Health & Social Care Professionals	5	6	7	4	4	1	5	8	5	46
Management/ Admin	4	5	3	2	6	1	7	5	3	35
General Support Staff	6	5	2	4	17	2	4	6	6	53
Other Patient & Client Care	7	10	8	4	5	2	8	13	7	63
Grand Total	**53**	**54**	**56**	**53**	**70**	**17**	**47**	**62**	**44**	**457**

8.3.2. Maternity Leave

Unlike absence reporting there is no equivalent reporting for maternity leave, carer's leave or statutory approved leave and there are unfortunately too many gaps in this data for it to be reported on. [View recommendation DCQ.7a]

Separately within mental health a collection process was set up as part of the Monthly Community data collection process which requests that teams record the numbers of staff on Maternity Leave within the reporting month. However for anonymity reasons it does not request staff discipline.

In Community Mental Health the monthly data collection process has shown us that there is an average of 4% of the workforce on Maternity Leave. Figure 8.10 below highlights that Community CAMHS has the largest range from 2% to 11%.

Figure 8.10: Maternity Leave per CHO area against CAMHS, GAMHT and POLL

Maternity Leave	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
Adult Community	*3%*	*2%*	*4%*	*1%*	*5%*	*2%*	*0%*	*4%*	*4%*	*3%*
CAMHS Community	*4%*	*3%*	*3%*	*11%*	*6%*	*2%*	*2%*	*6%*	*4%*	*5%*
POLL	*3%*	*5%*	*5%*	*4%*	*3%*	*4%*	*0%*	*4%*	*3%*	*4%*

73% of the overall workforce is female and of this 29% is under the age of 40 years and most likely to avail of maternity leave. Figure 8.11 allows us to understand that 48% of Health & Social Care Professionals are females under 40 year old followed closely by Nursing at 34% and Medical at 27%.

Figure 8.11: Under 40 years by discipline who are likely to avail of maternity leave

Females < 40 years	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	Other	Total
General Support Staff	8%	3%	6%	10%	9%	7%	0%	3%	5%	7%	7%
Health & Social Care Professionals	35%	38%	59%	47%	46%	44%	51%	49%	50%	73%	48%
Management/ Admin	21%	13%	30%	29%	19%	21%	24%	24%	16%	26%	22%
Medical	27%	36%	23%	18%	17%	17%	36%	20%	42%	22%	27%
Nursing	30%	33%	39%	36%	35%	25%	41%	32%	34%	33%	34%
Other Patient & Client Care	12%	7%	13%	10%	13%	11%	18%	22%	10%	7%	12%
Grand Total	**25%**	**24%**	**36%**	**31%**	**28%**	**22%**	**36%**	**29%**	**31%**	**30%**	**29%**

Note: the age and gender profile of staff is only available for HSE employees

As can be seen from the monthly data collection extract an average of 4% of staff are on maternity leave. Figure 8.11 above highlights that potentially the number of under 40 year old females in the service could lead to services having a reduction in staff by approximately 126 each month. Figure 8.12 below shows that nursing followed by Health & Social Care Professionals are the two groups most impacted by potential maternity leave.

Figure 8.12: Under 40 years by CHO area who are likely to avail of maternity leave

Females < 40 years	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	Other	Total
General Support Staff	3%	1%	1%	2%	6%	4%	0%	1%	1%	1%	2%
Health & Social Care Professionals	16%	18%	32%	21%	17%	17%	24%	23%	26%	16%	22%
Management/ Admin	8%	5%	8%	6%	5%	6%	6%	9%	5%	13%	7%
Medical	8%	11%	4%	5%	4%	6%	11%	5%	16%	5%	8%
Nursing	60%	58%	51%	62%	66%	62%	51%	51%	49%	63%	57%
Other Patient & Client Care	4%	7%	4%	3%	3%	6%	8%	12%	3%	3%	5%
Grand Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

In order to provide meaningful reporting data, payroll systems need to ensure data quality assurance protocols are in place by the Community Health Organisations. [View recommendation DCQ.7]

9. Head count versus Whole Time Equivalent and associated Budgetary Impact

The HSE has a variety of other leave arrangements available to employees including parental leave, flexible working schemes, etc. These family friendly working arrangements are important in the overall attraction and retention of our workforce. In the context of the calculation of the headcount and subsequent impact on WTE, these initiatives, where unpaid, result in a reduced WTE figure, but have no impact on headcount. It is therefore important to take account of the WTE as, for example there may be available WTE budget to close the gap between headcount and WTE. For example a team of 20 staff may have a head count of 20, with an associated WTE of 15 due to flexible working arrangements. On this basis, the team has an available budget for 5 WTE that may result in a further 5 recruitments that could take place. This would result in a final headcount of 25 and a WTE of 20 with no overall impact on the budget allocation of 20 WTE.

Vision for Change recommends approximately 12,354 WTE and this is a 22% variance from the current WTE levels of 9,690. Of this 22%, 8% refers to absence leave (4%) and maternity leave rates (4%). [View recommendation RD.5]

It would be reasonable to add an additional 8% to budgetary requirements when maximising WTE number(s).

Figure 9.1: VFC Requirements including WTE contingency

	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	Other	Total
Head Count	**1,068**	**1,488**	**880**	**1,712**	**1,414**	**647**	**992**	**1,250**	**1,435**	**395**	**11,281**
WTE	**925.4**	**1,285.1**	**774.3**	**1,414.9**	**1,194.6**	**563.2**	**866.0**	**1,094.9**	**1,213.2**	**358.5**	**9,690.0**
Variance Head Count vs. WTE	***13%***	***14%***	***12%***	***17%***	***16%***	***13%***	***13%***	***12%***	***15%***	***20%***	***14%***
Sick Leave 4% & Mat Leave 4%	***8%***	***8%***	***8%***	***8%***	***8%***	***8%***	***8%***	***8%***	***8%***	***8%***	***8%***
VFC Recommendation total	*1,023*	*1,176*	*999*	*1,792*	*1,324*	*1,156*	*1,674*	*1,599*	*1,612*		*12,354*

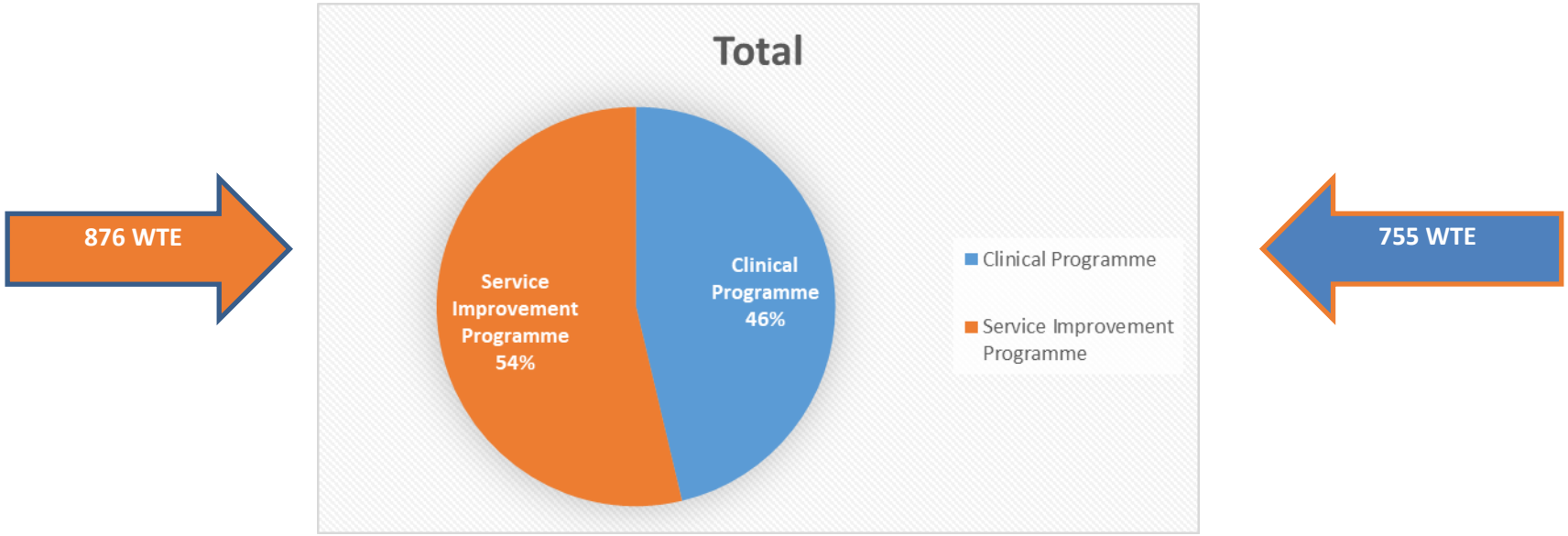
As the data has consistently shown the need for constant review and quality assurance, there is a need to continually produce a workforce plan every two to three years. The output of this activity would allow emerging requirements to be clearly documented. It would be prudent for each CHO to produce their own standardised workforce plan to assist a workforce plan at the national level. [View recommendation DEV.2a]

10. Future Requirements

Figures 10.1 and 10.2 highlight the future requirements for staff within Mental Health Services over the next five year period (i.e. 1631.03 WTEs) This staffing need is the result of a number of Service Improvement Initiatives and Clinical Programmes run by the Strategic Portfolio and Programme Management Office within MHS and the Clinical Strategy & Programmes Division respectively. It is important to note that the staffing requirement identified for these initiatives would need to be examined against the impact of the implementation of the initiatives on demand for core services; this may involve reorientation of existing staff elsewhere. It is acknowledged that there are sometimes dual costs if a service is being redesigned – but in the longer term there should be an impact elsewhere that may create efficiencies. The engagement with the Clinical Programme Managers allowed the working group to understand the synergies which can be gained through joint collaboration. [View recommendations RD.3]

Appendix 16.1 and 16.2 provide further detail on the type of initiatives and programmes which are within the current Service Improvement and Clinical Programme portfolios.

Figure 10.1: Future Workforce Requirements by programme type



Apart from the VfC gap, workforce requirements within MHS are split into two categories: (i) Funded Workforce Requirement, e.g. Self-Harm and Weekend Service Provision, and (ii) Unfunded Workforce Requirement, e.g. National Forensics Hospital, New Children's Hospital and Recovery Framework. Figure 10.2 below highlights the funded versus unfunded workforce requirements for both the Clinical and Service Improvement Programmes. The workforce planning group within Mental Health will focus on recruiting staff for those programmes which are currently funded before prioritising the unfunded workforce category.

Figure 10.2: Future Workforce Requirements: Funded versus Unfunded WTE

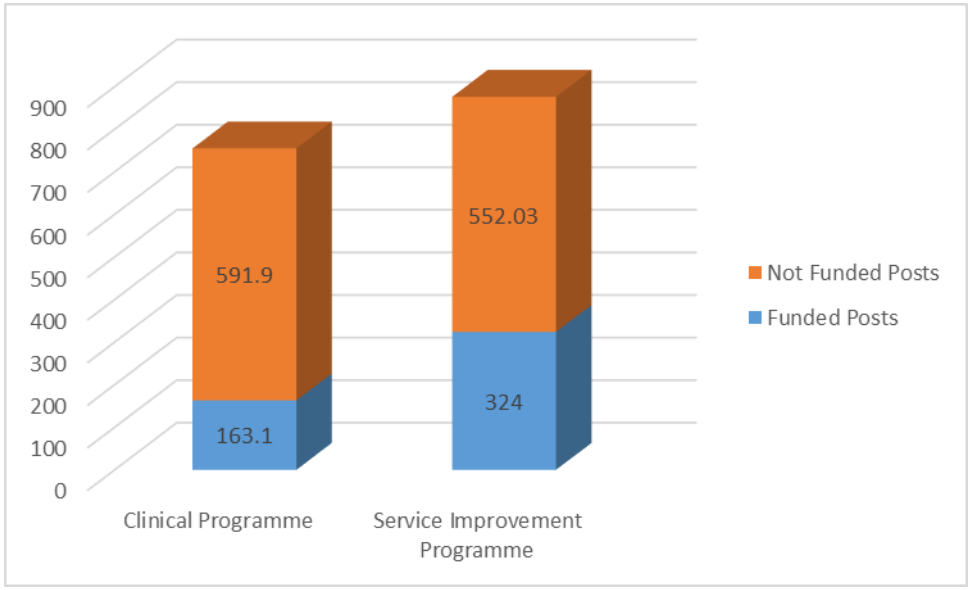
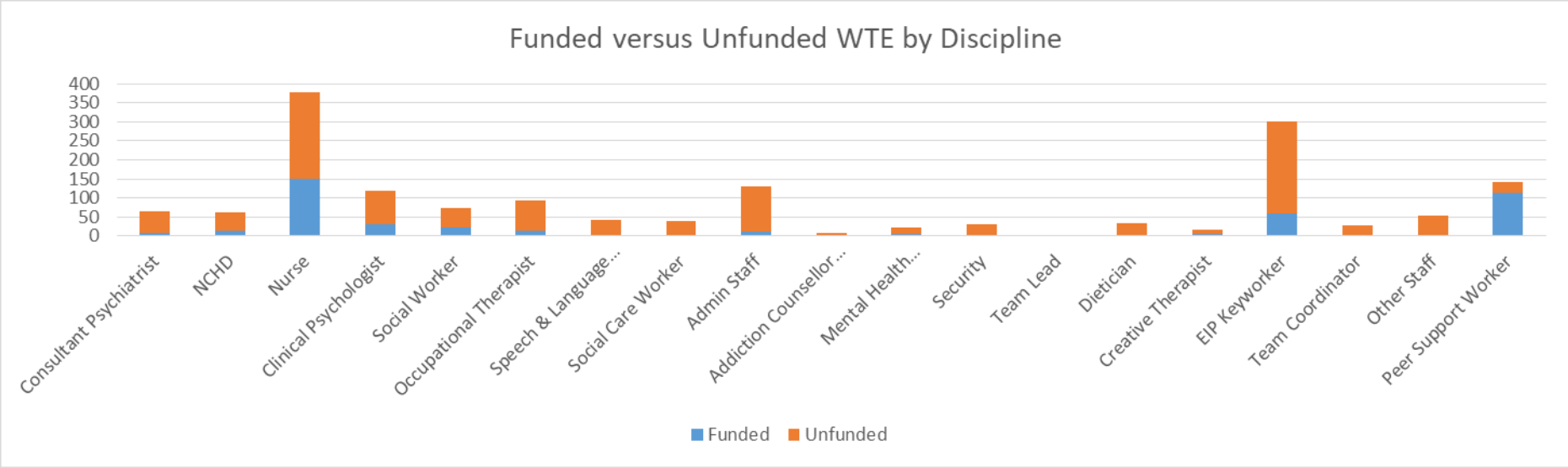
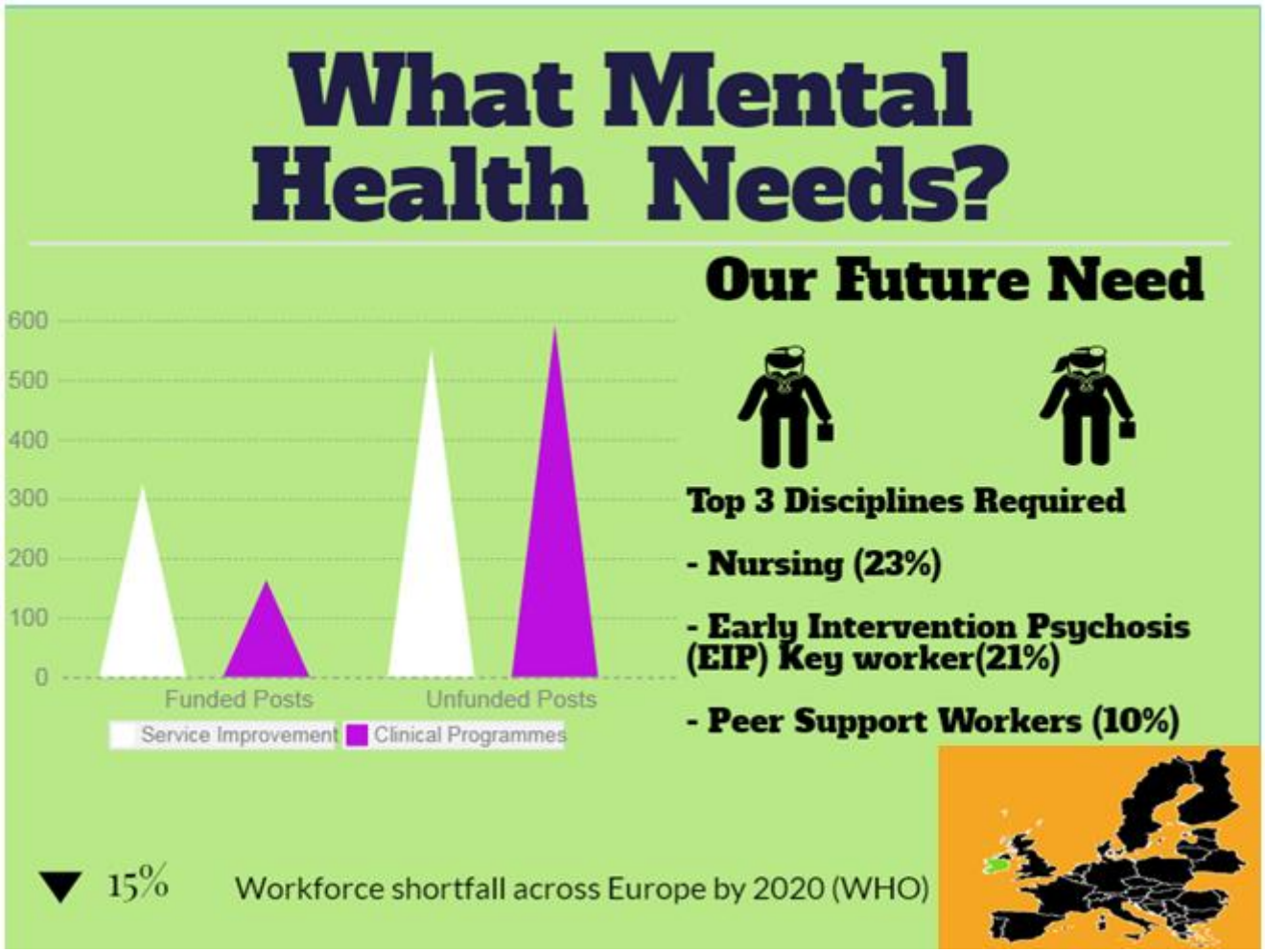


Figure 10.3: Future Workforce Requirements by Discipline (Funded versus Unfunded WTE)

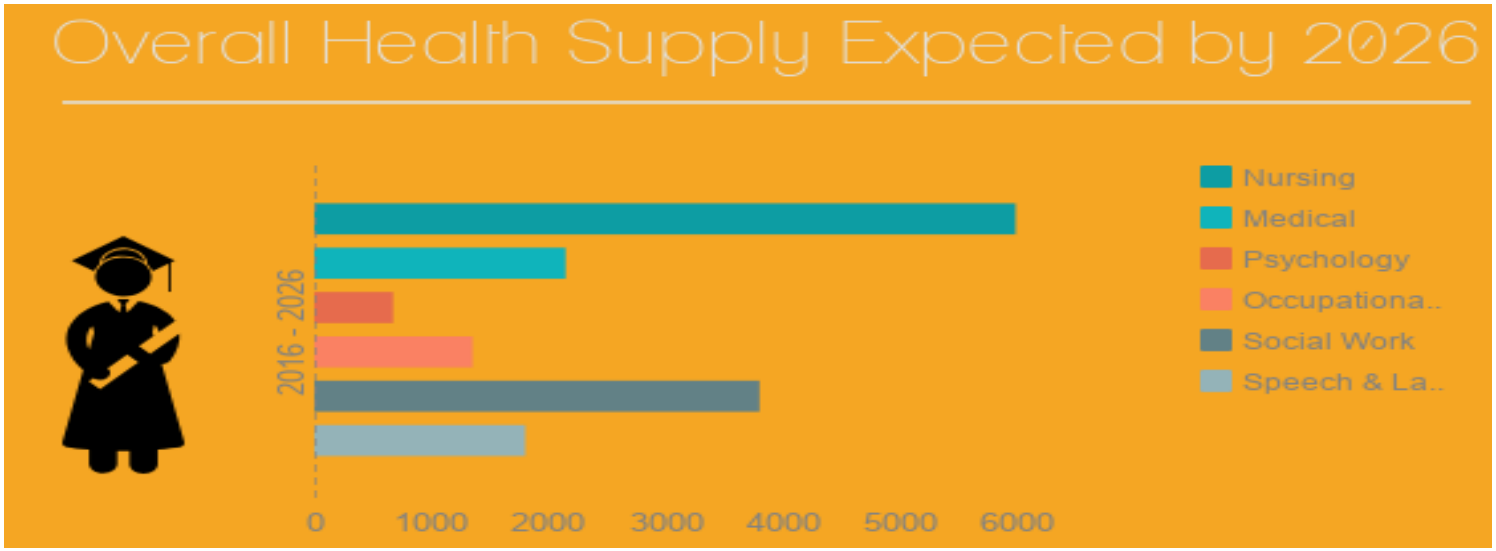



What Mental Health Needs?
Our Future Need
600
500
400
300
200
100
0
Funded Posts
Unfunded Posts
Service Improvement
Clinical Programmes
Top 3 Disciplines Required
- Nursing (23%)
- Early Intervention Psychosis (EIP) Key worker(21%)
- Peer Support Workers (10%)
15%
Workforce shortfall across Europe by 2020 (WHO)

11. Future Supply

"The WHO (World Health Organisation) predicts a health professional shortfall of up to two million (or 15% of the workforce) across the EU by 2020".
[Deloitte, Nov 2017]

The data presented in Section 9 highlighted a current workforce shortfall of 22% when compared to Vision for Change recommendations as set out in 2006, i.e. VFC requirement 12,354 versus current workforce 9,690 WTE. Various different initiatives have been undertaken at each of the discipline levels to help bridge this gap and these can be viewed under Appendix 16.3.



The overall health supply figures for each discipline predicted above includes an attrition percentage for each discipline

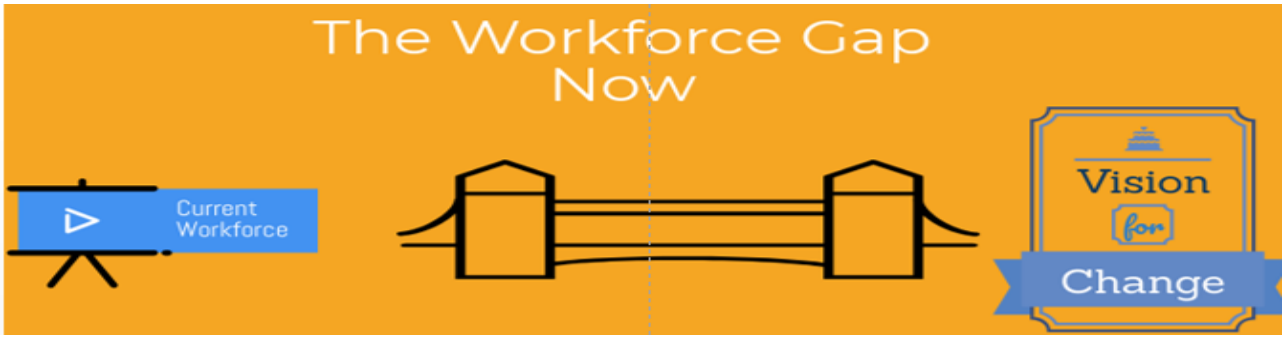
Mental Health Nursing graduates will directly enter MHS due to their specialisms but Medical Staff and Health and Social Care Professionals have the flexibility to go to any service area within Health, e.g. Primary Care, which in turn makes it much more difficult to predict from a supply perspective. For the purpose of predicting potential supply, the project team has taken the number of successful posts for Health and Social Care professionals that entered into MHS over the past 5 year period and applied a weighted ratio against the overall supply assumed to enter the Health sector over the next 5 year period.

It is important to note that the number of successful posts into Mental Health Services should not be the only indicator as development funding may increase the actual supply.

Please refer to Appendix 16.4 for a detailed understanding of the supply calculation within Mental Health Services.

12. Mental Health Workforce Gap

12.1. 2017 Gap Summary View



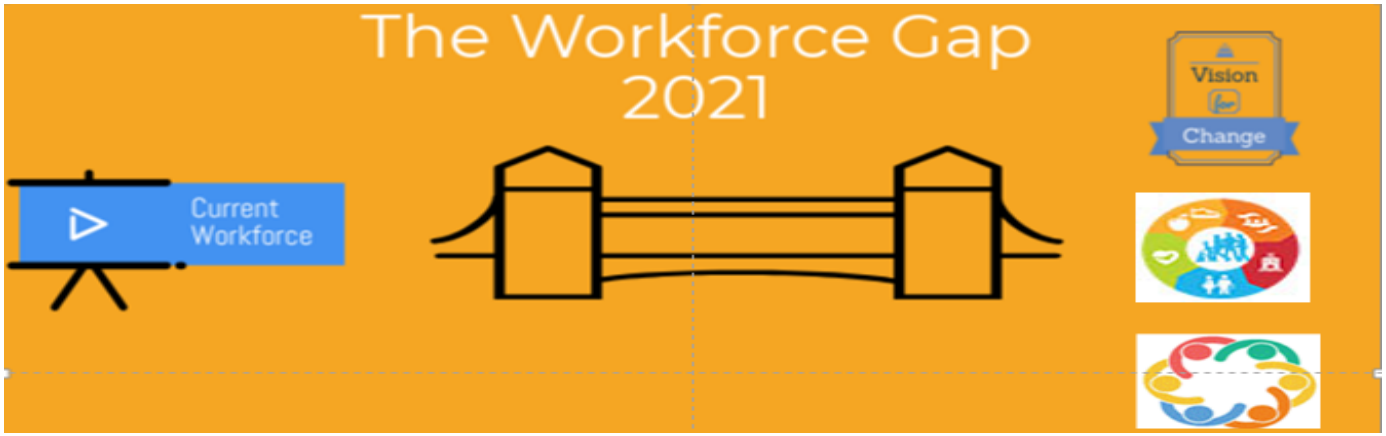
	Current Workforce*	Absence Levels**	Retirement	*Total reduction in Workforce*	Actual Staff Available to Work	*VFC Recommendations*	*Adjusted VFC Requirements****	WFP Gap June 2017
WTE	9,690	515	805	*1,320*	8,370	*12,354*	*12,712*	4,342

The current workforce includes Corporate and the Central Mental Hospital

****Absence Levels reflects both planned and unplanned leave (8%)***

*****Adjusted VFC Requirements includes the addition of the current Corporate and Central Mental Hospital as Vision for Change does not prescribe the workforce requirement for these service types***

12.2. 2021 Gap



	Total Workforce*	*Total reduction in Workforce***	Actual Staff Available to Work	*Funded Future Requirements****	*VFC Recommendations*	*Adjusted VFC Requirements*****	WFP GAP June 2021
WTE	13,366	2,747	10,619	371	12,725	*12,987*	*2,739*

The Total workforce includes both the current workforce as projected in Figure 12.1 and the future supply up to 2021

****The Total Reduction in Workforce includes both planned and unplanned leave (8%) and projected Retirement figures up to 2021***

*****Future Requirements is the sum of the <u>funded</u> workforce complement needed for the Service Improvement Initiatives and Clinical Programmes within Mental Health ("Funded" Includes 2018 funded posts, and posts put forward for the 2019 estimates)***

****** Adjusted VFC Requirements includes the addition of the current Corporate and Central Mental Hospital staffing levels as Vision for Change does not prescribe the workforce requirement for these service types***

The comparative analysis above highlights that there is a workforce shortfall now of 4,342 WTE and in 2021 this shortfall will be 2,739 WTE. Even if it was assumed that Mental Health Services would gain all the potential supply predicted in Section 11 above, it would still not be enough to meet the current need as per VfC and funded future requirements. At the national level, there is effort underway within the Department of Health to address the workforce shortage through the development of a Strategic Framework for Health and Social Care Workforce Planning in Ireland.

13. Findings & Recommendations

13.1. Data Collection and Quality

Number	Finding	Recommendation	Task	Owner	Completion Date
DCQ.1	There is an absence of standardised services and sub services within Mental Health	**Develop a Provision of Services Hierarchy**	Organisational Design	Work force planning project	Completed. See Appendix 16.5
DCQ.2	Organisational Structure of Payroll & Financial systems need aligning	**Implement the Provision of Services Hierarchy**	Organisational Design to be mapped to payroll & financial systems	Health Business Services	2022
DCQ.3	Multiple data Sources were used to capture the current reporting requirements	**One Source of Data is required i.e. staff data base should be interoperable with the expenditure reporting systems**	Implement the National Integrated Staff Records and Pay (NiSRP) Programme	Health Business Services	2022
DCQ.4	Granular levels of data with voluntary providers (Section 38s) is difficult to access	**Short Term - Service Level Agreements should be in place with all providers to produce granular levels of data on a monthly basis**	Review of new and existing SLAs to enhance the levels of data returned	HSE Community Operations Mental Health / HSE National Service Compliance Unit	2019
DCQ.4a		**Long Term – Section 38s staffing details will be captured through SAP/NiSRP**	Transition from the interim process (see DCQ.4) to the long term recommendation	HSE Community Operations Mental Health / HSE National Service Compliance Unit / Health Business Services/National HR	Post 2022
DCQ.5	There are a number of posts in Acute Services, Primary Care and Social Care which are not captured within HSE Mental Health Payroll, e.g. Mental Health Acute Units, Liaison, Dual Diagnosis, MHID, etc.	**Short term - Review of staffing numbers indirectly working in Mental Health but paid from alternative budgets is required**	Review of staffing numbers indirectly working elsewhere other than Mental Health acute approved centres	Mental Health services/ Community Health Organisations / Hospital Groups / NDTP	2019
DCQ.5a		**Long Term – Staffing details relating to other services outside of Mental Health will be captured through SAP**	Transition from the interim process (see DCQ.5) to the long term recommendation	HSE Community Operations Mental Health / Health Business Services	Post 2022

DCQ.6	Service Management can require staff to work across more than one service setting There is no current ability to report this scenario through a single data source	**Implement the capturing of this information on SAP** **Refer back to DCQ.2 for long term strategy**	Reporting protocols to capture location & hours/ratio of staff working in more than one service for a proportional period	E-Rostering Project Group / NiSRP (National Integrated Staff Records and Pay) Programme	2022
DCQ.7	Data Maintenance is inconsistent and varies between CHO areas	**Data Maintenance needs to be reviewed to establish standardised practices**	Continual Quality Assurance of Data protocols to be put in place by each CHO	Community Health Organisations HR & Finance / Health Business Services	2019
DCQ.7a	Data records for leave such as Sick, Maternity or Parental, etc., are not all recorded through the payroll system	**Data Maintenance needs to be reviewed to establish standardised practices**	Payroll system needs to be able to report Maternity Leave and Sick Leave as a singular report	Community Health Organisations HR & Finance / Health Business Services	2019
DCQ.8	The manual monthly patient activity data collection process (Qlikview) is a reliable indicator for Community WTE staffing calculations against VFC recommendations and can be utilised on an interim basis	**Manual processes need to remain in place until other reliable sources, i.e. SAP, can replace them**	Use of Payroll data only could lead to the standing down of the use & reliance on other reporting mechanisms	Community Operations BIU / Community Health Organisations	Until 2022
DCQ.9	The NiSRP programme will result in the validation of staffing within community and non- community settings In the interim (until 2022), the community workforce data is validated through Qlikview (see DCQ.8 above) However, another mechanism should be put in place for the non-community workforce	**Create an interim measure to validate non-community staffing data**	To create a monthly process which will validate non-community staff	Community Operations Mental Health / Health Business Services	2019

13.2. Resource and Deployment

Number	Finding	Recommendation	Task	Owner	Completion date
RD.1	Vision for Change does not provide a recommended skill/grade mix For a sustainable workforce capable of delivering senior decision making, professional development and career opportunities, this is an area requiring review The synergies between services and developments need to be considered in this context	**Conduct review of the formal structures required for each discipline based on agreed models of care**	Conduct review of the formal structures required for each discipline based on agreed models of care	Community Strategy & Planning Mental Health/Community Operations Mental Health / National HR	On-going
RD.2	Workforce flexibility is dependent on Service User needs and models of care.	**Service User needs and models of care should determine workforce requirement**	Service Users will participate in assessing need and designing models of care	Community Operations Mental Health/ Community Health Organisations / Mental Health Engagement	On-going
RD.3	There is a requirement for close collaboration between Clinical Programmes and Service Improvement Programmes to ensure that significant synergies are achieved when looking at the workforce as a whole	**Service Improvement and Clinical Programmes collaborate to ensure alignment to all programmes**	Add workforce planning as a key activity for both programme types.	Clinical Programme Managers / Service Improvement Unit	On-going
RD.4	The recruitment implications of the current levels of attrition/retention were deemed out of scope of this phase of workforce planning	**To establish separate appropriate recruitment and retention initiatives for the mental health workforce**	Establish Recruitment and Retention Initiatives	Community Health Organisations/National Mental Health Services / HBS Recruit/National HR / Communications	2019
RD.5	Currently there is a gap between AVFC recommended workforce and actual workforce (WTE) of approximately 22%. 14% is the result of family friendly arrangements which has associated budgetary backfill which may or may not be utilised	**Build in capacity for levels of leave when resourcing services**	It is reasonable to add an additional 8% to budgetary requirements when agreeing estimates for services	Community Health Organisations /HR / Finance	On-going

	The balance of 8% is the combination of sick leave [4%] and maternity leave specific to females under the age of 40 years [4%] which is not resourced				

13.3. Building Capacity

Number	Finding	Recommendation	Task	Owner	Completion date
BC.1	There is insufficient engagement between Mental Health Services and current educational providers regarding workforce demands	**Work with current educational providers to match workforce requirement with supply**	Work with current educational providers to match workforce requirement with supply	ONMSD, NDTP, National Health and Social Care Professionals Office (NHSCPO)/ Educational Providers, Strategic Workforce Planning and Intelligence	On-going
BC.2	New service initiatives are developing with new models of care resulting in a new type of workforce, e.g. Peer Support Workers, Housing Co-ordinators, etc.	**Work with current educational providers to match emerging workforce requirement**	Work with current educational providers to match emerging workforce requirement	ONMSD, NDTP, National Health and Social Care Professionals Office (NHSCPO)/ Educational Providers, Strategic Workforce Planning and Intelligence	On-going
BC.3	New service initiatives will draw on the same supply pool from within existing Health workforce and NGOs This may still result in insufficient yield even though there appears to be significant workforce capacity in other arenas	**Closer alignment and engagement is needed between Health sector and community partners**	Engage more closely with community partners	ONMSD, NDTP, National Health and Social Care Professionals Office (NHSCPO)/ Educational Providers, Strategic Workforce Planning and Intelligence	On-going
BC.4	Limited engagement with regulators regarding potential opportunities for recognition of professional qualifications to further support registration	**To develop a process for engagement with the regulators to support identification of opportunities for recognition of professional qualifications for mental health professionals**	Establish engagement with the regulatory bodies to explore opportunities for registration of EU/non EU nurses for entry into the Mental Health Division of the register in Ireland	Strategic Workforce Planning and Intelligence, Office of CCO (Chief Clinical Officer), ONMSD, HSCPO and NDTP	Dependent on necessary resourcing
BC.4a	Requirement to access international sources	**Ensure Mental Health Services are included in tenders for international recruitment services**	Coordinate staffing requirements and provide to contracted tenderer	HBS HR	Dependent on necessary resourcing

13.4. Continuation and development of the workforce planning process

Number	Finding	Recommendation	Task	Owner	Completion date
DEV.1	In the absence of a fully funded and operationalised strategic workforce planning unit, the future strategic direction of mental health workforce planning is challenging at a national level, e.g. there is insufficient capacity within HR/HBS Recruit to source international markets	**To support the acceleration to establish a fully funded strategic workforce planning unit in the HSE, there is a need to operationalise a national approach to strategic workforce planning**	Include in the 2019 estimates bid proposals to accelerate the establishment of a fully funded strategic workforce planning unit	National HR / Workforce Planning	2019
DEV.1a			DoH National HR unit to review Mental Health Workforce report in the context of the National Strategic Framework for Health and Social Care	Department of Health / National HR	On-going
DEV.2	There has been no visibility of strategic workforce plans by CHOs in order to understand the context, nor has there been the capacity within CHOs to do so	**To establish a funded capacity and capability at CHO level which will enable service managers to deliver on the operational component of a strategic workforce plan**	Outcome of DEV.1 will include and enable outcome of DEV.2	National HR / Workforce Planning/ CHOs and Community Operations Mental Health	
DEV.2a	There are no CHO mental health workforce plans in place, or a process in place, to enable better understanding of workforce planning	**Ensure CHO Mental Health Workforce Plans are informed by National Mental Health Workforce planning document**	Develop CHO mental health workforce plans which will link to mental health national workforce planning document in a consistent and coordinated way	Community Health Organisations / Community Operations Mental Health	Every two / three years
DEV.3	The Mental Health Workforce Planning document should inform future requirements and budget allocation for mental health services	**Mental Health Workforce planning document to be disseminated to inform and assist future planning**	Report to be circulated and plan to be introduced that provides a framework for future workforce plans	Mental Health Services / Community Health Organisations	Every two / three years
DEV.4	There needs to be a system in place for identifying mental health development posts within the national payroll systems	**Implement identifier to each position relating to the original funding source**	Develop and utilise current processes to facilitate and operate in conjunction with HBS Recruit and Finance	Finance/HR/HBS Recruit	2022

14. Conclusions and Next Steps

It is clear that both supply and demand of the Mental Health workforce need to be more aligned in order to reflect the ever changing community and healthcare landscapes. In addition, the work needs to be understood in the context of the implementation of the Sláintecare report, and actions emanating from this. From the Data Collection exercise, it can be seen that high quality, and robust staffing data along with the technical systems to support accurate reporting and maintenance of data from the Operational Services are vital to the workforce planning function.

It is important to note that it should not be assumed that new Service Improvement and Clinical Programme Initiatives will necessarily result in the need for additional staff. The current emphasis on integration and the importance of primary care provision for the service user may necessitate local services reconfiguring and reorienting services. We need to be mindful of the potential for, and the benefits arising from reconfiguration, particularly in the context of a diminishing pool of health care staff globally.

To allow Community Healthcare Organisations to build on this report, there is a need for an operational workforce plan and on-going planning process to be developed. This will need to be considered as a separate piece of work, and it will also need to incorporate the recommendations of the Final Oireachtas Report from the Joint Committee on the Future of Mental Health Care, published in October 2018.

15. List of Acronyms

Acronym	Description
ADHD	Attention deficit hyperactivity disorder
ADoN	Assistant Director of Nursing
CAMHS	Child and adolescent Mental health service
CHO	Community Healthcare Organisations
CMHT /MHT	Community Mental Health Team or Mental Health Team
CNS	Clinical Nurse Specialist
DCQ	Data Collection and Quality
DoH	Department of Health
DoN	Director of Nursing
ED	Emergency Department
EIP	Early Intervention Psychosis
FWR	Future Workforce Requirements
GAMHT	General Adult Mental Health Team
HBS	Health Business Services
HR	Human Resources
HSE	Health Service Executive
MDT	Multi-Disciplinary Team
MHID	Mental Health Intellectual Disabilities
MHS	Mental Health Services
NCHD	Non Consultant Hospital Doctor
NGO	Non-Governmental Organisation
NiSRP	National Integrated Staff Records and Pay
NDTP	National Doctors Training and Planning
NMBI	Nursing and Midwifery Board of Ireland
NHSCPO	National Health and Social Care Professionals Office

NMPDU	Nursing Midwifery Planning and Development Unit
ONMSD	The Office of the Nursing and Midwifery Services Director
POLL	Psychiatry of Later Life
SSHAARP	Suicide & Self Harm Awareness, Assessment & Response Project
SU	Service User
VFC	Vision for Change
WFP	Work Force Plan
WHO	World Health Organisation
WTE	Whole Time Equivalent

Trademarks

Product	Trademark
SAP payroll	Systeme, Anwendungen und Produkte SAP ® payroll
Qlikview	Qlik ® is the provider of QlikView

16. Appendices

16.1. Clinical Programmes

Project Name	Project Summary
Dual Diagnosis	The development of specialist teams looking at co-morbidity of substance abuse and moderate to severe mental disorders
ADHD in Adults	The development of 10 MDT ADHD (in adults) national clinics for defined catchment areas
Early Intervention Psychosis (EIP)	3 EIP teams being rolled out with the intention of 25 EIP teams nationally working to a "Hub and Spoke" model The EIP keyworker is a new grade which can be at CNS or Senior Therapist level
Eating Disorders Adults and Children	The development and implementation of eating disorder services based on the agreed Model of Care
Self-Harm	Assessment and management of patients who present to the Emergency Department following self-harm act

16.2. Service Improvement Initiatives

Project Name	Project Summary
Perinatal[3]	The development of Specialist Perinatal Mental Health Services outlined within the Model of Care
MHID CAMHS	The development of a model of care for children and adults with moderate to profound Intellectual Disability who experience mental health problems
MHID General Adult	
Weekend Community MHS (7 over 7)	To extend community mental health services in order to provide a seven day community service to all sector areas for known service users
Team Co-ordinators	To develop a framework to support the standardised implementation of team coordinators across all CMHTs
Specialised Rehab Units	To create a model of care which ensures service users with severe and enduring mental health illness and challenging behaviour will have their needs met within a continuum of care along the rehabilitation spectrum

[3] Perinatal is not considered as one of the Clinical Programmes, however there is a significant workforce component involved within the Model of Care

Connecting for Life - SSHAARP	Identifying the assessment approaches currently in use in the HSE with a view to designing a minimum set of uniform guidelines for an assessment approach across the HSE
Connecting for Life - Bereavement	To deliver enhanced bereavement support services to families and communities affected by suicide of those people known to mental health services
Family Therapy	To develop a model of care for adults accessing talking therapies, as part of attending mental health services in the community
Recovery Framework	The continued development of the recovery orientation of Irish Mental Health Services involves the implementation and application of the National Framework for Recovery in Mental Health 2018 – 2020 at local level
Peer Support Workers Adult	The continued establishment of Peer Support Workers (PrSW) within Multidisciplinary Teams and mainstream services following the introduction of 30 PrSW to 7 sector areas in 2017/18
Peer Support Workers Rehab & Recovery	
Peer Support Workers CHO level	
Homeless Mental Health	To create a stepped model of care to ensure the homeless population in CHOs 6, 7 & 9 receive timely access and appropriate mental health care relevant to their mental health needs
Physical Health	This programme of work will explore health promotion, prevention and early intervention solutions for people with coexisting mental and physical health needs

As the Mental Health service becomes more informed by stakeholder perspectives, and prevalence of common mental health disorders, the model of care is likely to include additional workforce requirements. There are a number of additional service improvement projects which have yet to define the workforce requirement needed to deliver the service improvement.

Project Name
Standardised process for Service User Journey with General Adult Community Mental Health Teams
Developing Digital Mental Health Supports in Ireland
Choice & Partnership Approach (CAMHS)
Standard Availability of Talking Therapies in Mental Health Services
Specialised Rehab Units (Development of a further 3 units throughout the country)

In addition to the Clinical and Service Improvement programmes there are a further two programmes under the Capital Investment programme which will have an implication on the future workforce requirement needed and these include:

Project Name
New National Forensic Hospital
New Children's Hospital

16.3. Discipline Supply – Impact on resources (+/-)

Discipline Type	Description
Nursing	Undergraduate Programmes (+)
	Postgraduate Programmes (+)
	Graduate Entry Nursing Programmes (2 year program) (+)
	International Recruitment (+)
	Rehiring Retirees (+)
	Transfer of tasks to Nursing based on Haddington Road Agreement (+)
Psychology	Clinical Training Places being reviewed (+)
	Professional Supervision implications - ratios between trainee, basic and senior grades (-)
	Assistant Psychologist Pilot program in Primary Care (+)
Social Work	Focus on vacancy replacements (+)
	Implications of Authorised Officer in relation to Assisted decision making (+)
Occupational Therapy	Occupational Therapy in CAMHS Report 2018 (+)

16.4. Future Supply Calculations

	Potential Supply 2016			Potential Supply 2021		
Discipline Type	**Overall Health Supply 2016**	**Net supply (Health supply less Attrition Rates)**	**Mental Health Supply 2016***	**Overall Health Supply 2021**	**Net Supply (Health Supply less Attrition Rates)**	**Mental Health Supply 2021****
Psychology[1]	164	155.80	55	244	232	55
Medical[2]	725	363	73	725	363	73
Psychiatric Nursing[3]	1706	1612	1612	2140	2022	2022
Under Graduates	*1640*	*1550*	*1550*	*2100*	*1985*	*1985*
Post Graduates (other nursing degrees)	*38*	*36*	*36*	*40*	*38*	*38*
Advanced Nurse Practitioners	*28*	*26*	*26*	*0*	*0*	*0*
Occupational Therapist[4]	450	428	58	450	428	58
Social Work[5]	1200	1080	71	1300	1170	71
Speech & Language Therapist[6]	600	570	33	600	570	33
	4845	**4208**	**1901**	**5459**	**4784**	**2312**

[1] Assumed number of funded psychology posts in clinical training will remain as per September 2019 graduate level. 5% attrition level has been applied against the total predicted supply figures for Psychology

[2]Source Annual Assessment of NCHD posts (NDTP, 2016-2017)

[3]The 2017 increase to 420 Psychiatric Nursing places is assumed to continue from 2018 to 2021. 5.5% attrition level has been applied against the total predicted supply figures for Psychiatric Nursing

[4]5% attrition level has been applied against the total predicted supply figures for Occupational Therapy

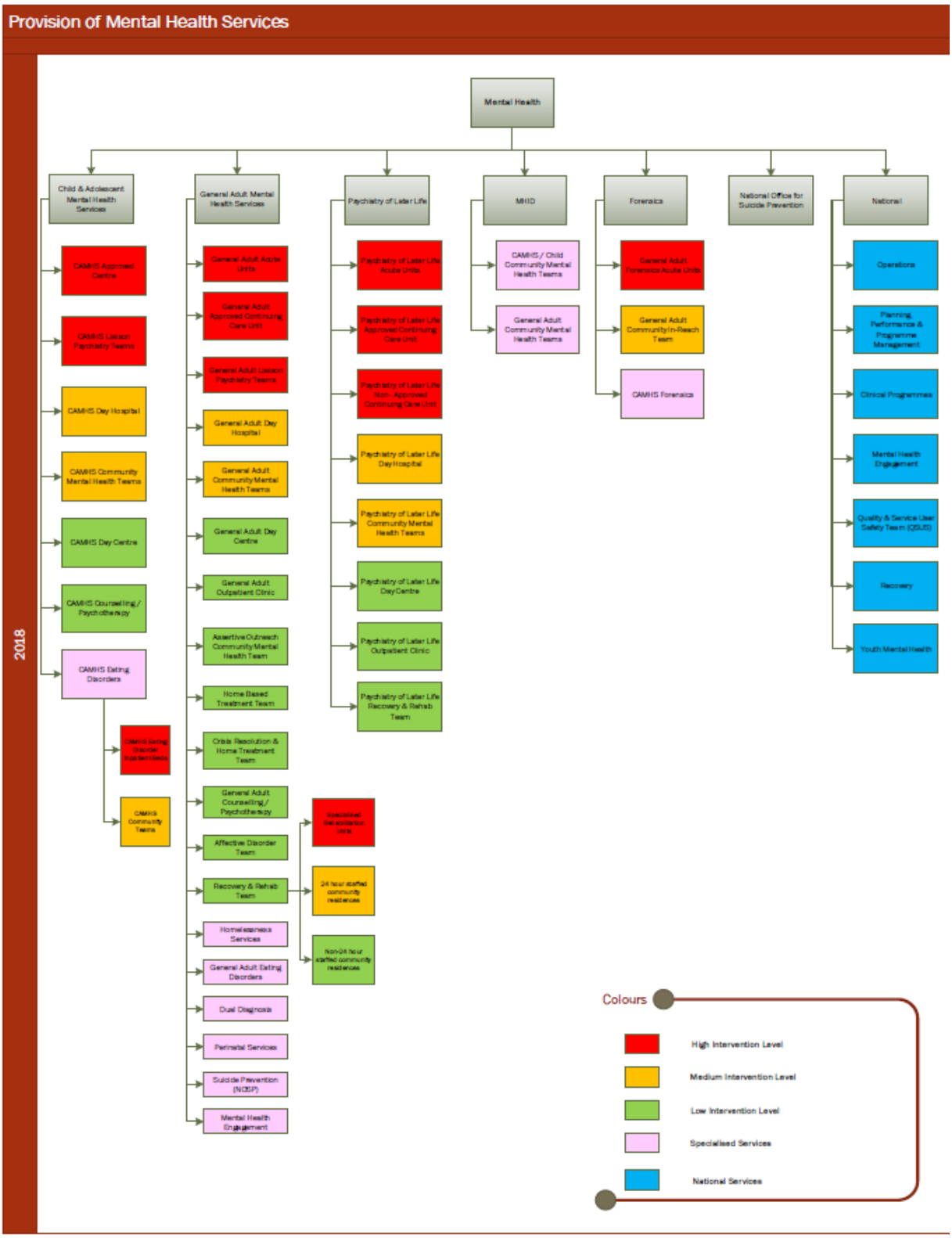
[5]10% attrition level has been applied against the total predicted supply figures for Social Work. There are a number of new courses being established by educational providers e.g. Sligo Institute of Technology and National University of Ireland Maynooth which will assist the overall Health supply in the future. However, as they have yet to be registered with CORU the project team has excluded the increase in placements from the Future Supply table above

[6]5% attrition level has been applied against the total predicted supply figures for Speech & Language Therapy

**Predictions on the number of supply for each discipline except nursing have been based on the Joint Council Report documented in October 2017*

***Predictions on the potential supply generated by 2021 are based on the assumption that the same level of funding for new placements will continue to apply as per 2016*

16.5. Provision of Mental Health Services



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