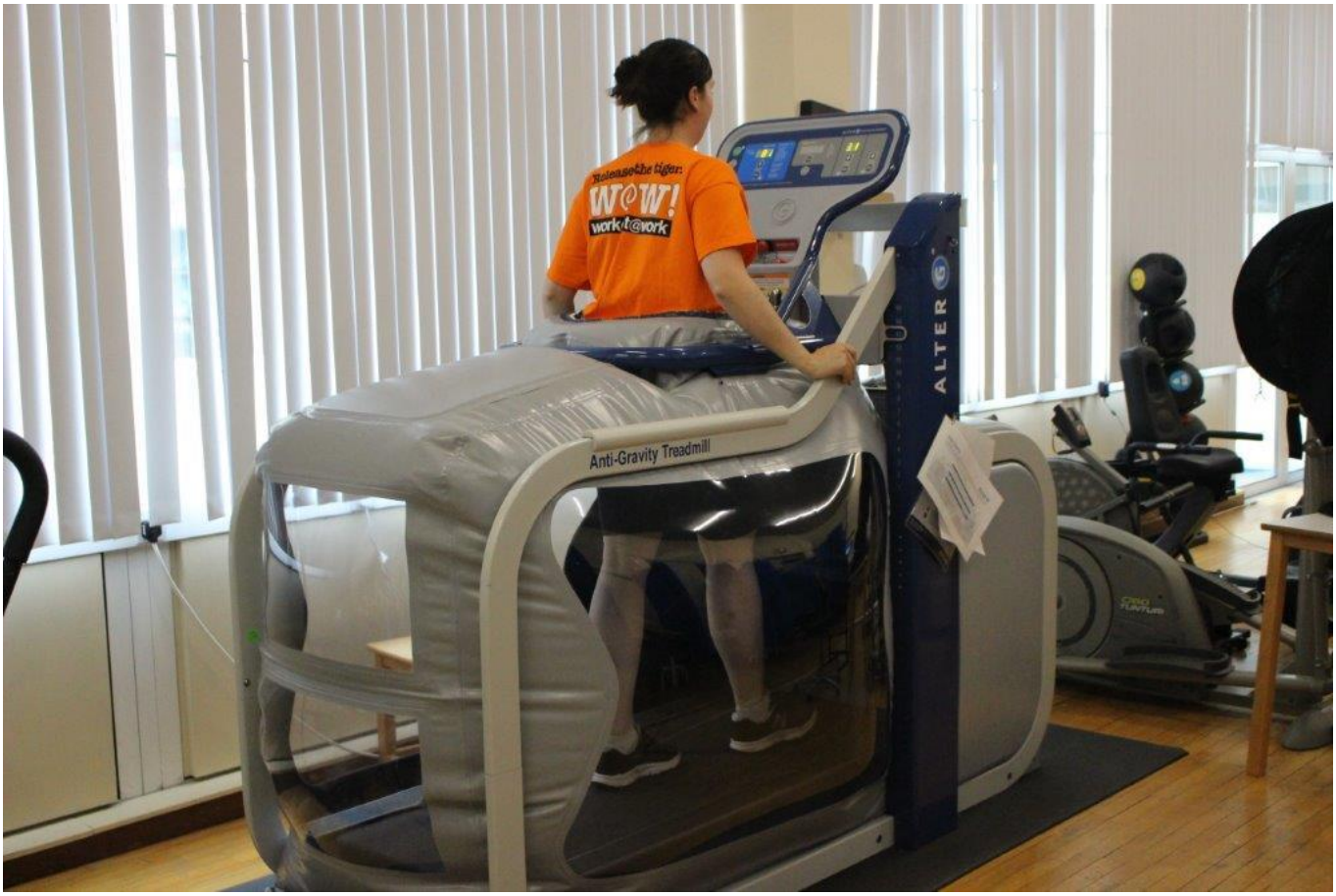
Department of Health

Workforce Review Report

Physiotherapy

2019 - 2029



Space Age Technology Alter G Anti-Gravity Treadmill to Improve Rehabilitation of Patients of all Ages with a wide range of conditions.

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Foreword

Since October 2016, Health and Social Care workers and the Department of Health have been cooperating to deliver the transformation set out in ***Health and Wellbeing 2026: Delivering Together***. This ambitious ten year plan was our response to the report produced by an Expert Panel led by Professor Bengoa, who were tasked with considering how best to re-configure Health and Social Care Services in Northern Ireland.

The aim is a health and social care system that helps people to stay well for longer, with services delivered in the community or at home, where possible. Allied Health Professions (AHPs) will play a key part in responding to this challenge, particularly as we expand the role of innovative, multidisciplinary teams across a range of integrated care pathways within health and social care settings. No matter how or where AHP staff work, they will continue to maintain their clear professional focus: supporting people, who are ill, have disabilities or special needs, to live the fullest lives possible.

Since these AHP workforce reviews commenced, the landscape across Health and Social Care has changed considerably. Opportunities for AHPs have been created across a range of primary care multi-disciplinary teams. These are to be welcomed, but it is important to have the highly skilled workforce required to take these opportunities as they arise. This series of workforce reviews are written with a view to identifying and quantifying the workforce required to meet these challenges and help drive the transformation agenda forward.

The AHP workforce reviews will help to address one of the immediate priorities set out in the ***New Decade, New Approach*** document published at the time of the establishment of the new Northern Ireland Executive. The commitment being that the Executive will transform HSC services through reconfiguration of services.

There is however currently a bigger challenge facing the HSC system in the guise of the current Covid-19 pandemic. This is challenging us in many ways, including the immense pressures placed on our workforce and the need to think and act differently, and to consider how we currently work and how we may work in the future.

In this changing environment, it is even more essential that we have an understanding of our workforce needs, so that we can plan effectively to maintain and develop our services into the future. This was recognised in ***Health and Wellbeing 2026: Delivering Together*** and appears as a key theme in the associated ***Health and Social Care Workforce Strategy 2026: Delivering for Our People.*** Recognising that the HSC is a changing environment and will continue to evolve, this series of workforce reviews are “living documents” which will be reviewed throughout the period of the reviews.

This Workforce Review Report, and the clear recommendations it contains, is the result of a wider Workforce Review Programme covering all thirteen AHPs in Northern Ireland. Since March 2017, Project Groups comprising representatives from across the health and social care service, professional bodies, staff side representatives and the Department of Health, have been meeting regularly to consider how these professions / services are likely to develop in the period 2019 – 2029. Their work has been overseen by the AHP Workforce Review Programme Steering Group and applies the ***Regional HSC Workforce Planning Framework's*** six step methodology.

This process and its resulting Workforce Review Reports are the products of active co-design and co-production, delivering together to ensure the workforce needs of the HSC are met. Project Groups have engaged with their stakeholders, including service users and carers, both in formal engagement events and through ongoing involvement with relevant individuals and organisations. Their input has been invaluable in producing this final document and its recommendations. We would like to thank everyone who has contributed to the work of the AHP Workforce Review Programme.

Our vision is for Northern Ireland to have an AHP workforce that has the capacity and capability to deliver the best possible care, for patients and clients, and has the leadership skills and opportunities to lead and transform services to improve population health. The Physiotherapy Workforce Review Report and its recommendations set us on course to do just that for this profession.

Charlotte McArdle
Chief Nursing Officer
Department of Health

Preeta Miller
Director of Workforce Policy
Department of Health

Jennifer Keane
Chief AHP Officer
Department of Health

Executive Summary

On the 31st March 2017 within NI HSC Trusts the physiotherapy workforce was comprised of 995.6 WTE Physiotherapy posts. Translated to headcount this represents 1202 Physiotherapists.

The Ulster University (UU) is the only institution in NI offering BSc (Hons) in Physiotherapy. UU had previously been commissioned by DoHNI for 69 undergraduate places; however this was reduced over time to 60, then 55 and for the past two years (16/17 and 17/18) the UU intake of undergraduate places has been reduced to 50 DoHNI commissioned places. The evidence is that not all of these will take up work in the HSCNI although all have been funded by the DOHNI. The BSc is the only pathway to qualify as a Physiotherapist in NI as there are currently no masters post graduate courses offered in physiotherapy. It is important to note that the HSC has jobs for all of these graduates and we also have a capacity gap for additional posts required to fill vacancies and take up transformation posts.

The quantitative summary of the processes expected to have a significant impact on the physiotherapy human resource pool required by the HSCNI services over the next 5 years highlights the need for an ongoing and robust workforce planning cycle. Using available information from the UU Employability unit; 2012-2016 outturns, the average loss of UU Physiotherapy graduates to HSCNI employment has been calculated at 21%; this should not be an option for DoHNI funded places as all commissioned places are required to ensure an effective recruitment pool for HSCNI service sustainability as per table 8.

While not an exact science, the quantitative analysis summary; Table 8 in this paper, estimates a cumulative deficit of 422 Physiotherapists over the period 1st April 2018 – 31st March 2023. This equates, on average terms, to the need for an **additional 85 Physiotherapists to be recruited per year** to ensure the workforce numbers to deliver the services planned to meet the patient/population needs. To be very clear, this 85 is in addition to the '50' annual UU graduates that are currently funded by DoHNI; the subsequent expectation being that they join the HSCNI Human Resource pool over the next 5 years.

The working group explored the other three countries of the UK; Scotland, England and Wales, as potential benchmark comparators regarding the number of DoH commissioned undergraduate places. As Scotland and England have multiple providers of BSc Physiotherapy programmes and also a masters route to qualify as a Physiotherapist these were ruled out as there were too many variables. Wales was chosen as they have a similar population, geography, their undergraduate training places are all funded by their health department and they have only one third level education provider. Based on these factors Wales was considered to be a better benchmark match.

Based on the rationale outlined above, the rudimentary benchmarking comparison with Wales regarding the number of DoH commissioned undergraduate places (Table 9) indicates that the current UU undergraduate intake of 50 should be increased to **86 DoHNI commissioned places per year**. This year, the health department in Wales has moved to encourage those students accepting DoH Wales funded places on the Cardiff University physiotherapy programme to commit to work in NHS Wales for a period of 2 years.

An **additional 36 undergraduate places commissioned by the DoHNI** through UU would have a significant impact on the estimated annual shortfall of 85 Physiotherapists outlined in this document. As per the recommendations, **other strategies also need to be applied to ameliorate the total estimated annual deficit of 85 qualified physiotherapists;** evidenced in clinical practice over the past two years and now a high risk situation in line with the transformation agenda and the need for permanent Physiotherapists to fill the new posts created.

Abbreviations

AHP:	Allied Health Professional
CEC:	Clinical Education Centre
CIS:	Community Information System
CSP:	Chartered Society of Physiotherapy
DfE:	Department for Economy
DoHNI:	Department of Health Northern Ireland
ECG:	Education and Commissioning Group
GP:	General Practitioner
HRPTS:	Human Resources Payroll Travel & Subsistence System
HCPC :	Health and Care Professions Council
HSC:	Health and Social Care
HSE:	Health Service Executive
HSC Trusts:	Belfast, Northern, Southern, South Eastern, Western & Northern Ireland Ambulance Service Trust (NIAS)
HSCB:	Health and Social Care Board
IPC:	Institute of Public Care
NI:	Northern Ireland
NISRA:	Northern Ireland Statistical & Research Agency
NMP:	Non-Medical prescribing
PFA:	Priorities for Action
PHA:	Public Health Agency
Q&A:	Questions and Answers
QALYs	Quality adjusted life years
RQIA:	Regulation and Quality Improvement Authority
RWPG:	Regional Workforce Planning Group
SDS:	Self Directed Support
TIG:	Transformation Implementation Group
TYC:	Transforming Your Care
UU:	Ulster University
WLI:	Waiting List Initiative

1. Introduction

a) Drivers for change

There are many strategic drivers which support co-ordinated, timely effective workforce planning and which recommend proactive management to plan effectively for the wide range and complexity of needs within the population;

- The recognition of the changing nature of health and social care needs and the link to demographic changes in local populations and the greater emphasis on preventative approaches, supporting and empowering people.

- The requirement that appropriate aspects of the wider service delivery model reflect the 7-day needs of patients / clients and that education and training provision meets the needs of the health and social care workforce in Northern Ireland and empowers them to enhance patient safety, quality and outcomes of care.

- Ensuring affordability of services given the challenging financial context for all organisations.

- The need to connect workforce issues with the overall strategic direction, e.g. Delivering Together, Programme for Government, Transforming Your Care, Making Life Better, HSC Quality Strategy 2020, AHP Strategy for Northern Ireland, the Annual Commissioning Plan Direction and the Review of Urgent and Emergency care.

The Bengoa (Expert Panel) Review was tasked with producing proposals to remodel the HSC in order to deliver safe, high quality, and sustainable services for the population in Northern Ireland. Recommendations were submitted to the Minister in the summer of 2016 and following consideration of these, the 'Bengoa / Expert Panel report 'Systems not Structures: Changing Health and Social Care' was published in October 2016.

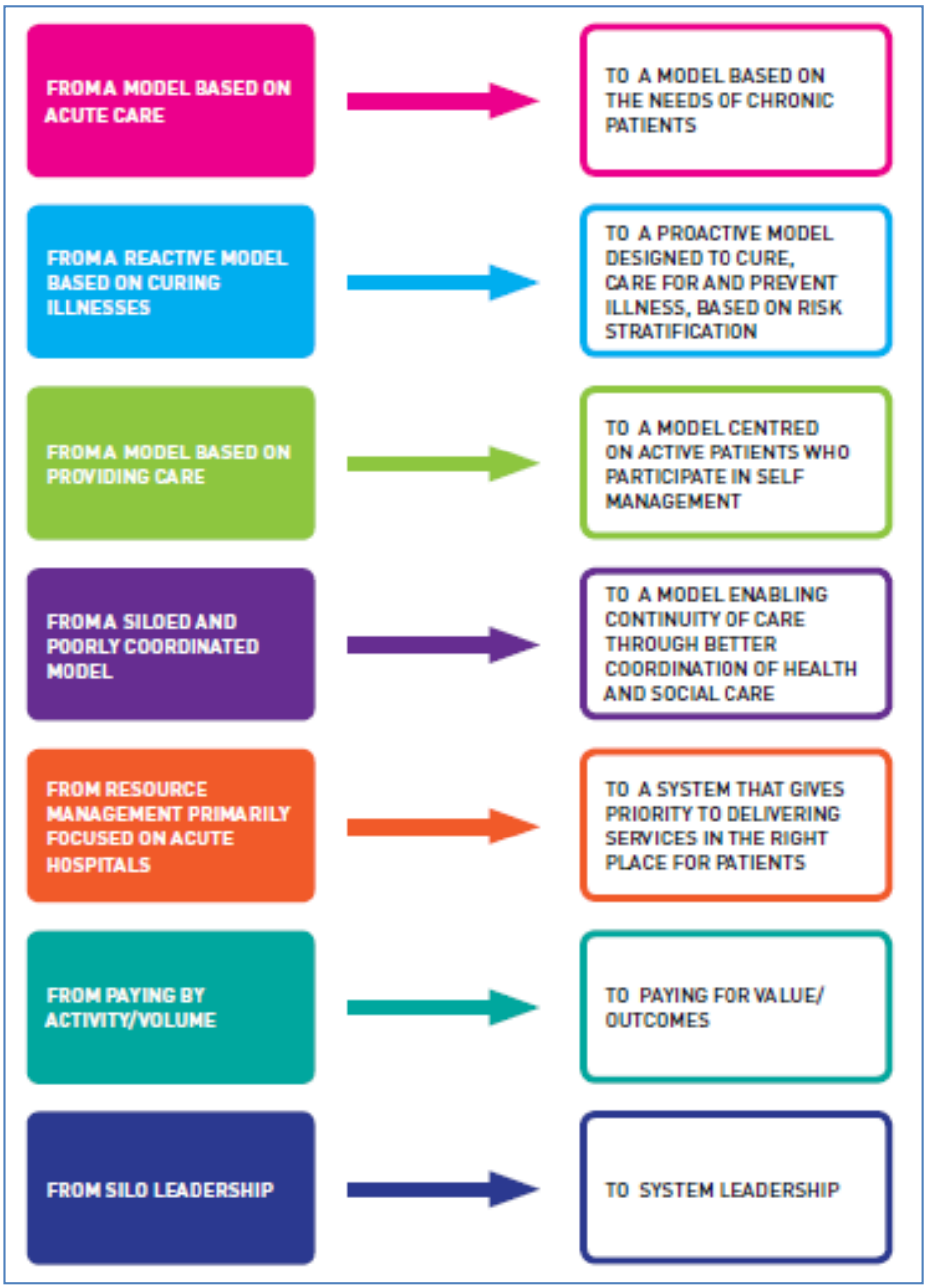


Figure 1 - HSC Model proposed by the Expert panel [Source: Mark Taylor, NI AHP Conference 18.10.17]

In response to the Bengoa / Expert Panel report the Department published 'Health and Wellbeing 2026 – Delivering Together'. This report re-affirmed that effective workforce engagement and planning are key enablers to HSC transformation and that the far-reaching transformation journey needs the commitment and engagement of workers across every band / grade if it is to succeed. 'Delivering Together', is now considered the only road map for reform. A Workforce Strategy; one of 18 key priority actions (no.16) to be taken forward, has been developed. The Workforce Strategy will cover all aspects of HSC Workforce,

including; retention and recruitment, opportunities for introducing new job roles and re-skilling and up-skilling initiatives. In line with the then Minister's vision, the strategy will be developed through co-design and co-production with staff, patient's / clients, communities etc.

Figure 2 - Drivers for Change [Source: Mark Taylor, NI AHP Conference 18.10.17]

b) Strategic content

In December 2016 the Department of Health (DoHNI) Northern Ireland embarked on a number of regional workforce reviews across a range of Allied Health Professional groups including Physiotherapy. These workforce reviews were deemed necessary to ensure AHP services delivered across NI would be sustainable to meet future demands and needs of the population and to ensure services were delivered to an appropriate standard in line with strategic policy directions. It is recognised that there are a number of challenges faced by the health and social care system to ensure a workforce that is constituted correctly in terms of their ability to provide the best care for service users and their families;

- numbers and skills to ensure they are an adaptive workforce and

- organised and deployed in the most efficient and effective way

The overall analysis and review of the Regional Physiotherapy workforce review was pitched at a level to enable completion of an effective workforce plan by avoiding drill-down to a level that would become too complex and challenging if individual Trust information recording and reporting systems and service variations were taken into account. This was achieved through effective engagement of relevant organisations and stakeholders; Physiotherapy Managers, Trust AHP Leads, Policy Officer and service users.

Challenges included determining the necessary workforce to deliver sustainable Physiotherapy services that would provide timely support for clients at both population and specialist levels into the future – Horizon Scanning via analysis of;

- Demographic trends, the increase in patient's presenting with more complex issues
- Proposed service developments / transformation including enhanced partnership working with Health and Social Care colleagues and other agencies.
- Pre-registration Training places and alternative routes for training including Apprenticeship opportunities
- Post registration Training needs and skills enhancement linked to professional practice Frameworks and a sustainable qualified workforce.
- The evidence of the past two years of the shortage of qualified Physiotherapists to maintain core services has identified the risk of lack of access to a readily available workforce/recruitment pool and also the lack of numbers of graduates/staff available to work in Trusts in NI. There is also a risk that some trusts are more attractive to potential employees than others which need to be explored further to ensure measures are actioned to ease the recruitment pressures in the region and the individual Trusts. These risks have been added to by the transformation agenda and the increased numbers of Physiotherapists required to fill the range of vacant new and core service posts; Table 8.
- Turnover rate per year – currently at 14% and vacancy rates – currently at 11.5%

This approach facilitated active and effective participation and subsequent ownership throughout the duration of the workforce review.

c) Workforce plan methodology

The Physiotherapy workforce review was completed in line with the 6 step methodology outlined within the Regional HSC Workforce Planning Framework as denoted in the diagram below. This allowed a sequenced framework to be adopted to complete all aspects of the workforce review within the set 1 year period which ended in March 2018.

Skills for Health

Regional HSC Workforce Planning Framework

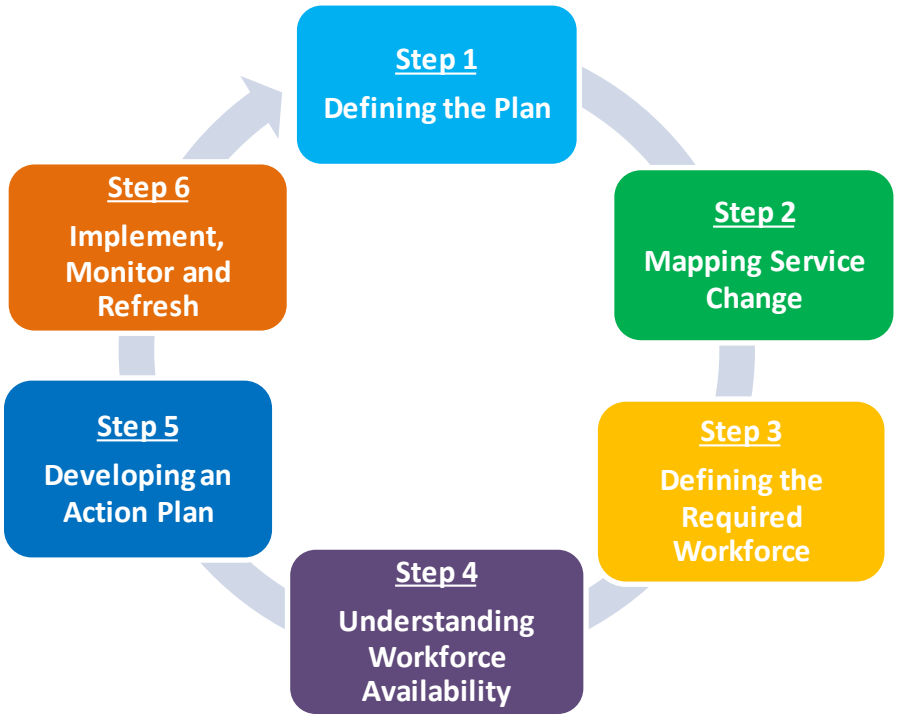


Figure 3 - Skills For Health - Regional HSC Workforce Planning Framework

A key component for the successful completion of the Physiotherapy Workforce Review was to obtain relevant stakeholder engagement. In the initial stages of the review a regional professional sub-group was established with relevant stakeholders. This group agreed and worked through specific actions outlined within the Programme Plan, and clear reporting lines were set and communicated to the AHP Workforce Review Programme Steering Group at regular intervals. (Refer to Appendix 1 for Workforce Review Programme Steering Group and Professional Sub-group membership and terms of reference)

d) Assumptions and constraints

Due to the challenging nature of completing this Physiotherapy workforce review it was important to consider any possible assumptions, constraints and / or risks early in the process. This was particularly important due to wide and varied nature of Physiotherapy Services which not only work within HSC but has had recent developments in partnership working with other statutory and non-statutory agencies. A number of identified assumptions and constraints are listed below, and measures were taken to help manage these and reduce their implications throughout the process of the review.

The Key Assumption on completion of the Physiotherapy Regional workforce review is that the Recommendations will be fully endorsed to support implementation by an action group over the next two years. The recommendations cover all aspects of workforce capacity, quality, skills/knowledge and sustainable delivery of effective evidence based services and include undergraduate and post graduate learning and development, viable recruitment pools and processes to enable career development and structures, key financial commitments required and future proofing of services to meet population and patient health and social care needs. The working group have used the HSC Workforce strategy to embed the six step tool methodology. Failure to implement the recommendations will result in not having the workforce required to meet the needs of our aging and growing populations and will restrict the reform and transformation identified in the Bengoa report and Delivering Together proposals.

ASSUMPTIONS & CONSTRAINTS

Assumptions	Constraints
• **Timeframe and Professional Capacity** - completion within 12 month period was challenging. • **Availability and Access to relevant data** – Information on activity and staffing levels across the region is currently collated in different formats and to varying levels because of the different HSC Information systems deployed throughout Trusts/region which raised comparisons / benchmarking challenges. • **Impact of Current and Future Developments** – Physiotherapy practice continues to develop in many areas with a particular focus on primary care, stroke, Home based rehabilitation, unscheduled and acute care at Home. • **Recruitment and Retention** – Quantifying the recruitment pool required to provide the workforce numbers and skills identified. Reviewing and standardising the recruitment processes and valuing of staff within HSC • **Future Population Health and Social Care Needs and the impact of Technological Advances and Social and Medicines prescribing** – The predicted demographic trends and needs of the population will inform the type of service models and subsequent workforce required for the future. • **The Future HSC** and the restructuring of the HSC system is uncertain and this is influencing the availability of current and future funding.	**Difficulty In Achieving Effective Engagement for this piece of work** – is an area to be addressed with key stakeholders at each stage to ensure co-production. **Lack of Consensus** – Widespread consensus is required at all levels across the range of organisations with a vested interest in the outcomes and findings of the review, this was achieved through active engagement with a wide range of partners(add reference to list). **Lack of development**- The full extent of Transformational service developments are not fully realised at the time of the workforce review however need to be included in the predictions of workforce for the future.

• **Implementation of the Agreed Action Plan** –Recommendations from the Physiotherapy workforce review are required to be supported and implemented to ensure achievement of the Transformation agenda and to provide a sustainable Physiotherapy workforce in NI for the next 10 years.	

Table 1 - Assumptions and Constraints

2. Defining the plan

a) Purpose, aims and objectives, guiding principles and scope of the Physiotherapy workforce review based on the evidence gained through the use of the Six Step tool.

A number of key factors have been established within the Terms of Reference of the Physiotherapy Workforce Review, including:

- Make recommendations on workforce profile to ensure service sustainability
- Make recommendations to the DOHNI regarding the commissioning of pre-registration training. (***Recommendation 1)***
- Make recommendations regarding post registration training requirements. (***Recommendation 3***)
- Produce a programme plan and agree processes and timescales for delivering of project outputs.

  Effective communication and engagement with key stakeholders, including dissemination of information relevant to the project within each of the participating organisations. User satisfaction questionnaires, user forums, patient / carer stories are all methods whereby service users and physiotherapists gain understanding, learn and share ideas as regards future planning for effective change and co-production. (Section 7 Stakeholder Engagement pages 38-40)
- Make recommendations on the recruitment processes to ensure service sustainability and maximum capacity to deliver services.
- Make recommendations on measures including structures and skills to align and develop information on the AHP workforce to assist with HSC wide service transformation.

b) Ownership

Relevant professional and workforce leads were identified as nominated members of the AHP Workforce Review Programme Steering Group and the Regional Physiotherapy Sub-Group. This included nominations from the Department of Health (DoHNI), Human Resources Directors in HSC Trusts, Physiotherapy Heads of Service from each Health and Social Care Trust, Public Health Agency (PHA), AHP Leads from the Health & Social Care Trusts, Directors/leads from Health and Social Care Board (HSCB),Staff side, the Chartered Society of Physiotherapy (CSP), policy officer for the CSP and service user involvement in line with requirements of the Public and Personal Involvement legislative frameworks.

It was identified that Physiotherapy Workforce Review progress would be reported on a monthly basis in line with processes outlined by DoHNI.

3. Mapping service change

a) Population and health profile

NI 2017 mid-year statistics estimate the population to be 1.874million with population projections anticipating a rise of 4.68% to 1.961m by 2027. Information and population statistics suggest varied levels of increase across each of the LCG areas; ranging from 2.5% to 9.8% in the same period.

Currently, the largest proportion of the population is aged between 40-64 years (31.9%), followed by those aged between 16-39 years (31.1%). It is predicted that by 2027, the over 65 population is expected to increase by 28%, representing 19.9% of the overall population. This will have a significant impact in terms of service demand / pressure across the health and care system; as people grow older the likelihood of illness and disability typically increases. A more detailed breakdown of predicted population growth to 2027 by Trust and region is outlined in the table below:

Age Band (Yrs)	Belfast	Northern	South Eastern	Southern	Western	NI
0-15	71,444	94,325	71,608	92,045	63,124	392,546
16-39	119,079	135,866	101,364	125,295	87,591	569,195
40-64	109,928	155,448	117,888	128,516	97,681	609,461
65+	66,201	104,691	85,183	73,207	60,757	390,039
All ages	**366,652**	**490,330**	**376,043**	**419,063**	**309,153**	**1,961,241**
%	**18.7%**	**25.0%**	**19.2%**	**21.4%**	**15.8%**	**100.0%**

Table 2 - NI resident Populations by Local Commissioning Group - 2027

Source: NISRA, Based on 2014 Population Mid-Year Estimates

Available evidence suggests the prevalence of long term conditions such as COPD, Diabetes, Stroke, Asthma, Lymphoedema and Hypertension is increasing; the number of people coping with co-morbidities having likewise increased.

The advances in diagnoses and treatment of cancer related illnesses has resulted in people surviving longer and requiring rehabilitation to ensure they live well after cancer.

Deprivation, lack of social support, low self-esteem, unhealthy life-style choices, risk taking behaviour and poor access to health information and quality services all have an impact on general health and wellbeing; possibly compounding the growth in Mental Health problems.

The average life expectancy for NI males is currently 78.3 years compared to 82.3 years for NI females.

Physiotherapists will have significant input with patients during their long-term condition or palliative / end of life journey to enhance the quality of life for the person and their family; providing practical advice in relation to respiratory or ambulatory need - moving and handling in the person's own home, care package advice, etc.

Chartered Physiotherapists have a professional aspiration to ensure people live well for longer; the evidence for this is presented by the CSP in a series of "Physiotherapy Works" evidence briefings including the economic evidence in terms of QALYs (Quality adjusted life years). *Reference: CSP Council 2017*

b) Statistics

Within the region, recent activity figures; April 2016 to March 2017 for Acute / Non-Acute, Community / Primary Care, older people, Learning / Physical Disability and Children's services indicate that Physiotherapists professionally managed a minimum of 222,692 new referrals; evidencing the significant role Physiotherapy has played and continues to play in the health, well-being and social integration of the population of N.I.

c) Regional Service Profile of Physiotherapy

Physiotherapy Workforce Profile for NI as of the 31st March 2017

1202 Physiotherapists working in HSCNI Trusts (995.6 WTE)

Point of Note – There is an increasing requirement from the current workforce for Flexible Working; work-life balance, job share requests etc. which will impact on the head count required for stability of the 'Region wide Physiotherapy service'.

Known challenges for Physiotherapy workforce planning:

Predominantly female staffing
83% Female **17% Male**

- Analysis of Headcount : WTE percentages % across NI indicates a stable position;
  2007 – 19.3%
  2012 – 19.5%
  2017 – 20.7%

It is important that workforce planning is based on Headcount and not on older models of WTE as that is no longer the best metric to use for stability of the workforce or workforce pool. This change to headcount is required due to the increase in part time working, job shares, family friendly working arrangements, seven day working rotas, extended working days etc.

The figures above indicate that, on average terms, each 1 headcount physiotherapist employed by HSCNI facilitates the cover of patient need equivalent to 0.83 WTE. As such, assuming the number of DOHNI commissioned places reflects the WTE needs of the services to enable them to adequately meet the needs of the population, there is a necessity to train 20% more people to cover flexible working arrangements.
(Recommendation 1)

This should be kept under review as it is predicted by Heads of Service that the Head Count : WTE will rise by 20% in the next few years. (**Recommendation 4**)

d) Emerging Service Development Opportunities and Cost Implications

Across the region there are significant challenges which require careful planning, co-production and design to manage them effectively. To achieve this, Health and Social Care organisations must strive to avoid silo working, secure additional resources and use these appropriately and effectively. They must work in partnership with other services and agencies including service users, councils, the community and voluntary sectors to manage the growing demand related to demographics and the diverse needs of our population; reforming and transforming services via smarter working with partners and users.

Delivering Together requires a greater focus on health promotion, prevention, early intervention and self-management to educate and embed public health messages within the N.I. population to enable them to take on the responsibilities; where appropriate, of their own health and well-being.

Services which are co-produced and co-designed are key and must be provided in a way that ensures safety and effectiveness for service users and staff, while keeping pace with innovative approaches and technology that steer health and social care developments. The 'Delivering Together' strategy acknowledges that staff require the opportunity to develop professionally; enabling them to expand their knowledge, skills and expertise to be future fit to deliver more specialised person-centred services that meet service user needs whilst maintaining personalised compassionate care.

Ongoing and Emerging Developments predicted to occur over the next ten years which will impact on the NI regional Physiotherapy Workforce Numbers and Profiles.

- Targeted workforce commissioning will facilitate prevention of admission and more effective, safe hospital discharge including discharge to assess models; Service continuity – acute and community services require to be commissioned on a 52-week basis. Transformation - acute and community services move from 5 to 7-day provision. (***See impact of this on workforce numbers in text box below this will be explored further on page 33***)

NOTE - Enhancement of Service; Continuity and 7-day Provision

Will need to be defined further on the basis of service need:

- Posts funded for 52 week service provision to enhance continuity
  52/42 = ***1.24 WTE***
- Posts funded for 42 weeks X 7 days/week
  +2/5 = 0.4 so 7 days/week = ***1.4 WTE*** for 7 day service 42 weeks of the year
- Posts funded for 52 weeks X 7 days/week
  52/42 - 1.24 x 1.4 = ***1.74 WTE*** for enhanced service continuity across 7 days/week

- Advanced Practice Physiotherapists i.e. First Contact Physiotherapy Practitioners in Musculoskeletal (MSK) to support GPs and meet service user needs. It is now known that for three trust areas 37 Band 8A posts are in the process of being recruited and appointed.)
- Independent Prescribing by Physiotherapists.
- Reshaping Stroke services.
- Physiotherapy Led Pelvic Health and Continence services.
- Integration and further development of Intermediate Care (IC); 4 categories - Crisis Response, Bed-based IC, Home-based Rehabilitation IC and Re-ablement.
- Specialist service developments to meet the specific needs of the population i.e. Vestibular Rehabilitation, Headaches service, Out of hours community respiratory services for children and adults with complex, life limiting and long term conditions to enable them to live in their own homes and be part of their community for as long as possible.
- ENCOMPASS programme will recruit a significant workforce and these posts will be a potential new employment/redeployment opportunity for Physiotherapists.
- Increased Public Health remit - Health Promotion and lifestyle management - Physical activity promotion / obesity management etc. This is an expansion of the

role of Physiotherapists to meet patient/population need and will include the application of social prescribing to prevent ill health, self-manage long term conditions and ensure the ability of patients and populations to be independent.

- Recruitment–widening the 'pool'/marketing NI Physiotherapy Services is essential to ensuring a viable workforce source. **(Recommendation 6)**
- *Optimisation of the Undergraduate commissioned places ***(Recommendation 1)*** will ensure that we have a viable pool of Physiotherapists to recruit into the workforce.

Not an exhaustive list but gives a sense of the journey the Physiotherapy workforce is on.

4. Underpinning Requirements of the NI HSC Physiotherapy Workforce

a) Practitioner Regulation - Health and Care Professions Council (HCPC)

Physiotherapists are autonomous practitioners who provide essential diagnostic and therapeutic services including; primary prevention, assessment, treatment, promotion of self-management, functional rehabilitation in a range of settings, specialist disease management and secondary prevention.

All Physiotherapists must be registered with the HCPC to practice in the HSC. Only those physiotherapists with a professional qualification from a training organization recognised by the HCPC can register with the regulatory body and can lawfully use the protected title - Physiotherapist. The HCPC is responsible for setting and maintaining standards of professional training, performance and conduct of the health professions it regulates.

N.I. Physiotherapy - Regional Mission Statement

HSCNI Physiotherapists will use a 'whole person' approach to ensure high quality prevention, diagnosis, rehabilitation and therapeutic services that work to enhance the health and wellbeing of people living in Northern Ireland.

Reference - NI Physiotherapy Heads of Service 2017

b) Service Delivery; Profession & Employer of Choice

This Physiotherapy Workforce Review Report is informed by the objectives of the Health and Social Care Workforce Strategy 2026 – Delivering for Our People, which has recently been published.

(Objective 1; Theme 1; Action 1)

Establishing a Regional Health and Social Care careers service aims to put a service in place which will ensure a good supply of people to the health and social care professions.

(Objective 1: Theme 3; Actions 5 and 6)
Developing an optimum workforce model for reconfigured Health and Social Care Services and the ongoing application of the Regional HSC Workforce Planning Framework aims to ensure the conditions are in place for effective workforce planning across all of the health and social care workforce.

The recommendations from this Physiotherapy Workforce review will take on board the ongoing work from these actions both now and during the scheduled interim review.

c) Career Development

Advanced Practice, First Contact and Extended Scope roles make optimum use of the knowledge and skills of Physiotherapists to facilitate Physiotherapy and AHP Led services, to enhance the patient journey and release Medical and other healthcare professionals to focus on patients with conditions and complexities that they can deal with better This move will enable the transformation of services in Musculoskeletal (MSK), Minor Injuries in ED, Falls, Intermediate Care, Neurology, Cancer, Palliative Care, Pelvic Health, Continence, etc.

The Advanced AHP Practice Framework 2019, currently being developed will provide a regional approach in addressing the requirement for advanced AHP/Physiotherapy practice within Health and Social Care in N. Ireland. It outlines the knowledge, skills, experience and competency level for advanced practitioner roles. Implementation of robust ECG (Education and Commissioning Group) planning and committed funding for three year periods is key to achieving the competent, skilled workforce required to deliver the future services required for the population. Currently the funding for the AHP ECG plans is agreed on an annual basis and it is usually at the end of March beginning of April each year. This process is detrimental to the planning process as (a) The AHP services do not know what their annual budget will be and (b) The AHP services already have lost valuable time in the planning resulting in re prioritising the priority list due to lack of funding. Also,

delivery is concentrated on the last quarter of each year making it hard to release staff to attend and maintain service delivery during winter pressure period.

The DoHNI AHP Advanced Practitioner Framework will inform planning in relation to the existing and future AHP workforce profile and the knowledge and skill assets required for advanced practitioner up to consultant posts. This framework will be key to further informing Physiotherapy Workforce Planning.

d) Postgraduate ECG Training Budget –

An ECG budget agreed for a three year period for AHPs is vital for the planning, delivery and release of staff to gain the directed postgraduate skills and knowledge key to the development of Physiotherapists. Confirming this budget annually in March/April is a significant limitation in relation to the planning, organisation and commissioning of the agreed training programmes required to ensure effective service development, continuity and future proofing. The three year planning cycle is important to support workforce development in a planned, co-ordinated way that ensures release to attend training but is dependent on committed funding streams confirmed for the three year cycle. This is key from an education provider and service perspective as the current model is not meeting service need due to the inability to forward plan. **(Recommendation 3)**

A recurring funded planning cycle is key to developing the workforce, securing more timely release of the right staff through better planning and scheduling of the various programmes throughout the calendar year(s). Currently due to present processes the majority of training is delivered in the last quarter of the year which coincides with the “winter pressure” period, end of year leave, making it very difficult to release staff to the training they need to deliver safe effective care. (***Recommendation 3***)

Changing of funding per WTE to funding per head of Physiotherapist / AHP is a key requirement in the ECG budget build - baseline funding for Physiotherapists at all levels in the organisation should match the need to address proactively the

transformation agenda and ensure the workforce pool is readily available and appropriately skilled. (Refer to Section 3(c) Workforce profile and (***Recommendation 4***)

5. Understanding Workforce Availability

a) Commissioned Undergraduate Places at UU; 2009 – 2017 Intake

UU Student Attrition from HSCNI Physiotherapy Workforce; Extrapolated from DoHNI & **UU Employability unit**.

UU indicate that 1 student per intake year does not complete the BSc programme.

Using available information from the UU Employability unit; the *average loss* to the HSCNI Physiotherapy workforce across 2012-2016 outturns, has been calculated to 'predict' the 2017-2020 outturn available to HSC.

Intake Year	Intake / Graduate Numbers	Change in DOH Funded places	Graduation Year	Graduates going into Non-HSCNI Employment	Graduates Not Available to Work for HSCNI	Total Graduates Lost to HSCNI	Maximum Number of Graduates Available to HSCNI
2009	69 / 68		2012	9	5	14	54
2010	59 / 58	-10	2013	13	0	13	45
2011	59 / 58		2014	11	0	11	47
2012	59 / 58		2015	11	5	16	42
2013	59 / 58		2016	7	1	8	50
Average %	-		-	*51/300 17%*	*11/300 4%*	*62/300 21%*	*238/300 79%*
2014	59 / 58		2017	-	-	12	46
2015	55 / 54	-4	2018	-	-	11	43
2016	50 / 49	-5	2019	-	-	10	39
2017	50 / 49		2020	-	-	10	39

Table 3 - UU Student Attrition from HSCNI Physiotherapy Workforce

Placement Capacity – HSCNI previously managed 69; 2009 intake year.

To increase the recruitment pool in the initial five year period of this workforce review we need to mitigate against the lack of commissioned places and the loss of

graduates to the HSCNI by scoping other routes to pursue BSc Honours in Physiotherapy. These options will need to be explored with Education partners, DOHNI and the Profession and should include Postgraduate routes inclusive of the Open University and apprenticeship models which are currently not available in the public sector at present *(**Recommendations 1, 2 & 5**).* It is important to note that each year there are nine times as many undergraduate applicants as there are current commissioned places for evidencing the scope to fill the additional funded places recommended.

b) Undergraduate Marketing

With limitations in the expansion of the human resource pool due to the current undergraduate out-turn from Ulster University there is need to explore the availability of Physiotherapy graduates from NI, across universities in England, Scotland and Wales.

Though no Physiotherapy specific data could be gathered, the DoH was able to advise that there are 427 AHP undergraduates from NI currently training in England, Scotland and Wales – with a total of **2,154 since 2012**. This data was gained from the workforce planning department at DOHNI. The evidence in a recent survey of NI AHP students studying in England, Scotland and Wales also shows that only one third of those people come back to NI to work. The evidence for all those students who train at home is that at least two thirds stay at home to work after graduation. It is essential to explore ways to encourage people to not go away in the first instance after graduation; one mechanism being to secure the post graduates in employment for the HSCNI for two years (Recommendation 5). It will also be important to explore ways to reach out to and encourage those graduates from UK universities to return home for employment opportunities in NI within the five Trust Physiotherapy services.
(***Recommendation 6***).

c) Recruitment and Retention – Standard

Demand on Human Resource Pool 2013/14 – 2017/18: Ongoing Service Developments and Retirements

On average terms over the last 5 years, the HSCNI required an additional 33 qualified Physiotherapists per year to join the human resource pool to address year-on-year service development / business case bids that secured new funding.

On average terms over the last 5 years, the HSCNI required an additional 13 qualified Physiotherapists per year to join the human resource pool to maintain existing services from the impact of retirements.

In real terms, these demands alone, account for most of the current 49 annual UU graduates. (***Evidence to support Recommendation 1, 2 & 5)***

HSC Trusts NI	Headcount	WTE	Average / Year HC / WTE
Service Developments	166	143.27	33.2 / 28.7
Retirements	64	52.21	12.8 / 10.5
Total	**230**	**195.48**	**46 / 39.2**

Table 4 - Permanent B5 - B8 Service Developments and retirements across all Directorates for HSCNI Physiotherapy

Recruitment - Horizon Scanning; Significant Step Change

Baseline Resets to Enhance Continuity of Current Physiotherapy Services

NOTE - Enhancement of Service; Continuity Over 52 weeks and 7-day Provision

Will need to be defined further on the basis of service need:

- Posts currently funded for 42 weeks to be increased to 52 weeks service provision 52/42 = ***1.24 WTE***
- Posts Currently funded for 42 weeks over 5 days increase to 7 days/week +2/5 = 0.4 so 7 days/week = ***1.4 WTE*** for 7 day service 42 weeks of the year
- Posts funded for 52 weeks X 7 days/week 52/42 - 1.24 x 1.4 = ***1.74 WTE*** for enhanced service continuity across 7 days/week

Stabilise Service Continuity - Planned Absence; Annual, Study Leave, etc.

On average terms over the next 5 years, the HSC Trusts NI will require up to 89 additional qualified Physiotherapists to join the human resource pool to stabilise the continuity of care across existing unscheduled care services; extrapolated across the 5 years to 0(18/19)-20(19/20)-20(20/21)-25(21/22)-24(22/23) = 89. (***Support for Recommendation 1, 2 & 5***)

NOTE: Targeted Baseline Resetting – *Unscheduled Services Only

- *AC@H, ED (not MSK), OPALS, Acute and Intermediate Care Inpatients

TRUST	Unscheduled WTE	Stabilise 52 week service over 5 days X 1.24 (change)	Enhance to seven days over 42 weeks X 1.4 (change)	Enhance to seven days over 52 weeks X 1.74 (change)
BHSCT (Existing 42/52 7/7)	105.1 24.4	130.3 (25.2) 30.3 (5.9)	147.1 (42) 34.2 (9.8)	182.9 (77.8) 42.5 (18.1)
NHSCT (Existing 42/52 7/7)	37.2 2.1	46.1 (8.9) 2.6 (0.5)	52.1 (14.9) 3 (0.9)	64.7 (27.5) 3.7 (1.6)
SEHSCT (Existing 42/52 7/7)	14.6 27.2	18.1 (3.5) 33.7 (6.5)	20.5 (5.9) 38.1 (10.9)	25.4 (10.8) 47.3 (20.1)
SHSCT (Existing 42/52 7/7)	49.7 6.4	61.6 (11.9) 7.9 (1.5)	69.6 (19.9) 9 (2.6)	86.5 (36.8) 11.1 (4.7)
WHSCT (Existing 42/52 7/7)	40.6 2.9	50.3 (9.7) 3.6 (0.7)	56.8 (16.2) 4 (1.1)	70.6 (30) 5 (2.1)
Total (Change) WTE	**310.2**	**384.5 (+74.3)**		
Headcount x 1.2		**89**		

Table 5 - Potential Staffing Implications of Baseline Resets to Enhance Continuity of Current HSCNI Physiotherapy Service

Peripatetic Teams; Approved and Prospective

In 2018-19, Peripatetic Teams approved across HSC Trusts NI, will require a baseline reset of 73 qualified Physiotherapists. The potential for 2019/20 is a further baseline reset of 47 Physiotherapists (***Support for Recommendation 1, 2 & 5***). The calculations for the numbers in Peripatetic pools were based on 50% maternity leave cover and to cover the recruitment period linked to turnover vacancies, it is important to note that sickness absence has not been factored in.

TRUST; Basis of Use	**Approved 2018-19 *SE Trust – Calculated Risk £**	**Sought (inc. additional) Requiring Trust Approval**
BHSCT ML/Vacancy gaps	24	-
NHSCT ML/WP	4	11
SEHSCT ML/LTSL/Vacancy gaps/WP	6*	5*
SHSCT ML/LTSL >6/12	30	24
WHSCT ML	10	6 (Vacancy gaps)
Sub-total	**73**	**47**

Table 6 - Potential Staffing Implications of Peripatetic Teams : Approved and Prospective

ML; Maternity Leave, LTSL; Long-term Sick Leave, WP; Winter Pressures

d) Recruitment Process Issues

Generally, there are significant delays in the recruitment process with regard to the timeliness of advertising vacancies and processing waiting lists, offers of posts and appointing staff evidencing the need to standardise the processes, systems and timelines in the Region to support the NI Regional HR Strategy, continuity of service delivery, reform and transformation. (***Recommendation 6***)

e) Competition within the UK Employment Market

HSC AHPs fall under Agenda for Change (AFC) pay arrangements however NI is at a disadvantage as;

- Competition within the UK Employment market is becoming more relevant to recruitment processes and in ensuring that N.I. Physiotherapy has a large enough recruitment pool. NI AHPS fall under Agenda for Change (AFC) pay and terms and conditions, however because pay is developed separately in each country there have been subtle differences emerging since 2013 across the four UK countries.
  It is out with the scope of this review to be able to deal with the pay differences but it is something that is required to be considered and factored in to the recruitment challenge.

- There have been several enquiries from staff and recruiting agencies to the Heads of Physiotherapy, the Chartered Society of Physiotherapy Policy Officer for NI and to Physiotherapy staff side officers in relation to this pay difference in relation to decisions from Physiotherapists thinking about returning home to NI or taking up posts in NI. As a result several potential candidates have chosen to not take up the offers from NI or have negotiated individual terms through agencies.

Protecting the DoHNI funded new graduate places for the HSCNI is one important step to maintain the recruitment pool. (***Recommendation 5***).

In the past two years HSCNI Physiotherapy Managers have struggled to have a large enough Band 5 pool to fill vacant posts in Trusts. In June 2018 HSCNI undertook a regional recruitment process for Band 5 Physiotherapists and created a waiting list of 77 people. By 1st September 2018 all applicants had been recruited and are in post. HSCNI has had to undertake a second recruitment drive in October 2018 with only 21 applicants. Currently the number of Band 5 posts required to be filled in the region is a minimum of 60 meaning there is a gap of 39.

Using available information **from the UU Employability unit;** the average loss to HSC employment of Physiotherapy Graduates across 2012-2016 outturns, has been calculated at 21% (Table 3). In addition any students that study in other areas of the UK are less likely to return. Research evidence suggests that for the overwhelming majority of graduates the country location of their employment is the same as that of their University (McQuaid & Hollywood 2008; McGregor, McKee and Thanki, 2003; Faggian et al., 2006; McCann and Sheppard 2001). HSCNI has an average of 60 vacancies at Band 5 evidencing that there are sufficient jobs for all graduates.

- Competition from non-HSC Sector organisations and other employers; Independent / Private sectors, Capita, PIP (Personal Independence Plans) – offering direct employment of Band 5 graduates and third level education facilities offering Masters completion on graduation (***Section 5a***).

f) Potential Service Developments & HSC Transformation Agenda

In line with the expectation of 'Delivering Together' and the Bengoa report, the HSC Transformation Agenda will move at pace over the rest of 2018/19 and for the next four years.

Physiotherapists have an identified strategic role to play in the achievement of the transformation agenda (Figure 4 overleaf) e.g. First Contact Physiotherapy as part of multidisciplinary teams in primary care and therefore workforce development needs to keep pace with this.

The capacity of HSC Trust NI Physiotherapy to deliver fully against this agenda in the absence of a readily available workforce and recruitment pool could put certain aspects of the agenda and therefore patient health and wellbeing at risk.

Non-recurrent funding arrangements over the past five years have had an impact on the human resource pool; stop start / short term contracts have led to potential employees moving to areas / countries where more permanent, sustainable employment opportunities existed.

End of year WLI (Waiting List Initiative) monies is not conducive to effective workforce planning, good manpower management or effective quality service delivery. It is important that realistic "lead in" periods are in place and more stable / recurrent/permanent employment status would positively impact on the assurance for continuity of service and the achievement of PFA target areas.

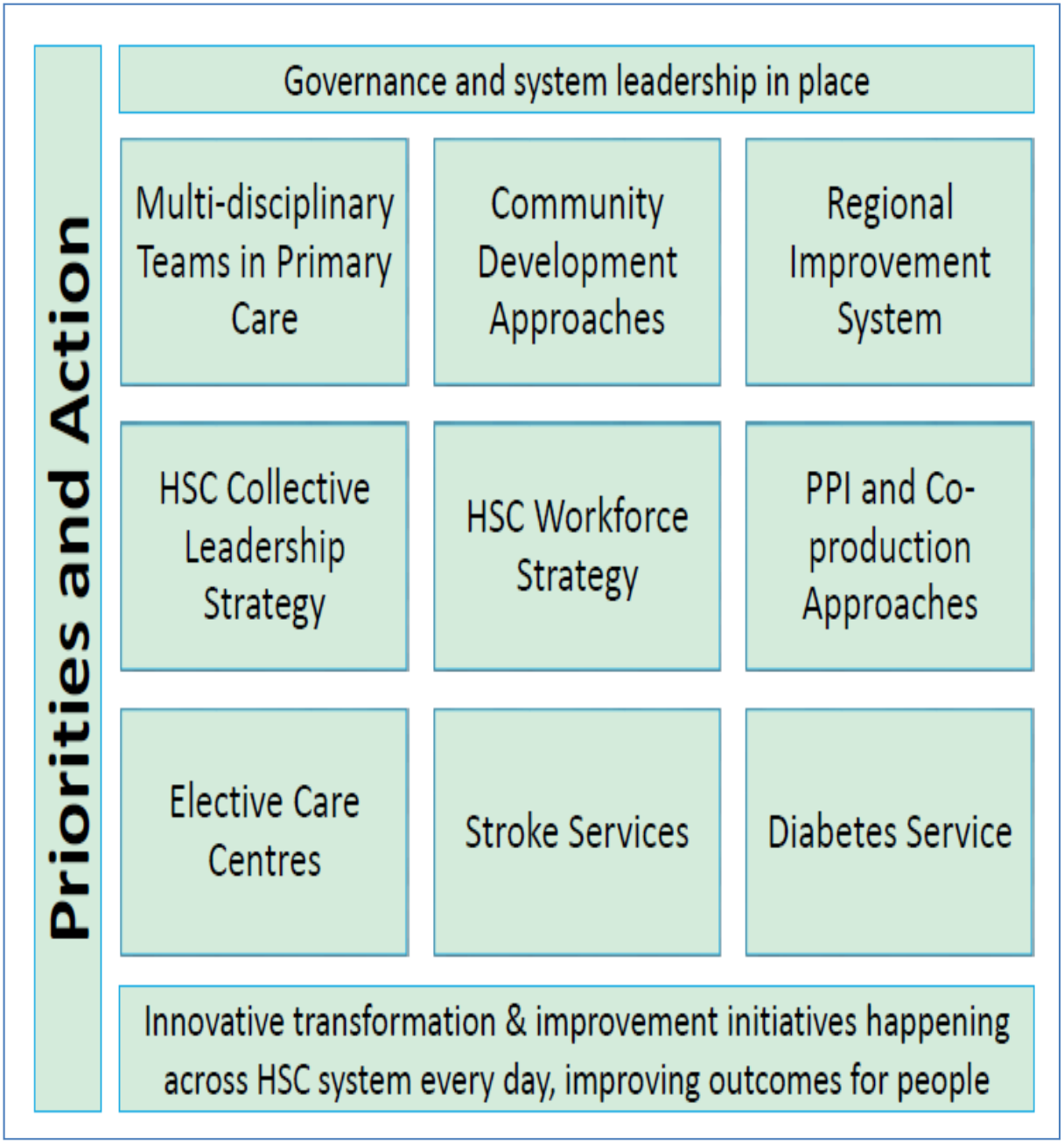
The current Turnover rate per year - 14% and vacancy rate - 11.5% escalates the requirement to ensure the complete implementation of this workforce review to guarantee that there is the staff available to deliver the services the population of NI need and the HSC are commissioned to provide.

Emerging Themes:

The table below outlines some of the potential and actual service developments currently known within the HSC continuum of core services delivery and the initiatives within the Transformation agenda.

The information in Figure 4 below came from the regional TIG group and Table outlines the key themes and initiatives where physiotherapy will be a core element of transformation.

Figure 4 – HSC Transformation Initiatives [Source: Mark Taylor, NI AHP Conference 18.10.17



Theme	Initiative
Elective Care	• Waiting List initiatives • ICP Elective care pathways
Enhancing support in primary care	• First Contact Primary Care Physiotherapists There were 2 FCPP pilots in play; SEHSCT (Dec 17) and WHSCT (Jan 18). At this point, the model guide is 1 WTE 8a Advanced Practice Physiotherapist per 10000 patient population. Early qualitative and quantitative data looks very positive and comparable to outcomes across England, Scotland and Wales.
Transformation of Community, Intermediate Care and Hospital Services	• Elective care centres • Elective specialty plans • Falls prevention and rehabilitation • Unscheduled care • Intermediate Care • Implementation of new model for stroke services • Acute care at Home • Frailty services • Learning disability • Physical Disability • Community Respiratory services (5 to 7 day extended hours) to support discharge/prevent admission/attendance at day care/living life to the full with long term respiratory conditions) all age groups • Public Health drive for population health.

Table 7 - Key Transformation Initiatives for the Physiotherapy Workforce

The impact of these emerging themes and commissioned services (many currently being recruited through C&S transformation initiatives) on the workforce have been factored into this Physiotherapy workforce review however there is a likelihood that it is based on an underestimation of Physiotherapy staffing demand over the next four years. (***Recommendation 6 & 7***)

6. Summary of Influences on the NI Physiotherapy Human Resource Pool

The following table provides a quantitative summary of the measures that are expected to have a significant impact on the physiotherapy human resource pool required by the HSCNI services over the next 5 years.

It furthermore provides the evidence to highlight the need for ongoing and robust workforce planning cycle. As has already been said, the average loss to HSCNI employment of Physiotherapy Graduates across 2012-2016 outturns, has been calculated at 21%; using available information **from the UU Employability unit;**

Headcount	**2018-19**	**2019-20**	**2020-21**	**2021-22**	**2022-23**
Maximum UU graduates available to HSCNI based on 50 commissioned places. **(Page 31)**	43	39	39 + 8	39	39
Recruitment & Retention HSCNI – Service Development **(Page 33)**	33	33	33	33	33
Recruitment & Retention HSCNI – Retirements **(Page 33)**	13	13	13	13	13
Recruitment - Stabilise Existing Workforce (Acute) x 1.24 2019-23 **(Page 34)**	-	20	20	25	24
Recruitment - Peripatetic 2018-19 **(Page 35)**	73	-	-	-	-
Recruitment - Peripatetic + 2019-20 **(Page 35)**	-	47	-	-	-
Transformation Agenda FCPP Implementation 2018-20(1 WTE / 10k pop) **(Page 38-40)**	95	95	-	-	-
Shortfall UU Out-turn V HSC Trusts NI need	**-171**	**-169**	**-19**	**-32**	**-31**
Cumulative need beyond current DOH commissioned level through UU	**171**	**340**	**359**	**391**	**422**

Table 8 - Summary of Potential HSCNI Physiotherapy Staffing Issues 2018 - 2023

While the potential HSCNI Physiotherapy staffing deficit over the next five years equates to 422, a significant proportion of this predicted shortfall relates to two step-change events – the implementation of Peripatetic staffing and the introduction of FCPP's within the Transformation Agenda. Given the need to implement a robust workforce plan it is likely that HSCNI will gradually address this deficit over the next few years. As such, on average terms, there is an indication of need for an additional 85 Physiotherapists per year; above that trained by UU, to join the HSCNI Human Resource pool over the next 5 years.

(***Recommendations 1, 2, 3, 4, 5, 6, & 7***)

Undergraduate Commissioning;

Rationale - for the purposes of this paper the HSCNI have benchmarked with Wales due to the similarity of geography; urban - rural and that it, like Northern Ireland, has only one University (Cardiff) that their DoH commission undergraduate training places from. We have also made the assumption that the health and care needs of the population of Wales and NI are similar.

Cardiff university is the main source of supply for training the numbers of undergraduates to meet the needs of the population of Wales. Using this benchmark Wales, have a population of 3.1 million, and offer 140 places at undergraduate level which equates with 1 Physiotherapist per 22143 of the population when we compare with NI with a 1.9 million population, 50 places are offered which equates to 1 Physiotherapist per 38,000.

2017	Population	Number of DoHNI Commissioned Places	Population Proportionality	Equivalence; Undergraduate Places Required For N.I.
Wales	3.1 million	140	1 per 22143	
NI	1.9 million	50	1 per 38000	86

Table 9 - Rudimentary Benchmarking of Undergraduate Commissioning

Based on this simple benchmarking comparison, the current annual UU recruitment pool of 50 places should be increased to around 86 commissioned undergraduate places. These additional 36 places alone will not address the predicted annual shortfall of 85 outlined above.

Of the 2180 students applying for the bursary in 2017/18 (first year of offer), only 3% declined to work in Wales post qualification. Assuming Wales DOH is able to enforce this measure, the vast majority of students trained in Wales will work in Wales after their studies.

It is crucial that similar steps are explored / taken by DoHNI to increase and protect the pool of NI physiotherapy graduates available to HSCNI via DoHNI commissioned places. (***Recommendations 1, 2 & 5***)

Cost Estimate; Incremental Increase from 50 to 86 DOHNI Commissioned Places

Many of the above developments will require robust workforce planning, partnership working with the Ulster University and Trusts as well as increased funding to be realised. This will ensure a skilled recruitment pool and the co-ordinated planned approach to ensuring the continuous professional development of the workforce. With the agreement of the DOH to these recommendations this would result in the annual commissioning of the optimum additional places identified in this paper (86) from the University (including Trust Placements). Based on the current model of commissioning, the current tuition fees, and an average bursary award of £1,500 p/a per student, the funding increase required for the 36 additional
Undergraduate Commissioned Places per financial year would be:

Year 1: £190k
Year 2: £516k
Year 3: £842k
Year 4: £976k (recurrent thereafter)

Regional Placement Cost Increase: 36 people x £60x 3 placements approx £6480 per annum

A phased increase would require additional funding for Undergraduate training from the 2018/19 baseline as set out in the table below. (***Recommendation 1***)

Year	Total places	Additional required	Trust Placement Costs
2018/19	60	£53k	£1800
2019/20	70	£196k	£3600
2020/21	80	£339k	£5400
2021/22	86	£641.5k	£6480
2022/23	86	£786k	£6480
2023/24	86	£976k	£6480

Table 10 - Phased increase in Undergraduate Training and associated costs

UU and the HSC Trusts have indicated that if the department supports the recommendation to commission a phased increase to 86 places by 2021/2022, these additional numbers can be accommodated within the university and the Trusts for clinical placements. Potential solutions include placements in emerging areas of clinical practice.

7. Stakeholder Engagement

An important element of the review involved stakeholder engagement in the spirit of co-production and co-design. The Project Team comprised of representatives from DoHNI, PHA, and Trusts. The Steering Group comprised of representatives from DoHNI, PHA, Trusts, PCC and Staff Side.

An engagement strategy was discussed at Steering Group level. It was agreed a collective communications effort regionally would be important to encourage service user and carer involvement. This input to the review process would ensure solutions were coproduced appropriately.

The PCC undertook a digital communications strategy to support the involvement agenda. This included social media postings across Facebook and Twitter; published article updates in PCC monthly newsletter with a reach of 15,000 across Northern Ireland and event listings on PCC website for 'Engage' events.

In addition, the Project Group hosted an 'Engage' event on Friday 24th November 2017 at the Ulster University, Jordanstown Campus. Over 100 delegates registered to attend the event from across the statutory, independent sector, staff side, carers and users. The purpose of the event was to consult on the development of the draft Allied Health Professions Workforce Review with a Focus on Physiotherapy, Occupational Therapy, Speech & Language Therapy. The event took the format of an interactive e-participation 'Engage' session.

The engage discussion focused on four main topics:
Question 1 – Recruitment – What needs to be done to attract the right people with the right skills into these professions?
Question 2 – Retention – What needs to be done to make the HSC a brand that people aspire to work for?
Question 3 – Workforce Planning Process – Are there any gaps in the process that you would wish to have addressed?

Reflection – Having discussed all of this today, what would you now suggest as the top priority for the AHP workforce reviews to deliver?

The 'Engage' method combines the live aspect of small-scale discussion with information and communication technologies; on one hand it allows rapid transmission of work-group results to a plenary assembly; while on the other it permits surveys of individual participants' opinions through a polling system. Information gathered at the engage event has been reflected in the review. Each of the round table groupings at the event were asked to prioritise their responses in each topic and the top responses captured.

The full report of the 'Engage' can be found at **Appendix 3**

The Public Health Agency (PHA) is carrying out an extensive piece of work across all Health and Social Care Trusts (HSCTs), with the aim of introducing a more patient-focused approach to services and shaping future healthcare in Northern Ireland. The '10,000 Voices' project now '10,000 more voices', gives patients, as well as their families and carers, the opportunity to share their overall experience highlighting anything important, such as what they particularly liked or disliked about the experience. The project is supported by a software package called sensemaker & the National Health Service in Northern Ireland are among the earliest users of SenseMaker®.

Personal and Public Involvement (PPI) is the active and effective involvement of service users, carers and the public in the design, development, delivery and evaluation of Health and Social care (HSC) services. Personal and Public

Involvement (PPI) is now a legislative requirement for Health and Social Care organisations as laid down in the Health and Social Services (Reform) Northern Ireland Act 2009. While PPI may be relatively new term, the concept is not. The HSC system has long recognised the benefits of meaningful and effective engagement of service users, carers and the public. Within all Trusts in the region Physiotherapists are actively involved in building partnerships and networks with service users, adults and children, carers, families, charitable organisations, user forums, voluntary organisations and other agencies including councils, education, police, Ambulance and Fire Services, to identify some areas.

The Physiotherapy profession proactively leads on engagement with patients, carers, all staff members, support and professionally qualified staff who in turn are potential service users as well as providers of services. On the 20th of November 2017, an event was held for our new Physiotherapy graduate (Band 5) staff for them to add their voices and stories to help ~~us~~ develop the undergraduate training, services and leaders within the profession which in turn will benefit the patient journeys and pathways.

Within the Region SHSCT Physiotherapy Musculoskeletal service is piloting the use of the Bridges approach to Self -Management and Independence; this is a first for the nation in this clinical area.

Innovative approaches e.g. “Dragon’s Den” events have enabled partnership development of quality improvement projects/services through the use of service user stories, reflection, learning and joint working with service users and physiotherapists. As a result of events like these new service models have been implemented and learning from what works for service users has resulted in service user centred services.

8. Conclusion

This report has been written to inform the Physiotherapy Workforce development needs for Northern Ireland. This is inclusive of evidencing the need for an increase in the number of undergraduate physiotherapy training places in the context of Northern Ireland HSC in 2018 and over the coming years.

Considering all of the evidence and projections outlined in this report the trend does demonstrate the need to increase the number of undergraduate places to ensure growth in the recruitment pool to meet future recruitment needs of the HSC workforce and to ensure Physiotherapy as a key partner of the HSC, delivers on and meets service needs and transformation plans.

This increase in undergraduate commissioned places will support the maintenance of existing services, the transformation agenda outlined in Delivering Together and the delivery of initiatives such as First Contact Physiotherapy amongst the numerous other transformation agenda items set out within section 3 (d).

The report further explores the post graduate Knowledge and Skills developments required by the HSC NI Physiotherapy workforce to enable productive and sustainable transformation of services. This highlights the need for fully funded postgraduate training and development that is planned on a minimum of three year cycle basis.

The recommendations set out in the next section have been informed by the first four steps of the workforce planning framework considered throughout this report. The recommendations and action plan complete the workforce cycle in line with step 5 and step 6.

Effective workforce planning for Physiotherapy and full implementation of the recommendations will ensure we have the right people, in the right place at the right time to ensure the efficient, effective delivery of the HSC services in NI over the next five years.

It is also key that there is a formal midterm review of the actions taken to evaluate the impact and adjustments required to inform the next cycle of workforce planning.

9. Recommendations of the Physiotherapy Workforce Review

Based on the findings of the Physiotherapy workforce review the key recommendations are set out below, these have been structured under key headings and will inform the Action Plan.

	RECOMMENDATIONS
Undergraduate Training	1. DoHNI to fund uplift in undergraduate training places – evidence supports the increase from 50 to 86 with the optimum numbers to be reached by 2021/22. Phased approach over a five year period; ➢ 2018/2019 – 60 Places ➢ 2019/2020 - 70 ➢ 2020/2021 - 80 ➢ 2021/2022 - 86 ➢ 2022/2023 - 86 It is important to note that the initial impact of uplift will not be realised in the workforce until 2021 at the earliest. (Section 5: Workforce Availability 2. The Physiotherapy Profession and DOH with Education to explore alternative routes to BSc Physiotherapy ***page 32***: ➢ UU, as the local provider to scope the development of an accelerated 2 year undergraduate Masters and postgraduate Masters routes in partnership with the Physiotherapy professional leads and the DOHNI as the commissioner of education and training sources.

	➢ Professional body to scope Open University Physiotherapy Degree course or apprenticeship route - access to apprenticeship levy.(***Appendix 9: Q&A (Questions and Answers) on Apprenticeship Developments CSP Website Feb 2017 & Appendix 10: Apprenticeships - the back story***). The DOHNI, and the profession progress this approach in partnership.
Post Graduate Training	3. DoHNI to ratify the training and funding for an ECG, budgeted, 3 year planning cycle to enable implementation of the transformation agenda from a knowledge & skills context. 4. The funding of the ECG budget is required to be based on the Head count of physiotherapists and not WTE which is currently the case. (***Regional Physiotherapy Service profile page 22***)
Recruitment and Retention	5. To formalise the commitment process of UU graduates funded by DoHNI in line with the Welsh model to be secured for HSC NI employment for two years on qualification. This will help mitigate against the loss of new graduates from the pool to other markets/employers. 6. Under the HSC WF Strategy for the region, work with physiotherapy partners and Shared Services to support HSC Trusts in NI to promote themselves as an employer of choice and Physiotherapy as a profession of choice. This will include the standardisation of regional recruitment and robust workforce planning evidenced in this paper.

	From the knowledge around the workforce numbers required there is evidence of the need to expand the Physiotherapy marketing profile to enable recruitment from across a wider human resource pool inclusive of Scotland, England, Wales and the South of Ireland through the use of Social media etc. (***Section 5 Understanding Workforce Availability***) The DoHNI to develop and recruit on a permanent basis an AHP Workforce Lead role who will work to proactively manage and alert to the actual and changing workforce needs across Allied Health Professionals.
Transformation	7. DoHNI, PHA, HSC Trusts NI, Physiotherapy professional leads to carry out an interim review of the physiotherapy workforce to take into account the ongoing impact of service developments and transformational service changes on the HSC Physiotherapy workforce over the next five years. (***Section 3: Mapping Service Change***)

10. Action plan

An appropriate action/implementation plan will be developed and published on the Department of Health's website and the Workforce Strategy Programme Board will be updated on progress.

Appendixes

Appendix 1 - Membership of AHP Workforce Programme Steering Group, former Regional Workforce Planning Group and Physiotherapy Sub-Group

ALLIED HEALTH PROFESSIONS (AHP) WORKFORCE REVIEW	
PROGRAMME STEERING GROUP - MEMBERS	
Name	**Organisation**
Charlotte McArdle	DoH – Chief Nursing Officer
Andrew Dawson	DoH – Workforce Policy Director (Acting)
Peter Barbour	DoH – Workforce Policy Directorate
Catherine Donnelly	DoH – Workforce Policy Directorate
Hazel Winning	DoH - AHP Lead Officer
Erin Montgomery	DoH – IAU
Jill Bradley	NHSCT - Lead for Allied Health Professions
Paula Cahalan	BHSCT AHP Lead
Eamon Farrell	SHSCT – Acting Assistant Director of AHP Governance, WFD and Training
Carmel Harney	SHSCT - Assistant Director of AHP Governance, WFD and Training
Mary Hinds	PHA
Raymond Irvine	WHSCT – Senior HR Manager
Patricia McClure	Ulster University
Joanne McKissick	Patient and Client Council
Pauline McMullan	BSO Assistant Head of Clinical Education Centre
Margaret Moorehead	SEHSCT - Assistant Director – AHP
Paul Rafferty	WHSCT - Head of AHP Services
Claire Ronald	Staff Side
Claire Smyth	SEHSCT - Assistant Director Organisation & Workforce Development
Michelle Tennyson	PHA
Heather Trouton	Interim Director of Nursing and AHP

ALLIED HEALTH PROFESSIONS (AHP) WORKFORCE REVIEW	
PROGRAMME STEERING GROUP - MEMBERS	
Name	**Organisation**
Marie Ward	WHSCT - Assistant Director of Human Resources

ALLIED HEALTH PROFESSIONS (AHP) WORKFORCE REVIEW	
PROGRAMME STEERING GROUP – FORMER MEMBERS	
Name	**Organisation**
Mary Hannon-Fletcher **Until 10 August 2017**	Ulster University
Brendan McGrath **Until 20 September 2017**	WHSCT - Assistant Director of Nursing: Workforce Planning and Modernisation
Angela McVeigh **Until 20 September 2017**	SHSCT - Director Older People & Primary Care & Interim Executive Director Nursing & AHPs

FORMER REGIONAL WORKFORCE PLANNING GROUP - MEMBERSHIP	
UPDATED: 31 MAY 2018	
Name	**Position and Organisation**
Andrew Dawson	Acting Director, Workforce Policy Directorate, Department of Health
Peter Barbour	Assistant Director, Workforce Policy Directorate, Department of Health
Catherine Donnelly	Deputy Principal, Workforce Policy Directorate, Department of Health
Erin Montgomery	Principal Statistician, Information and Analysis Directorate, Department of Health
Sharon Allen	Principal Economist, Infrastructure Investment Directorate, Department of Health
Paddy Woods	Deputy Chief Medical Officer, DCMO - Safety, Quality and Standards, Department of Health
Heather Finlay	Nursing Officer, Nursing, Midwifery and AHP Directorate, Department of Health
Adrian Mairs	Acting Director of Public Health, Public Health Agency
Roger Kennedy	Assistant Director of Commissioning, HSC Board
Patricia Higgins	Director of Regulation and Standards, Northern Ireland Social Care Council
Karen Hargan	Human Resources Director, Business Services Organisation
Jacqui Kennedy	Human Resources Director, Belfast HSC Trust

FORMER REGIONAL WORKFORCE PLANNING GROUP - MEMBERSHIP	
UPDATED: 31 MAY 2018	
Name	**Position and Organisation**
Elizabeth Brownlees	Human Resources Director, Northern HSC Trust
Myra Weir	Human Resources Director, South Eastern HSC Trust
Vivienne Toal	Human Resources Director, Southern HSC Trust
Ann McConnell	Human Resources Director, Western HSC Trust
Roisin O'Hara	Human Resources Director, Northern Ireland Ambulance Service HSC Trust

Physiotherapy Workforce Sub-Group Members	
Name	**Organisation**
Hazel Winning	DoH (Chairperson)
Shane Breen	PHA (Co-Chair)
Peter McAuley	DoH
Catherine Donnelly	DoH (WFD)
Gerard Tinney	DoH
Alison Dunwoody	DoH
Paula Cahalan	BHSCT (AHP Lead)
Elaine McConnell	BHSCT (PT HOS)
Lynne McCartney	NHSCT (PT HOS)
Aveen McCraith	SET (PT HOS)
Teresa Ross	SHSCT (PT HOS) Chair Of Regional Physiotherapy Managers Forum
Seamus Doherty	WHSCT (PT HOS)

Tom Sullivan	CSP (Policy Officer)
Claire Ronald	Staff-side CSP

Appendix 2 – AHP Workforce Strategy Terms of Reference	
Click on Icon to open	AHP WORKFORCE REVIEW - PHYSIOTHE

Appendix 3 - DoH HSC AHP Workforce Strategy Engagement Event – 24th November 2017	
Click on Icon to open	DoH HSC AHP Workforce Strategy E

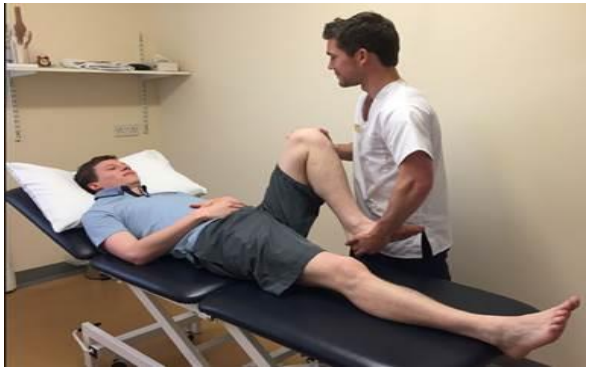
Appendix 4 - AHP Care pathways	
Click on Icon to open	Physiotherapy Elective Care Pathwa

Appendix 5 – Fundamental Units of Evidence	
Click to open Icon	Fundamental Units.pdf
Appendix 6 – Key Risks and Mitigation	
Click to open Icon	Key Risks and Mitigation.pdf
Appendix 7 – Health Service capacity Review 2018 (HSE) – Main Report	
Click to open Icon	Health-Service-Capacity-Review-2018-Ma
Appendix 8 – Facing the facts, shaping the future – a draft health and care workforce strategy for England to 2027	
Click to open Icon	Facing the Facts Shaping the Future a

Appendix 9 – CSP: Questions and Answers Related to apprenticeships	
Click to open Icon	CSP Questions and Answers Related to A
Appendix 10 – Apprenticeships: the back story	
Click to open Icon	Apprenticeships The Back Story.pdf
Appendix 11 – Educational Migration in Northern Ireland 2008	
Click to open Icon	EducationalMigrationinNIreland2008.pdf
Appendix 12 –Physio Works - CSP	
Click to hyperlink to view documents	https://www.csp.org.uk/professional-clinical/clinical-evidence/clinical-briefings

Physiotherapy in Action

MAHI - STM - 102 - 1925



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Department of Health

Workforce Review Report

Speech and Language Therapy

2019 - 2029

ROYAL COLLEGE OF SPEECH & LANGUAGE THERAPISTS

HSC Health and Social Care

DoH Department of Health www.health-ni.gov.uk

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Foreword

Since October 2016, Health and Social Care workers and the Department of Health have been cooperating to deliver the transformation set out in ***Health and Wellbeing 2026: Delivering Together***. This ambitious ten year plan was our response to the report produced by an Expert Panel led by Professor Bengoa, who were tasked with considering how best to re-configure Health and Social Care Services in Northern Ireland.

The aim is a health and social care system that helps people to stay well for longer, with services delivered in the community or at home, where possible. Allied Health Professions (AHPs) will play a key part in responding to this challenge, particularly as we expand the role of innovative, multidisciplinary teams across a range of integrated care pathways within health and social care settings. No matter how or where AHP staff work, they will continue to maintain their clear professional focus: supporting people, who are ill, have disabilities or special needs, to live the fullest lives possible.

Since these AHP workforce reviews commenced, the landscape across Health and Social Care has changed considerably. Opportunities for AHPs have been created across a range of primary care multi-disciplinary teams. These are to be welcomed, but it is important to have the highly skilled workforce required to take these opportunities as they arise. This series of workforce reviews are written with a view to identifying and quantifying the workforce required to meet these challenges and help drive the transformation agenda forward.

The AHP workforce reviews will help to address one of the immediate priorities set out in the ***New Decade, New Approach*** document published at the time of the establishment of the new Northern Ireland Executive. The commitment being that the Executive will transform HSC services through reconfiguration of services.

There is however currently a bigger challenge facing the HSC system in the guise of the current Covid-19 pandemic. This is challenging us in many ways, including the

immense pressures placed on our workforce and the need to think and act differently, and to consider how we currently work and how we may work in the future.

In this changing environment, it is even more essential that we have an understanding of our workforce needs, so that we can plan effectively to maintain and develop our services into the future. This was recognised in ***Health and Wellbeing 2026: Delivering Together*** and appears as a key theme in the associated ***Health and Social Care Workforce Strategy 2026: Delivering for Our People.*** Recognising that the HSC is a changing environment and will continue to evolve, this series of workforce reviews are "living documents" which will be reviewed throughout the period of the reviews.

This Workforce Review Report, and the clear recommendations it contains, is the result of a wider Workforce Review Programme covering all thirteen AHPs in Northern Ireland. Since March 2017, Project Groups comprising representatives from across the health and social care service, professional bodies, staff side representatives and the Department of Health, have been meeting regularly to consider how these professions / services are likely to develop in the period 2019 – 2029. Their work has been overseen by the AHP Workforce Review Programme Steering Group and applies the ***Regional HSC Workforce Planning Framework's*** six step methodology.

This process and its resulting Workforce Review Reports are the products of active co-design and co-production, delivering together to ensure the workforce needs of the HSC are met. Project Groups have engaged with their stakeholders, including service users and carers, both in formal engagement events and through ongoing involvement with relevant individuals and organisations. Their input has been invaluable in producing this final document and its recommendations. We would like to thank everyone who has contributed to the work of the AHP Workforce Review Programme.

Our vision is for Northern Ireland to have an AHP workforce that has the capacity and capability to deliver the best possible care, for patients and clients, and has the

leadership skills and opportunities to lead and transform services to improve population health. The Speech and Language Therapy Workforce Review Report and its recommendations set us on course to do just that for this profession.

Charlotte McArdle
Chief Nursing Officer
Department of Health

Preeta Miller
Director of Workforce Policy
Department of Health

Jennifer Keane
Chief AHP Officer
Department of Health

Abbreviations

Adult learning disability	ALD
Adverse childhood experience	ACE
Allied health professional	AHP[1]
Alternative and augmentative communication	AAC
Acute care at home	ACAH
Association of speech and language therapists in independent practice	ASLTIP
Autism spectrum disorder	ASD
Business services organisation	BSO
Child and adolescent mental health	CAMHS
Chronic obstructive pulmonary disease	COPD
Communication advice centre	CAC
Clinical Education Centre	CEC
Department of Health	DoH
Developmental language disorder	DLD
Eating, drinking and swallowing disorders	EDS
Elderly mentally ill	EMI
Emergency department	ED
Gastro-oesophageal reflux	GOR
General practice/practitioner	GP
Heads of service	HOS
Health care professionals council	HCPC
Health and social care	HSC
Health and social care trusts	HSCT
Integrated care partnerships	ICP
Local commissioning group	LCG
Motor neurone disease	MND
National health service	NHS
Northern Ireland	NI
Programme for government	PFG
Public Health Agency	PHA
Post Graduate Education and Training	PET
Royal College of Speech and Language Therapists	RCSLT
Sentinel stroke national audit programme	SSNAP
Social emotional mental health	SEMH
Speech and language therapists	SLTs
Speech and language therapy assistants	SLTAs
Speech language and communication needs	SLCN
Special educational needs	SEN
Technical instructors	TIs
United Kingdom	UK
University of Ulster	UU
Whole time equivalent	WTE
World health organisation	WHO

[1] http://www.publichealth.hscni.net/directorate-nursing-and-allied-health-professions/allied-health-professions-and-personal-and-publi-6

1. INTRODUCTION

Speech and language therapy is a cost effective and vital service which transforms lives, empowers lives and saves lives. If left unidentified and unsupported, speech, language and communication needs (SLCN) can have long-term implications for educational attainment, employment, social inclusion and mobility, mental health and involvement with the justice system. Speech and language difficulties are a key risk factor in safeguarding for vulnerable children, young people and adults.

Speech and language therapists also play a key role in the management of dysphagia. Unidentified and untreated eating, drinking and swallowing difficulties (EDS[2]) are significant risk factors in children with complex needs and in adults with conditions such as cancer, progressive neurological conditions, dementia and stroke and can lead to aspiration pneumonia and death.

Currently in Northern Ireland there are 472.6 whole time equivalent (WTE) SLTs (headcount 569, DoH March 2018). Of these, 68% are employed to work with children and 32% to work with adults. Of the 68% working with children approximately 20% work in school settings.

Some examples of relevant statistics are detailed below:

More than 10% of children have speech, language and communication needs (SLCN). At age five, 7.58% have a language disorder that isn't linked to another condition, referred to as developmental language disorder. A further 2.34% have a language disorder linked to or co-occurring with another biomedical condition, such as autism or hearing impairment (Norbury et al, 2016). In areas of social deprivation, upwards of 50% of children can start school with communication difficulties (Law et al, 2011)

Another area of risk for children and young people can be found in feeding and swallowing difficulties, which between 26.8% and 40% of infants born prematurely can experience (Uhm et al, 2013; Lee et al, 2011). https://www.rcslt.org/members/children/childrens_services

Only 10% of stroke-related deaths are caused by neurological deficits, while 30% of post-stroke deaths are due to pneumonia (Heuschmann P., et al., 2004, Kwan et al 2008). Pneumonia is almost invariably associated with swallowing problems (Enderby, 2014). https://www.rcslt.org/clinical_resources/stroke/prevalence

One-third of stroke survivors are affected by aphasia (Backheit et al 2007, Stroke Association 2015). And more than 50% of people with stroke or brain injury have been described as having dysarthria or apraxia of speech. https://www.rcslt.org/clinical_resources/stroke/prevalence

[2] The clinical term for EDS is dysphagia

Speech and language therapists (SLTs) support peoples' health and healthcare needs across the full age spectrum with the greatest needs coming from children and older people. SLTs work across all aspects of the health sector - primary, secondary, tertiary and community care in patients' homes and workplaces and in the education sector in early year's settings, nurseries and schools.

Using specialist skills, SLTs work directly with clients and their carers and provide them with tailored interventions and support. They also work closely with other health professionals, including doctors, nurses, other allied health professionals (AHPs) and psychologists as well as other agencies including education staff to develop individual treatment programmes.

SLTs have a key role in training others to support people with communication and EDS and in developing environments which support good communication and eating and drinking management. SLTs are supported in the workforce by speech and language therapy assistants (SLTAs) and technical instructors (TIs) and knowledgeable administration staff who undertake delegated tasks, under the supervision of the SLT.

Changing demographics, changing prevalence and survival rates for conditions which cause communication and eating, drinking and swallowing difficulties, advances in practice through new ways of working, increased awareness and knowledge about the needs of certain groups for example children, all have an impact on the challenge of trying to measure demand for services.

The recommendations of this speech and language therapy workforce review should assist the Department of Health (DoH) and the wider health and social care (HSC) commissioners to determine the size of the speech and language therapy workforce required to support the delivery of safe, effective and person-centred care now and into the future. It should also determine the skills and developments required for the whole workforce as well as offering a more informed basis for the department to determine the number of undergraduate places it commissions each year.

Governance

SLTs must be registered with the Health and Care Professions Council (HCPC) to practice. Only those SLTs with a professional qualification from a training organisation recognised by HCPC can register with the regulatory body and can lawfully use the 'Speech and Language Therapist' protected title.

a) **Assumptions and constraints**

Due to the challenging nature in completing a workforce review it was important to consider any possible assumptions, constraints and/or risks early in the process. This was particularly important due to the wide and varied nature of speech and language therapy services which not only work within HSC but also work in partnership with other statutory and non-statutory agencies. The main assumptions and constraints are tabulated below.

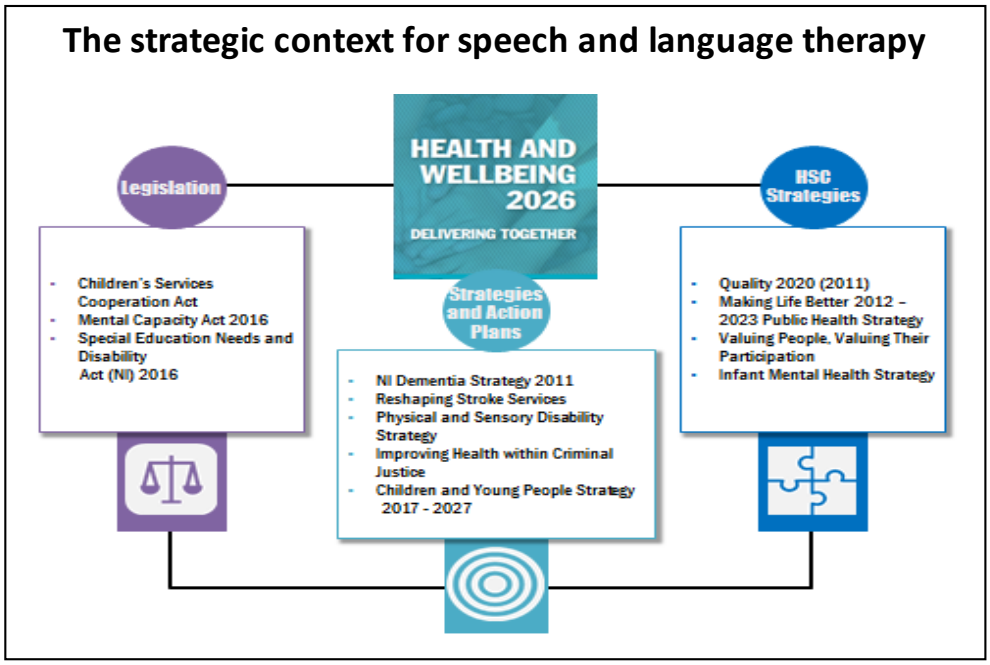
Assumptions	Constraints
Staffing –the focus of this review is solely for qualified speech and language therapists rather than the wider workforce.	Financial – workforce development has and will continue to be impacted by fiscal pressures.
Engagement – key stakeholders were able to input into this review at each stage of the process in a co-produced way.	Engagement – the ability to engage more widely with a range of stakeholders and users has been a challenge.
Data /information –use of robust sources of demographic or population data for Northern Ireland, for example; NISRA, DE and the DoH. .	Data/information – the lack of regionally agreed data sets and systems make accurate projections and comparisons difficult to achieve.
All members of the working group would be able to input into each stage of the process.	Timeframe and professional capacity – due to competing demands and pressures of those involved in completing the review.

b) Strategic context

In December 2016 DoH embarked on regional workforce reviews across all of the allied health professional (AHP) groups including speech and language therapy to ensure services would be sustainable to meet future demands and would be delivered to an appropriate standard in line with strategic policy direction.

This plan has therefore been developed to align with Northern Ireland's overarching programme for government (PfG)and the 10 year strategy launched by DoH in October 2016, 'Health and Wellbeing 2026: Delivering Together' which was the Minister's response to the Bengoa report.

In addition, there are a considerable number of other strategic drivers across health, education, and justice which also have the potential to influence the outcome and recommendations of this plan. Some of these can be viewed in the figure below and further information is included in Appendix A



Currently, there are also two major new pieces of legislation which once implemented will most certainly impact on speech and language therapy delivery as they place a statutory duty on the SLT service to provide advice and/or support:

- Mental Capacity Act 2016 Mental Capacity Act (Northern Ireland) 2016
- SEND Legislation - Special Education Needs and Disability Act (N.I.) 2016 Special Educational Needs and Disability Act (Northern Ireland) 2016

Speech and Language Therapy delivering transformation

In response to the programme for government, 'Delivering Together' proposes a 'whole system' transformation plan which requires cultural and operational change in order to meet future demand. The over-arching aims are to:

- Improve the health of the population;
- Improve the quality and experience of care;
- Ensure sustainability of the services delivered; and
- Support and empower staff delivering health and social care services.

Speech and language therapists can make a major contribution to the implementation of this transformation by:-

Core SLT functions		**Interim outcomes**		**Transformational outcomes**
Enhancing speech and language development in children and young people	→	Improved literacy and numeracy	→	Better educational and employment outcomes for the population
Providing additional or enhanced communication methods for people who have impaired or limited communication	→	Ensuring people can express themselves and make choices Making health and social care accessible to all	→	Improving societal health and well being and experience and quality of care
Managing eating drinking and swallowing difficulties	→	Preventing pneumonias and choking	→	Staying well longer and preventing hospital admissions

The speech and language therapy workforce is well placed to deliver by;

- Enabling people to stay well longer or where care or support is needed especially in community settings and as part of community multidisciplinary teams
- Providing input into new transformational teams e.g. acute care at home, rapid response, adults with autism spectrum disorder (ASD) , respiratory teams, adult learning disability forensic teams and CAMHS
- Building capacity in the workforce who support people with EDS in order to deliver the recommendations in the recently published Thematic Review of Choking

Economic value of speech and language therapy

The expert assessment, advice and treatment provided by speech and language therapists also create financial savings for NHS services. An economic evaluation of the value of speech and language therapy conducted by Matrix Evidence[3] (a company specialising in social return on investment studies) analysed the net annual benefit per £1 invested in SLT provision to be as follows within NI:

- Dysphagia post stroke = net benefit of SLT of £.04 million
- Aphasia post stroke = net benefit of SLT of £.04 million
- Speech and language impairment = net benefit of SLT of £.24.2 million
- Autism = net benefit of SLT of £.24.2 million

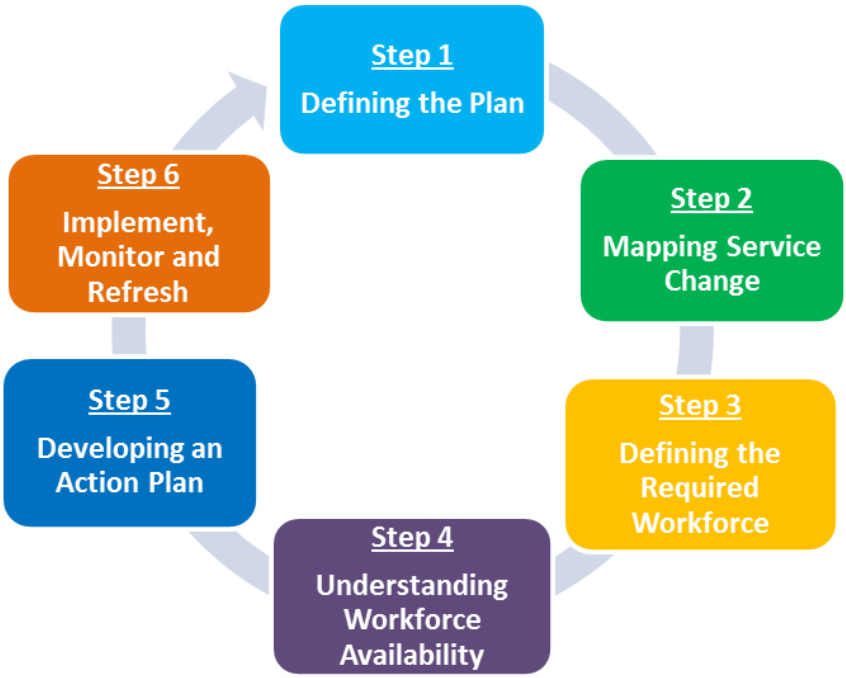
Speech and language therapy has also been shown to play a crucial role in delivering effective urgent and emergency care and can support earlier discharge, thereby reducing length of stay.

[3] Matrix evidence. An economic evaluation of speech and language therapy. Final report:December 2010 http:/ww.rcslt.org/giving_voice/matrix_report

c) Workforce planning methodology

This speech and language therapy workforce review was completed in line with the six step methodology outlined within the Skills for Health and Social Care Workforce Planning Framework as denoted in the diagram below. This allowed a sequenced framework to be adopted to complete all aspects of the workforce review within the set one year period which ended in March 2018.

Skills for Health Regional HSC Workforce Planning Framework



2. DEFINING THE PLAN

a) Purpose

In March 2017 the lead allied health professions officer in the DoH formed a number of sub groups to develop a workforce plan for an initial three AHP professions, physiotherapy, speech and language therapy and occupational therapy. The following terms of reference for each review were subsequently agreed:

- Produce a work plan and agree processes and timescales for delivery of project outputs.
- Ensure effective communication and engagement with key stakeholders including dissemination of information relevant to the project within each of the participating organisations.
- Make recommendations on workforce profile to ensure service sustainability.
- Make recommendations on recruitment processes to ensure service sustainability and maximum capacity to deliver services.
- Make recommendations on measures, including structures and skills, to align and develop information on the AHP workforce to assist with HSC-wide service transformation.
- Make recommendations to The Strategic Workforce Planning Implementation Group regarding the commissioning of pre-registration training.
- Make recommendations regarding post- registration training requirements.

The main focus of this plan is to support the forecasting of the number of speech and language therapists needed to deliver person-centred services and to help inform the DoH on the number of speech and language undergraduate places to be commissioned on an annual basis over the ten year period 2018–2028.

The range of challenges faced by the HSC system has reinforced the need to ensure that the speech and language therapy workforce is balanced correctly in terms of numbers and skills to ensure an adaptive workforce of the right size, with the right skills, deployed in the right way.

Speech and language therapy heads of service have worked closely with the Royal College of Speech and Language Therapists (RCSLT) in Northern Ireland to identify the demographic changes in population and what they consider to be the main drivers of future

service demand that should influence the eventual outcome of this review. These will be considered in more detail later in the document.

b) Ownership

The need to ensure the support and ownership of the health and social care system and the speech and language profession was considered critical in the development of this plan. A sub-group was formed by DoH chaired by the AHP Lead Officer DoH, with representation from the DoH Workforce Policy Directorate, heads of service from each of the five HSC trusts, RCSLT, the Public Health Agency, project support analysis branch DoH and the trade union. Membership of the sub group is listed in Appendix B.

3. MAPPING SERVICE CHANGE

a) Population statistics and health profile

Northern Ireland 2017 mid-year statistics estimate the population to be 1.874 million with projections anticipating a rise of 4.68% to 1.961m by 2027. Information and population statistics available suggest there will be varied levels of increases by 2027 across each of the local commissioning group (LCG) areas, ranging from 2.5% to 9.8%.

The highest proportion of the population is aged between 40-64 years (31.9%), followed by those aged between 16-39 years (31.1%). It is predicted that the ageing population will continue to rise and that by 2027 the number of people over 65 will have increased by 28%, representing 19.9% of the overall population. This will have an impact on service demands and pressures across the health and social care system. As people grow older the incidence of illness and disability is likely to increase.

A more detailed breakdown of population statistics in 2017 and the predicted statistics for 2027 is outlined in the table below.

N Ireland Resident Populations by Local Commissioning Group - 2027

Age Band (Yrs)	Belfast	Northern	South Eastern	Southern	Western	NI
0-15	71,444	94,325	71,608	92,045	63,124	392,546
16-39	119,079	135,866	101,364	125,295	87,591	569,195
40-64	109,928	155,448	117,888	128,516	97,681	609,461
65+	66,201	104,691	85,183	73,207	60,757	390,039
All ages	**366,652**	**490,330**	**376,043**	**419,063**	**309,153**	**1,961,241**
%	**18.7%**	**25.0%**	**19.2%**	**21.4%**	**15.8%**	**100.0%**

Source: NISRA, Based on 2014 Population Mid-Year Estimates

Evidence available suggests that the prevalence of long term conditions such as Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Stroke, Asthma and Hypertension is increasing and the number of people coping with co-morbidities has also increased.

Longer life expectancy and increasing numbers of people living with chronic conditions is likely to result in an increase in the number of people who require support with their communication, eating, drinking and swallowing difficulties, particularly among older people. Deprivation is also proven to have an adverse impact on health and wellbeing resulting in a lack of social support, low self-esteem, unhealthy life-style choices, risk taking behaviour and failure to access health information and support services.

NISRA

Northern Ireland is unique and fortunate in having some objective data on the current population who identify themselves as having a communication difficulty. **The 2011 NISRA census reports almost 30,000 adults in Northern Ireland have identified themselves as having a long term communication difficulty.**

Speech, language and communication needs (SLCN) are thought to be one of the most common disabilities amongst children, with prevalence estimates varying from between 7 to 10%[4]. In areas of social disadvantage up to 50% of children start school with language delay[5].

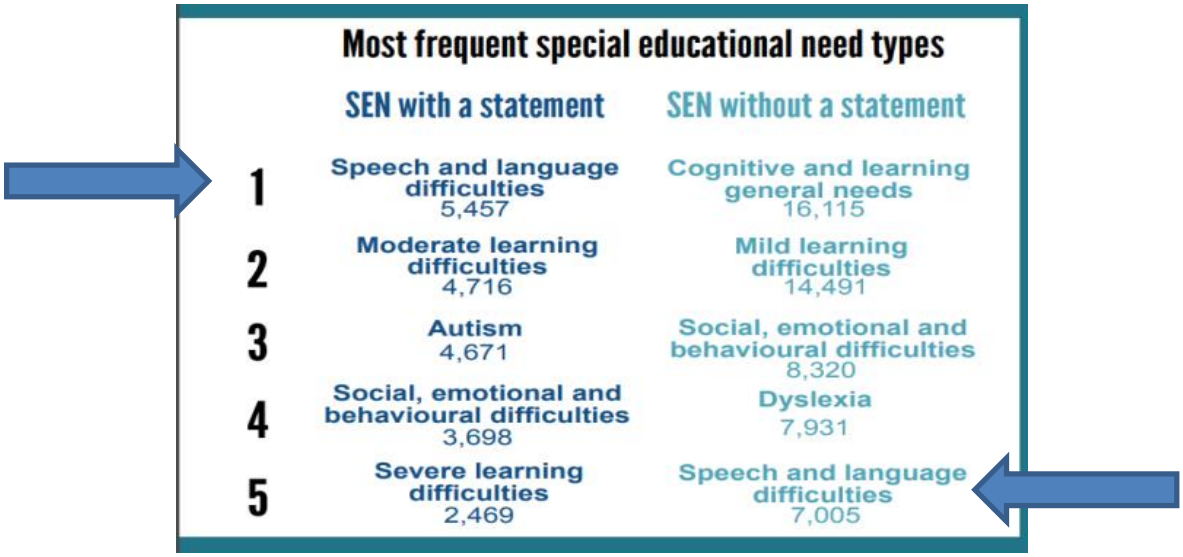
[4] What are Speech, Language and Communication Needs (SLCN)? Communication Trust, undated; What are speech, language and communication needs (SLCN)? Afasic, accessed 28 June 2018; What are speech, language and communication needs?, Royal College of Speech and Language Therapists, undated

[5] Locke, E., Ginsborg, J., and Peers, I. (2002) Development and Disadvantage: implications for early years. International Journal of language & Communication Disorders. 27 (1). P.3 -15

Department of Education

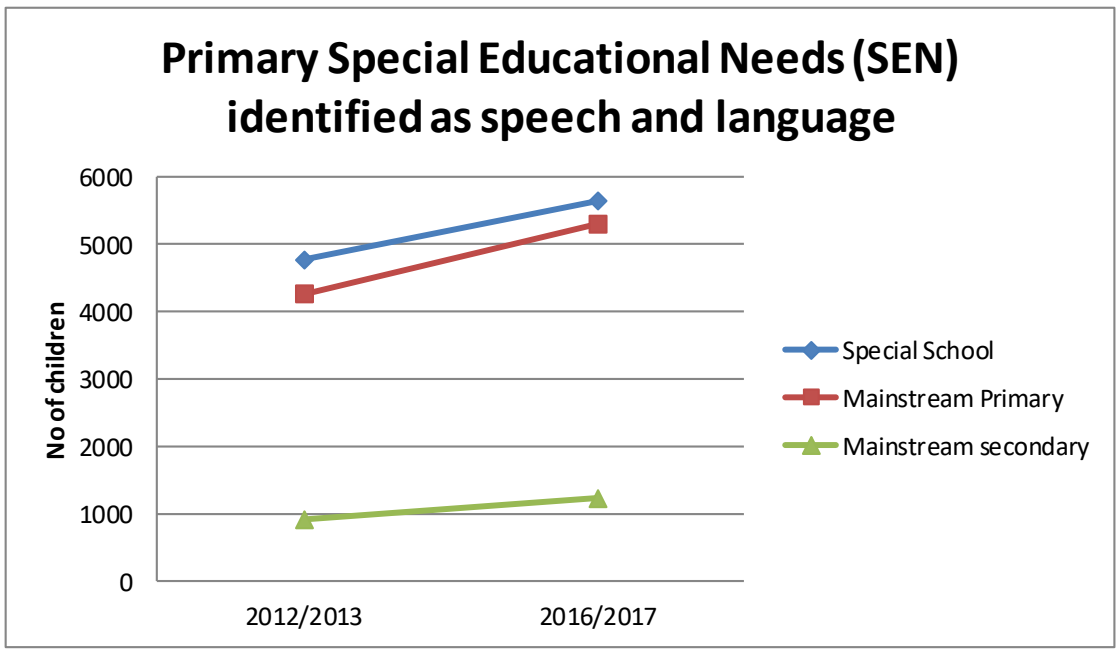
The Department of Education also collects census data each year on the types of special educational needs (SEN) of pupils. Pupils with a statement have a legal right to provision of support to address their special needs.

The figures for 2017/2018 report that 'speech and language difficulties' is the most frequent special educational need type and is ranked first out of five categories which include severe learning difficulties, and autism, (which also present with SLCN difficulties).



Source: NI school census

The school census figures below clearly demonstrate that there has been an increase in the number of children with SLCN across all school settings.



b) **Current workforce configuration and supply**

Currently in Northern Ireland there are 472.6 whole time equivalent (WTE) comprising 569 SLT head count (HC) (DoH March 2018). In the last two years there has been a significant expansion in the SLT workforce. Since March 2016 the SLT workforce grew by 6.97% annually which represents an increase of 59.6 WTE. Due to the sustained and growing demand for SLT, it is anticipated that this trend is indicative of future workforce growth.

68% of SLTs are employed to work with children and 32% are employed to work with adults. However it is likely that over the next 10 years this configuration will change in the light of an aging population. Approximately 20% of the 68% of paediatric SLTs work in school settings.

Assistants/technical instructors

2018 DoH workforce data indicates that the SLT support workforce is comprised of 28.3 WTE SLTA (32 headcount) and 41.8 WTE band four SLTA/Technical Instructors (63 headcount).

Independent sector

Data is limited as to the number of therapists who work solely in independent practice and those who may combine private practice with their HSC contract. The only data available is from ASLTIP (Association of Speech and Language Therapists in Independent Practice) who had 25 SLTs registered to work in Northern Ireland in September 2018.

Service Provision

There is a wide variation in the distribution and provision of HSCT core services and regional speech and language therapy services across Northern Ireland. Access and availability of services can vary significantly across each HSC trust area. Services for some clinical or demographic client groups can be patchy and inconsistent and there does not always appear to be a regional consistency in the size and resourcing of services to meet local population demands. This can be summarised as:

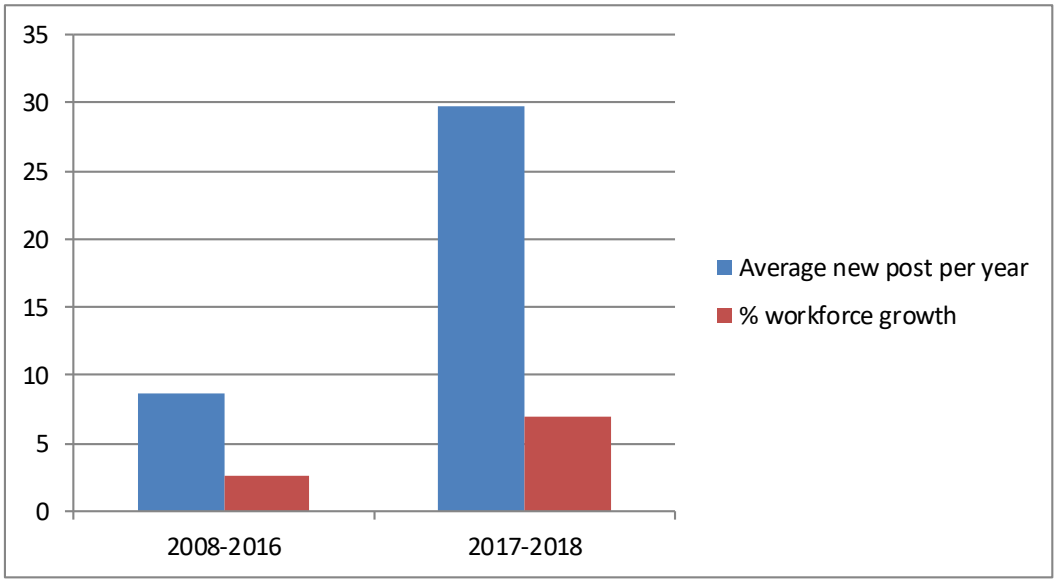
- Core speech and language therapy services provided in all HSC trust areas but not at an adequate level to meet existing demand.
- Regional speech and language therapy services.
- Speech and language therapy services developing in some but not all trusts.

An example of this was reported in the most recent Sentinel Stroke National Audit Programme (SSNAP) which provides evidence that there is inequity of speech and language therapy provision for stroke survivors across Northern Ireland.

Workforce growth 2008 - 2018

Workforce data supplied by the DoH (March 2018) records indicated that in the eight year period between 2008 and 2016 the SLT workforce grew on average by 2.66% annually and this was insufficient to meet demand. However, in the two year period between 2016 and 2018 the SLT workforce grew on average by 6.97% annually in an attempt to meet current and future demand.

	2008 – 2016 (8 years)	2016 – 2018 (2 years)
Growth in SLT WTE	85.9	59.6
Average new posts per year	8.59	29.8
Workforce growth	2.66%	6.97%



Whilst there has been an overall growth in WTE SLTs per trust per year, this has clearly been insufficient to meet the current waiting list demands and may pose greater strains on the service if there is not a significant increase in the workforce over the next ten years.

Workforce Profile

Gender:

In Northern Ireland within the HSC workforce, 99% of speech and language therapists currently employed are female.

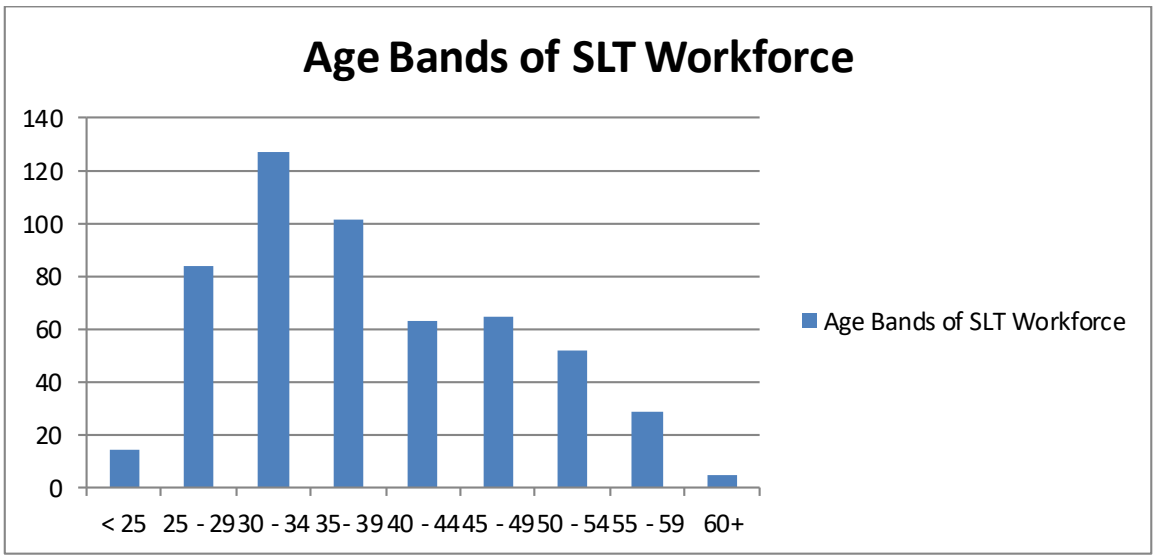
HSC SLTs March 2018 DoH	Full-Time Headcount	Part- Time Headcount	Part time Total WTE	Headcount	WTE
Female	286	276	179.8	562	465.8
Male	6	1	0.8	7	6.8

The high proportion of women working within the speech and language therapy profession increases the demand for part-time and flexible working patterns and creates additional management challenges in terms of back-fill and maternity cover.

Work-life balance policies (extended maternity leave, paternity and term time arrangements) all affect how managers organise the service to minimise disruption and ensure continuity to patients and clients.

Age:

Analysis of the DoH HSC workforce information below indicates that approximately 60% of speech and language therapists are under 40 years of age.



The predominately female mid age-range workforce profile helps us make the prediction that there will be a higher level of maternity leave over the next ten years and this in turn will provide challenges in providing continuity of service delivery.

Recommendation:

Maternity leave vacancies should be fully funded to provide continuity of provision

Retirement

DoH workforce figures suggest that 20% (108 HC) of the workforce will reach retirement age over the next ten years and that 8.6 WTE SLTs in senior bands will continue to retire each year as they reach the age of 60 years. This increasing number of retirements is likely due to the first cohorts of locally trained SLTs approaching normal retirement age. This increasing trend needs to be factored in to undergraduate commissioning as well as succession planning to avoid significant experience and knowledge gaps being created.

It is important to note that DoH workforce figures indicate that due to a higher proportion of staff in the 50-54 age range, retirement projections for 2023 – 2028 will rise to 10.4 SLTs retiring annually.

Therefore, recommendations are based on this projection.

Retirement projections for 2023 - 2028

TRUST	Age 50-54	Assume *80%* Retirement In 5-10 years / Average per year	Assume 100% retirement In 5-10 years/average per year
Total	52	41.6 = 80% in this age bracket estimated to retire in 5-10 years 8.32 estimated to retire per year	52 = 100% in this age bracket estimated to retire in 5-10 years 10.4 estimated to retire per year

Assuming a rate of 100% retirement of SLTs within the age range above over the next 10 years an additional 10.4 SLTs will be required per year to meet the workforce attrition due to retirement.

SLT Leavers

The profile of leavers below is extrapolated from DoH figures and SLT services regionally.

Year	Retirements	Other	Total Leavers
2012/2013	7	7	14
2013/2014	7	10	17
2014/2015	7	16	23
2015/2016	6	12	18
2016/2017	6	11	17
2017/2018	9	7	16
Average	7	10.5	17.5

Further analysis of the 'Other' column completed by DoH indicates that 20% of those SLTs are now back in HSC employment. The 80% of leavers may be accounted for by Voluntary early retirement (VER) or retirement on ill-health.

Year	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	Total
Others	7	10	16	12	11	7	63
Returners	13 now back in HSC employment = 20%						13
Average leavers who did not return	50 did not return within that timeframe = 80%						50

The factors relating to retirements and leavers support our projections for increased commissioned places. On the basis of the figures above the SLT service has required 18 additional SLTs per annum to replace retirees and leavers.

Recommendation:

An increase in commissioned places for under-graduate SLT training

Part-time/flexible working patterns

On the basis of DoH information, in 2018, 48% of the workforce is part-time, compared to 41% in 2008. The largest percentage of the part-time workforce are band six and seven SLTs. Part-time contracts put additional demands on the service in terms of mandatory training, supervision and management requirements.

An analysis of the change in Headcount: WTE ratio (569 HC: 472.6 WTE) across NI between 2008 and 2018 indicates an increase in the number of SLTs working part-time over the last decade as outlined in the table below. In 2008 there was a headcount of 48 more than the WTE. In 2018 there is a headcount of 96 more than WTE.

Year	Headcount: WTE ratio	%
2008	397: 338.8	17%
2018	569: 472.6	20%

It is not unexpected that a predominantly female workforce may require flexible working patterns. It will be vital that this workforce profile is acknowledged to inform cyclical workforce planning going forward.

Vacancy rates

Recent figures indicate that 15% of the SLT posts are vacant. These vacancy levels are at a critical status and impact significantly on the ability of the workforce to deliver a sustainable service.

Trust SLT data as of 31st August 2018 report the vacancy rates below.

Vacancy	%	WTE
Average vacancy rate	15%	70.13
Permanent vacancy rate	13%	58.73
Temporary vacancy rate	2%	11.4

Moreover, these figures show that 84% of the vacancies are for permanent posts. Further analysis of the data show that half of the vacancies are adult SLT posts. The adult SLT service represents only one third of the total workforce. This level of vacancy in the smallest sector of the workforce is a concerning workforce pressure particularly in light of the demographic changes outlined previously.

Within a small profession, staff promotion will create vacancies at a lower band and a resulting vacancy chain. The speech and language therapy workforce remains relatively small meaning vacancy controls and delays in filling of posts can have a disproportionate effect on service delivery. Succession planning will be required to address those areas which are difficult to fill, offset by committing to a combination of structured and robust post-graduate training and career nurturing at local management level.

The difficulty in sourcing specialist staff for vacant senior posts require SLT services to procure agency cover. As of 31 August 2018 there were eleven locum/agency staff employed in the HSC as compared with two locum/agency staff employed as of 30 June 2017.

Permanent peripatetic posts are being introduced to provide a sustainable solution for vacancies due to maternity leave. Peripatetic posts are cost neutral as they are financed from within funded establishment. Whilst this initiative aims to reduce gaps in service this flexible workforce is not without challenges in terms of vacancy rates, recruitment and retention issues. By the end of 2018/2019 the adoption of this model in some Trusts across the region will have increased the overall workforce by a further 22 additional SLT posts.

The high number of permanent vacancies have significant workforce implications because it is indicative of a lack of suitably qualified staff to take on these roles and/or a shortage of available SLTs**.** The vacancy rates indicate a need for a strategy to address the knowledge and skills gap in the current workforce to enable staff to move into other roles. This could be addressed by providing more access to postgraduate training in relevant specialist areas or by creating development posts where new skills can be learnt 'on the job' .

With nearly a sixth of the workforce capacity unavailable, it is understandable that waiting lists are increasing. Moreover, with decreasing numbers of students qualifying (intake of 21 students in 2018) it will be impossible to fill the 70.13 WTE vacancies with the current level of commissioning.

Recommendations

- **Increase the number of under-graduate places to ensure a sufficient supply of SLTs**
- **Enhancement of post-graduate training to ensure a sufficient pool of suitably trained staff**
- **The part-time workforce profile of 48%needs to be accounted for in any future**

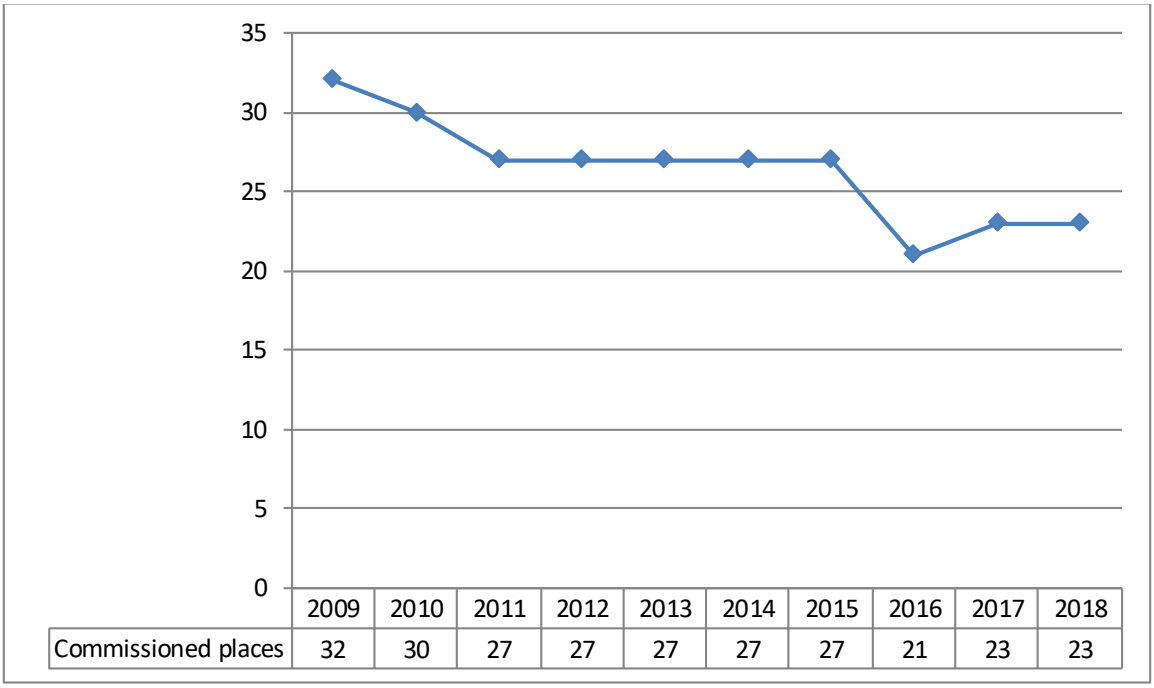
workforce projections.

- **Strategic approach to creation of development posts to address workforce shortage within adult services**

Current undergraduate commissioning and attrition rates

Commissioned places

This table shows that the numbers of undergraduate commissioned places have continually fallen since 2009. This should now be considered in relation to the evidence presented in this report of increasing workforce growth rates, increasing waiting lists, and 70.13 WTE vacancies (a sixth of the workforce),



	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Commissioned places	32	30	27	27	27	27	27	21	23	23

Attrition Rates

Analysis of the Ulster University (UU) data shows attrition rates of approximately 10% during and subsequent to qualification. Information provided by the UU employability unit highlighted that 19% of graduates were working in non-HSC NI SLT posts, six months post-graduation. This profile may be attributable in part, to the timing of the Band 5 regional recruitment exercise and timescales for subsequent appointments and is insufficient to suggest that these SLTs are unavailable to the HSC NI workforce.

On the basis of data from UU for commissioned places from 2009 – 2014 it can be inferred that approximately 90% of UU graduates are available to HSC NI.

Regional recruitment for band five posts

For the past five years, recruitment of band five SLTs has been carried out as a regional exercise on an annual basis. Information regarding the profile of the applicants is insufficient to inform the workforce planning process as the following information is not available:

- The number of SLTs in permanent posts within HSC NI who are on the waiting list to move location
- The number of existing SLTs in temporary positions who are on waiting list for permanent positions
- The number of new graduates who are on the waiting list

The amalgamation of candidates on the regional Band 5 waiting list inflates the number of available SLTs and can give a false impression of workforce availability.

In addition, concerns have previously been raised by SLTs engaged in the recruitment process. This led to a 2017 RCSLT survey of members which highlighted specific concerns regarding the implementation of the process and the annual recruitment timeline.

From a workforce planning perspective the lack of reliable data in sufficient detail means that information from BSO regarding the regional recruitment of band 5 SLTs cannot be used as a basis to inform recommendations for a 5-10 year plan. In order to mitigate loss of graduates to the HSC, Trust SLTs proactively support new graduate recruitment by providing training to undergraduates at Ulster University to support interview skills.

Recommendation:
A full review of the regional band 5 recruitment process should be undertaken

c) Future workforce demand

Factors which also influence the future demand for speech and language therapy services are listed below:

- Changing demographics
- New ways of working to deliver transformation
- Education and training requirements

Changing demographics

NISRA population and other data sources for Northern Ireland also gives us a clear indication that over the next decade there will be increasing demands on our services due to demographic population shifts summarised below.

Demographic shift	Evidence	Impact
Population of people aged 65 and over in NI will have increased by 65% by 2041	https://www.bbc.co.uk/news/uk-northern-ireland-41776649 based on NISRA report	Greater demand for speech and language therapy in adult services
23% of children in Northern Ireland live in poverty	https://www.jrf.org.uk/report/poverty-northern-ireland-2018	Over 50% of children in areas of social disadvantage have speech, language and communication needs
Improved survival rates of premature babies	https://www.rcm.org.uk/news-views-and-analysis/news/improved-survival-of-premature-babies-over-last-two-decades-finds-study 2017	Higher numbers of children are at risk of developmental delay
People born outside of the UK and live in NI grew from 3.5% in 2007 to 5.9% in 2017	https://www.nisra.gov.uk	Higher numbers of bilingual and non English speaking families will require SLT support.

Considering the major demographic changes detailed above it is possible to consider the implications this will have for the speech and language therapy workforce.

The table below outlines the prevalence of some conditions with associated communication, eating and drinking difficulties. Further information on prevalence can be found in Appendix C.

Condition	Prevalence of the condition	NI population figures extrapolated	Prevalence Rate of Dysphagia in condition	NI prevalence (extrapolated) for a population of 1.800000	Source
Stroke	200/100,000 (Rates are higher for NI) 250/100,000	36,000 (2)	76% (1)	27,360	**1**. (Mann et al 1999). Heuschmann P., et al., 2004, Kwan et al 2008). **2**.https://www.stroke.org.uk/what-we-do/northern-ireland
Motor neurone disease	7/100,000 population have MND	126	90% have dysphagia	114	http://mnd.rcnlearning.org.uk/what-is-motor-neurone-disease/statistics/
Dementia		24,980 by 2021 (2)	68% (1)	16,986 by 2021	**1** Steele CM, Greenwood C, Ens I, Robertson C and Seidman-Carlson R. (1997) Mealtime Difficulties in a Home for Aged. Dysphagia; 12: 1, 43-50. **2** https://www.mariecurie.org.uk/globalassets/media/documents/policy/policy-publications/april-2015/living-dying-dementia-ni-full.pdf
Adult Learning disability	2.2% of population	40,177 (1)	15% (2)	6,026	1.http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2014/employment_learning/5014.pdf 2. Ref Public Health England (2016). Making reasonable adjustments to dysphagia services for people with learning disabilities. Available at: www.improvinghealthandlives.org.uk/securefiles/160823_1012//Dysphagia%20RA%20report%20FINAL.pdf

In light of these changing demographics, the tables below describe the impact that SLT can make in delivering transformation to achieve well-being outcomes.

Adults The proportion of over-65s will grow by 65% by 2041				
Population Shift/ Evidence		**Impact of SLT intervention**		**Delivering Transformation**
Frail Elderly COPD Dementia ALD Stroke Adults with mental health difficulties Cancer	→	Reduce preventable death due to choking and aspiration Provide communication life-line to people who have lost/impaired ability to speak Provide alternative means of communication (e.g. communication devices or signing) Reduce social isolation	→	Reduce preventable death due to choking and aspiration Prevent hospital admissions Reduce length of stay Enable people with communication difficulties to exercise their rights in making decisions (Mental Capacity Act, 2016) Improved life satisfaction Increase employment opportunity

Children An increase in the number of children with complex needs and SLCN across all settings				
Population Shift/ Evidence		**Impact of SLT intervention**		**Delivering Transformation**
Neo-natal Children with complex needs Developmental Language Disorder (DLD) Bilingualism ASD CAMHS Looked after children Youth Justice Social disadvantage	→	Eating and drinking difficulties are identified early on and aspiration and choking risks are reduced Speech, language and communication needs are identified early on and are developed Alternative means of communication (e.g. communication devices or signing) are provided enabling children to be involved in decisions that affect them Significant others are trained to support children's communication, learning and eating/drinking needs Families are equipped to support speech, language, communication, eating and drinking, and social skills development Children are able to develop and maintain meaningful relationships	→	Reduce preventable death Prevent hospital admissions Reduce length of stay Improve educational outcomes Reduce educational inequality Improve mental health and well being Reduce poverty Reducing offending Improve life chances

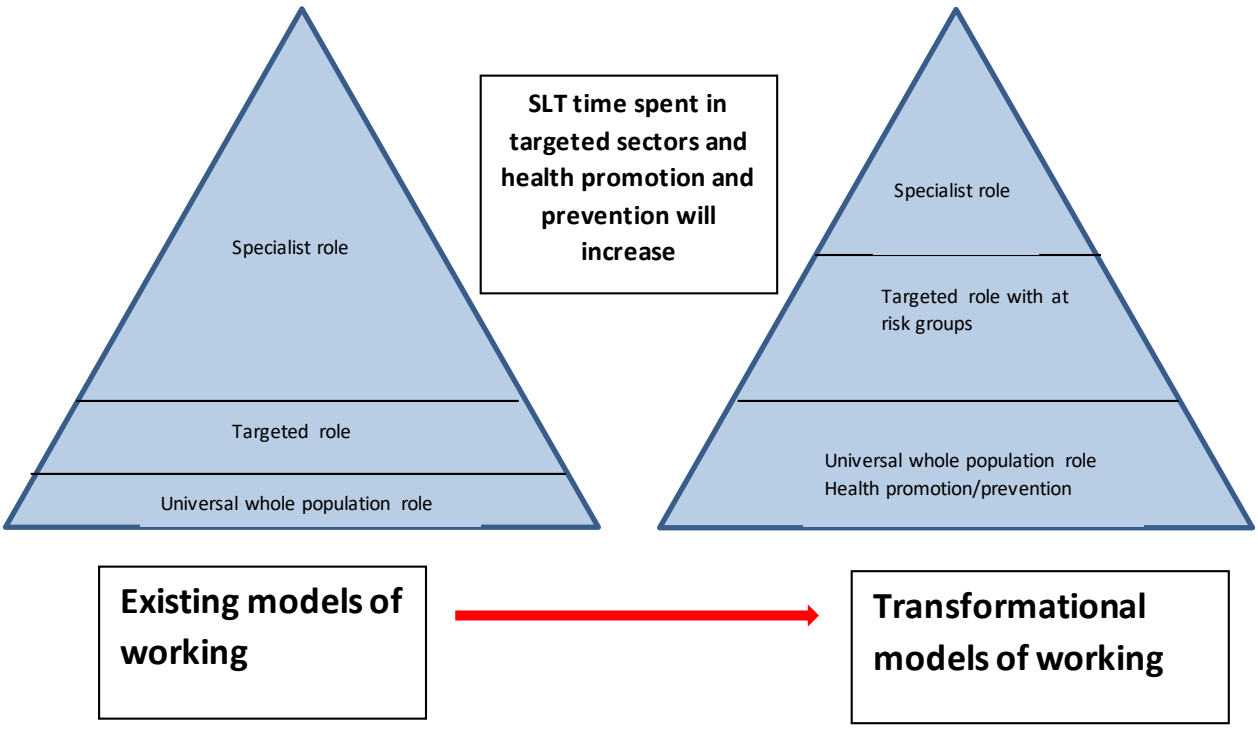
New ways of working to deliver transformation

In addition to meeting demographic shifts in the population as outlined above, the profession will also have to engage in new ways of working to deliver transformation by increasing preventative and targeted services in addition to providing existing specialist provision.

This means implementing a balanced system, working with families and communication environments, the wider workforce as well as our role in identifying communication and EDS difficulties and providing direct intervention at a specialist level.

(attributed to Marie Gascoigne)

This shift in the application of SLT services will require new skills and a workforce resourced in a more dynamic fashion to implement transformational policies.



Education and Training

Flowing from the information above it is clear that we need to consider the education and training of the workforce to meet future population needs and evolving roles within multi-disciplinary teams to deliver on public health, prevention and self-management outcomes. For the purpose of workforce planning we are highlighting the areas where existing or projected skills gaps are anticipated to have the most impact on service provision going forward.

Eating, drinking and swallowing difficulties

The need to address EDS in the population is now recognised across the HSC as a result of the Thematic Review of Choking. Currently transformative work is ongoing in the establishment of multi-disciplinary Dysphagia Support Teams regionally.

However within the SLT workforce there is a shortage of suitably qualified SLTs with specialist skills in the management of EDS to meet current and emerging need. This is both at NQP level and also in the existing workforce.

In order to meet the future EDS needs of both adults and children, basic dysphagia training must be incorporated at under-graduate level and advanced dysphagia training needs to be provided at post-graduate level. At present, post-graduate training, usually runs once a year in Northern Ireland, but would be available at a greater frequency in the rest of the UK or in the Republic of Ireland.

A cyclical training programme at a frequency to meet existing and future workforce demands will be essential to address the dysphagia skills gap. Consideration will need to be given to existing training provision, funding, current workforce capacity to train colleagues and alternative training models.

Leadership

Succession planning for clinical leadership roles is essential within SLT as our workforce ages and retires and clinicians “shift left” into transformative roles leading public health and preventative work-streams to promote well-being outcomes.

Training to support “High need - low incidence” specialisms

As the SLT workforce is relatively small it is faced with challenges to ensure appropriate commissioning of education and training to support highly specialist services e.g. cleft, paediatric VFS, cochlear implant, etc.

4. DEFINING THE REQUIRED WORKFORCE / WORKFORCE AVAILABILITY

a) 2018 – 2028 Workforce growth projection

In order to make as accurate as possible workforce projections, this section will consider the factors previously discussed, as they will undoubtedly influence the delivery of SLT services over the next decade.

Data from DoH for WTE from 2008 to 2018 indicates an average service increase of 16.5 WTE SLTs across the region per year. However the average service increase from 2016 to 2018 was 29.8 WTE SLTs. In the light of future demands, this increase in service growth is a more accurate projection of future workforce demands. Taking into account our WTE/HC ratio this would equate to a requirement of 36 additional SLTs annually.

Waiting lists

In April 2018 the total number of people waiting for SLT assessment stood at 6,285. Of these 3,128 were for children and 3,039 were for adult services. These figures demonstrate that the current workforce is unable to meet existing demand.

Maximising speech and language therapy provision

Current services are commissioned on the basis that 1 WTE SLT will have 6 weeks annual leave, 2 weeks statutory holidays and 2 weeks for mandatory training/study leave. On this basis 1.0 WTE SLT provide services for 42 out of 52 weeks of the year. When services were commissioned for a 52 week service 1.24 WTE would be required. Service stabilisation for 52 week provision would be vital across a range of both adult and paediatric service areas. Adult and paediatric acute services, adult community and adult learning disability need to be considered as a priority. Enhancement to a 52 week service model would then provide a basis for expansion to 6 day working as required.

Prioritised enhancement to 6 day service across 52 weeks

If prioritised services were reconfigured to provide 52 week cover we would require 1.24 WTE (Appendix D). To further enhance service provision to a 6 day model an additional 0.24 is required. In summary, to provide a 6 day service for 52 weeks of the year 1.48 WTE is required.

On the basis of figures compiled by Trust SLT Departments:

Client Group	WTE X Ratio	Increased WTE
Adult & Paediatric Acute	67.14 + 6.49 x 1.48 = 100.03	35.34
Adult Community	53.02 x 1.48 = 84.01	25.45
Adult Learning Disability	29.51 x 1.48 = 43.67	12.16
Total	156.16 x 1.48= 231.12	74.95

To provide **6 day provision for 52 weeks** of the year across the entire sector below an additional **72.15 WTE** would be required for the workforce**.** With the headcount: WTE ratio at the current rate of 1.21% this would require an increase of headcount of **91 SLTs**.

A conservative approach has been taken in calculating an accurate workforce projection which may increase across the lifetime of this plan. The factors relevant are tabulated below. They include factors relating to;

- Maintaining the existing service model, taking account of new demands, and factoring in attrition rates, retirements, leavers and flexible working.
- Extending the existing service model with a 6 day 52 week cover

	Annual requirements for SLT Headcount taking into account 1.21 WTE/HC ratio
Service Growth Average service growth at 6% will create 30 new posts annually (see table 20)	36
Retirements Workforce profiling indicates a projected retirement rate of 9-10 SLTs per year for the next 10 years (see page 22)	10
HSC Leavers Workforce profiling indicates 8 SLTs will leave the HSC per year (see page 23)	8
Total Projection based on evidenced demand	54

SLT workforce requirements to support enhanced services in prioritised areas	**SLT Headcount taking into account 1.21 WTE/HC ratio**
Enhance service model to accommodate 6 day working cross 52 weeks	91

Anticipated additional SLT Workforce requirements
Projected Service Growth The average service growth of 6% between 2016 and 2018 is likely to increase over the next ten years in light of significant increases in demands for management of: • Dysphagia • Stroke reconfiguration • Children with complex needs • Capacity building in the wider paediatric and adults workforce • Mental capacity legislation • Bilingual service users • 25% increase in school age children with SLCN • Multi-disciplinary Teams e.g. Acute Care at Home • Prison health/Youth Justice • Looked after children • Long term conditions • Dementia • Children and Adolescent Mental Health

5. STAKEHOLDER ENGAGEMENT

This review has engaged with stakeholders through formal and informal processes. These include a focus event and conversations with key partners including the Department of Education, the Stroke Association, and Save the Children.

The stakeholder event held on 23 November 2017 in the Ulster University, focused on four specific areas for speech and language therapy - recruitment, retention, process and priorities. The main findings were;

Value and impact of speech and language therapy

- SLTs give preventative intervention which is critical for better long term outcomes.
- SLTs help develop communication skills for life.
- SLTs are encouraging and aiding healthy and active lives.
- SLTs are transforming the lives of those with eating, drinking and swallowing difficulties.
- SLTs provide a cradle to grave service.

Recruitment:

- There is a need for awareness-raising in schools.
- We should be tapping into public health campaigns and other overarching opportunities to promote the profession for example stammering awareness day.
- There should be better use of social media.
- There should be better information and access opportunities for those considering entering the profession.
- There should be a proactive campaign to address the gender balance

Workforce Planning

- There should be better partnership working between health and education.
- In the next 10 years the demands on children with SLCN will increase significantly.
- SLTs need to be skilled to empower and train others to support speech language and communication development and EDS- this needs to be consistent across Northern Ireland.
- Recruit workforce planning specialists available to support the professions through an ongoing process of workforce planning, ensuring workforce plans are evidence based.

- Recognise the need to upskill SLT staff through rotational training/mandatory training.
- Embrace contribution of other sectors beyond department and trusts, e.g. community and voluntary sectors.
- Implement a regionalised approach to recruitment and transfers.
- Introduce peripatetic posts at a senior level to be clinically effective and team lead posts that are not uni-professional but multi-professional.
- Establish safe staffing levels are to meet needs of population.

In addition to the focus group event, the RCSLT also engaged with users and key stakeholders in early years, education, and stroke provision consulting on issues relevant to service development over the next ten years.

The main issues raised with the RCSLT have been:

- Need for more public health messaging and research in SLCN and EDS difficulties in early years and later years.
- Increasing numbers of children entering primary with speech, language and communication difficulties.
- Increasing numbers of stroke survivors with communication and EDS difficulties.
- Lack of equity in speech and language therapy provision across Northern Ireland.
- Lengthy waiting times for SLT across Northern Ireland particularly for adult services.
- A need for SLTs to be upskilling the wider workforce in supporting good communication and EDS

Conclusion

The current vacancies across the workforce are at a critical level. With one in six of the workforce vacant and over 6.000 children and adults currently waiting for SLT services, this plan is crucial in addressing future needs. With evidenced growing demand for services there is not an option to "stand still". The variation in service provision across the region needs to be addressed through equitable commissioning of services.

The risks to the HSC of not addressing the recommendations are two-fold:

- Failure to comply with legislative requirements i.e. SEND legislation and Mental Capacity legislation
- Inability to deliver on the transformational agenda across acute and community settings

The risks to service users are also two-fold:

- Quality of care and outcomes for service users will be negatively impacted by SLT workforce shortages
- Safety of clients will be compromised by absence or delay in receiving appropriate SLT intervention due to SLT workforce shortages

Therefore we urge the DoH to implement the recommendations as noted.

6. RECOMMENDATIONS AND ACTION PLAN

These recommendations have been derived on the basis of workforce information outlined in the report.

UNDERGRADUATE COMMISSIONING	**1**	• The number of commissioned undergraduate SLT places at UU needs to be increased on a phased basis to 40 places by 2024 • Consideration should be given to alternative routes to SLT qualification to include accelerated MSc at post-graduate level and pathway for progression for SLT support staff
ATTRACTING, RECRUITING & RETAINING	**2**	• The Regional Band 5 recruitment process including the annual timeline needs to be reviewed • A proactive recruitment strategy should look at ways to extend the recruitment pool beyond Northern Ireland and to increase the diversity of the SLT workforce in line with Theme 1 of the HSC Workforce Strategy 2026 • Consideration should be given to securing UU graduates for HSC NI employment for two years on qualification. This will help mitigate against the loss of new graduates from the pool to other markets/employers.
TRAINING AND DEVELOPMENT	**3**	• Specific clinical and leadership training should be commissioned on a three year cycle to ensure that identified skills gap are addressed to enable the SLT workforce to be fit for the future • Appropriate funding should be secured for post-graduate education and training to support service provision and development, including digital literacy skills to support e-health • A task and finish group should be established to explore options to address the dysphagia skill gap in the workforce e.g. dedicated SLT dysphagia trainers, rotational posts, extension of undergraduate course to encompass dysphagia skills • A regional approach should be considered to support in-service skills development for SLTs to ensure that the workforce can meet the changing service needs e.g. rotational posts, development posts

WORKFORCE SUSTAINABILITY	**4**	• A dedicated regional AHP workforce role should be developed alongside relevant technology to proactively manage the workforce needs across Speech and Language Therapy and the wider AHP workforce
WORKFORCE Review Cycle	**5**	• A mid-cycle review of this SLT workforce review will be necessary to review against the transformation agenda

An appropriate action/implementation plan will be developed and published on the Department of Health's website and the Workforce Strategy Programme Board will be updated on progress.

7. APPENDICES

Appendix A: Strategic drivers

- **Bengoa –** this report highlights the importance of investing, empowering and 'building capacity in networks of existing health and social care providers (such as Integrated Care Partnerships and the developing GP Federations) to move towards a model based on accountable care systems for defined population based planning and service delivery'.
- **Health and Wellbeing 2026-Delivering Together** (the Government response to the Bengoa Report) puts people at the forefront. The focus is on enabling people to stay well longer. Where care or support is needed, it will be wherever possible provided in the community setting. This shift in delivery structures may result in SLTs working in new community multidisciplinary teams commissioned by GP federations. SLTs have a valuable role to play in integrated primary care teams for example 'Acute care at home', Adult ASD teams, Forensic Adult Learning Disability teams, CAMHS and Respiratory Teams, many of whom do not currently have SLT as part of the core provision. A structured service development model would ensure equity across the region. We hope that this workforce review will highlight existing gaps in provision as well as shining a light on new and innovative workforce transformation project teams.
- **The Northern Ireland Programme for Government (PFG)** contains 14 strategic outcomes which set a clear direction of travel and enable continuous improvement on the essential components of societal wellbeing. They touch on every aspect of government, including the attainment of good health and education, economic success and confident and peaceful communities.

Legislation

- **Mental Capacity Act 2016.** This legislation will result in increasing demands upon SLT services. SLTs may be required to give communication support for individuals to enable them to demonstrate capacity in decision making and may also be required to deliver communication disability awareness training to named professionals so that individuals being assessed for capacity are appropriately supported.
- **SEND Legislation - Special Education Needs and Disability Act (N.I.) 2016.** The new special educational needs legislation and inclusion agenda will require more SLT provision in mainstream primary and post primary settings. Speech and Language Therapy has a role in the identification of children's special educational needs. Advice must be submitted within a 6-week timescale to inform a child's statement,

which is a legal document. Under the new legislation, provision of SLT will become a statutory responsibility of the trusts with some concern about how this will influence service provision. SLTs may also be required to provide more provision in mainstream schools which will impact upon resources.

Strategy

- **Quality 2020 (2011).** From a service perspective, the implementation of this strategy is still work in progress. The capacity of the workforce to absorb all the objectives around delivering high quality care, partnership working, measuring outcomes and use of best practice guidance is limited by the availability of resources and increasing service demand.
- **Making Life Better 2012 – 2023 Public Health Strategy**. The main objective of this strategy is about people being enabled and supported to take control of their full health and wellbeing potential and to reduce inequalities in health. Speech and language therapists have a key role in early identifications and intervention programmes, particularly in more deprived communities, thus ensuring that children have the best start in life.
- **Valuing People, valuing their participation.** This sees an increased importance and a requirement to include personal and public involvement in Health Service development. Speech and language therapists have a key role to facilitate and advocate for clients with communication disability to have involvement in the planning, development, delivery and evaluation of services from their own care through to a policy and/or commissioning level within speech and language therapy and wider health and social care.
- **Infant Mental Health Strategy.** Speech and language therapy can make a major contribution to the promotion of better social, emotional and mental health and wellbeing in children. One in 10 children and young people aged younger than 16 have a mental health disorder. 81% of these children and young people will have an unidentified communication and interaction difficulty. SLTs have a crucial role to identify and support communication and interaction difficulties in these children.
- **NI Dementia Regional Strategy 2011** - SLTs have an increasingly recognised and well-documented role in providing services for people with specific communication or swallowing needs associated with dementia. However, there has been a lack of consistency in service development within the HSC and wide variability in service provision remains. Speech and language therapy services should be planned and resourced adequately, based on local demography and need.

- **Reshaping stroke services –** SLTs have a role in specialist assessments and interventions for communication and dysphagia for stroke patients.
- The plan is to reconfigure and streamline acute stroke services with specialist units that draw on national guidelines and best practice in prevention, rapid 7 day access, better emergency care including mechanical thrombectomy and clot busting treatment and better equipped hyper-acute and acute stroke units. Current services do not provide seven day working for stroke and timely assessment is an ongoing challenge.
- **Physical and Sensory Disability Strategy and action plan**. The HSCB is continuing to support a greater recognition and awareness of communication disability and improved support and accessibility for people with communication support needs in the future. This may well increase demands upon the workforce to provide core training and accessible resources.
- **'Improving Health within Criminal Justice; a Strategy and Action Plan'** was launched in March 2016 covering the health and social care needs of children, young people and adults at all stages of the criminal justice journey in Northern Ireland. There is an increase in children and young people presenting with significant mental health needs, learning disability and communication needs and substance misuse. Local data collected sources in 2013 indicated that 58% of young people engaged with the Youth Justice Agency had speech, language and communication needs. Specialist speech and language therapy services need to be developed for this client group.
- **Children and Young People Strategy 2017-2027** The outcomes identified in the strategy can only be delivered if there is agreement and recognition of the importance of children and young people having appropriate access to speech and language therapy intervention if they are identified as having persistent speech language and communication impairments. Failure to identify and address problems early on in a child's development can lead to significant integration and social behaviour difficulties as children progress into adulthood or for example, in finding employment.

Appendix B: Membership of the Speech and Language Therapy Workforce Review Project Group

Name	Position	Organisation
Hazel Winning (Chair)	Lead AHP Officer	DOH
Peter McAuley	AHP Policy	DOH
Catherine Donnelly	Workforce Planning	DOH
Alison Dunwoody	IAD	DOH
Gerard Tinney	Workforce Planning	DOH
Joanne O'Hagan	IAD	DOH
Cathy Jordan	Head of SLT	BHSCT
Gillian Montgomery	Head of SLT	NHSCT
Lorraine Coulter	Head of SLT	SEHSCT
Joan White	Head of SLT	SHSCT
Una Isdell	Head of SLT	WHSCT
Jill Bradley	AHP Lead	NHSCT
Mary Emerson	AHP Consultant	PHA
Alison McCullough MBE	Head of the Northern Ireland Office RCSLT	RCSLT
David Moorehead/Kevin McAdam		Unite

Appendix C: Further adult dysphagia references[6]

Stroke

- Studies report an incidence of dysphagia between 40% and 78% (Martino 2005). Of those with initial dysphagia following stroke, 76% will remain with a moderate to severe dysphagia and 15% profound (Mann et al 1999).
- Only 10% of stroke-related deaths are caused by neurological deficits, while 30% of post-stroke deaths are due to pneumonia (Heuschmann P., et al., 2004, Kwan et al 2008).

Pneumonia

- In 67% of patients, pneumonia manifests within 48hrs of admission (Hassan A., et al. 2006). It is almost invariably associated with swallowing problems.
- In 75% of patients with early swallowing problems dysphagia will continue to be moderate to severe, and in 15% it will remain profound (Mann G., et al.1999).

Chronic obstructive pulmonary disease

- 27% suffer from dysphagia. (McKinstry et al 2009)

Multiple Sclerosis (MS)

- 33% of the MS individuals in one study indicated impairment of chewing and swallowing abilities (Hartelius & Svensson, 1994).

Parkinson disease

- 200/100,000 UK population have dysphagia due to Parkinson's disease (Hartelius and Svensson 1994).

Motor neurone disease

- More than 90% of those with motor neurone disease will develop dysphagia

Dementia

- 68% of those with dementia in homes for the aged have dysphagia (Steele 1997).

Adult Learning disability

- 5.27% of all adults with a learning disability were referred for advice regarding dysphagia (Chadwick et 2003).
- 5.3% of community-based individuals and 36% of hospital based individuals displayed dysphagia (Hickman & Jenner, 1997).

Nursing home residents

- Between 50 and 75% of nursing home residents have dysphagia (O'Loughlin & Shanley 1998).

[6] https://www.rcslt.org/clinical_resources/dysphagia/incidence

Acute hospitalised elderly

- 10% of acutely hospitalised elderly. (Lugger 1994).

Cervical discectomy and fusion

- A study of those having cervical discectomy and fusion indicated an incidence of dysphagia in 50.3% of patients (Frempong-Boadu et al, 2002).

Appendix D

Enhancement to 52 week service for

Adult and Paediatric Acute/Adult Community/ALD

On the basis of figures compiled by Trust SLT Departments:

Client Group	WTE X Ratio		Increased WTE
Adult & Paediatric Acute	67.14 + 6.49	x 1.24 = 91.30	17.67
Adult Community	53.02	x 1.24 = 65.74	12.72
Adult Learning Disability	29.51	x 1.24 = 36.59	7.08
Total	156.16	x 1.24= 193.64	37.47

To stabilise the service for these client groups an additional 37.47 WTE would be required. With the headcount: WTE ratio at the current rate of 1.21% this would require an increase of headcount of 45 SLTs.

Enhancement of 52 week Service to 6-day provision -

Adult and Paediatric Acute/Adult Community/ALD

If services were reconfigured to provide 52 week cover we would require 1.24 WTE as above. To further enhance service provision to a 6 day model an additional 0.24 is required. In summary, to provide a 6 day service for 52 weeks of the year 1.48 WTE is required.

On the basis of figures compiled by Trust SLT Departments:

Client Group	WTE X Ratio		Increased WTE
Adult & Paediatric Acute	67.14 + 6.49	x 1.48 = 100.03	35.34
Adult Community	53.02	x 1.48 = 84.01	25.45
Adult Learning Disability	29.51	x 1.48 = 43.67	12.16
Total	156.16	x 1.48= 231.12	74.95

To provide **6 day provision for 52 weeks** of the year across the entire sector below an additional **74.95 WTE** would be required for the workforce**.** With the headcount: WTE ratio at the current rate of 1.21% this would require an increase of headcount of **91 SLTs**.

Department of Health

Workforce Review Report

Podiatry

2019 - 2029

The COLLEGE of PODIATRY

HSC Health and Social Care

DoH Department of Health www.health-ni.gov.uk

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Foreword

Since October 2016, Health and Social Care workers and the Department of Health have been cooperating to deliver the transformation set out in ***Health and Wellbeing 2026: Delivering Together***. This ambitious ten year plan was our response to the report produced by an Expert Panel led by Professor Bengoa, who were tasked with considering how best to re-configure Health and Social Care Services in Northern Ireland.

The aim is a health and social care system that helps people to stay well for longer, with services delivered in the community or at home, where possible. Allied Health Professions (AHPs) will play a key part in responding to this challenge, particularly as we expand the role of innovative, multidisciplinary teams across a range of integrated care pathways within health and social care settings. No matter how or where AHP staff work, they will continue to maintain their clear professional focus: supporting people, who are ill, have disabilities or special needs, to live the fullest lives possible.

Since these AHP workforce reviews commenced, the landscape across Health and Social Care has changed considerably. Opportunities for AHPs have been created across a range of primary care multi-disciplinary teams. These are to be welcomed, but it is important to have the highly skilled workforce required to take these opportunities as they arise. This series of workforce reviews are written with a view to identifying and quantifying the workforce required to meet these challenges and help drive the transformation agenda forward.

The AHP workforce reviews will help to address one of the immediate priorities set out in the ***New Decade, New Approach*** document published at the time of the establishment of the new Northern Ireland Executive. The commitment being that the Executive will transform HSC services through reconfiguration of services.

There is however currently a bigger challenge facing the HSC system in the guise of the current Covid-19 pandemic. This is challenging us in many ways, including the immense pressures placed on our workforce and the need to think and act differently, and to consider how we currently work and how we may work in the future.

In this changing environment, it is even more essential that we have an understanding of our workforce needs, so that we can plan effectively to maintain and develop our services into the future. This was recognised in ***Health and Wellbeing 2026: Delivering Together*** and appears as a key theme in the associated ***Health and Social Care Workforce Strategy 2026: Delivering for Our People.*** Recognising that the HSC is a changing environment and will continue to evolve, this series of workforce reviews are “living documents” which will be reviewed throughout the period of the reviews.

This Workforce Review Report, and the clear recommendations it contains, is the result of a wider Workforce Review Programme covering all thirteen AHPs in Northern Ireland. Since March 2017, Project Groups comprising representatives from across the health and social care service, professional bodies, staff side representatives and the Department of Health, have been meeting regularly to consider how these professions / services are likely to develop in the period 2019 – 2029. Their work has been overseen by the AHP Workforce Review Programme Steering Group and applies the ***Regional HSC Workforce Planning Framework's*** six step methodology.

This process and its resulting Workforce Review Reports are the products of active co-design and co-production, delivering together to ensure the workforce needs of the HSC are met. Project Groups have engaged with their stakeholders, including service users and carers, both in formal engagement events and through ongoing involvement with relevant individuals and organisations. Their input has been invaluable in producing this final document and its recommendations. We would like to thank everyone who has contributed to the work of the AHP Workforce Review Programme.

Our vision is for Northern Ireland to have an AHP workforce that has the capacity and capability to deliver the best possible care, for patients and clients, and has the leadership skills and opportunities to lead and transform services to improve population health. The Podiatry Workforce Review Report and its recommendations set us on course to do just that for this profession.

Charlotte McArdle

Chief Nursing Officer

Department of Health

Preeta Miller

Director of Workforce Policy

Department of Health

Jennifer Keane

Chief AHP Officer

Department of Health

Executive Summary

The Podiatry Workforce Review has been initiated, guided and endorsed by the Department of Health (DoH) and co-produced by the podiatry heads of service from each of the five Health and Social Care Trusts in collaboration with the Public Health Agency (PHA).

The aim of the review is to ensure that adequate numbers of podiatrists are trained at undergraduate level to meet the anticipated demands for the profession over the next 5-10 years.

A range of methods were employed over the period of the review including gathering and analysing statistical data, conducting a range of workshops, surveys, focus groups, interviews and meetings with stakeholders across the Health and Social Care (HSC) system, including the independent sector and reviewing relevant policies and strategies to identify proposed service developments or changes over the next number of years.

It is evident that the podiatry profession, like all Allied Health Professions (AHPs), faces a number of challenges in terms of having a staffing resource with the capacity to manage the anticipated increase in demand in all the service areas it currently operates in. These areas are clearly highlighted in the review content. The document demonstrates that over the next five years 27 extra undergraduate places need to be commissioned. In doing so the profession is mindful of the need to ensure the delivery of safe and effective services that continue to meet the needs of service users both in primary and secondary care settings.

The review outlines a number of key recommendations in order to achieve these objectives which are outlined within the Terms of Reference (ToR) in Appendix 2.

Introduction

This report forms part of a programme of data development and analysis on the podiatry profession as part of the Allied Health Professionals (AHP) in NI. It describes both undergraduate and post-graduate education and training and the HSC labour market for podiatrists. It has drawn on several sources of routinely collected data at different stages of the education and employment pathway from university through to the provision of services.

The aim of the report is to examine trends in the supply of and demand for podiatrists in NI using aggregate data collected over several years by the five Trusts. It is anticipated that this report will be of interest to podiatry leads and professionals responsible for planning the education and workforce landscape for podiatric services across NI and the rest of the United Kingdom (UK).

Strategic context

The direction of travel for transformational change within the HSC has been clearly set through the publications of 'Health and Wellbeing 2026 – Delivering together' and 'Systems not Structures: Changing Health and Social Care – Expert Panel Report'.

These documents have been developed to help HSC to ensure services can meet the predicted demographic needs and challenges facing the region over the next decade and beyond.

These strategic drivers stress the importance of investing in our workforce, providing opportunities to develop their skills and find suitable career paths at all levels.

'We must invest in our staff and provide the environment to allow them to do what they do best – provide excellent high quality care' – 'Health and Wellbeing 2026-Delivering Together'

In doing so it has been recognised that effective workforce engagement and planning are key enablers to HSC transformation. Therefore in December 2016 the Department of Health (DoH) NI embarked on a number of regional workforce reviews across a range of AHP groups including podiatry. These workforce reviews were deemed necessary to ensure AHP services delivered across NI would be

sustainable to meet future demands, needs of the population and to ensure services were delivered to an appropriate standard in line with strategic policy directions. It is well acknowledged that there are a range of challenges faced by the HSC system which supports the need for the workforce to be balanced correctly in terms of size and skills, ensuring there is an adaptive workforce, well organised and deployed correctly to provide the best possible care for service users and their families.

Engagement between relevant organisations and stakeholders facilitated effective and active participation throughout the duration of the review. Another challenge experienced in completing the review was in determining the necessary workforce to deliver sustainable services in the future, some of which was unknown. The review completed a horizon scanning exercise to determine future service needs. This involved:

- Analysis of demographic trends
- Analysis of complexity of need
- Predicting subsequent need
- Predicting service developments
- Identifying potential partnerships with other agencies in the delivery of services.

The main focus of the 'Delivering Together' Framework is to put people at the forefront of services, to enable them to stay well for longer, with any specialist interventions required being delivered to a high standard in a safe and timely manner.

The Health Minister's 'Delivering Together' Strategy proposes a whole system transformation plan that requires cultural and operational change in order to meet future demands. This proposed transformation of HSC services is a long-term goal.

Fig 1 - Delivering Together Ambition

By embedding the 'Delivering Together' Strategy into all stages of this review, there is greater assurance that the ultimate findings will be in keeping with the strategic direction for the future model of HSC in NI.

Workforce plan methodology

The review used the sequenced six-step methodology outlined within the Skills for Health, Regional HSC Workforce Planning Framework as denoted in the diagram below with completion agreed by March 2018.

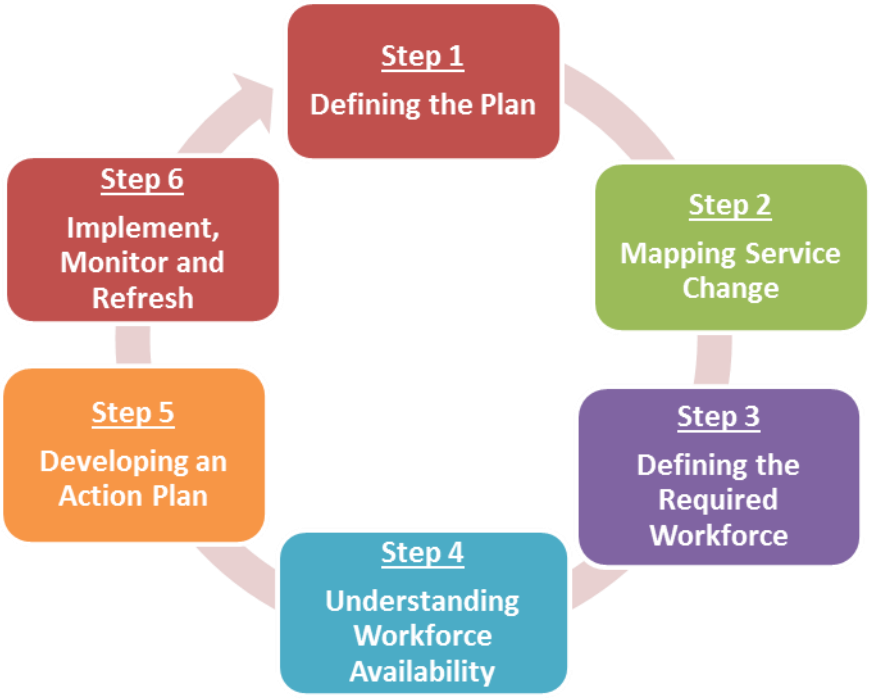


Figure 2 - Six Step Methodology.

Meeting the terms of reference

A key component for the successful completion of the review was to obtain relevant stakeholder engagement. In the initial stages of the review, a regional professional sub-group was established with relevant stakeholders. This group agreed and worked through specific actions outlined within the programme plan and clear reporting lines were set and communicated to AHP Workforce Review Programme Steering Group at regular intervals.

Assumptions and constraints

Due to the challenging nature of a workforce review, it was important to consider any possible assumptions, constraints and/or risks early in the process. A number of assumptions and constraints were identified and measures were taken to help manage these and reduce their implications throughout the process of the review. While the key points are outlined in Table 1, additional constraints can be found in Appendix 2

Constraint/Assumption	Description	Measures Taken
Engagement	Active involvement of key stakeholders is critical at every stage of the review. Engagement will ensure that recommendations made from the review have senior DoH agreement to support implementation.	A Stakeholder Engagement event was held. To inform key stakeholders gain opinion and support. Relevant, findings determined at each stage of the review were also communicated routinely with the Programme Steering Group.
Timeframe and Professional Capacity	Completion of a comprehensive review within a year was likely to prove challenging, particularly due to the competing demands and pressures of those involved.	The development of a programme plan with clear timeframes and responsibilities which shared the work amongst the sub-group members helped manage this.
Access to Data	Podiatry staff work across a range of settings and deliver a diverse range of service models including; uni-professional, multi-professional, and multi-agency basis.	All available information was accessed and utilised in carrying out the review and a process was set to ensure professional sign off and authorisation of the information used.
Future HSC and Political Structures	NI is experiencing system change and uncertainty, particularly within the political and health care arenas, with associated financial uncertainty.	The sub-group based their analysis on key strategic frameworks e.g. the Bengoa Report and 'Delivering Together – Health and Well-being 2026' Framework.

Table 1 – Constraints and assumptions considered in approaching the review with an outline of measures taken

Defining the Plan

Purpose, aims and objectives guiding principles scope of the workforce review

The focus of the podiatry workforce review was to ensure services across NI are both sustainable and delivered to an appropriate standard. The range of challenges faced by the HSC system has reinforced the need to ensure that the podiatry workforce is balanced correctly in terms of numbers and skills. This will ensure that an adaptive Podiatry workforce is deployed in the right way and ensure services provide timely support for clients at both population and specialist levels.

Ownership

Relevant professional and workforce leads were identified as nominated members of the AHP Workforce Review Programme Steering Group and the regional podiatry sub-group. This included nominations from relevant organisations such as DoH, podiatry heads of service from each of the HSC Trusts, Public Health Agency (PHA), Staff side, the College of Podiatry and service user involvement in line with requirements of the Public and Personal Involvement (PPI) legislative frameworks. The Project Group report to the AHP Steering Group.

Drivers for change

There are many strategic drivers which support workforce planning, and which recommends proactive management to help plan for the wide range and complexity of needs within the population. This is particularly evident in the overarching ambition of Delivering Together 2026 as outlined in Figure 3.

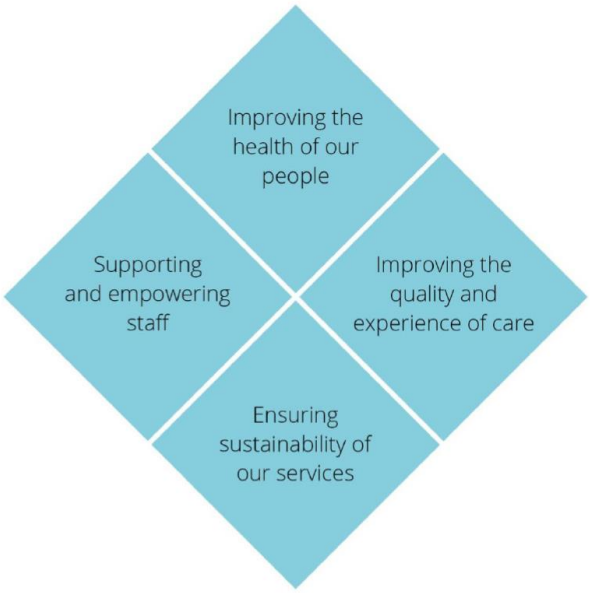


Figure 3 - Components involved in achieving the Ministers ambition – Every one of us leading long healthy and active lives.

Within this context, it is essential that this workforce review:

- Recognises the changing nature of HSC needs and the link to demographic changes in local populations (greater emphasis on preventative approach and supporting people)
- Revises service delivery models to meet the needs of patients, clients, carers and health and social care staff in the wide ranging geography of NI
- Considers the career progression and succession planning requirements of the present and future HSC workforce
- Enhances patient safety and quality of care
- Ensures affordability of services given the challenging financial context for all organisation

- Connects workforce issues with the overall strategic direction, e.g. Delivering Together, Programme for Government, Transforming Your Care, Making Life Better, HSC Quality Strategy 2020, AHP Strategy for NI and the annual Commissioning Plan Direction.

The Bengoa (Expert Panel) Review was tasked with producing proposals to remodel the HSC in order to deliver safe, high quality, and sustainable services for the population in NI. Recommendations were submitted to the Minister in the summer of 2016 and following consideration of these, the 'Bengoa/Expert Panel report 'Systems not Structures: Changing Health and Social Care' was published in October 2016.

In response to the Bengoa/Expert Panel report the DoH published 'Health and Wellbeing 2026 – Delivering Together'. This report re-affirmed that effective workforce engagement and planning are key enablers to HSC transformation and that the far-reaching transformation journey needs the commitment and engagement of workers across every grade if it is to succeed. 'Delivering Together', is now considered the only road map for reform. It lists the development of a workforce strategy as one of the 18 key priority actions (no.16) to be taken forward in the next 12 months as part of the transformation process. The Workforce Strategy is to cover all aspects of HSC Workforce, including retention and recruitment; opportunities for introducing new job roles; and re-skilling and up-skilling initiatives. In line with Minister's vision, the strategy will be developed through co design and co-production.

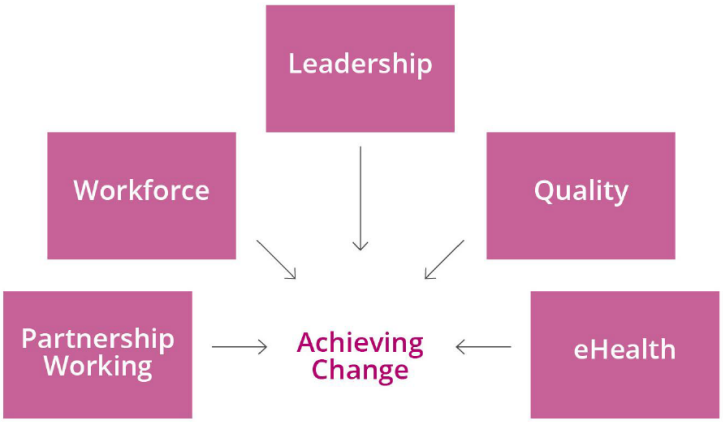


Figure 4- 'How we plan, design, support and implement service transformation is as important as the changes we wish to make.'

The NI Programme for Government (PFG) contains 14 strategic outcomes which set a clear direction of travel and enable continuous improvement on the essential components of societal wellbeing. They touch on every aspect of government, including the attainment of good health and education, economic success and confident, peaceful communities.

Making Life Better 2012 – 2023 Public Health Strategy - The main objective of this strategy is about people being enabled and supported to take control of their full health and wellbeing potential and to reduce inequalities in health. Podiatry has a key role in early identification and intervention programmes, particularly in more deprived communities.

In addition the AHP Strategy 'Achieving Health and Well-being Through Positive Partnerships' 2012-2017 sets a clear framework for the key strategic directions for AHP's across NI. Within the Strategy 40 actions were identified under four key themes:

- Promoting person-centred practice and care
- Delivering safe and effective practice and care
- Maximising resources for success
- Supporting and developing the AHP workforce.

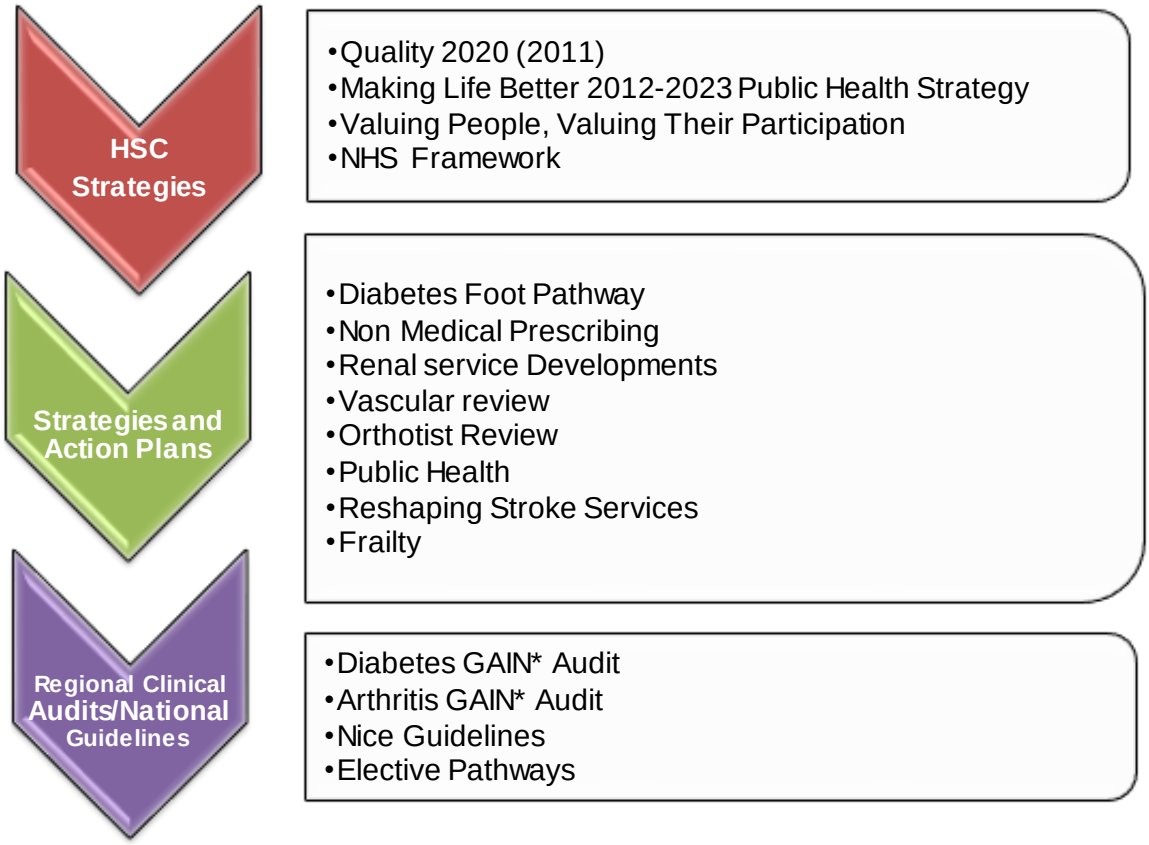


Figure 5 Influential Regional Audits, Policies and Strategies

*GAIN = Guidelines and Audit Implementation Network

Mapping the Service

Population demographics, health profile and statistics

NI 2017 mid-year statistics estimate the population as 1.874million and population projections anticipate a rise of 4.68% to 1.961m by 2027. Information and population statistics available suggest there will be varying levels of increase by 2027 across each of the Local Commissioning Group (LCG) areas, ranging from 2.5% to 9.8%.

The highest proportion of the population is aged between 40-64 years (31.9%), followed by those aged between 16-39 years (31.1%). It is predicted that the ageing population will continue to rise and by 2027 the over 65 population is expected to increase by 28%, representing 19.9% of the overall population. This will have an impact on service demands and pressures across the health and care system, as people grow older the likelihood of illness and disability is anticipated to also increase. The predicted population statistics for 2027 are displayed in Table 2. Current Population Statistics see Appendix 3

Age Band (yrs.)	Belfast	Northern	South Eastern	Southern	Western	NI
0-15	71,444	94,325	71,608	92,045	63,124	392,546
16-39	119,079	135,866	101,364	125,295	87,591	569,195
40-64	109,928	155,448	117,888	128,516	97,681	609,461
65+	66,201	104,691	85,183	73,207	60,757	390,039
All ages	**366,652**	**490,330**	**376,043**	**419,063**	**309,153**	**1,961,241**
%	**18.7%**	**25.0%**	**19.2%**	**21.4%**	**15.8%**	**100.0%**

Table 2 N.I resident population predictions by LCG – 2027

Evidence available suggests that the prevalence of long term conditions that directly impact foot health such as diabetes, arthroplasty and stroke and hypertension are increasing and the number of people coping with co-morbidities has also increased. https://www.health-ni.gov.uk/publications/201718-raw-disease-prevalence-trend-data-northern-ireland

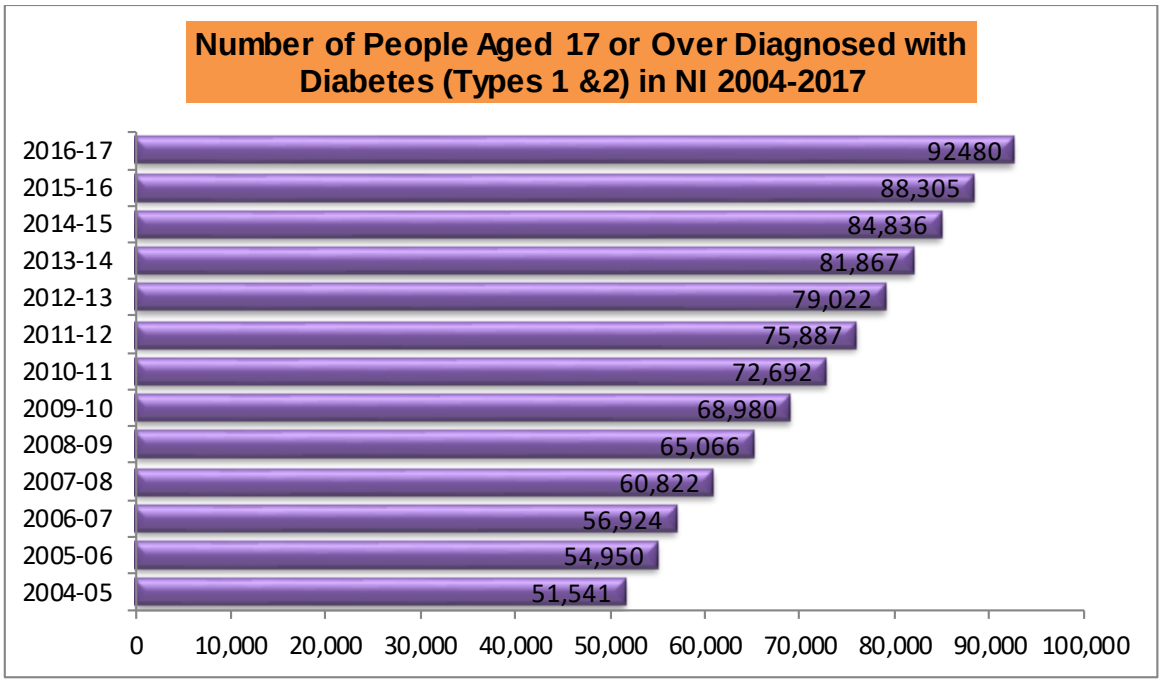
Deprivation has an impact on health and wellbeing in many ways resulting in the lack of social support, low self-esteem, unhealthy life-style choices, risk taking behaviour and poor access to health information and quality services. This is a contributing factor to the increasing numbers of patients being diagnosed with diabetes and once diagnosed with diabetes those in the most deprived areas are twice as likely to develop physical complications.

Podiatry has a significant role in optimising and supporting the transformation of the overall health and well-being of our population through:

- Undertaking roles in health promotion, health improvement, diagnosis, early detection, early intervention and self-management;
- Supporting service users to avoid illness and complications;
- Supporting people of all ages to manage long term conditions e.g. diabetes and rheumatology

Analysis of diabetes demographics highlights an increase in incidence and prevalence of people with diabetes. The numbers of people diagnosed with diabetes in NI has increased by 62.5% in the past 10 years (Diabetes UK, 2018) this has a significant impact on podiatry services.

As of April 2018 there were nearly 100,000 adults with diabetes living in NI. The management of these patients accounts for 60% of current podiatry activity



Graph 1 Increase in diabetes incidence 2005-2017.

Source: Department of Health Quality Outcomes Framework

https://www.health-ni.gov.uk/publications/quality-and-outcomes-framework-qof-achievement-data-201617

Podiatry services

HSCNI podiatry provides a comprehensive foot health service for conditions affecting the foot and lower limb in order to maintain and maximise mobility for all ages of the population

Podiatry plays a key role in the prevention of lower limb problems, through a programme of triage, screening, assessment, diagnosis, treatment and foot health education to patients with a lower limb condition or systemic condition that affects

the lower limb. The service is needs-led and person-centred to support and enable self-care where possible to relieve pain, keep the public mobile and sustain and promote active living.

Patients can have systemic, acute or chronic long-term conditions, including diabetes, arthritic, vascular and /or neurological conditions, which give rise to further complications of feet and lower limbs.

The management of podiatry's chronic caseload, which is predominantly feet at risk of ulceration, represents 70% of podiatry activity in HSCNI. This equates annually to over 200,000 contacts

Podiatry services are delivered across a variety of settings, including health centres, GP practices and domiciliary visits in the community and both inpatient and outpatient clinics in the acute hospital setting. Regional vascular and orthopaedic services are provided predominately by Belfast with the podiatrist working as part of the multidisciplinary team providing specialist care where required.

Podiatry services offer assessment and management of a range of foot problems arising from multiple aetiologies including:

- Diabetes
- Vascular disease
- Renal Disease
- Biomechanical and musculoskeletal conditions
- Systemic arthropathies and other rheumatological conditions
- Provision of orthoses
- Footwear
- Nail Surgery
- Orthopaedic conditions
- Dermatological
- Soft tissues disorders including corns, calluses
- Steroid Injections
- Falls prevention

Care pathways, eligibility criteria and key facts and figures

In 2016 the podiatry professional heads of service developed regionally aligned care pathways**.** The development of these pathways ensures greater regional equity, clarity of processes, caseload management and sharing of good practice.

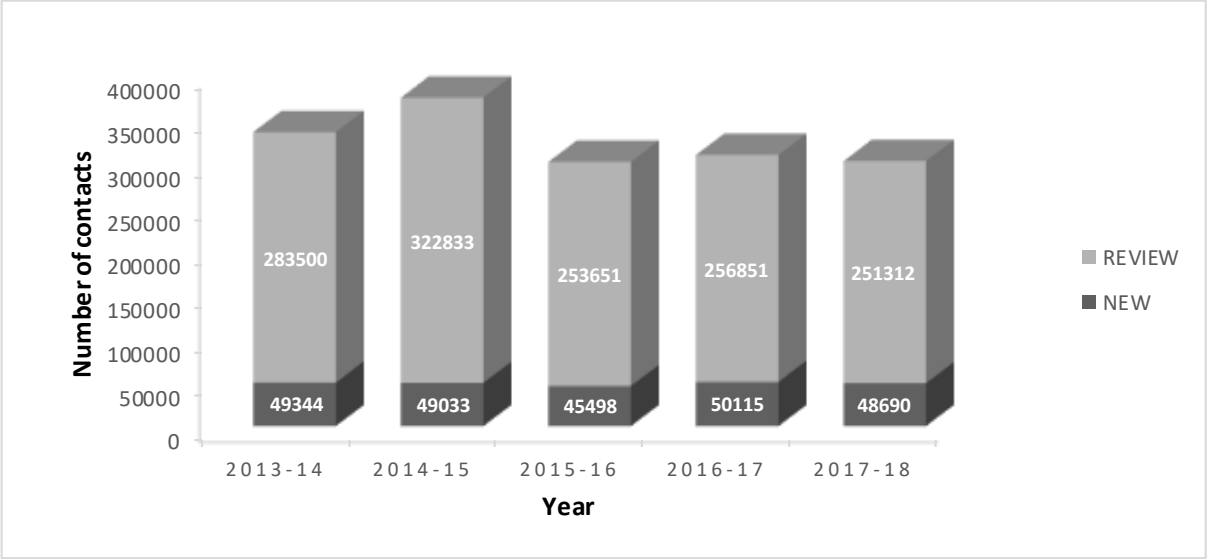
The pathway guidelines specified a number of key facts regarding podiatry services in HSCNI.

- Referral to podiatry services remains by direct access.
- Regionally agreed episodic pathways for all patients referred for nail surgery, musculoskeletal conditions and podiatric need.
- Ongoing care for a chronic caseload based on individual risk stratification for each patient. A Regional Multidisciplinary Diabetic Foot pathway has been agreed and supported by the DoH.

An analysis of waiting list figures from April 2016 to April 2018 indicates that there have been significant improvements over the last three years for the podiatry service in achieving the elective targets. Podiatry services across the HSC are aware of the need to reassess the podiatry caseload. All new and existing patients are actively assessed against the regionally agreed Podiatry Risk Allocation Tool (Appendix 4).

Those patients who are assessed as having no risk of ulceration associated with their presenting condition are discharged to self-care with advice or following intensive intervention. This ongoing review of the new and existing patients is essential to ensure that the service has capacity to deal with an increasingly complex caseload

Graph 3 demonstrates the number of elective patient contacts across the region over the past 5 years excluding any footwear service contacts or patients seen by Integrated Clinical Assessment and Treatment Services (ICATS)



Graph 2 New and Review Activity

A detailed breakdown of podiatry contacts for each trust is available in Appendix 5.

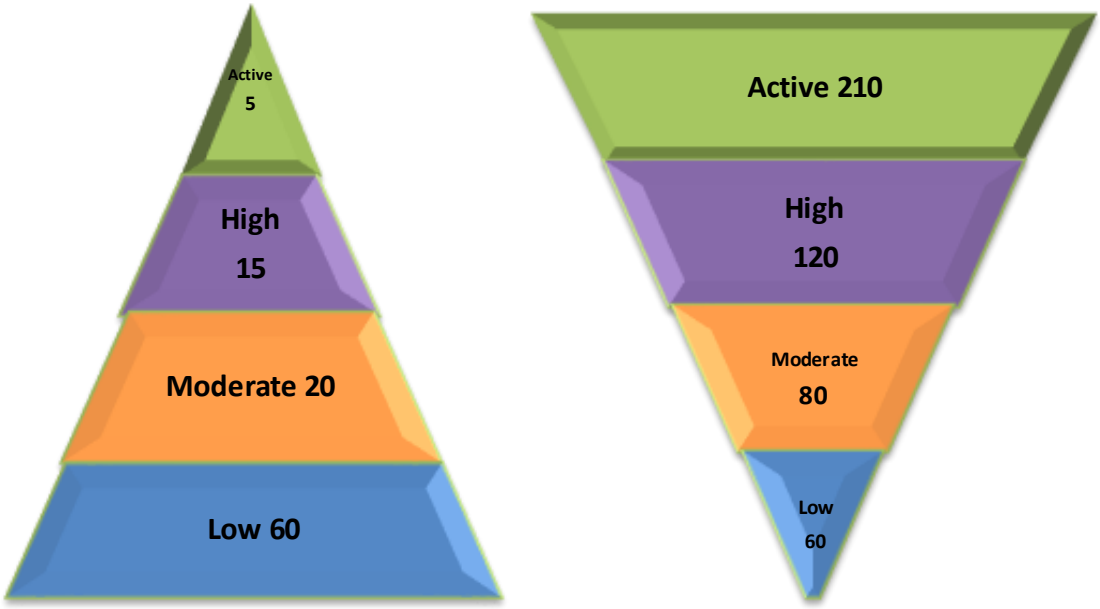
The graph shows that although the number of new referrals has remained largely constant since 2013.There has been a reduction in the number of review contacts regionally in the same period. This reduction mirrors the decline in contacts seen in podiatry in NHS England. It has been professionally recognised that a more complex caseload requires an increased intensive level of intervention: this is reflected in an increased length of appointment resulting in a reduction in the amount of contacts each podiatrist can see.

NHS Commissioners require podiatry activity to focus on patients with complex foot problems and specialist interventions; it is therefore not surprising that the amount of activity generated by the podiatry workforce has reduced.

Mike Townson; Developing a sustainable Podiatry Workforce for the UK towards 2030. (2014)

It has also been professionally recognised that a complex caseload requires more reviews. Figure 6 highlights that 5% of the most complex caseload for diabetes

requires an average of 42 appointments per year. In calculating podiatry service needs it is important to identify the level of risk the patient has, to identify the resource requirement.



Number of diabetic patients in each risk category per 100 diabetic patients

Number of appointments generated annually per 100 Diabetic patients

Figure 6. Diagrammatic representation of complexity of podiatry appointments

In scoping current models the professional podiatry heads of service compiled a template of services offered to gain a better insight into service models and potential developments which may impact on the future workforce needs (Appendix 6). This information was used to evidence gaps in service which will be discussed on pg. 27 of this document.

Financial and IT challenges

Across the region, there are significant financial challenges which need careful planning to manage effectively. To achieve this, HSC organisations must use resources effectively and work in partnership with other services and agencies including the community and voluntary sectors to manage the diverse needs of our

population. There needs to be a focus on health promotion and prevention to embed public health amongst the wider population. Services need to be provided safely and at a high quality, which keeps up with the fast pace of innovation and HSC developments. There is acknowledgement within the Delivering Together Strategy that staff need the opportunity to develop their expertise in an environment which allows for a degree of specialisation, whilst maintaining personalised compassionate care.

One of the key areas that needs developed in podiatry is expertise to support the IT agenda. Currently all trusts are using IT to support their services in recording activity and key facts. Some trusts are also using IT to record patient clinical records. In completing this review all trusts used their local IT systems to gather information (Appendix 7). The review process not only identified the variation and limitation of IT systems but also highlighted the professional knowledge gap.

Defining the Required Workforce

Service regulation Health and Care Professions Council (HCPC)

Podiatrists deliver services and provide support to patients and carers across a wide range of care pathways in a variety of locations and sectors within acute, community and primary care settings.

Podiatrists like their AHP counterparts are autonomous practitioners who provide essential diagnostic and therapeutic roles including assessment, diagnosis, treatment and discharge ranging from primary prevention through to specific and specialist disease management.

Podiatrists must be registered with the HCPC to practice. Only those podiatrists with a professional qualification from a training organisation recognised by HCPC can register with the regulatory body and can lawfully use the 'Podiatrist' protected title. HCPC is a regulatory body set up to protect the public and are responsible for setting and maintaining standards of professional training, performance and conduct of the health professions it regulates which includes podiatry and chiropody. HCPC keeps a register of the health and care professionals who meet their standards for training, professional skills, behaviour and health.

The HCPC also maintain the register of podiatrists who have the ability to supply and issue prescription only medicine (POMs) from a defined exemptions list. This is annotated separately on the register. Legislation sets out that podiatrists can act as Supplementary/ Independent prescribers if they complete additional post-registration training. One may only practise as a prescriber if one has completed approved training and have a prescribing 'annotation' on HCPC Register. In NI there are two independent prescribers currently trained and the podiatry managers are working towards ensuring the majority of HSC Podiatry staff have POMs annotation by 2020. These additional skills are utilised in the care pathways described in the document. (pg. 21)

Podiatrists can also be annotated on the HCPC register as podiatric surgeons. Podiatric surgery is the assessment and surgical treatment of the foot and its associated structures. It is carried out by podiatrists who have undertaken additional specialist training in foot and ankle surgery, typically treating bone, joints and soft tissue disorders. The majority of treatments are usually performed as a day case under local anaesthetic. It is important to note that podiatrists who specialise in surgery are not doctors (i.e. Registered Medical Practitioners) but are podiatrists who specialise in the surgical management of foot and ankle conditions.

Supervision

In line with effective governance, regulatory and accountability arrangements required to ensure the delivery of safe and effective care, podiatry must have access to regular supervision as outlined within the 'Regional Supervision Policy for AHPs – Working for a Healthier Future (2014). Supervision is an essential component of good quality, safe and effective services ensuring that services delivered meet the needs of service users and their families. The importance of supervision has been highlighted in a number of reviews and is particularly referenced in the Mid-Staffordshire NHS Foundation Trust Public Inquiry in 2013.

Workforce projections based on demand/capacity

The current model of podiatry is categorised under a number of service areas and specialities, which are summarised below.

- Diabetes /High Risk model
- Core podiatric needs
- Nail surgery
- Musculoskeletal model
- Rheumatology model
- Orthopaedic ICATS
- Footwear model

Key factors impacting on workforce projections

It has been highlighted in the document that a number of podiatry clinical services are commissioned equitably across NI. However there are still a number of clinical areas with local variation and service gaps e.g.

- Rheumatoid arthritis (RhA)
- Renal
- Homeless
- Footwear model
- Paediatrics
- Implementation of podiatric surgery model
- Prescription only medicines (POMS) and independent prescribing
- Training advanced practice/career development
- Growth in diabetes

Staffing issues this is discussed in the next section of the document - Understanding Workforce Availability pg. 34

Gaps in service delivery

Rheumatoid Arthritis (RhA)

The GAIN audit, A Regional Podiatry Audit of the Multidisciplinary Management of Rheumatological Foot Health Problems in Adults and Children in NI (2018), demonstrated that only 18% of the population with RhA were on the current podiatry caseload. If we consider that the risk factors for foot ulceration in RhA are similar to those in the diabetic foot then there is a massive unmet need in this specialty. Treatment of patients with inflammatory conditions represents approximately 10% of the podiatry caseload with only ad hoc funding in situ for specialist posts in the acute sector across the region. Appendix 8 demonstrates the number of appointments required against current capacity and shows a gap of 16 wte across NI .These staff is required to deliver the clinical interventions necessary to make a positive difference to the foot health of this patient population as evidenced in NICE guidelines.

Only 18% of the current population with RhA are on the current podiatry caseload. The risk factors for foot ulceration in RhA are similar to those in the diabetic foot. This evidences that there is a massive unmet need in this specialty.

A Regional Podiatry Audit of the Multidisciplinary Management of Rheumatological Foot Health

Renal Services

Podiatry services provide dedicated input into four of the six renal units in NI: Antrim, Altnagelvin, Daisy Hill and the Ulster Hospital. Renal specialist podiatrists function at advanced practitioner level and have additional training in comparative anatomy to facilitate the need for debridement of hands as well as feet.

Table 3 demonstrates current gaps in renal funding based on the numbers receiving dialysis in each location and a 14% ulceration rate. In line with NICE (NG19) all patients receiving dialysis are considered as high risk and should receive monthly assessment and intervention from a renal specialist podiatrist.

	South Eastern	Northern	Southern	Belfast	Western
No. receiving dialysis	139	88	90	165	151
14% 52 appts	1040	658	673	1235	1130
86% 12 appts	1427	903	924	1694	1551
Total contacts	2467	1561	1597	2929	2681
Podiatry Annual Capacity	1750	1750	1750	1750	1750
Resource Required	1.4	0.9	0.9	1.7	1.5
Current Funding	1.0	0.5	0.6	0	0.5
Gap wte	0.4	0.4	0.3	1.7	1.0

Table 3 Gaps in renal staffing across region.

Homeless

Many homeless people have complex health needs and are often the most socially excluded, isolated, disadvantaged and hard to reach members of the community.

In 2015 /16, 18628 people presented to the NI Housing Executive as homeless. There is an increase prevalence of long term conditions in those who are homeless and sleeping rough. Evidence shows that 78% of homeless people report as having a physical health condition compared to 37% in the general population (Health needs audit 2016, homeless.org.uk)

> The prevalence of diabetes in the homeless population is over 3 times higher than in the general population
>
> ***Public Health Agency/ Council for homeless NI, Health Survey. 2016***

The homeless population (especially rough sleepers) are likely to have foot pathology and are known to have a higher risk of skin problems, including wounds and/or infections and musculoskeletal conditions. Foot trauma is common in homeless people due to walking for long periods in inappropriate footwear. Standing or sitting for long periods and sleeping in doorways or other cramped spaces can lead to venous stasis, oedema, infection, frost bite and skin anaesthesia due to alcoholic peripheral neuropathy (Wright, 2006).

Homeless outreach is currently not a commissioned service and many homeless people do not meet a regional access criterion which is based on a medical model (Appendix 4). The homeless client's chaotic lifestyle leads to a high Did Not Attend (DNA) rate in core services, therefore the delivery of an outreach model results in reduced DNA rate and savings to the service (Tiffney, E. 2018).

It would be hoped that if funding could be secured to replicate the current pilot model in Belfast HSC Trust then outcomes for the homeless population could be significantly improved.

Footwear models

There is scope for expansion of the role of the podiatrist in the delivery of footwear services across the region. Currently podiatrists are involved in the delivery of footwear services in 3 of the 5 trusts, Belfast, Northern and South Eastern. Podiatry led footwear models can ensure that footwear services are delivered effectively and efficiently to the right patient at the right time. Podiatrists working closely with the orthotists can ensure that the patients receive timely intervention, triaging referrals to ensure that patients are referred to the service most appropriate to their need. In order for this aim to be realised, models of care for footwear service delivery need finalised. Staff involved in the prescription, fitting and issue of stock and modular footwear also need the appropriate level of training. Training for podiatrists requires a period of mentoring by an orthotist or a qualified footwear specialist podiatrist.

Delivering Together provides the opportunity for us to consider new ways of working. Podiatry professional heads of service hope that this provides an opportunity for the PHA and professional representatives to look at potential new models of delivering orthotist services across NI and reduce inequity of provision across the region.

Paediatrics

Specialists in podopaediatrics have expert knowledge in childhood disabilities and a child's lower limb development. They work independently and within an integrated multidisciplinary team of physiotherapists, occupational and speech therapists to develop a unique treatment plan to meet a child's individual needs and abilities .They assess lower limb function and undertake gait analysis with the aim of improving the foot and lower limb function of the child. Podopaediatrics is currently not a commissioned service however two trusts have reprofiled clinical resources and have created two specialist posts. Evidence based podopaediatric regional care pathways have been developed in conjunction with orthopaedic paediatricians to standardise practice across NI.

Implementation of podiatric surgery model

The development of a podiatric surgery service in NI has the potential to make a cost effective contribution to reducing the demand/capacity gap in orthopaedic foot and ankle surgery. The positive impact of this service on orthopaedic waiting lists was also recognised in the DoH document 'Workforce summary – Trauma and Orthopaedic Surgery' (2008). GPs in England have been referring to podiatric surgeons for over thirty years however implementation in NI has never secured funding although has gained political support in recent years. Foot surgery accounts for 15% of orthopaedic activity so redirecting part of this workload to podiatric surgeons has the potential to release orthopaedic resources to manage large joint replacements and patients with complex medical conditions. Moreover as most podiatric surgery is performed as a day case, and under a local anaesthetic administered by a podiatrist the requirement for an anaesthetist resource is negated

Research suggests that quality and productivity improvements could be achieved by providing podiatric day-case foot surgery in all NHS trusts

Society of Chiropodists and podiatrists.
A guide to the Benefits of Podiatry to Patient Care 2010

Prescription Only Medicines (POMs) and Independent prescribing.

Since 2004 all new podiatry graduates qualify with an ability to administer and supply Prescription only medicines (POMs). People qualifying before this date only have an ability to administer POMs. It is recognised that ability for the podiatrist to supply POMs is beneficial to the practitioner, patient and the service.

There is a rolling programme to ensure that all podiatrists who qualified pre 2004 complete the access and supply examination enabling them to both supply and administer POMs. This rolling programme is delivered in a distance learning format and commissioned through the DoH AHP Educational Commissioning Group.
In addition, two HSC podiatrists are registered as Non-Medical Prescribers (NMP) enabling them to independently prescribe within their scope of competence and in line with the parameters of their treatment plan. The transformational agenda requires more advanced practitioners to move to independent prescribing to support the new care pathways.

A podiatry medicines management group, established by the regional podiatry managers group, is currently working in conjunction with the PHA to finalise the implementation of NMP for podiatry in NI.

Training advanced practice and career development

The DoH provides training for principal and advanced podiatrists through a commissioned education model that includes MSc level university modules, post graduate study and individually designed courses.
Alongside the academic route, training is also completed through shadowing and work-based competency models in the Trusts.
Training is on-going/ planned in the areas of:

i. Rheumatology (adult and paediatric)
ii. Ultrasound guided steroid injection therapy
iii. Supplementary and Independent prescribing
iv. Therapeutic and stock footwear provision
v. Total contact casting
vi. Research and post graduate work
vii. Debridement of necrosis and lesions on hands (renal patients)

The podiatry services welcome the opportunity to access ongoing professional training through the AHP ECG and recognise the need to embed research and evidence based care more effectively into practice. There is limited availability of clinical academic and research roles to enhance the process. Indeed, current allocation for training is not meeting the required need. The need to prioritise training

delays staff progression and impedes staff having the requisite skill set to be able to respond quickly to the transformational agenda. A smaller workforce also results in a small pool of staff eligible to undertake MSc modules which can destabilise the workforce when staff are released.

Growth in diabetes

In December 2018, investment into podiatry services ensured the current gaps in services were addressed for the management of patients with diabetes by ensuring the effective implementation of the regionally agreed Diabetes Foot Care Pathway standardising the delivery of diabetes foot care across all trusts. This Investment will ensure that the current need is met. However it does not address any future growth in the number of people diagnosed with diabetes in NI or those patients who may present with complications due to a lack of previous preventative care arising from a historical unmet need.

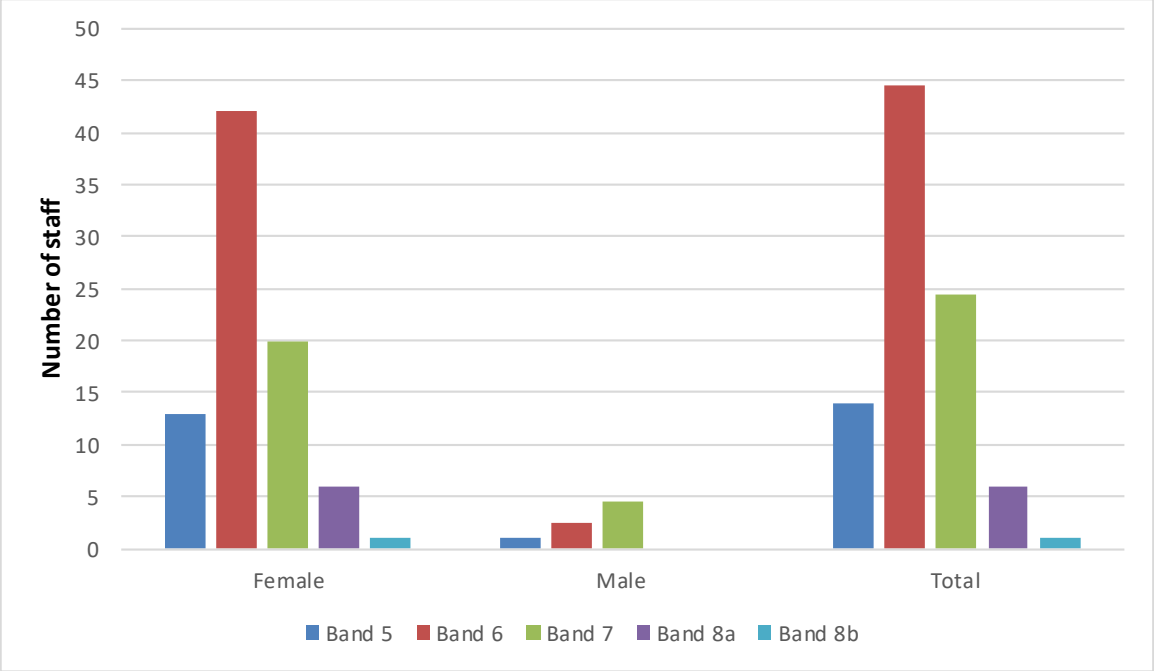
Understanding Workforce Availability

Demographics of professional workforce

Based on the DoH HSC workforce information (September 2017) the podiatry HSC workforce is comprised of 256 podiatrists with a whole time equivalent (wte) of 203. This wte figure has increased by 3 wte staff over the last 10 years (2007 = 200 WTE). Podiatry services have streamlined their models of service delivery over the past ten years to ensure that the appropriate level of service is directed to those patients at risk of foot ulceration.

At present, females represent 79% of podiatrists employed within the HSC in NI. The high proportion of women working within the podiatry profession, create an increased demand for part-time/flexible working patterns. Currently, 142 (55%) of staff are part time of which 90% are female. Analysis of working patterns for the past 10 years indicates there is a growing trend in part time working within podiatry. (39% part time

2007 and 52% part time 2012). DoH HSC information demonstrates that 61 (42% of part time staff) work more than 3 days a week.



Graph 3 Part time staff by banding and female/male split

It is important to note that additional resources are required in terms of mandatory training and supervision where there are increased numbers of part time staff.
Graph 2 shows that the greatest numbers of part time staff are at band 6 level (specialist podiatrists). This has a direct impact on succession planning for the advanced practitioner roles. If we consider the graduate gender split and the trend for females to become part time, workforce planners need to plan to graduate 3 potential HSCNI employees for every 2 wte positions.

DoH HSC 2017 information indicates a 3.6% maternity level and 4.2% absence level for podiatry both figures are equitable to other AHPs.

Demographics of non-professional workforce

Podiatry assistant practitioners (PAPs) were introduced to the workforce to promote improved skill mix and release professional staff time for more complex caseloads. Their main role is to provide routine foot care to low risk patients combined with

assisting with audit, stock management, nail surgery, foot health training and annual screening. As they are not registered by the HCPC, they work under delegated responsibility of registered staff once they have completed the College of Podiatry assistant practitioner training. A minimum of 6 months is required to complete the syllabus, submit a learning portfolio and undertake a practical examination. This training is delivered at trust level by podiatrists within the service. Ongoing training is provided by the regional managers group annually and not governed by ECG process.

In December 2018 additional investment to support the implementation of the diabetes feet pathway will see an additional 13 WTE PAPs recruited across the region.

Undergraduate courses

For the last three years DoH have commissioned 17 undergraduate places at Ulster University (UU). The 3-year programme contains both academic and clinical modules of study supported by dedicated NHS placements in each year.

All of the 17 commissioned places have been filled for the 2018 intake.

In previous years, the university encountered challenges filling all 17 commissioned places. These challenges combined with attrition rates, resulted in a reduced number of graduates which subsequently impacted on the recruitment pool. The HPAT will no longer be used as part of the application process, it is hoped that this will increase the numbers of applicants and continue to maximise the uptake for commissioned places.

The profile of podiatry as a profession should be raised amongst those in post primary education and those who are considering retraining or returning to work.

The podiatry UU course also provides graduates for the private sector. This should not be considered a lost resource, as the private sector provides care for many of the

patients with a social need who are not eligible for health service podiatry. Without the private sector many more patients would develop significant pathology that would then require health service intervention.

Table 4 shows the destination of the graduates in their 1st year after qualifying. Currently commissioned places are available for students from NI and the Republic of Ireland.

Cohort	HSC	Private	Unknown	% Graduates employed in HSCNI
2012-13	5	6	1	45%
2013-14	4	9	2 left	26%
2014-15	3	7	2	16%
2015-16	6	8	3	35%
2016-17	2	12	1	15%

Table 4. Destination of New Podiatry graduates from UU.

The average ratio of male to female graduates is 22% to 78% which is reflective of the current HSC workforce information.

Of the new graduates that took employment in the private sector 70% said that they would have preferred to work in the HSCNI, but could not find a job.

The regional professional podiatry managers group conducted a survey of current staff to identify where staff who graduated in the last 10 years were trained. The survey highlighted that HSC podiatry is reliant on graduates from Scotland and England to fill vacancies.

- Graduates UU 57%
- Scottish graduates 30%

- Salford and Durham 13%

Permanent contracts were more difficult for the graduates to obtain, with only 7 (20%) having a permanent contract within 12 months of graduating. This is compared to 9 (25%) who took over 3 years to get a permanent contract and 6 (17%) who did not have any permanent employment as of June 2018. Health trusts in other parts of the UK have developed vocational training posts for new graduates to stabilise and maintain the graduate level workforce and prepare for succession planning.

80% of new graduates worked in the private sector whilst trying to find work in HSCNI. Many new graduates are reluctant to give up a permanent job in the private sector to take up a temporary post in HSC.

The change in the podiatry programme in 2012 required an increase in student placement in the HSC setting. The five trusts now provide 712 hours of student placement per student each financial year. This is divided across the 3 years of the course as shown Appendix 9. On average each trust takes 4 students per placement. This commitment affects staffing availability and contacts.

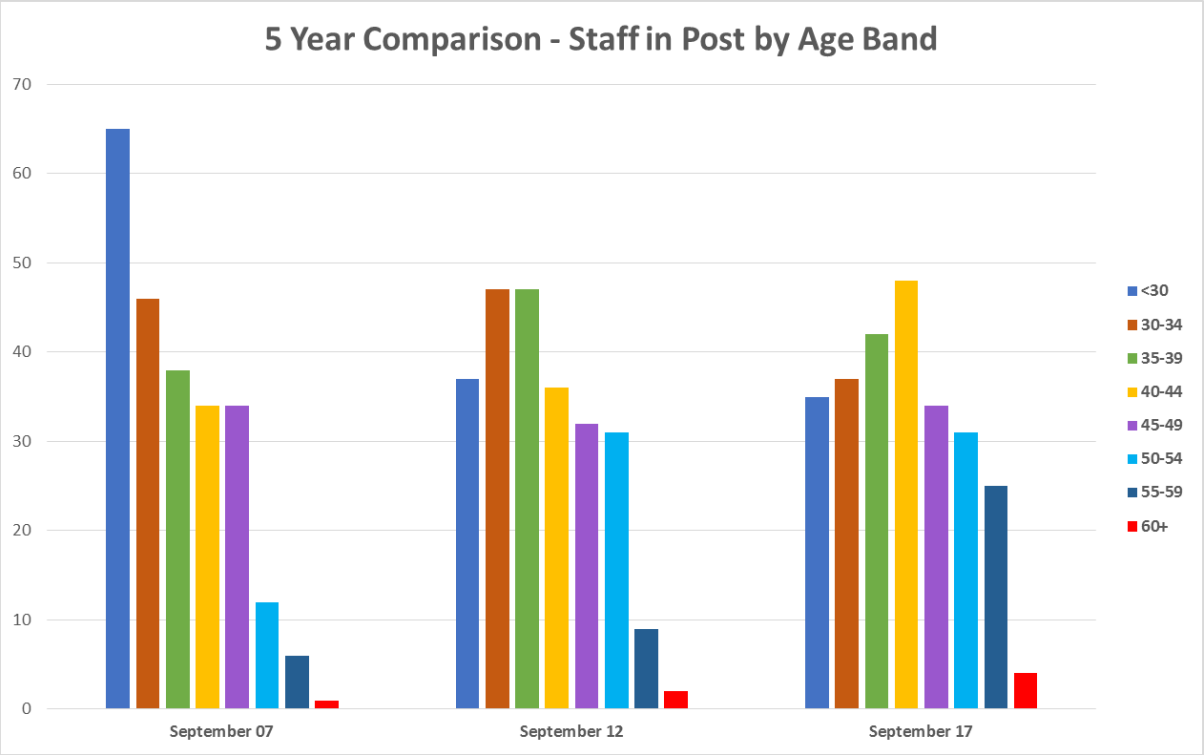
NHS England has highlighted that podiatry is the only AHP profession that has seen negative growth over the past 5 years

Facing the Facts, Shaping the Future,
Health and care workforce strategy for England (2018)

Given the projections for retirement which are discussed later in the document, the numbers graduating fall short of the numbers required to replace the staff that are eligible to retire and the numbers of staff required to meet the demographic and developmental growth of the service. Table 8 demonstrates the shortfall in the number of required graduates and associated costs.

Analysis of workforce

DOH workforce information states that in September 07, 28% of staff were working at band 5 level. By September 17 this number had reduced to 14%, a 50% reduction. This change in workforce banding was necessary to manage the change in caseloads for all trusts to a more complex patients. This caseload requires graduate staff to have support to acquire the necessary skills to become specialist (band 6) and advanced podiatrists (band 7).



Graph 4 demonstrates the age profile by banding for the last 5 years.

Analysing the change in age profile from Sept 12 - Sept 17 there is an increase from 7 to 29 staff who are over 55. If we consider current staff numbers aged over 50 (including 55+) and assume they will retire over the next 12 years the numbers increase to 60 staff out of 256.

The majority of staff members who are over 55 are working at Band 7-advanced podiatrist or higher. Assuming this group of people retire at 60, there is potential that a vast amount of clinical expertise and local knowledge will be lost over the next 5

In order to help address the deficit that will be created by these 29 people retiring, the regional managers group commissioned a succession planning course for podiatrists that will ran from May 2018 to February 2019. The aim of the programme is to identify and develop the podiatry leaders of the future. The overall objective of the course is to equip the specialist podiatrists with the knowledge and ability to develop their leadership skills therefore maximising the possibility of having a high quality pool of applicants for future podiatry leadership roles across all five trusts.

Taking account of gaps in service delivery, the aging workforce, the issue with commissioned undergraduate places, there is a cumulative workforce deficit, (Table 8). The following table provides a quantitative summary of the issues that will have an impact on the workforce over the next 5 years. The review recognises that based on the assumptions in table 8, that as of September 2019 the HSC workforce is in deficit of 23 undergraduate places.

The table is based on previous trends where 33% of graduates were employed in HSCNI. Appendix 10 is a table with 50% of graduate places employed in HSCNI.

Graduated in	**18/19**	**19/20**	**20/21**	**21/22**	**Comments**
UU commissioned places	12	15	17	17	Commissioned places by DoH(pg35)
Average number of places converted to HSC (33%) (-)	4	5	6	6	Previous trends of 33% who took up a HSC post (pg. 36)
Available pool from other Universities (+)	2	2	2	2	Previous trends of non UU graduates who took up HSC post (pg. 37)
Average retirement per year (-)	6	6	6	6	Predicted rate of retirement from HSC (pg39)
Gaps in staff due to new development(RhA, Renal) (-)	5	5	5	0	Identified gaps in service page 27-30 of this report
Average demographic (-)	7	7	7	7	Demographic patient growth (pg33)
Shortfall in required graduates	-12	-11	-10	-5	
Cumulative shortfall – this does not take into account flexible working arrangements	-12	-23	-33	-38	
	£121,968	£233,772	£335,412	£274,428	Cost of funding undergraduate

Cost of funding additional place					places based on £8664 tuition fees per year and average AHP Bursary of £1500 per year. Total £10164

Table 5. Shortfall in Podiatry graduates, assuming 33% of graduates take a HSC post.

Recruitment and retention

As the workforce is predominantly female, there are annual requirements for maternity leave. Temporary positions created because of maternity leave are often difficult to fill particularly in more clinically specialised areas and as a result, many of these maternity positions are not back filled.

Regional information available on recruitment trends would suggest significant difficulty in appointing posts on a temporary basis. This is because successful applicants generally choose to wait for a permanent position.

To address these issues it is important that there is a proactive way of appointing staff where possible on a permanent basis. This will reduce the constant shift in staff appointments across different trusts areas and sites and by doing so enabling greater continuity of care for the service user. There are models already developed in some Trusts, which are demonstrating significant benefits. These models could be considered on a regional basis to ensure service regional equity, stability and sustainability as well as benefits for service delivery to the population.

Succession planning is also required to address difficulties in appointing to some clinical specialities which could be supported by targeting a proactive and robust post-graduate training structure over the next 2/3 years.

It is important to note that the current disparity in pay between NI and the rest of the UK can potentially increase the difficulty in recruiting.

Anecdotal evidence suggests AHPs from NI who have trained or work outside of the region may not apply for posts in NI due to the gap in pay.

Regional podiatry recruitment process

Recruitment of Band 5 Podiatrists is conducted regionally on an annual basis. New graduates apply and if successful will be offered a post when one becomes available. At present participation in this recruitment exercise is only mechanism for podiatrists to move across trusts. This is reflected in the numbers of staff in post who apply to keep their name on the waiting list in case a post becomes available in their preferred area.

A number of Trusts have adopted a peripatetic model of recruitment for both Band 5 and other qualified grades in an attempt to stabilise the workforce due to absence figures related to maternity and sickness. This is in the early stages of implementation and the outcomes and impact of this model should be evaluated to help inform future recruitment practices in this profession across each Trust area.

Regional recruitment needs reviewed for smaller services. It is felt that a regional voluntary transfer policy needs developed and more appointments to peripatetic posts.

Stakeholder Engagement

An important element of the review involved stakeholder engagement in the spirit of co-production and co-design. The Project Team comprised of representatives from DoH, PHA, and Trusts. The Steering Group comprised of representatives from DoH, PHA, Trusts, PCC and Staff Side.

An engagement strategy was discussed at Steering Group level. It was agreed a collective communications effort regionally would be important to encourage service user and carer involvement. This input to the review process would ensure solutions were coproduced appropriately.

The Patient and Client Council undertook a digital communications strategy to support the involvement agenda. This included social media postings across Facebook and Twitter; published article updates in PCC monthly newsletter with a reach of 15,000 across NI and event listings on PCC website for 'Engage' events.

In addition, the project group hosted an 'Engage' event on Friday 13th April 2018 at Craigavon Civic Centre, Craigavon. Over 100 delegates registered to attend the event from across the statutory, independent sector, staff side, carers and users. The purpose of the event was to consult on the development of the draft AHP Workforce Review with a Focus on Dietetics, Orthoptics, Podiatry and Therapeutic Radiography. The event took the format of an interactive e-participation 'Engage' session.

Information gathered from this event will help inform recommendations required to ensure that the necessary workforce is available to meet service user needs and demands for the next 10 years within Podiatry.

The engage discussion focused on four main topics as shown in Table 6

Table 6.

Qu. No	Topic	Question
Qu.1	**Recruitment**	What needs to be done to attract the right people with the right skills into these professions?
Qu. 2	**Retention**	What needs to be done to make the HSC a brand that people aspire to work for?
Qu. 3	**Workforce Planning Process**	Are there any gaps in the process that you would wish to have addressed?
Reflection	Having discussed all of this today, what would you now suggest as the top priority for the AHP workforce reviews to deliver?	

The 'Engage' method combines the live aspect of small-scale discussion with information and communication technologies; on one hand it allows rapid transmission of work-group results to a plenary assembly; while on the other it permits surveys of individual participants' opinions through a polling system. Information gathered at the engage event has been reflected in the review. Each of the round table groupings at the event were asked to prioritise their responses in each topic and the top responses captured.

Personal and Public Involvement (PPI) is the active and effective involvement of service users, carers and the public in the design, development, delivery and evaluation of Health and Social Care (HSC) services. PPI is now a legislative requirement for Health and Social Care organisations as laid down in the Health and Social Services (Reform) NI Act 2009. While PPI may be relatively new term, the concept is not. The HSC system has long recognised the benefits of meaningful and effective engagement of service users, carers and the public. Within all Trusts in the region Podiatrists are actively involved in building partnerships and networks with service users, adults and children, carers, families, charitable organisations, user forums, voluntary organisations and other agencies including councils and education authorities.

Each podiatry department is actively engaged in varying levels of PPI within their own trusts, which includes patient user surveys and focus groups, 10000 voices, audits and contribution to the regional AHP strategic action plan.

E-Health

Podiatry services are currently utilising a range of different IT systems across the 5 trusts. There is significant variation in the systems used to record contacts, make appointments and maintain records. The implementation of the regional digital integrated care record, encompass, will address all of these issues by ensuring that everyone involved in the patient's care will have access to the necessary health and care information from one record.It should be noted that it is envisaged that although encompass will significantly improve governance it will not create additional capacity.

There is a need for the current and future workforce need to be equipped to maximise use of E-health technologies. This will require the support of the undergraduate workforce so as to ensure that graduates are able to fully utilise a regional IT system.

Conclusion

The NI podiatry workforce review has evidenced the current scope of practice in podiatry, the current resource, predicted gaps in resource requirements and the projected areas for service development.

Using the Six Step Methodology the review describes the key clinical areas podiatry delivers services and highlights regional variances in delivering these services.

The work completed in developing the regional aligned elective pathways (2016) recognised the change in complexity of the podiatry caseload. The recognition that podiatry is integral to hospital services, also has a demand on the workforce pool. Considering the change in complexity, the gaps in current service delivery models and analysing demographic trends, the review assuredly projects the workforce required to sustain the current service.

Along with other AHP's several key factors impact on the podiatry workforce projections i.e. workforce availability, female dominant profession, working patterns and number of staff retiring. However, combine these key factors with podiatry having no increase in workforce for 10 years and reduced undergraduate training posts have led to a predicted cumulative shortfall of 38 graduate posts by the year 2022.

The review further analyses the profile of the 29 staff (12%) who could retire over the next 5 years and highlights that most of these staff are working at advanced podiatry level or above. This potential skill lost requires a robust post graduate training programme to address the potential skill gap.

This post graduate training programme needs to consider service developments and strategic drivers such as the transformational agenda. Total contact casting, steroid therapy and the introduction of independent prescribing require continued investment in the current staff to support these service developments.

The workforce review has allowed the profession to highlight several clinical practices that are not optimised or are not delivered in HSC NI. Inequalities across trusts for footwear service, homeless services and renal services are highlighted in

the document. Nationally podiatric surgery has been operational across the UK. The podiatric surgery service can address the orthopaedic foot and ankle unmet demand. To date NI has never secured funding to implement this service.

In summary the workforce review demonstrates that with the correct levels of investment at all levels for the service there is clear evidence that HSCNI Podiatry services can continue to provide an exemplary level of care across NI.

Recommendations and action plan

Based on the findings of the review the key recommendations are set out below, these have been structured under key headings and will inform the Action Plan.

	RECOMMENDATIONS	
UNDERGRADUATE TRAINING	1	**There is a requirement to sustain and maximise the pre-registration podiatry places annually to meet current and future predicted demand, and increase the number of graduates coming into HSCNI.** **It is recommended that the following are considered in order to ensure that the workforce demand is met.** -Commission 27 extra undergraduate places over the next five years
RECRUITMENT AND RETENTION	2	**Promote podiatry within HSC as a profession of choice for prospective and current students which includes;** - Raise the profile of podiatry in post primary education schools and with members of the public, in line with the Workforce strategy. [It's important to educate and inform on the full scope of the profession and communicate the benefits and positive clinical outcomes podiatry achieve.] - Appropriate investment in services to maximise the uptake of new graduates in a timely manner - A scoping exercise is undertaken to identify the value in Designated vocational training posts with a guaranteed HSC

		job post qualification - Band 5 regional recruitment process need reviewed for smaller services such as podiatry - Consideration given to a voluntary transfer policy between trusts.

POST GRADUATE TRAINING	**3**	**Prioritise post-graduate (PG) training and secure required funding to support the transformation agenda and Delivering Together Strategy to provide opportunities to meet HCPC CPD requirements and support advanced practitioner progression including;** - Develop a proactive and robust Post graduate training programme to support advanced clinical and management roles. - Consider the Development of Clinical academic, research and consultant roles which will enhance professional leadership across the profession. - Secure investment in the post graduate training budget to meet the needs of the transformational agenda.
WORKFORCE DEVELOPMENT & STABILITY	**4**	- Continue proactive workforce and succession planning for all levels of staff and provide access to leadership training schemes. - The appointment to permanent peripatetic posts needs to be standardised across NI. - Support the needs assessment for the implementation of podiatric surgery in NI

WORKFORE DEMOGRAHY		- Implementation of workforce plans to ensure that the projected workforce deficit caused by an ageing workforce, increased flexible working and staff maintaining a work life balance is addressed. • Ensure sufficiently skilled staff in post to deal with the increasingly complex caseload and increased numbers of patients with systemic conditions leaving their feet in an "at risk" state is addressed. • Identify and address gaps in the current service delivery and ensure implementation of best practice and equitable service delivery regionally, with particular reference to rheumatoid arthritis, homeless and renal podiatry services.
E HEALTH		• Develop a plan to ensure the current and future workforce are equipped to maximise use of E health technologies. • Liaise with UU to ensure that the IT agenda is supported at undergraduate level to ensure that graduates are able to utilise the standardised regional IT system upon graduation.

Action plan

An appropriate action/implementation plan will be developed and published on the Department of Health's website and the Workforce Strategy Programme Board will be updated on progress.

Appendices

Appendix 1 - Membership of AHP Workforce Programme Steering Group and Podiatry Sub-Group

AHP Workforce Programme Steering Group Members	
Name	**Organisation**
Charlotte McArdle	DoH (Chairperson)
Andrew Dawson (Co-chair)	DoH (NI) – Acting Director, Workforce Policy
Hazel Winning	DoH (NI) – Nursing, Midwifery and AHP Group
Erin Montgomery	DoH (NI) – Information and Analysis Directorate
Peter Barbour	DoH (NI) – Workforce Policy Directorate
Catherine Donnelly	DoH (NI) – Workforce Policy Directorate
Paula Cahalan	Belfast HSC Trust
Raymond Irvine	Western HSC Trust
Patricia McClure	Ulster University
Joanne McKissick	Patient and Client Council
Pauline McMullan	Business Services Organisation
Margaret Moorehead	South Eastern HSC Trust
Paul Rafferty	Western HSC Trust
Claire Smyth	South Eastern HSC Trust
Jill Bradley	Northern HSC Trust
Peter Barbour	DoH (NI) – Workforce Policy Directorate
Carmel Harney	Southern HSC Trust
Brendan McGrath	Western HSC Trust
Claire Ronald	Staff Side – Chartered Society of Physiotherapy
Mary Hinds	Public Health Agency
Angela McVeigh	Southern HSC Trust
Nicola Shaw	South Eastern HSC Trust
Marie Ward	Western HSC Trust – represented by R Irvine
Gerard Tinney	(Note taker) DoH (NI) – Workforce Policy Directorate

Podiatry Workforce Sub-Group Members	
Name	**Organisation**
Hazel Winning	DoH (NI) – Nursing, Midwifery and AHP Group
Catherine Donnelly	DoH (NI) – Workforce Policy Directorate
Peter McAuley	DoH (NI) – Nursing, Midwifery and AHP Group
Alison Dunwoody	DoH (NI) – Information and Analysis Directorate
Joanne O'Hagan	DoH (NI) – Information and Analysis Directorate
Gerard Tinney	DoH (NI) – Workforce Policy Directorate
Margaret Moorehead	South Eastern HSC Trust
David Mc Keown	Staff Side
Eileen Dolan	Western HSC Trust
Julie Williams –Nash	Policy Officer Society of Chiropodists & Podiatrists
Geraldine Teague	Public Health Agency
Denise Russel	Southern HSC Trust
Pete Burbidge	South Eastern HSC Trust
Alison Campbell Smyth	Northern HSC Trust
Denise Killough	Belfast HSC Trust

Appendix 2 ToR and Assumption and Constraints

Terms of Reference

The purpose of this document is to:

- Make recommendations on measures, including structures and skills, to recalibrate the Podiatry workforce to assist with HSC wide transformation;
- Make recommendations to the DoH via the AHP Workforce Steering Group regarding the commissioning of pre-registration training;
- Make recommendations regarding post-registration training requirements;
- Develop a shared understanding of the core elements of effective workforce planning;
- Provide greater clarity of roles and responsibilities, processes, structures and governance;
- Provide an understanding of how organisations and individuals can contribute effectively in a mixed economy;
- Encourage partnership working both within and between organisations; and;
- Enable better-informed education commissioning decisions.

Additional assumptions and constraints that need to be considered.

- Elective SBA agreement in place. However no SBA for hospital activity.
- Regional elective variance of service delivery : Footwear, Homeless, Falls, Learning Disability L&D)
- Regional variances in internal reporting mechanisms.

Appendix 3 Population Statistics for 2017

N Ireland Resident Populations by Local Commissioning Group – 2017

Age Band (Yrs.)	Belfast	Northern	South Eastern	Southern	Western	NI
0-15	69,117	96,773	71,920	87,195	64,884	**389,889**
16-39	124,799	141,288	102,990	120,503	92,609	**582,189**
40-64	108,043	155,239	117,759	118,606	97,475	**597,122**
65+	54,371	82,130	65,823	55,427	46,551	**304,302**
All ages	**356,330**	**475,430**	**358,492**	**381,731**	**301,519**	**1,873,502**
%	**19%**	**25.4%**	**19.1%**	**20.4%**	**16.1%**	**100%**

Appendix 4 Risk Tool

Podiatry Risk Allocation Tool and Discharge Planning Guide

Level of Risk	Definition	Suggested Review Time	Discharge *(Guidance on care pathway outcome)*
No Risk	Patients With No medical reason* requiring: Short term interventions to include: -Biomechanical assessments -Nail surgery -need for foot health advice to support self-management	Advice or Intensive treatment Leading to Discharge	Discharge following assessment and advice or intensive intervention
Low Risk	Medical reason* With Foot Pathology **Or** Diabetes with or without foot pathology	52 weeks for review Or Discharge Or review as per Podiatric need	Annual review with appropriate healthcare professional. Refer on to PAP caseload if appropriate
Low Risk	No Medical reason **With** Patients with potential risk associated with Chronic on-going debilitating podiatric pathology Example. Severe N/V HD Severe Hyper keratosis	As per podiatric treatment plan.	Not suitable for initial discharge as patients have a definite need for intervention
Moderate Risk	Medical Reason **With** Loss of Protective Sensation (LOPS) **Or** PAD Significant Deformity associated with Inflammatory Arthritis	12-52 weeks	Not Suitable for Discharge Refer on to PAP caseload if appropriate
High Risk	Medical reason with Previous amputation Previous History of Ulceration Renal replacement therapy	4-12Weeks	Not suitable for Discharge

	Neuropathy combined with PAD Neuropathy or PAD in combination with callus and or deformity Consolidated Charcot Neuroarthropathy		
Active	Active Bacterial Infection Critical limb ischaemia Ulcer present Active/Suspected Charcot Red/Hot swollen foot Gangrene/ Necrosis	0-4 weeks	Not suitable for discharge
At Risk	Patients with potential risk associated with no support and evidence of self-neglect. Or may be a Designated Vulnerable adult due to neglect.	As per podiatric treatment plan	Not suitable for discharge as identified as being vulnerable with no support Refer To PAP if appropriate

* Medical reasons are:

- Diabetes.

- Podiatric need in combination with any of the following :
  Rheumatology
  Chronic Kidney Disease level 3 and above
  Peripheral Arterial Disease (PAD)
  Immuno- compromised

Appendix 5 Contacts per trust 2013-17

SET	NEW	REVIEW	NEW MSK	NAIL SURGERY	Prevalence of RHA
13-14	6516	52487	4524	235	
14-15	6864	51601	2800	244	
15-16	6153	45839	2548	222	2142
16-17	6693	46113	2744	218	
17-18	6745	42820	2581	238	

WESTERN	NEW	REVIEW	NEW MSK	NAIL SURGERY	Prevalence of RHA
13-14	5520	51668	1689	238	
14-15	5957	51090	2200	271	
15-16	4798	45381	2435	244	2400
16-17	5128	44677	2091	382	
17-18	4607	41037	2122	474	

BELFAST	NEW	REVIEW	NEW MSK	NAIL SURGERY	Prevalence of RHA
13-14	7444	65753	1629	413	
14-15	7327	57457	1516	458	
15-16	7354	54957	1394	380	2560
16-17	8642	54180	1515	508	
17-18	8594	56521	1315	530	

SOUTHERN	NEW	REVIEW	NEW MSK	NAIL SURGERY	Prevalence of RHA
13-14	5466	36658	2308	80	
14-15	5606	37785	2477	88	
15-16	5095	36716	2239	116	3190
16-17	6698	41879	2321	133	
17-18	5896	42704	2055	129	

NORTHERN	NEW	REVIEW	NEW MSK	NAIL SURGERY	Prevalence of RHA
13-14	10407	76934	3841	496	
14-15	10265	73299	4021	554	
15-16	9639	70758	3843	516	3930
16-17	10246	70002	4037	486	
17-18	10573	69230	4202	475	

Appendix 6 Current Models of Practice

- The high risk foot (including the diabetes foot, the renal foot and those presenting with Peripheral Arterial Disease (PAD) ref GAIN audit, DUK docs, DF pathways anything on renal?
- Wound management in the high risk foot ref any pathways or models
- Dermatological (skin) conditions
- Nail Surgery ref regional guidelines
- Rheumatological conditions including Rheumatoid and Osteoarthritis
- Musculoskeletal Conditions in Adults and Children ref regional
- Sporting injuries
- Therapeutic and stock footwear
- Falls prevention
- Pain management
- Patient education and empowerment through 1-1 assessment sessions

Appendix 7

IT systems currently in use in each trust

	Clinical Use	Data Collection
Western	NIECR Diamond	PAS
Southern	Clinical Manager Diamond NIECR	Clinical Manager
Northern	LCID NIECR	LCID
SE TRUST	LCID NIECR	LCID
BELFAST	PARIS	PARIS

Appendix 8. Rheumatoid Arthritis caseload across NI and WTE deficit.

Factor	Statistic
Population	14222
60%Low risk =1 contact per year	8533
20%Moderate =4 contacts per year	2844x 4= 11376
16% High = 12 contacts per year	2275 x12=27300
4% Active = 42 contacts per year	568 x 42=23856
Total contacts	71065
Band 7 annual contacts	1750
Requirement For RA	40wte
Funded wte For RA	24.4wte
Gap	15.6wte

Appendix 9 Student Placement commitment 2018-19

Semester	Week	Placement
1	1-8	No Placements
	9-12	Year 2= 4 week placement
2	1-8	Year 1= 1 week Placement Year 3= 8 week placement
	9-10	No Placement
	11-12	Year 1= 2 week placement
3	1-4	Year 2= 4 week placement
	5-12	No Placement

Appendix 10 Shortfall in Graduate numbers from UU.

Graduated in	**18/19**	**19/20**	**20/21**	**21/22**	
UU commissioned places	12	15	17	17	Number of places commissioned by the DOH
Average number of places converted to HSC (33%) (-)	6	8	9	9	Based on previous trend of 33% .This indicates the number of graduates each year that will be expected to take HSC post.
Available pool from other Universities (+)	2	2	2	2	Based on previous trends. This represents the number of non UU graduates who will be expected to take a HSC post
Average retirement per year (-)	6	6	6	6	Based on analysis of current staff. This is the predicted rate of retirement from HSC
Gaps in staff due to New development(RhA, Renal) (-)	5	5	5	0	Identified gaps in service evidenced on page 27-30 of this report
Average demographic (-)	7	7	7	7	Demographic patient growth
Shortfall in required graduates	**-10**	**-8**	**-7**	**-2**	Demonstrates the shortfall of the required graduates
Cumulative shortfall	**-10**	**-18**	**-25**	**-27**	Demonstrates the cumulative shortfall of required graduates
Cost of funding additional Place	**£101640**	**£182952**	**£254100**	**£274428**	Cost of funding undergraduate place based on £8664 Tuition fees per year and average AHP Bursary of £1500 per year Total £10164

Assuming 50% conversion to HSC

Graduated in	18/19	19/20	20/21	21/22
UU commissioned places	12	15	17	17
Average number of places converted to HSC (50%) (-)	6	8	9	9
Available pool from other Universities (+)	2	2	2	2
Average retirement per year (-)	6	6	6	6
Gaps in staff due to New developments (RhA, Renal)(-)	5	5	5	0
Average demographic(-)	7	7	7	7
Shortfall in required graduates	**-10**	**-8**	**-7**	**-2**
Cumulative shortfall	**-10**	**-18**	**-25**	**-27**

Department of Health

Workforce Review Report

Occupational Therapy

2019 – 2029

Royal College of Occupational Therapists

HSC Health and Social Care

DoH Department of Health www.health-ni.gov.uk

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Foreword

Since October 2016, Health and Social Care workers and the Department of Health have been cooperating to deliver the transformation set out in ***Health and Wellbeing 2026: Delivering Together***. This ambitious ten-year plan was our response to the report produced by an Expert Panel led by Professor Bengoa, who were tasked with considering how best to re-configure Health and Social Care Services in Northern Ireland.

The aim is a health and social care system that helps people to stay well for longer, with services delivered in the community or at home, where possible. Allied Health Professions (AHPs) will play a key part in responding to this challenge, particularly as we expand the role of innovative, multidisciplinary teams across a range of integrated care pathways within health and social care settings. No matter how or where AHP staff work, they will continue to maintain their clear professional focus: ensuring that people, who are ill, have disabilities or special needs, can live the fullest lives possible.

Since these AHP Workforce reviews commenced the landscape across Health and Social Care has changed considerably. Opportunities for AHPs have been created across a range of primary care multi-disciplinary teams. These are to be welcomed but it is important to have the highly skilled workforce required to take these opportunities as they arise. This series of workforce reviews are written with a view to identifying and quantifying the workforce required to meet these challenges and help drive the transformation agenda forward.

The AHP Workforce reviews will help to address one of the immediate priorities set out in the “New Decade New Approach” document published at the time of the establishment of the new NI Executive. The commitment being that the Executive will transform HSC services through reconfiguration of services.

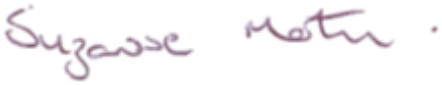
The Covid-19 pandemic challenged us in many ways including the immense pressures placed on our workforce, but there are others pressures challenging us to think and act differently and to consider as to how we currently work and as to how we may work in the future.

In this changing environment, it is even more essential that we have an understanding of our workforce needs, so that we can plan effectively to maintain and develop our services into the future. This was recognised in ***Health and Wellbeing 2026: Delivering Together*** and appears as a key theme in the associated ***Health and Social Care Workforce Strategy 2026: Delivering for Our People.*** Recognising that the HSC is a changing environment and will continue to evolve, this series of workforce reviews are "living documents" which will be reviewed throughout the period of the reviews.

This report and the clear recommendations it contains are the result of a wider Workforce Review Programme covering all thirteen AHPs in Northern Ireland. Since March 2017, Project Groups comprising representatives from across the health and social care service, professional bodies, staff side representatives and the Department of Health have been meeting regularly to consider how these professions / services are likely to develop in the period 2018 – 2028. Their work has been overseen by the AHP Workforce Review Programme Steering Group and applies the ***Regional HSC Workforce Planning Framework's*** six-step methodology.

This process and its resulting workforce review reports are the products of active co-design and co-production, delivering together to ensure the workforce needs of the HSC are met. Project Groups have engaged with their stakeholders including service users and carers, both in formal engagement events and through ongoing involvement with relevant individuals and organisations. Their input has been invaluable in producing this final document and its recommendations. We would like to thank everyone who has contributed to the work of the AHP Workforce Review Programme.

Our vision is that to Northern Ireland has an AHP workforce that has the capacity and capability to deliver the best possible care for patients and clients and has the leadership skills and opportunities to lead and transform services to improve population health. This Review Report and its recommendations set us on course to do just that for this profession.



Suzanne Martin
Chief AHP Officer
Department of Health

Philip Rodgers
Director of Workforce Policy
Department of Health

Executive Summary

The Occupational Therapy Workforce Review has been initiated, guided and endorsed by the Department of Health (DoH) and completed by the Occupational Therapy Heads of Service from each of the five Health and Social Care Trusts in collaboration with the Public Health Agency (PHA).

The aim of the Review is twofold, firstly ensuring that adequate numbers of Occupational Therapists are trained at undergraduate level to meet the anticipated demands for the profession over the next 5-10 years. Secondly, assuring that the workforce is suitably equipped to meet the changing demographic needs and demands of the population.

A range of methods were employed over the period of the review including gathering and analysing statistical data, conducting workshops, surveys, focus groups, interviews and meetings with stakeholders across the Health and Social Care system. This included the independent sector and reviewing relevant policies and strategies to identify proposed service developments or changes over the next number of years.

It is evident that the Occupational Therapy profession faces a number of challenges in terms of having a staffing resource with the capacity and skills to manage the increasing demand across all areas. These areas are clearly highlighted in this review document. In doing so, the profession is mindful of the need to ensure the delivery of safe and effective services that continue to meet the needs of service users.

This report recommends a number of key actions which are required to achieve the identified aims of the review.

1. Introduction

Definition of Occupational Therapy

The Royal College of Occupational Therapists (RCOT, 2019) states that Occupational Therapy services provide practical support to enable people to recover and overcome barriers that prevent them from doing the occupations (activities) that are purposeful and meaningful to them. Occupational Therapists work with people of all ages, who are experiencing difficulties through injury, illness, disability or a major life change in completing activities that are important and that matter to them. Occupational Therapists therefore focus on what matters to the people they work with, agreeing therapy goals that are meaningful to them and that will have a positive impact on their health and wellbeing.

Occupational Therapists analyse a person's strengths, skills and needs in carrying out day-to-day activities and they help service users develop, recover, improve, as well as maintain the skills needed for daily living and working. To achieve this, they deliver interventions through a variety of mediums that include but is not limited to; therapeutic use of activity which is meaningful to the person; altering the environment to enhance the person's ability to function on a daily basis; empowering through self-management of chronic long term conditions.

Occupational Therapists deliver services across a wide range of settings, to address identified needs of service users and their carers. To address these needs and improve occupational performance, Occupational Therapists are required to work in partnership and across HSC, statutory and non-statutory organisational boundaries. They have a significant role in interagency working specifically in relation to education and housing within which Occupational Therapy has statutory responsibilities.

The statutory responsibility to assess, prescribe and provide equipment, specialised seating, wheelchairs and housing adaptation recommendations is devolved to Occupational Therapy services.

Meeting this statutory obligation requires specialist expertise, sustainable funding, therapeutic resources and effective partnership working with housing providers.

In 2016 Health and Social Care Occupational Therapy services developed regionally agreed care pathways for their services. This sought to ensure greater regional equity and transparency, clarity of processes, caseload management and sharing of good practice. The care pathways relate to Occupational Therapy provision within Adult Community, Adult Learning Disability and Children and Young People's Services. These pathways reflect current evidence based practice, with models of service delivery designed to meet the increasingly complex needs of those who use our services in an equitable way.

Strategic Context

The direction of travel for transformational change within HSC has been clearly set through the publications of 'Health and Wellbeing 2026 – Delivering Together' (DOH, 2016) and 'Systems not Structures: Changing Health and Social Care – Expert Panel Report' (DOH, 2016) which aims to:

- Shape HSC to ensure services can meet the predicted demographic needs and challenges facing the region over the next decade and beyond;

- Stress the importance of investing in our workforce, providing opportunities to develop their skills and find suitable career paths at all levels;

- Put people at the forefront of services, to enable them to stay well for longer, with any specialist interventions required being delivered to a high standard in a safe and timely manner.

By embedding the 'Delivering Together' Strategy into all stages of this review, there is an assurance that the findings and recommendations will be in keeping with the strategic direction for the future model of HSC in NI and the role Occupational Therapy will play in achieving this, particularly within the transformation implementation priorities outlined in *Diagram 1*:

Diagram 1 –Transformation Implementation Group Priorities

In addition, there are specific, strategic, legislative and policy contexts which have an impact on the future Occupational Therapy workforce demand. This will need considered as part of this review and is outlined in diagram 2;

Diagram 2 Strategic drivers impacting on the delivery of Occupational Therapy within NI over the next 10 years.

Workforce Plan Methodology

The review followed the sequenced six-step methodology outlined within the Regional HSC Workforce Planning Framework (DHSSPS, 2015) as denoted in *Diagram 3* with completion agreed by March 2018. (For details of Terms of Reference see Appendix 1)

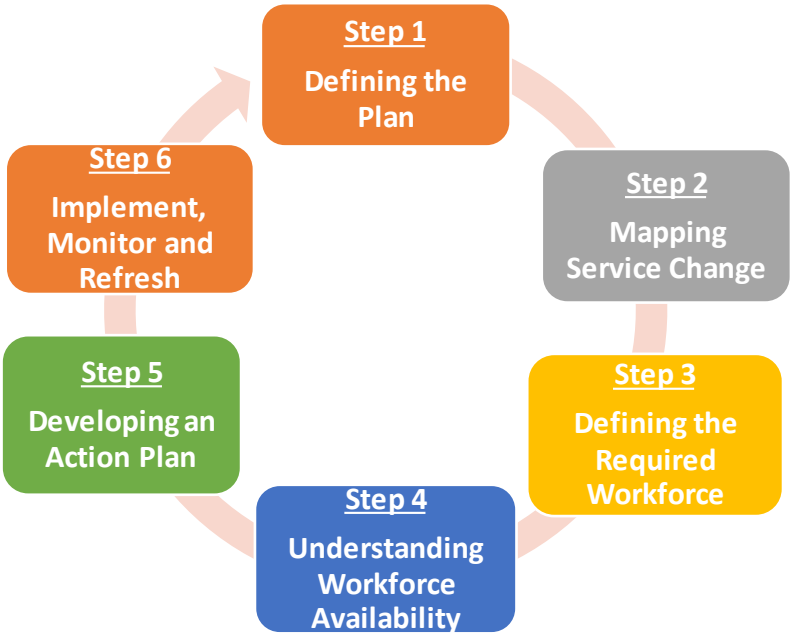


Diagram 3 – Regional HSC Workforce Planning Framework

Assumptions and Constraints

Due to the challenging nature of completing a workforce review, it was important to consider any possible assumptions, constraints and/or risks early in the process. This was particularly important due to the wide and varied nature of Occupational Therapy services. Occupational Therapy is a profession that not only works within HSC but has developed partnerships working with other statutory and non-statutory agencies. A number of assumptions and constraints were identified and measures were taken to help manage these and reduce their implications throughout the process of the review as outlined in Table 1.

Assumptions/ Constraint	Description	Measures Taken
Engagement	Active involvement of key stakeholders is critical at every stage of the review.	A Stakeholder Engagement event was held. To inform key stakeholders, gain opinion and support.
Availability and Access to Relevant Data	Occupational Therapy staff work across a range of settings and deliver a diverse range of service models.	All available information was accessed and utilised in carrying out the review and a process was set to ensure professional sign off and authorisation of the information used.
Impact of Interdepartmental Developments	Occupational Therapy practice and services are developing into other statutory and non-statutory agencies and impact on these may not have been fully realised.	A widespread scoping exercise was completed to assist in determining future models and workforce needs with involvement from the RCOT.
Future HSC and Political Structures	NI was experiencing system change and uncertainty, particularly within the political and healthcare arenas, with associated financial uncertainty.	The sub-group based their analysis on key strategic frameworks e.g. the Bengoa Report and 'Delivering Together 2026.

Table 1 – Assumption and Constraints Summary

2. Defining the Plan

Workforce Review Aims and Objectives

The purpose of the Occupational Therapy workforce review was to work with service users, colleagues and stakeholders, to ensure services across NI are both sustainable and delivered to an appropriate standard, as outlined within the Terms of Reference (see Appendix 1), which are summarized below:

- Review of structures and skills, to recalibrate the Occupational Therapy workforce to assist with HSC wide transformation;
- Responsibility for the commissioning of an adequate number of pre-registration training places to ensure viable recruitment pool;
- Sufficient support for fully funded post-registration training over a three-year period to ensure skills and experience are advanced;
- Development of a shared understanding of the core elements of effective workforce planning to positively influence staffing levels and knowledge & skills assets to ensure services are fit for purpose, meet future health and social care demands and responsive to patient / service user needs;
- Clarity of roles and responsibilities, processes, structures and governance to ensure a fuller understanding of how organisations, partners in care and individuals can contribute effectively in a mixed economy;
- Audit, research and benchmarking locally, regionally and nationally are key methods of assessing user engagement and informing service development and innovation. User satisfaction questionnaires, user forums, patient/carer stories are all methods whereby service users and Occupational Therapists gain understanding, learn and share ideas with regard to future planning for effective change and co-production.

The range of challenges faced by the HSC system has reinforced the need to ensure that the Occupational Therapy workforce is balanced correctly in terms of numbers and skills. This will ensure that an adaptive Occupational Therapy workforce is adequately supported and resourced to proactively respond to changing and increasing demands and that services are developed in accordance with the strategic direction of ‘Delivering Together 2026’.

Ownership

From the outset it was agreed that a co-produced/co-designed approach was essential to ensure any outcomes prove to be meaningful. Relevant professional and workforce leads were identified as nominated members of the AHP Workforce Review Programme Steering Group and the Regional Occupational Therapy sub-group. This included nominations from relevant organisations such as DoH, Occupational Therapy representation from each of the HSC Trusts, PHA, Union representation, RCOT, and service user involvement in line with requirements of the Public and Personal Involvement (PPI) legislative frameworks (PHA, 2012). It was agreed that the review would be reported to the DoH on a monthly basis.

3. Mapping Service Change

Population Demographics

In 2017, mid-year statistics estimate the population of NI to be 1.874 million and the population projections anticipate a rise of 4.68% to 1.961m by 2027 (NISRA, 2017).

The highest proportion of the population is aged between 40-64 years (31.9%), followed by those aged between 16-39 years (31.1%). It is predicted that the over 65 population will rise by 28% between 2017 and 2027, representing 19.9% of the overall population. This will have an impact on service demands and pressures across the health and care system as when people grow older, the likelihood of illness, long-term conditions and disability is anticipated to also increase (Age UK and University of Exeter, 2015). For more detailed population statistics see Appendix 2.

Financial Challenges

HSC are experiencing significant financial challenges which will require creativity and innovation to ensure that the impact upon the delivery of Occupational Therapy services is minimised. These financial challenges, along with the strategic drivers within HSC have reinforced the need for services to be delivered with prevention at their core. Occupational Therapy services must therefore focus on embedding health promotion and public health into their service delivery models which are used by the population of NI.

It is within this context that Occupational Therapy must further enhance partnership working with those who use our services to include, co-delivery and co-production approaches, cross agency working and partnerships with other statutory and non-statutory services.

4. Defining the Required Workforce

Professional Qualification and Regulation

Occupational Therapy is a science degree-based, health and social care profession which is regulated by the Health and Care Professions Council (HCPC). HCPC is an independent regulatory body responsible for setting and maintaining standards of professional proficiency including professional training, performance and conduct of the health professions it regulates. In order to practice within the United Kingdom, Occupational Therapists must be registered with HCPC. Only those Occupational Therapists with a professional qualification from a training organisation recognised by HCPC can register with the regulatory body and can lawfully use the 'Occupational Therapist' protected title within the United Kingdom.

Supervision

In line with effective governance, regulatory, corporate and professional accountability, arrangements are required to ensure the delivery of safe and effective care. Occupational Therapy must have access to regular supervision as outlined within the 'Regional Supervision Policy for AHPs – Working for a Healthier People (2014)'. Supervision is an essential component in the delivery of high quality, safe and effective services ensuring that they meet the needs of the population. The importance of supervision has been highlighted in a number of reviews and is particularly referenced in the Mid-Staffordshire NHS Foundation Trust Public Enquiry in 2013.

Occupational Therapy has well established governance structures to support supervision and continued professional development. This supports the delivery of statutory functions and assists in enhancing quality of service delivery across the profession.

Factors Impacting on Workforce Projections

HSC Reform Initiatives Impacting on the Occupational Therapy Workforce

The DoH 'Delivering Together 2026' Strategy outlines the changes required across the HSC and interagency sectors to ensure people are supported to lead long,

healthy, and active lives. To achieve the required transformation 'Delivering Together 2026' recommends developments in 4 main areas which will have the following implications on the required demand and skillset of the Occupational Therapy profession in the next 10 years.

BUILD CAPACITY IN COMMUNITIES AND IN PREVENTION

to reduce inequalities and ensure the next generation is healthy and well

Strong evidence supports the key role Occupational Therapy has in ensuring every child and young person has the best start in life while also supporting adults to live healthy and well. Occupational Therapy deliver this through their work in the following areas:

- Enhanced Occupational Therapy support in **Neonatology** to support premature babies developmental care, aid parent/infant relationships and facilitate safe and timely hospital discharge. This early support helps reduce long term support on services.
- The emerging role of Occupational Therapy within **Sure Start** Programmes allows therapists to support children and families from socially deprived areas to address social, emotional and developmental needs at the earliest possible stage and within their local community.
- Support **Infant and Perinatal Mental Health** pathways in doing so helping families to fulfil their parenting role, support emotional development, reduce social isolation and promote social engagement enhancing their overall health and well-being**.**
- Assisting in identifying and supporting children with **Special Educational Needs,** facilitating their access to the curriculum, achieve and contribute positively to society**.**
- Recognising and supporting children with **safeguarding needs** particularly to enhance areas currently being focused on e.g. Neglect and children with disabilities.
- Providing assessment and intervention for children with **Emotional Health and Well-being needs.**

- Supporting people with **mental and physical health conditions** to access, maintain and develop occupational roles and activities in education/training, employment, leisure and in the community setting.
- Promote the **health and well-being** of people and the wider community to increase self-esteem, reduce self-harming behaviours, promote resilience and to assist in suicide prevention.
- In delivering **preventative public health**, self-management and preventative approaches to the population, turning the curve on reactive services.

In WHSCT an Occupational Therapy Home Care Treatment team provided motivational and educational* groups to promote daily structure and routine for people with *mental ill-health to help them stay healthy and well. 100% of the people had improved outcomes and felt fully supported to explore options appropriate to their needs.

(RCOT 2016)

PROVIDE MORE SUPPORT IN PRIMARY CARE

to enable more preventive and proactive care, earlier detection and treatment of physical and mental health problems

Occupational Therapy models of service delivery within the Primary Care setting have a proven track record of managing and supporting patients with mental illness, co-morbid needs and complexities of the ageing population:

- Emerging role of Occupational Therapy within **Multi-disciplinary Teams in Primary Care** to promote enhanced health and well-being, self-management and proactively address mental ill-health.
- **Frailty and Falls Prevention** for the older person and those with physical disabilities to ensure the delivery of a holistic approach in falls prevention and recovery. Supporting independence within the home, reducing reliance upon care packages.

Since 2017, two Occupational Therapists have been working as part of multidisciplinary teams in two GP practices in NHS Lanarkshire, Scotland. Evaluation of 288 patients referred over a 14-month period measured key performance indicators. Patients were referred with mental health (97/34%) or physical health (70/24%) conditions or both (121/42%.). Qualitative evaluation (Sinclair A, 2019) shows that the impact of this has been:

1. ***reduction in need for referrals to secondary services;***
2. ***reduction in need for home care;***
3. ***reduced reliance on medication;***
4. ***reduced falls risks in older adults;***
5. ***reduced sickness absences and reliance on sickness benefits;***
6. ***reduced health inequalities; and***
7. ***improved carer wellbeing.***

55% of patients had fewer GP appointments after Occupational Therapy intervention than before.

REFORM OUR COMMUNITY AND HOSPITAL SERVICES

so that they are organised to provide care when and where it is needed

Reform of Occupational Therapy models within the acute setting has significantly improved patient flow and admission avoidance, however these models are in their infancy and need to be further developed:

- **Patient Flow:** by developing a **7 day working model** of service delivery, Occupational Therapy has enhanced patient outcomes and facilitated weekend discharges across the acute setting.
- Occupational Therapists are key in embedding **admission avoidance** into the acute care pathway through partnership working with Northern Ireland Ambulance Service (NIAS). This allows people to be kept at home safely following a fall.
- Occupational Therapists as part of the **Emergency Department team**. This allows patients' level of independence to be assessed at the earliest stage of the acute process, informing the team as to what may be required to facilitate discharge**.**
- **Supporting Successful Discharge:** Occupational Therapy Teams based in community settings including Reablement, Rehabilitation and Home Environmental assessments are essential for successful discharge. This becomes even more pertinent with the roll out of **Early Supported Discharge, Discharge to Assess** and **Enhanced Care at Home** models of care. Occupational Therapists involvement at this point ensures that the patient is maintained safely and as independently as possible within their own home.
- Development of the **Trauma Network** will require Occupational Therapists to have a key role throughout the patient's journey; this may include promoting independence and reducing long term impact at the early stages to delivering rehabilitation in local hospitals and within the patient's home.

The Safe Home – Occupational Therapists within NHS Lothian A&E prevented 100 admissions per month with an estimated saving of £864,000 per annum.

(RCOT 2016)

ORGANISE OURSELVES TO DELIVER BETTER

by ensuring that the administrative and management structures make it easier for staff to look after the public, patients and clients

Occupational Therapy has a strong tradition of working across traditional boundaries and developing effective partnership working approaches across the HSC system, other statutory and non-statutory agencies e.g. Education, Housing, Justice, Macmillan and other Community and Voluntary services:

- Involvement in **Integrated Care Partnerships (ICP), Elective Care Pathways** and enhanced specialty plans e.g. Trauma and Orthopaedics, Musculoskeletal, Rheumatology, Pain management to proactively address secondary care pressures.
- Assessment and provision of **Electronic Assistive Technology** and interface arrangements in relation to housing, employment and education.
- Meeting requirements as **Assessors of the Mental Capacity Act** to complete formal assessments of capacity to provide additional safeguard for more serious interventions under the **Mental Capacity Act (NI) 2016.**
- **Meeting recommendations of the recent Stroke Review** to provide timely access to the very latest treatments and care across the whole spectrum of stroke services to give patients the best possible chance wherever they are in Northern Ireland.
- Implementation of **Electronic Caseload Analysis and Activity Tool (ECATs)** across Children and Young People's and Community Adult Occupational Therapy Services. This will better quantify the growing complexity and demands upon these services, facilitating and achieving consistency and standardisation across clinical caseloads.
- Further development of **Therapy Led Clinics** to maximize extended scope roles, e.g. Neuro–Spasticity, Hand Therapy, reducing demand upon

Consultant and Medical staff, effectively managing secondary care pressures.

- **Prison Healthcare –** Supporting and enabling people to have pro-social daily routines, roles and habits as well as meeting their physical and environmental needs.
- Occupational Therapy support within **Diagnostic and Intervention Services** e.g. ASD, ADHD, Dementia and Learning Difficulties, helping to provide timely and differential diagnosis.
- **Enhanced Leadership development** and succession building programmes to ensure the Occupational Therapy workforce embeds collective leadership at all levels and delivers high quality outcomes based care.

Cwm Taf Intermediate Care and Rehabilitation and Older People Mental Health Team Memory Pilot resulted in a reduction of 13.4 days in hospital beds per person with a potential annual saving for the Health Board of £152,556 alongside a reduction of 181 local authority home care hours at a potential saving of £1,895.07 (per week) or £98,543.64 (per year).

(RCOT 2016)

The RCOT has been running a campaign since 2016 entitled 'Occupational Therapy: Improving Lives Saving Money'. The reports associated with this campaign outline the areas of health and social care that are under most pressure and evidence the cost effective and positive impact of occupational therapy.

The RCOT has been proactive in highlighting at a national and local level how the skills and competencies of occupational therapists and services are critical to transformation across a wide range of areas, such as enabling more people to either avoid admission to hospital or return swiftly home. The campaign demonstrates why Occupational Therapy is vital to the health and wellbeing of today's citizens and future

generations. By promoting best practice examples and their key elements, it is anticipated that the most effective use of occupational therapy expertise can be replicated.

Advanced AHP Practice and RCOT Career Development Framework

In order to deliver on the DoH, 10 year health and social care strategy Delivering Together 2016, the Occupational Therapy workforce will be able to meet the current and future service needs to the population through the application of the Advanced AHP Practice (2019) and RCOT Career Development Frameworks (2017). In addition, work has been developed and led by the DoH in supporting a strong, collective leadership base across all AHPs in NI including Occupational Therapy.

To ensure success, this will require access to a range of accredited post graduate training opportunities. Both frameworks provide Occupational Therapy with a blueprint, from which roles in professional practice, facilitation of learning, leadership, evidence, research and development can be clearly embedded, resulting in high quality evidence based occupational therapy practice.

The Advanced AHP Practice Framework (2019) will also support robust succession planning within the workforce **(Recommendations 5 and 6).**

5. Stakeholder Engagement

Stakeholder engagement is essential in any review to help ensure services delivered meet service-user needs and demands. As part of the Occupational Therapy service delivery, Personal and Public Involvement (PPI) is embedded across practice within local and regional service models. Information gathered from this work through service-user involvement, focus groups and PPI forums has been reflected within this report and has helped shape the recommendations.

In addition, as a specific aspect of this review, a stakeholder engagement event was held on the 24th November 2017 to consider stakeholder views for Occupational Therapy. This critical input from service users and stakeholders has helped to focus the review on the experiences and perspectives of our service users, ensuring that any findings are firmly based on a co-produced approach. For more details on the stakeholders' contributions see *Appendix 4*, however ***Table 3*** summarises the general themes which were forthcoming in response to the three questions posed.

Question	Respondent Themes		
What needs to be done to attract the right people with the right skills into these professions?	Develop Champions	Create more variety in pathways for students and new graduates, e.g. apprenticeships, rotations	Create opportunities to diversify the workforce
What needs to be done to make the HSC a brand that people aspire to work for?	Need a clear clinical/career pathway into Advanced Consultants and managerial roles	Better work/life balance and flexible working	Allow staff to be innovative
Are there any gaps in the workforce planning process that you would wish to have addressed?	Appropriate backfill for maternity leave and long term sick leave	Structured timely succession planning for older workers including retirement planning	Need a flexible consistent regional Occupational Therapy workforce, e.g. peripatetic and

			rotational posts in all Trust areas

Table 2: Summary of common themes feedback from stakeholder engagement

6. Understanding Workforce Availability

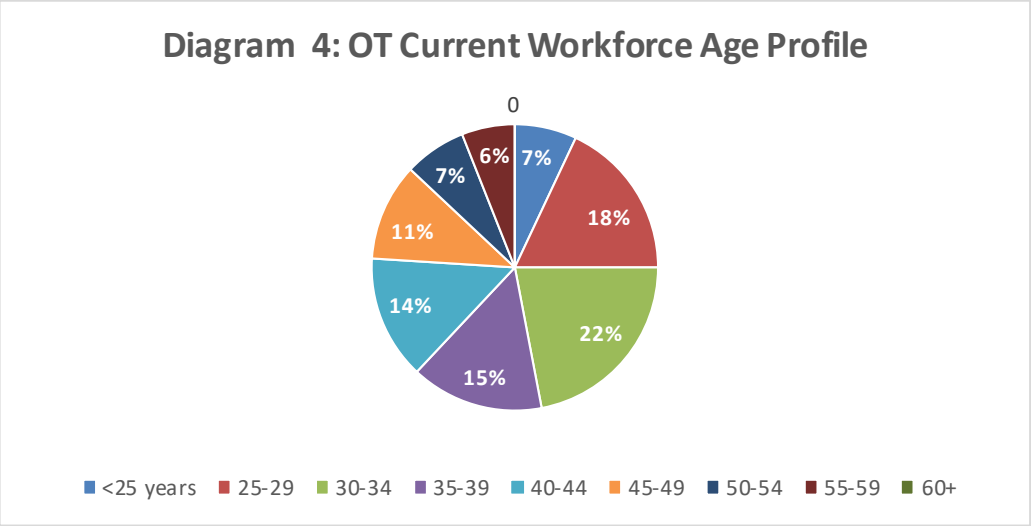
An analysis on the Occupational Therapy workforce needs for HSC NI was completed and took account of factors relating to supply, demand and need.

The following supply factors have been considered in determining the future Occupational Therapy workforce availability:

Existing Workforce Profile

Workforce profile as of the end of March 2017 is depicted in *Table 1.* This indicates 1,082 headcount Occupational Therapists (963.2WTE) currently working in the HSC system in NI. An analysis of the workforce profile shows that;

- 23% of the current AHP workforce in HSC NI is Occupational Therapy.
- 97% of the Occupational Therapy workforce is female
- 32% of the total Occupational Therapy workforce is currently female part-time staff.
- The Occupational Therapy workforce is predominantly a young female workforce with 62% of the workforce aged <40 years old
- >13% of the overall workforce being aged 50 years or over (see more detail in table 1 and diagram 6.
- In the 2016 financial year, the percentage of hours lost due to sickness absence/ industrial injury in Occupational Therapy was 4.7%.



In March 2017, 7% of Occupational Therapists were absent from work due to maternity/adoption/paternity/share parental leave compared to the overall percentage of HSC staff of 3%.

Workforce Profile - Impact of Retirement

There are 64 staff aged between 55-59 and 4 staff aged 60+. It is therefore projected that over the next 10 years, there will be an average of 7 retirements per year. This excludes early retirements due to Mental Health Officer Status, retirements due to ill-health, as a result of Voluntary Exit Schemes or those choosing to retire before the statutory retirement age. Therefore, it is projected that there will be an annual average of **10 retirements per year**

Occupational Therapist Headcount Profile across HSC in NI at 31/3/17									
	<25yrs	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+yrs
Head-Count	76 7%	191 18%	237 22%	167 15%	152 14%	117 11%	74 7%	64 6%	4 <1%

Table 3: Age range of Occupational Therapy Workforce in HSC NI as at 31/3/17. Source:-HRPTS Portal

Diversity of Existing Workforce

As outlined above, the Occupational Therapy Workforce is relatively homogeneous, particularly in respect of genders. Anecdotally, this would be true also in respect of ethnic and racial diversity.

Developing a diverse and inclusive workforce is imperative as not only can it help to develop new ways of working and thinking, leading to improvement and innovation but it better reflects the experiences, needs and values of the increasingly diverse population of Northern Ireland. There is a responsibility therefore, for HSC as an employer to consider how this workforce can be developed to reflect this diversity (DOH, 2018). **(Recommendation 3 and 4)**

Undergraduate Training Pipeline

The DOH commissions 50 undergraduate Occupational Therapy training places per year from Ulster University, which is the local Higher Education provider in Northern Ireland. This undergraduate training is a 3 year BSc (Hons) Degree in Occupational Therapy.

From 2010, there has been an overall decrease of 16.6% (n=10) in undergraduate Occupational Therapy commissioned training places in Northern Ireland, from 60 places in 2010 to 50 places in 2016. This is the 3rd year of the reduced numbers of commissioned training places and the impact of this is reflected in the available workforce for recruitment by HSC NI Trusts to Band 5 posts.

The demand for these 50 training places remains very high, as evidenced by the number of applications per year since 2010, which has averaged at 488 per year.
The attrition rate from the programme is approximately 10% and this is based on the number of commissioned places versus number of graduates from the cohort each year since 2010. Therefore, the available undergraduate outturn is 45 graduates each year becoming available to the NI labour market. This is based on the overall number of commissioned places remaining the same i.e. 50.

The available undergraduate outturn of 45 does not exclude the number of graduates who:

- Immediately commence post-graduate training and therefore do not enter the labour market; or
- Uptake posts outside of the HSCNI, e.g. it is estimated that an average of 2 graduates per year uptake posts with Capita Department for Communities; or
- Those who leave NI to travel.

This outturn figure does not include students from NI or elsewhere who graduate from other UK universities and are seeking to return to work and live in NI.

The National Institute of Economic and Social Research (Dolton et al, 2018) recommended that devolved governments must urgently review their workforce planning approaches across the Health and Social Care (H&SC) sector. Planning needs to recognise that public, private and third sectors form a common system and common labour market. It also needs to recognise that supply has to be sufficient to meet the whole system need and not focus solely on NHS employers.

BSc Hons Occupational Therapy 4463	Total Applications	Commissioned Places	Intake	Graduates from Cohort
2010	546	60	60	60
2011	581	54	56	50
2012	560	54	55	46
2013	465	54	60	57
2014	442	54	54	48
2015	460	54	56	TBC
2016	452	50	61	To graduate 2019
2017	411	50	51	To graduate 2020

Table 4 University of Ulster Undergraduate Output

Post-Graduate Profile

HSC Occupational Therapy recruiting managers report that the majority of entry level Occupational Therapist to HSC are Ulster University graduates with only a small number graduating from England, Scotland, Wales and ROI.

Regional Band 5 Recruitment Process and Waiting List

The recruitment of Band 5 Occupational Therapists is designed to be an annual regional HSC exercise. However, within an 8 month period during 2018/19, this recruitment took place 3 times. This process creates a regional waiting list for the recruitment of Band 5 posts, accessed by the 5 HSC Trusts in NI.

A survey in 2018, of those on the regional Band 5 waiting list provided an insight into the employment status of respondents at that time. The results of the survey were as follows:

- 40% (n=16) are currently employed as an Occupational Therapist on a permanent contact
- 32.5% (n=13) are currently employed as an Occupational Therapist on a temporary contact
- 20% (n=8) are currently employed as an Occupational Therapist as a locum/agency
- 2.5% (n=1) are currently employed as an Occupational Therapist in NI outside HSC.

Therefore, 92.5% (n=37) of respondents on the 2018 regional Band 5 waiting list were already employed as an Occupational Therapist in the HSC. The actual available Band 5 workforce to the HSC was therefore circa 7.5% of the regional Band 5 waiting list. This would equate to **8** applicants not already employed within the HSC of the 101 applicants on the regional Band 5 waiting list at March 2018.

Also, of note in this survey was that 25% of respondents had been offered a permanent post, however had declined this and chosen to remain on the waiting list. It is expected that these applicants declined the offer as they were already in employment as an Occupational Therapist and/or the post offered did not meet their preferences or needs.

The top three reasons indicated by applicants applying to be placed on the Regional Band 5 Occupational Therapy Waiting list were to obtain a permanent post, move geographical location or move to a different clinical speciality.

On the basis of this survey, caution must be taken if using the total number of band 5 candidates on the regional waiting list as an indicator of workforce availability.

In March 2019, the band 5 waiting list had been exhausted, i.e. while candidates remained on the waiting list, no offers for vacant posts were being accepted by these candidates. This resulted in a total of 38 band 5 HSC NI posts remaining unfilled until a subsequent recruitment event.

Consideration needs to be given to the future approach in the recruitment of band 5 therapists regionally, to ensure a system that will better meet service requirements and applicant choices and needs**. (Recommendation 1, 2, 3 and 4)**

With development and adoption of peripatetic workforce models within Trusts, early indications are that these types of flexible workforce models allow for a broader choice of experience in clinical practice areas and potentially choice of geographical areas, as well as assisting in filling posts in a timely manner. **(Recommendation 8)**

External Challenges to the Occupational Therapy Profession

The National Institute of Economic and Social Research in its paper, Brexit and the Health and Social Care Workforce in the UK (Dolton et al, 2018) examines recent trends in the UK's H&SC workforce and the critical role of European Economic Area nationals within it. It states that while many of the problems supplying new recruits into the sector pre-date the 2016 Brexit referendum, the vote to leave the European Union (EU) has added another layer of challenge and uncertainty for planning this future workforce. One of the key findings of this report is that a little over 5% of allied health professionals' workforce is from inside the European Economic Area (EEA). Not only are they a sizeable component of the workforce, the patterns of their numbers and their composition by occupation and geography has changed rapidly since the 2016 Brexit referendum.

This is a vital issue because the ongoing uncertainty will undoubtedly impact on this workforce's decision whether or not to stay with significant implications for the sector. It can also impact the decision of EEA nationals to move to the UK in the future.
By examining the pattern of leavers and joiners to the NHS over the year prior to June 2016 and the year post June 2016, the authors were able to estimate what might happen to the overall numbers of doctors and nurses going forward. Their model suggests that in the short run and over the period of Brexit transition, the UK will have a shortage, in addition to current vacancies, in their nursing workforce. A similar impact could be expected with the AHP workforce.

Furthermore, the Migration Advisory Committee's Full Review of the Shortage of Occupation List (SOL) (2019) has recommended that the entire Occupational Therapy profession is included in the SOL, with the profession ranking 19th in the shortage indicators with an above average vacancy rate (despite a fall in recent years).

7. Workforce Review Analysis and Findings

When considering the demand factors in determining the future Occupational Therapy workforce availability, a retrospective analysis was completed.

Retrospective Analysis of Occupational Therapy Workforce over a 10 year Period

Based on figures at 30 September in 2007 and 2017, there has been a 49% increase in the Occupational Therapy workforce in the past 10 years. These figures are based on data extracted from the HRMS and HRPTS systems and excludes bank staff and staff on career breaks. See below:

OTs in Post at	30 September 2007	30 September 2017	Increase 0ver 10 years	Average Annual Increase
Headcount	741	1,107	+366	37
WTE	659.49	979.88	+320.39	32

Table 5: Source: 2007 data - Human Resources Management Systems (HRMS); 2017 data - Human Resources, Payroll, Travel & Subsistence systems (HRPTS) Excludes bank staff and staff on career breaks.

Based on this rate of growth, (which excludes the recent transformational agenda) an annual increase of 32 wte Occupational Therapy posts would be required over the next 10 years. **(Recommendation 1)**

Projected Analysis of New Demands upon Occupational Therapy Workforce 2017-2027

Stabilising the Workforce

This review recognises that, in order to continue to deliver and develop services, there is an immediate need to stabilise the existing workforce. This is set in the context of the workforce profile outlined above (Pages 22-23). The challenges these dynamics bring is that managers have been unable to recruit to the required volume of temporary vacancies, as a means of backfilling permanent Occupational Therapy posts. These

are posts that require temporary cover or backfill in a timely manner (maternity leave, sick leave, paternity leave, career breaks, promotions and leavers etc). In addition, if recruitment was successful, there can be a three - four month interval before a new member of staff commences in post.

One potential solution is the development of a Peripatetic Workforce Model. Within this model, managers proactively appoint staff on a permanent basis. These staff are employed to provide cover within the service areas when and where the absences outlined above occur (supernumerary). There are models already developed in some Trusts, e.g. flexible recruitment/peripatetic models, which are demonstrating positive benefits which could be rolled out on a regional basis to ensure equity in services regionally.

Within the SHSCT, a Peripatetic Workforce Model has been developed in response to these challenges.

This workforce model aims to achieve a number of objectives including:

1. More stability for services to deliver safe, high quality care services;
2. Continuity for services for patients and their carers/families;
3. Achievement of the current staffing funding envelope;
4. Reduce/eliminate use of bank/agency staff;
5. Valuing our staff – provides security, feelings of worth, value and loyalty;
6. Relieve pressures to fill staff gaps; and
7. Support development of staff/ competencies and confidence.

A workforce analysis of funded staffing gaps over a three year period, found that 14% of the total WTE registered Occupational Therapy workforce (excluding bands 8a and 8b) was required to establish a peripatetic pool, similar to that established within SHSCT, to address the predicted funded workforce gaps.

The BHSCT also developed a similar workforce model which resulted in a requirement of 13% of the total WTE registered Occupational Therapy workforce.

If all five Trusts were to adopt this workforce model in order to backfill temporary vacancies arising in permanent positions, then this would equate to a requirement of

approximately **70.66 WTE** permanent new registrant Occupational Therapists in HSC NI.

950.02	WTE current staff in post in HSC
- 37.9	Combined 8a and 8b wte
902.12	Clinically Available Workforce

14% of 902.12 =119.46 wte required for a full HSC Peripatetic Workforce.

Currently 3 of the 5 Trusts employ 48.8 wte within a peripatetic model

119.46	WTE required as a full Peripatetic Model
- 48.8	Existing Peripatetic Model
70.6	Existing Shortfall to Regionalise a

Projected Areas of Service Growth

This report outlines many projected areas of service growth detailed in pages 15 to 20 that remain at this point unquantifiable in relation to workforce demands and required skill set. For the most, this is due to models of practice being within their infancy or dependent upon rapid advances in technology.

For this reason, the opportunity to appraise the progress of and requirements for these service areas is suggested before completion of the first of the proposed three consecutive actions plans (2018-2020) outlined in the Health and Social Care Workforce Strategy 2026.

Summary of Supply and Demand Projection for Occupational Therapy Workforce on Northern Ireland

Row identifier	Description of Supply/Demand	Year 1	Total Commissioned Places Yr 1 Available for HSC	Subsequent Years	Total Commissioned Places Yr 2 + Available for HSC
a)	Current UU commissioned places	50	50	50	50
b)	UU graduate out-turn available to labour market after attrition (10%) Page 24	45	45	45	45
c)	Estimated uptake to posts other than HSC e.g. Capita DfC Page 24	2	43	2	43
d)	Average new posts required for service developments per year in HSC Page 28	32	11	32	11
e)	Average annual retirements from HSC last 5 years Page 23	10	1	10	1
f)	Baseline peripatetic/ flexible workforce pool Page 29	14	-13	14	-13
g)	Increase in peripatetic/flexible workforce pool Year 1 would require an initial uplift of 20 reducing to 4 annually Page 29	20	-33	4	-17

h)	Projected shortfall	33	33	17	17
i)	Total commissioned under-graduate places required.	83	83	67	67

Table 6:- **Summary of New Graduate Headcount Demand Projection for Occupational Therapy**

Undergraduate Comparative Analysis

Consideration was given to the neighbouring demographics of Scotland, England and Wales, see table below:

Country	Population	Training courses (WFOT)
England	66.1 million	64
Scotland	5.3 million	7
Wales	3.1 million	2
NI	1.9 million	1

Table 7: comparative analysis of countries of the United Kingdom

Due to its similar population size and geo-demographic profile, Wales was selected for comparative analysis.

In Wales there are 115 commissioned places for Undergraduate Occupational Therapy training each year. Wales' population is 3.1 million (2017). This equates to one new graduate per 26,956 population.

In NI the population is 1,903,663 with an average of 50 new graduates annually equating to one new graduate per 38,073.

	Population	No. of Commissioned Places	New Graduate to population ratio	Equivalence shortfall in commissioned places for NI
Wales	3.1 million	115	1 : 26,956	
N.I.	1.9 million	50	1 : 38,000	20

Table 8: Comparative analysis of Commission places Wales/Northern Ireland

To be comparative to Wales, NI would require 70 commissioned places annually. This is based on the assumption that sufficient numbers of Occupational Therapists undergraduate places are commissioned within Wales.

Over a proposed 5 year period commencing 2020, both analysis, i.e. table 6 and 7 suggest an overall requirement of an additional l00 commissioned places for this 5 year period. **This can be achieved by commissioning an additional 20 undergraduate places annually from 2020.**

Option Appraisal

In order to address the identified gap in workforce supply, three options were considered and are outlined in Table 9.

Options	Description	Benefits	Risks
Option 1 **Status Quo.**	Maintain 50 commissioned undergraduate places. Based on providing a 3 year full time programme commissioned via the local Higher Education Provider.	No additional funding required to maintain this option.	The current supply of new graduates has been assessed as being insufficient to meet the needs of the HSC needs of the population of NI for the coming 10 years.
Option 2 **Front Load Commissioned Undergraduate Programme Places**	Year one commission additional 33 places with subsequent 4 years having an uplift of 17 commissioned places	More immediate impact upon the workforce supply, stabilising core services.	Significant financial investment required in year one compared to subsequent years. Challenge for HSC Trusts to provide 33 additional practice education placement opportunities

Option 3 **Averaging an increase over 5 years**	The total required commissioned place over the 5 year period is averaged for this period resulting in an additional 20 commissioned places annually.	Increase of workforce supply to meet identified workforce gap. Financial investment is fixed for 5 years, supporting financial planning.	Significant financial investment. Longer timeframe to stabilise the workforce with first cohort available 2023.

Table 9: Workforce Gap Option Appraisal

Estimated Costings Associated with Preferred Option 3

Option 3, increasing the commissioned places at a steady rate is recommended as the preferred option within this non-financial option appraisal.

This review has demonstrated that developing the Occupational Therapy workforce into the future is essential in order to ensure safe and sustainable service provision. While a full cost impact analysis is not at this point available, an estimated cost analysis in relation to option 3 suggests that the uplift of 20 places would equate to an additional £150,700 per academic year.

8. Conclusion

The timing of this Occupational Therapy Workforce Review aligns itself to one of the most challenging chapters in Health and Social care provision in NI. As has been outlined within this review the shortfall of available, qualified Occupational Therapists within Northern Ireland is increasing, resulting in numerous vacancies across the region. Without additional new entry therapists joining the workforce, the risks to service provision and patient safety is becoming more apparent.

This review has analysed current and predicted population needs and service trends, within the context of significant policy drivers such as Delivering Together 2026. The recommendations outlined are in keeping with these strategic drivers and with the support of the DoH, specifically through the forthcoming AHP Strategy Review, the implementation of the recommendations will ensure the delivery and provision of Occupational Therapy services to the population of NI will be sustainable for the coming 10 years.

This Workforce review was presented to DoH for further consideration and endorsement in line with the original Terms of Reference of the Project Group.

9. Recommendations

Based on the findings of the review there are four key recommendations proposed which are set out below, these have been structured under key headings and will inform the Action Plan.

	RECOMMENDATIONS	
UNDERGRADUATE TRAINING	1	An increase in the Pre-Registration Occupational Therapy places annually from **50** commissioned places to **70** to meet current and future predicted workforce pressures within the HSCNI. It is important to note that the impact of this increase will not be recognised until 2023.
	2	That consideration is given to formalising the commitment for newly qualified Occupational Therapists funded via DoH commissioned places to commence two years post-graduate employment in HSCNI within 12 months of qualifying.
	3	An exploration of alternative access routes to undergraduate Occupational Therapy courses is carried out within the context of an increasingly diverse population in Northern Ireland.
RECRUITMENT & RETENTION	4	Scope alternative models of recruitment that can be applied to Northern Ireland as a region and across banding levels.
	5	Occupational Therapy management, in conjunction with training facilities will focus upon further developing a robust postgraduate accredited training framework catering specifically to the needs of the Occupational Therapy workforce.

POST GRADUATE TRAINING	6	That consideration by DoH is given to ratifying the 3 year ECG training cycle and reviewing the funding to support a robust planning approach to the training and development of the HSCNI Occupational Therapy workforce in line with service needs, the DoH Advanced AHP Practice Framework (2019) and the RCOT 'Career Development Framework: guiding principles for occupational therapy 2017 .
	7	Scope the demands and benefits of developing dedicated roles across the Trusts to support effective management of undergraduate practice education and CPD requirements to include various research and development roles.
WORKFORCE DEVELOPMENT & STABILITY	8	Alternative workforce models are considered and scoped, e.g. peripatetic model, in developing innovative and flexible recruitment models across the Occupational Therapy workforce.
	9	Develop a proactive strategy framework to manage the workforce needs across Occupational Therapy through annual reviews of the progress made within the life of this review, including the opportunity of an appraisal of projections before completion of the first of the proposed three consecutive actions plans (2018-2020) outlined in the Health and Social Care Workforce Strategy 2026.

10. Action Plan

THIS TABLE REFLECTS THE PRIORITIES ABOVE

OCCUPATIONAL THERAPY WORKFORCE REVIEW - ACTION/IMPLEMENTATION PLAN 2018-2028

		ACTIONS	LEAD RESPONSIBILITY	IMPLEMENTATION TARGET DATE
UNDERGRADUATE TRAINING	1. An increase in the Pre-Registration Occupational Therapy places annually from **50** commissioned places to **70** to meet current and future predicted workforce pressures within the HSCNI. It is important to note that the impact of this increase will not be recognised until 2023. 2. That consideration is given to formalising the commitment for newly qualified Occupational Therapists funded via DoH commissioned places to commence two years post-			

	graduate employment in HSCNI within 12 months of qualifying. 3. An exploration of alternative access routes to undergraduate Occupational Therapy courses is carried out within the context of an increasingly diverse population in Northern Ireland.			
RECRUITMENT & RETENTION	4. Scope alternative models of recruitment that can be applied to Northern Ireland as a region and across banding levels. 5. Occupational Therapy management, in conjunction with training facilities will focus upon further developing a robust postgraduate accredited training framework catering specifically to the needs of the Occupational Therapy workforce.			

POST GRADUATE TRAINING	6. That consideration by DoH is given to ratifying the 3 year ECG training cycle and reviewing the funding to support a robust planning approach to the training and development of the HSCNI Occupational Therapy workforce in line with service needs, the DoH Advanced AHP Practice Framework (2019) and the RCOT 'Career Development Framework: guiding principles for occupational therapy 2017 . 7. Scope the demands and benefits of developing dedicated roles across the Trusts to support effective management of undergraduate practice education and CPD requirements to include various research and development roles.	.		

WORKFORCE DEVELOPMENT & STABILITY	8. Alternative workforce models are considered and scoped, e.g. peripatetic model, in developing innovative and flexible recruitment models across the Occupational Therapy workforce. 9. Develop a proactive strategy framework to manage the workforce needs across Occupational Therapy through annual reviews of the progress made within the life of this review, including the opportunity of an appraisal of projections before completion of the first of the proposed three consecutive actions plans (2018-2020) outlined in the Health and Social Care Workforce Strategy 2026.	.		

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12. Appendices

Appendix 1 - Terms of Reference

Department of Health
www.health-ni.gov.uk

ESTABLISHMENT OF
ALLIED HEALTH PROFESSIONS (AHP) WORKFORCE REVIEW
OCCUPATIONAL THERAPY PROJECT GROUP
TERMS OF REFERENCE

The Project Steering Board has been established to undertake a workforce review to support AHP practice within the HSC.

To achieve this uni-professional allied health professions sub groups will be established to undertake individual professional AHP workforce reviews to inform the commissioning process.

These will function within the following terms of reference:

1. Produce a programme plan and agree processes and timescales for delivery of project outputs.

2. Ensure effective communication and engagement with key stakeholders including dissemination of information relevant to the project within each of the participating organisations.

3. Make recommendations on workforce profile to ensure service sustainability.

4. Make recommendations on recruitment processes to ensure service sustainability and maximum capacity to deliver services.

5. Make recommendations on measures, including structures and skills, to align and develop information on the AHP workforce to assist with HSC-wide service transformation.

6. Make recommendations to the Department of Health regarding the commissioning of pre-registration training.

7. Make recommendations regarding post-registration training requirements.

Note:

- The sub groups will aim to complete their work in **12 - 18 months** with meetings at 10 bimonthly intervals.

- Membership of the Sub Group is non-transferrable, however deputies **will be acceptable** and with prior agreement of the Chair or Project Lead.

MEMBERSHIP OF OCCUPATIONAL THERAPY SUB GROUP

5 x Trust professional heads of service

One AHP trust lead

Staff side representative

RCOT representative

DoH WPD representative

DoH AHP Lead Officer - Chair

DoH AHP Deputy Principal

Other professional staff can be co-opted on as required

PHA Consultant AHP – Co-chair

Representative from Information and Analysis Directorate, DOH

Membership of AHP Workforce Programme Steering Group and Occupational Therapy Sub-Group

AHP Workforce Programme Steering Group Members		
Name	**Organisation**	**Email**
Charlotte McArdle	DoH (Chairperson)	
Andrew Dawson (Co-chair)	DoH (NI) – Acting Director, Workforce Policy	
Hazel Winning	DoH (NI) – Nursing, Midwifery and AHP Group	
Erin Montgomery	DoH (NI) – Information and Analysis Directorate	
Catherine Donnelly	DoH (NI) – Workforce Policy Directorate	
Paula Calahan	Belfast HSC Trust	
Raymond Irvine	Western HSC Trust	
Patricia McClure	Ulster University	
Joanne McKissick	Patient and Client Council	
Pauline McMullan	Business Services Organisation	
Margaret Moorehead	South Eastern HSC Trust	
Paul Rafferty	Western HSC Trust	
Claire Smyth	South Eastern HSC Trust	

Jill Bradley	Northern HSC Trust	
Peter Barbour	DoH (NI) – Workforce Policy Directorate	
Carmel Harney	Southern HSC Trust	
Brendan McGrath	Western HSC Trust	
Claire Ronald	Staff Side – Chartered Society of Physiotherapy	
Mary Hinds	Public Health Agency	
Angela McVeigh	Southern HSC Trust	
Nicola Shaw	South Eastern HSC Trust	
Marie Ward	Western HSC Trust – represented by R Irvine	
Gerard Tinney	(Note taker) DoH (NI) – Workforce Policy Directorate	

Occupational Therapy Workforce Sub-Group Members		
Name	**Organisation**	**Email**
Hazel Winning	AHP Lead DoH	
Peter McAuley	DoH	
Catherine Donnelly	DoH Workforce Policy Directorate	
Alison Dunwoody	DoH	
Joanne O'Hagan	DoH	
Shane Elliott	Occupational Therapy HOS NHSCT	
Siobhan Wright	Occupational Therapy HOS BHSCT	
Lorraine Ringland	Occupational Therapy HOS SET	
Brenda Byrne	Occupational Therapy HOS SHSCT	
Helena Doherty	Occupational Therapy HOS WHSCT	
Carmel Harney	AHP Lead SHSCT	
Ruth Watkins	Unison	
Julia Skelton	RCOT	
Geraldine Teague	AHP Consultant PHA	

Appendix 2

Table 1 from the N Ireland Resident Populations by LCG – 2020

Age Band (Yrs)	Belfast	Northern	South Eastern	Southern	Western	NI
0-15	71,626	97,588	73,005	90,415	65,377	**398,011**
16-39	122,399	138,707	101,891	120,966	90,519	**574,482**
40-64	109,851	156,876	118,846	122,324	98,248	**606,145**
65+	56,426	87,710	70,718	59,798	50,373	**325,025**
All ages	**360,302**	**480,881**	**364,460**	**393,503**	**304,517**	**1,903,663**
%	**18.9%**	**25.3%**	**19.1%**	**20.7%**	**16%**	**100%**

Table 2 - N Ireland Resident Populations by Local Commissioning Group - 2027

Age Band (Yrs)	Belfast	Northern	South Eastern	Southern	Western	NI
0-15	71,444	94,325	71,608	92,045	63,124	392,546
16-39	119,079	135,866	101,364	125,295	87,591	569,195
40-64	109,928	155,448	117,888	128,516	97,681	609,461
65+	66,201	104,691	85,183	73,207	60,757	390,039
All ages	**366,652**	**490,330**	**376,043**	**419,063**	**309,153**	**1,961,241**
%	**18.7%**	**25.0%**	**19.2%**	**21.4%**	**15.8%**	**100.0%**

Source: NISRA, Based on 2014 Population Mid-Year Estimates

Appendix 3 – Engagement Summary

The engage discussion focused on four main topics:

Qu. No	Topic	Question
Qu.1	**Recruitment**	What needs to be done to attract the right people with the right skills into these professions?
Qu. 2	**Retention**	What needs to be done to make the HSC a brand that people aspire to work for?
Qu. 3	**Workforce Planning Process**	Are there any gaps in the process that you would wish to have addressed?
Reflection	Having discussed all of this today, what would you now suggest as the top priority for the AHP workforce reviews to deliver?	

The 'Engage' method combines the live aspect of small-scale discussion with information and communication technologies; on one hand it allows rapid transmission of work-group results to a plenary assembly; while on the other it permits surveys of individual participants' opinions through a polling system. Information gathered at the engage event has been reflected in the review. Each of the round table groupings at the event were asked to prioritise their responses in each topic and the top responses captured.

Discussion Outcomes

Question 1 – **Recruitment** – What needs to be done to attract the right people with the right skills into these professions?

Remove artificial barriers preventing people moving between Trusts

Develop champions

Create different pathways for students e.g. apprenticeships, rotational posts, flexible working

Value-based at all entry levels – core to recruitment models

Sponsored undergraduate posts

Create opportunities to diversify the workforce

Raised awareness and understanding of the role of OT Promotion/Marketing

Question 2 - Retention - What needs to be done to make the HSC a brand that people aspire to work for?

Better work/life balance and flexible working

Allow staff to be innovative

Opportunities for CPD/Lifelong learning

Supporting and valuing staff

Need for clear clinical pathways into Advanced, Consultant and Senior Managerial roles

Opportunities for career development and progressions

Improved promotion of positive impacts of HSC interventions

Support health and well-being of staff

Question 3 – Workforce Planning Process - Are there any gaps in the process that you would wish to have addressed?

Training requirements e.g. Discharge to Assess

Appropriate back-fill for maternity leave and long-term sick leave

Multi-disciplinary approach within specialist areas to meet service user needs

Development of Inter-agency posts Housing, Justice, Education etc.

More work with Community and Voluntary agencies

Implement rotational Band 5 posts across all areas

Look at Care Pathways in complex case management

Recruitment of Generic and Networked posts

Shadowing opportunities with senior/specialist and managerial staff

Succession planning and career progression use of normative staffing levels

Structured timely succession planning for older workers including retirement planning

Need a flexible consistent regional OT workforce e.g. peripatetic posts

13. Abbreviations

Attention Deficit Disorder	ADD
Attention Deficit and Hyperactivity Disorder	ADHD
Accident & Emergency	A&E
Autism Spectrum Disorder	ASD
Allied Health Professions	AHPs
British Journal of Occupational Therapy	BJOT
Bachelor of Science	BSc
Chief Executive	CE
Chief Executive Officer	CEO
Child & Adolescent Mental Health Services	CAMHS
Continuous Personal Development	CPD
Children and Young People's Occupational Therapy	CYPOT
Department of Communities	DfC
Department of Health	DoH
Global Positioning System	GPS
Health and Care Professions Council	HCPC
Health & Social Care	HSC
Helicopter Emergency Medical Service	HEMS
Human Resources, Pay & Travel System	HRPTS

Intensive Care Unit	ICU
Local Commissioning Group	LCG
Multi-disciplinary Team	MDT
Musculoskeletal	MSK
Multiple Sclerosis	MS
Major Trauma Centre	MTC
Northern Ireland	NI
Patient Client Council	PCC
Programme of Care	POC
Programme for Government	PFG
Post-Graduate	PG
Paediatric Intensive Care Units	PICU
Public Health Agency	PHA
Royal College of Occupational Therapists	RCOT
Regional Disability Services	RDS
Serious Mental Illness	SMI
Special Education Needs	SEN
Strategic Recruitment Innovation Forum	SRIF
Therapy Led Clinic	TLC
Terms of Reference	ToR
Under-Graduate	UG

United Kingdom	UK
Ulster University	UU
Whole Time Equivalent	WTE

Department of Health
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Social Work Workforce Review

Northern Ireland

2022

Department of Education
Department of Justice
HSC Health and Social Care Board
Northern Ireland Social Care Council

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Executive Summary

Demographic changes, a steady rise in the number of families in need of social work intervention, an aging population, pressures on mental health services for adults and children, and a rise in domestic violence and poverty have all resulted in increased demand for social work services. Transformation initiatives in HSC, new legislation, innovations in service delivery and recent developments in the Justice and Education sectors have added to that demand.

The Covid-19 pandemic has further exacerbated pressures upon the social work workforce with vacancy data collated from, for example, HSC children's services, indicating significant workforce deficits in all of the Trusts.

Reviews are also underway in different HSC programmes of care to consider the best methods of delivery and the most appropriate mix of professions required to deliver more effective services, which will have inevitable consequences for the social work workforce.

For some years, the Department of Health has commissioned 260 places on the Degree in Social Work programmes in NI. In 2021, additional funding was secured to commission an additional 15 places on the Open University (NI) Degree in Social Work course. This newly developed programme is intended to attract and retain staff already working in social care roles in statutory and voluntary sectors organisations. Demand for the Open University training places has been encouraging and there is clearly an appetite among employers and staff for more diverse routes into social work training.

The Social Work Workforce Review has identified the pressing need to commission an increase of 60 student social work places in NI universities, however this is wholly dependent upon significant additional funding becoming available.

The data analysis and projections undertaken as part of the Review provide an evidential basis for the need for additional social workers, however it is also essential for employers to address current recruitment and retention processes to ensure newly qualified staff are adequately supported and enabled to remain in their posts.

A robust process to collate, analyse and report information on the entire social work workforce, using regionally agreed data collection methodology should be established in NI. Having access to comprehensive and accurate data sets will enable social work employers to better forecast future needs and inform regional workforce planning and decision making in the future.

Effective workforce planning is key to ensuring essential social work services are sustainable, and delivered to an appropriate and safe standard. The Department of Health, HSC Workforce Strategy 2026: Delivering for Our People aims to develop and sustainably fund, an optimum workforce model for a reconfigured health and social care system. The Strategy requires that all workforce planning follows the principles of the Regional HSC Workforce Planning Framework.

The Social Work Workforce Review has identified six **Strategic Themes** and seven **Strategic Recommendations** with 53 **Actions** to be undertaken.
The six Strategic Themes set out the key areas which will be critical to ensuring the provision of a social work workforce able to meet future challenges. These are;

- **Supply**
- **Safe Staffing**
- **Workforce Planning**
- **Workforce Business Intelligence**
- **Retention**
- **Workforce Development**

These themes inform the recommendations and the proposed actions, which will be timetabled and scheduled once the report has been approved.

An **Implementation Board,** comprised of senior social work leaders, will be established to provide the strategic leadership required to ensure all of the actions identified in the review are achieved. At the outset, a scoping exercise will be undertaken to capture work which has already been undertaken, to enable shared learning and inform future progress.
The Social Work Workforce Review relates to social work services delivered across all sectors in Northern Ireland, including Health and Social Care, Criminal Justice, Education and the Voluntary, Community and Independent service providers.

Operational workforce planning is a responsibility of employers; either HSC or other statutory organisations, and independent, voluntary or private sector

organisations from whom services are commissioned. This includes ensuring effective service delivery and safe staffing levels, vacancy management and recruitment, skills or 'band' mix, career progression pathways and workforce design to support newly developed models of care within organisations.

The Review report clearly sets out the challenges ahead. It articulates a strategic vision and provides an action plan which is intended to secure sufficient supply, and the effective recruitment and retention of social workers for the future. It is not a detailed account of the many actions which have already been undertaken by social work employers to address their immediate staffing needs.

The delivery of that strategic vision will require determined and decisive leadership at all levels within the social work profession. Leaders will have to work collaboratively and proactively to achieve the changes necessary to secure the confident and competent workforce which will be needed to meet future challenges.

Jackie McIlroy
Director of Social Work Strategy and Social Care Workforce Strategy

Philip Rodgers
Director of Workforce Policy

Abbreviations

Adult learning disability	ALD
Adverse childhood experience	ACE
Allied health professional	AHP
Approved Social Worker	ASW
Assessed Year in Employment	AYE
Business services organisation	BSO
Care Quality Commission	CQC
Child and adolescent mental health	CAMHS
Child Protection Support Services	CPSS
Continuous Assurance of Quality Enhancement	CAQE
Continuous Professional Development	CPD
Core Minimum Data Set	CMDS
Delegated Statutory Functions Report	DSF
Department of Education	DoE
Department of Health	DoH
Department of Justice	DoJ
Deprivation of Liberty Safeguards	DOLS
Designated Adult Protection Officer	DAPO
Education Authority	EA
Education Welfare Officer	EWO
Emergency Department	ED
Further Education Collaborative Management Board	FECMB
General practice/practitioner	GP
Health and Care Professions Council	HCPC
Health and Social Care	HSC
Health and Social Care Board	HSCB
Integrated Care Team	ICT
Investigating Officer	IO
Looked After Children	LAC
Mental Capacity Act	MCA
Mental Health Order	MHO
Multi-Disciplinary Teams	MDT
Northern Ireland Degree in Social Work Partnership	NIDSWP
National Health Service	NHS
Newly Qualified Social Worker	NQSW
Northern Ireland Social Care Council	NISCC
Northern Ireland Statistics and Research Agency	NISRA
Open University	OU
Probation Board for NI	PBNI
Queens University Belfast	QUB
Regulation and Quality Improvement Authority	RQIA
Relevant Graduate Route	RGR
Scottish Social Services Council	SSSC
Strategic Resourcing Innovation Forum	SRIF
Undergraduate Route	UGR

University of Ulster	UU
Whole time equivalent	WTE
Youth Justice Agency	YJA

SECTION 1: Introduction

1:1 Strategic Context

The Department of Health has been progressing a ten year transformation programme of health and social care in Northern Ireland as set out in **Health and Wellbeing 2026: Delivering Together, 2026** to ensure services can meet the challenges of the future including population changes, advances in technology, treatments and medicines and improve health and social wellbeing outcomes for all.

This Review has been commissioned to support the transformation agenda and as part of the HSC Workforce Strategy 2026[1] to deliver successful transformation and a more sustainable health and social care system for the 21st century. As stated in the strategy; "***At present there are significant pressures on social workers in several areas within the HSC including adult mental health, child protection and services for looked after children. Other factors which will increase the demands on social work services in the coming years include the NI Executive's target to improve social wellbeing through person –centred care, community development, self -directed support and co-production. New legislation such as the Mental Capacity Act and the Adoption and Children's Bill will also mean additional statutory roles and responsibilities***"

Social workers have a vital role in the delivery of front line services to individuals and communities impacted by Covid-19. Responding to the longer

[1] Health and Social Care Workforce Strategy 2026 :Delivering for Our People

term impacts on physical and mental health and wellbeing, will undoubtedly impact on workforce demands in the future

Social Workers have key roles within the education, justice and voluntary sectors. Each of these sectors are currently experiencing workforce challenges compounded by significant change. The social work role is fundamental to future developments and to enhanced service delivery.

The Review supports the strategic priorities of ' Improving and Safeguarding Social Wellbeing: A Strategy for Social Work (2012 – 2022) '[2]to 'strengthen the capacity of the workforce' and support the social work profession to be at the forefront of addressing new and emerging issues in society.

The Department of Health is responsible for commissioning professional training places for social work students in Northern Ireland. This review is tasked with identifying the numbers of social workers needed over the next five to ten years to meet projected need, which will, in turn, inform the numbers of professional training places required to ensure an adequate supply of social workers for all sectors.

As such, this review includes <u>all</u> sectors delivering social work services in Northern Ireland.

The review will make recommendations to strengthen the supply, recruitment and retention of social workers with the objective of meeting the needs of the workforce and securing a stable workforce to deliver safe, high quality social work services.

Social Work is a regulated profession with graduate entry level, protection of title and professional development requirements for maintaining registration.

1:2 Purpose, scope and ownership

The **purpose** of the review is to ensure there is sufficient capacity in the future to deliver safe, sustainable social work services across **<u>all</u>** fields of social work,

[2] Improving and Safeguarding Social Wellbeing: A Strategy for Social Work 2012-2022

in justice, education and the voluntary sector, **and** able to meet the demands of a transformed Health and Social Care Service.

The Departments of Justice and Education are fully aware of and supportive of the review and fully endorse the report and its recommendations.

The review will produce information, data and analysis on the current capacity and availability and anticipated numbers for the future, as well as outlining developments and changes likely to impact on the workforce in the future. It will include recommendations on the workforce profile required to ensure sustainable social work services regionally, on recruitment and processes required to maximise capacity of the workforce and on workplace supports to improve retention and ensure safe high quality social work practice. (Terms of reference Appendix 2)

A project group consisting of professional representatives and key stakeholders was set up and a project coordinator appointed to assist and progress the review. The group was co-chaired by Christine Smyth (Strategy Director for Social Work) and Andrew Dawson (Director, Workforce Policy Development) and work was progressed through a number of work streams or subgroups with individuals co-opted to the group as required. A writing group was established, comprising of representatives from the HSC Board, Northern Ireland Social Care Council, (Social Care Council) and the Department of Health, to assist with the development and drafting of the report. (Member ship of the project group is listed in Appendix 1)

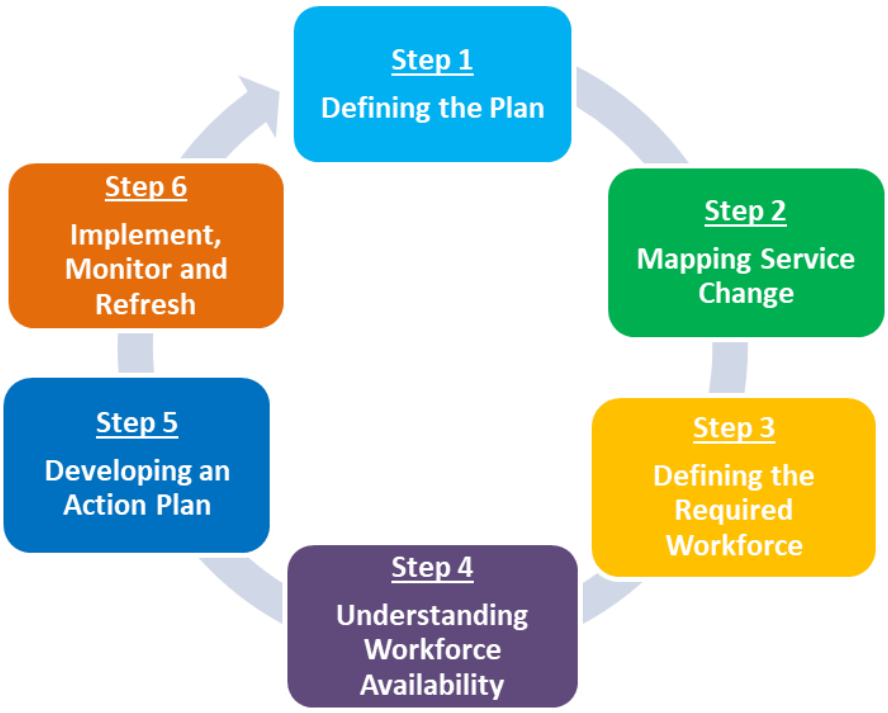
The Project Group reported to the Workforce Strategy Programme Board who, in turn, reported to the Top Management Group in the DoH.

Engagement events were held in early 2020 to consider stakeholder views and to help inform recommendations and actions.

Recommendations with any cost implications are subject to affordability and prioritisation and Ministerial approval.

The Regional HSC Workforce Planning Framework[3] is the recommended methodology (see diagram below) for all workforce reviews and has been used for this review.

[3] HSC Workforce Strategy 2026, Theme 3, Action 6).



The 6 steps, particularly steps 2, 3 and 4 are not sequential and the work has been reiterative and dynamic to fully understand the connections and dynamics impacting on the workforce from a systemic perspective.

1:3 Assumptions and Constraints

Due to the challenging nature in completing this social work workforce review it was important to consider any possible assumptions, constraints and/or risks early in the process. The main assumptions and constraints are tabulated below.

Assumptions	Constraints
Scope - the focus of this review is professionally qualified social workers across the whole spectrum of social work in NI	Financial – professional training places and workforce numbers are and will continue to be impacted by fiscal pressures.

Engagement – key stakeholders were able to input into this review at each stage of the process and to co-produce recommendations.	Meetings of the Project group were less frequent and took place online due to the impact of the COVID pandemic
Demographic/population data /information – use of robust sources of demographic or population data for Northern Ireland will be used including data from NISRA, DE and the DoH. .	Social work data/information – the lack of a regionally agreed data set across sectors and systems may make accurate projections and comparisons difficult to achieve.
All members of the project group are able to input into each stage of the process.	The impact of the pandemic on the delivery of services may have limited the ability of the project group to input at each stage of the process.
Future population, health and social care needs and the impact of technological advances and predicted demographic trends will inform the demand for services, type of service models and subsequent workforce required for the future	The full extent of Transformation service developments, in particular information on the impact on future workforce needs, are not fully detailed, however need to be included in the predictions of workforce needed for the future.
Time frame-completion within 12-18 months	
Implementation of the Agreed Action Plan – recommendations from the Social Work Workforce Review will need to be implemented to support the achievement of the Transformation agenda and to provide a sustainable social work workforce in NI for the next 10 years.	Financial – the implementation of the recommendations will be impacted on by availability of resources (personnel and financial).

SECTION 2: Understanding Current Workforce

As outlined in 'Delivering Together' foreword, the World Health Organisation defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity"

'Improving and Safeguarding Social Wellbeing' is the primary purpose of social work as set out in 'The Social Work Strategy 2012-2020[4]. This outlines five key social work roles that align with the over –arching aims of 'Delivering Together'. They are to improve the quality of life and outcomes for people and assist in reducing the need for more expensive targeted or specialist services in the immediate or longer term:

Social workers carry out these roles in a range of settings and sectors, in the community, in hospitals, in schools and prisons, with individuals, and families, children and adults.

Social workers enable and help individuals, families and communities to live safely, purposefully and well, play an active and productive part in society, have better life chances and outcomes and build social cohesion and capital.

Social workers, (Probation Officers) in the Probation Board for Northern Ireland (PBNI) have key roles in challenging offending behaviour and in

[4] Improving and Safeguarding Social Wellbeing: A Strategy for Social Work in Northern Ireland

supporting rehabilitation[5] as their core work. In addition they work alongside partner agencies to develop and deliver Problem Solving Justice initiatives that seek to tackle the root causes of offending behaviours and reduce harmful behaviours within families and communities.[6]

Social Workers in YJA deliver services to vulnerable children with complex needs as well as working with partners to develop and deliver early intervention policies and practice to divert children from the formal justice system. Proposals for a new Care and Justice Campus reflect the complexity of work and needs.

Social Workers within the Education Authority (EA) assist the EA with the discharge of its statutory functions, protecting and safeguarding children, and supporting children and families to get the best out of the education system. The service provides a regional service to schools and other provisions through the Education Welfare Service (EWS) and the Child Protection Support Service (CPSS).

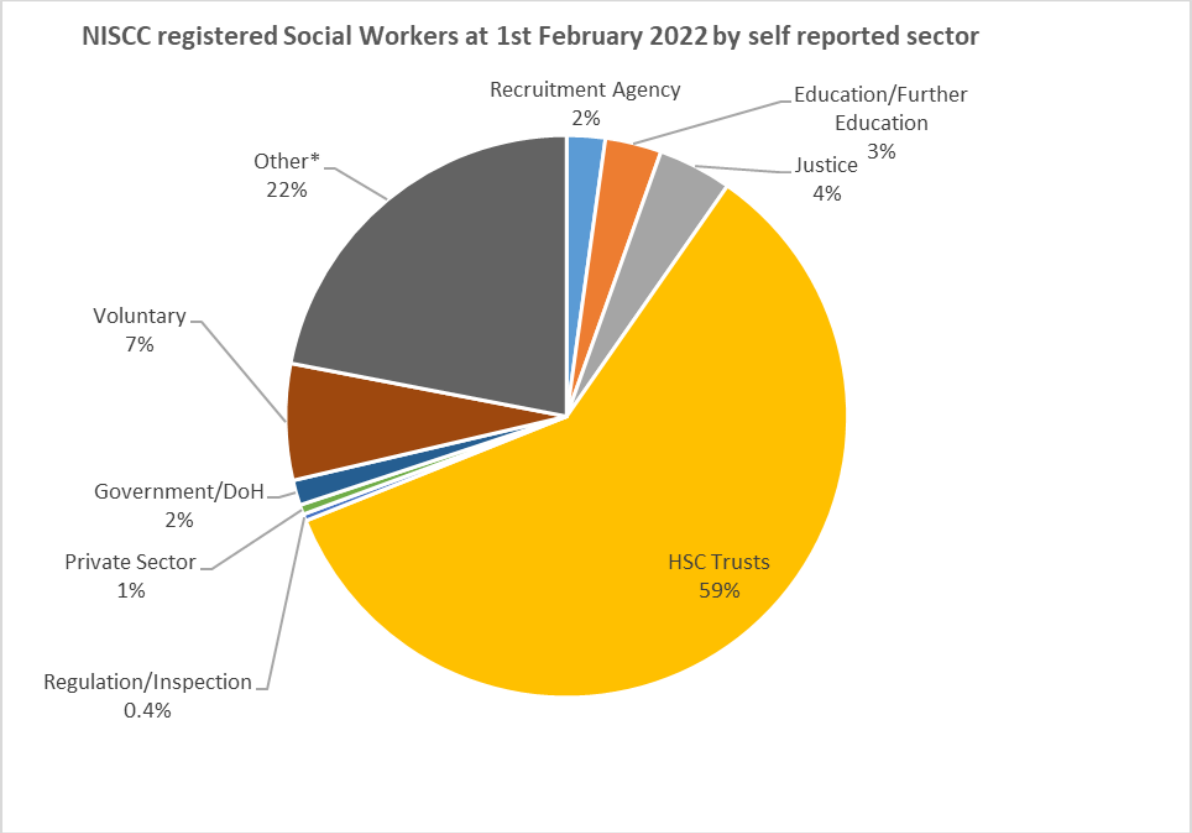
Social workers within the voluntary sector deliver a range of vital services and resources, many of which are commissioned by HSC Trusts, to vulnerable children, adults and families , through organisations such as Barnardo's, Praxis Care , NSPCC , Action for Children and Extern, helping to create safer communities and supporting individuals and families with complex needs.

Effective social work practice is informed by continuous professional development (CPD), is evidence based and incorporates and promotes research to ensure high standards of practice.

2:1 Current Capacity

There were 6,417 social workers registered with the Social Care Council at 1st of February 2022 working primarily in the statutory sector, in Health, Justice and Education, and in the voluntary/community (or 3rd sector), as set out below:

[5] DOJ Corporate Plan 2019-22 +Business Plan 2020-21
[6] For further information on Problem Solving Initiatives see https://www.nidirect.gov.uk/campaigns/problem-solving-justice



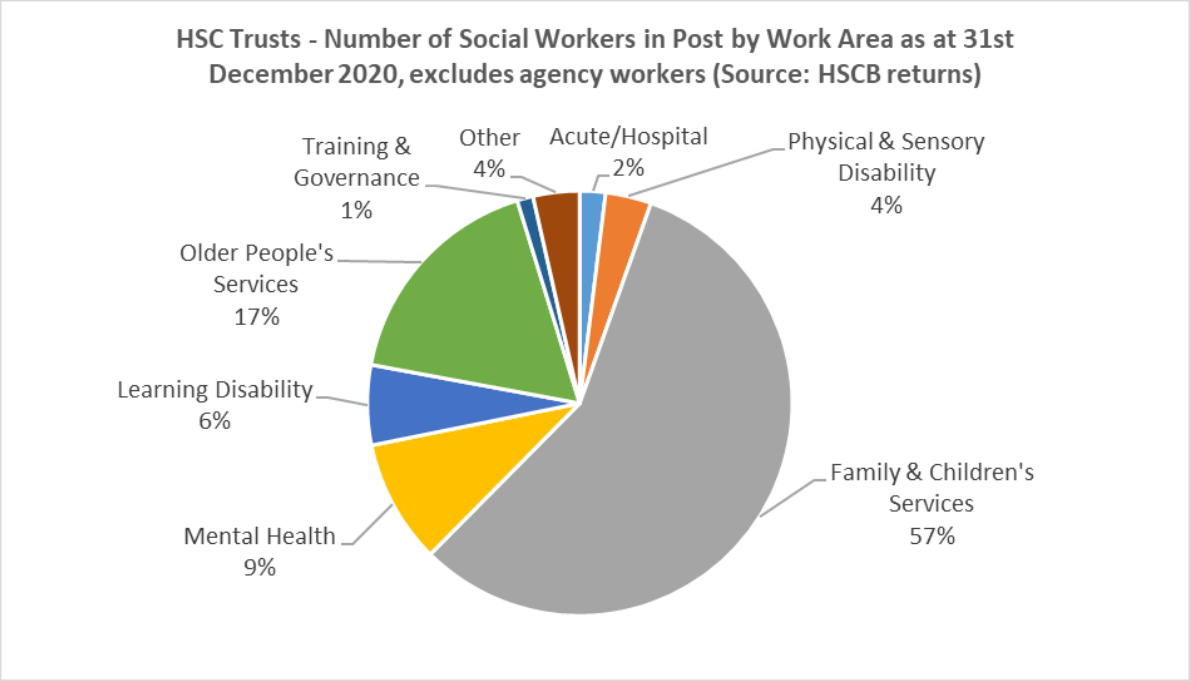
* Other Category - covers social workers who have noted that they work outside NI, are unemployed or retired but still maintain their registration.

There were over 270 social workers working in justice, over 200 in education and 1410 ,(22%) of registrants in the 'other' category, which includes self-reported as 'retired' , unemployed , self -employed, and working outside NI or UK.

It would be useful for workforce planning to have more details on the employment status of this group, and an understanding of the reasons for remaining on the register, if related to employment and whether there is potential for utilising within the workforce if required

Registrants have the option to update their work details at any point in time as part of the Social Care Councils Live Register.

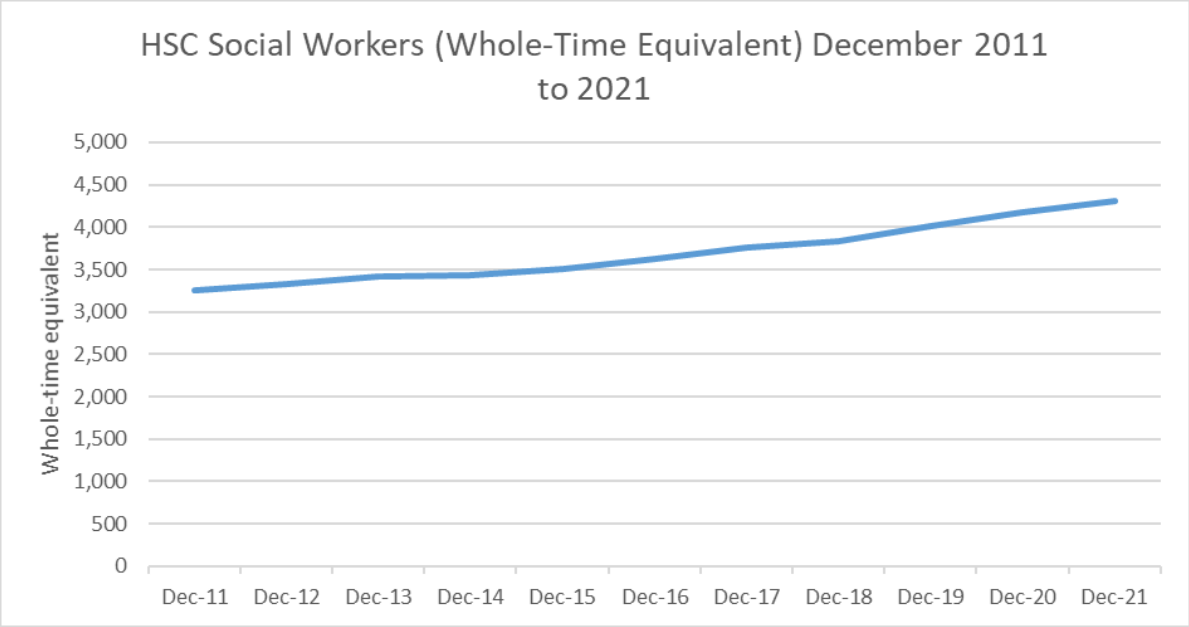
Almost six in ten of registered social workers work within the HSC Trusts, the breakdown across each sector is as follows, according to the annual HSCB data collation at 31st December 2020.



Trend data from the Social Care Council shows a 20% increase in Social Work registrants (1,076) over the period 2011/12 to February 2022.

*Note figures for 2020/21 are inflated due to the pandemic emergency register and the directive from the DOH not to remove anyone from the register.

The HSC workforce data source shows an increase in whole time equivalent social workers trend from December 2011 to 2021 (32.5 % increase).



Within PBNI reductions in budget from 2011/12 to 2016/17 necessitated a reduction in staff and greater use of agency staff, however an expansion in business, particularly the DOJ's problem solving initiatives led to gradual budget increases.Whilst some of this funding is permanent and allowed PBNI to increase its workforce, in recent years, project funding of this nature is often temporary which has caused difficulties with agency staff being recruited to short term posts.

The Youth Justice Agency report that staffing levels have remained fairly static.

There are approximately 208 social workers in the EA working primarily in Education Welfare, the Child Protection Support Service and the Inter-cultural Education Service.

The largest voluntary sector employer of social workers is Barnardo's NI with 78 social workers, followed by Praxis with 52, NSPCC 40, Extern 36 and Action for Children with 33. (NISCC Feb 2022)

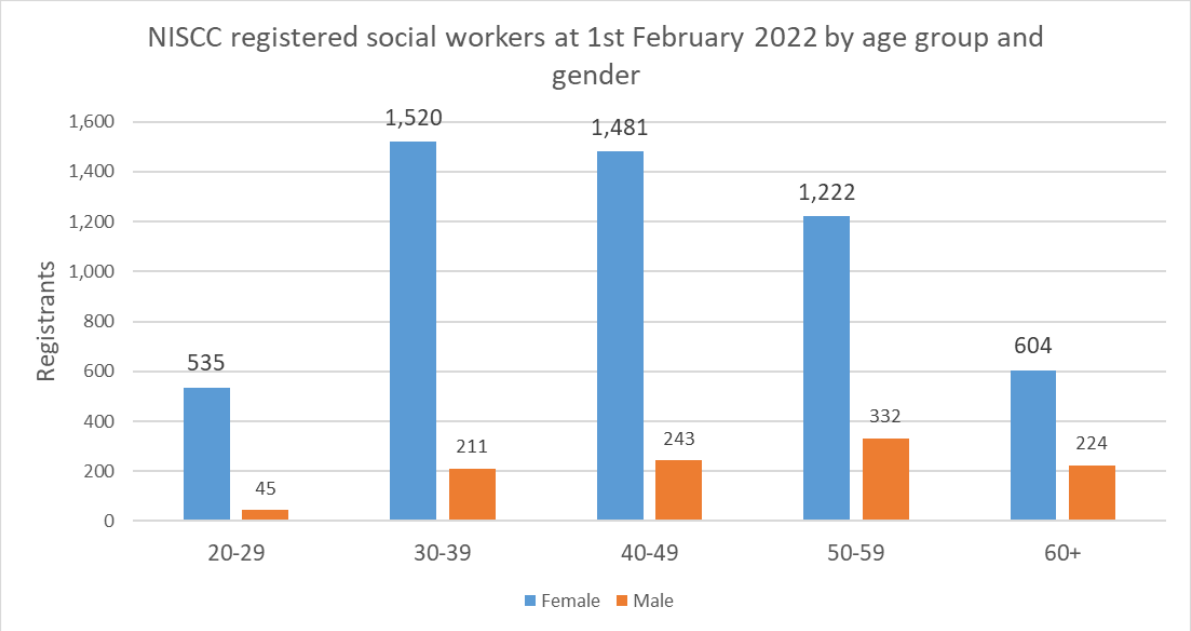
Staffing levels within the voluntary sector are dependent on adequate funding with decisions regarding numbers, experience and and qualification, influenced by affordability. Many services within the voluntary sector are commissioned by the HSC or Health Trusts, which occasionally have to be

reconfigured to make more use of non social work staff, due to financial constraints.

2:2 Gender

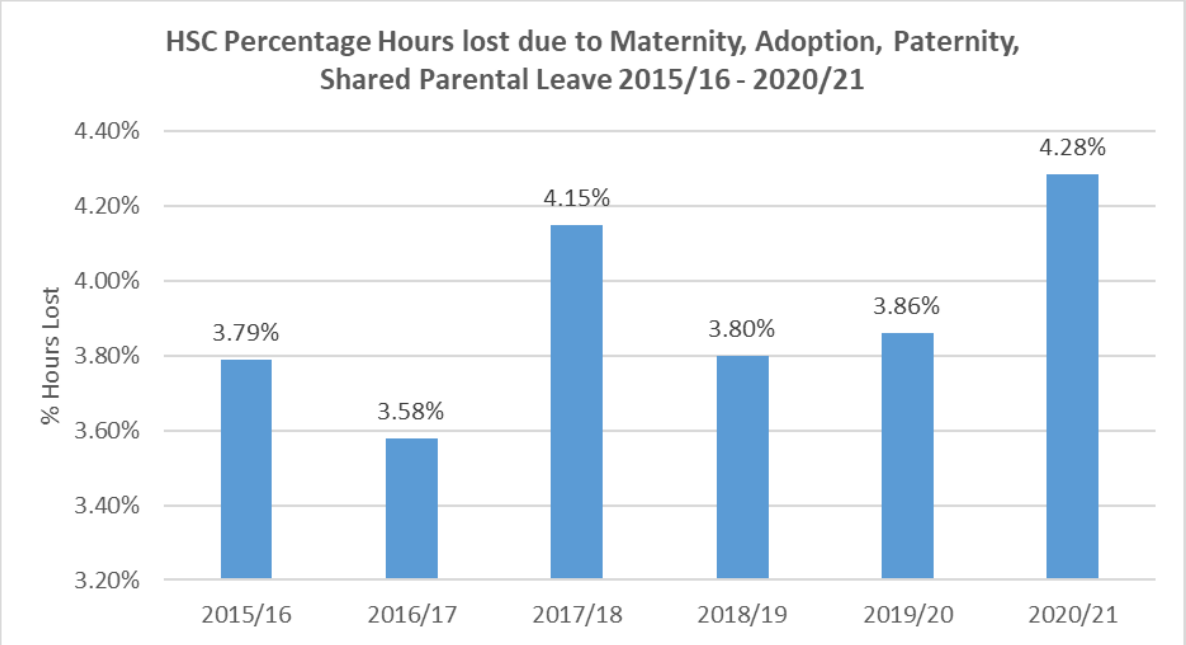
The Social Work workforce is predominantly female. 84% of NISCC registrants are women (85% female in HSC) with higher ratios of males in the older age ranges, as illustrated below. Admissions data from the Universities shows that fewer males are applying to undertake social work courses.

The predominance of a mainly female workforce has implications for workforce planning, for training and development , recruitment and retention and should be clearly understood and analysed. [7]



The level of HSC maternity, adoption, paternity and shared parental leave taken by HSC staff was 4.28% of working hours in 2020/21. The vast majority of this relates to female staff.

[7] NHS Employers: Gender in the NHS 2019



There are gender variations in different sectors, with traditionally higher ratios of males in the justice and education sectors (PBNI 80% female & YJA 69% female) suggesting that males may be more attracted to certain roles within social work. This is echoed in recent research by David Galley[8] which explores why there are fewer men in social work and their motivations to join the profession. The reasons for the gender imbalance and motivations are complex but research suggests there are differing motivations and aspirations that could be explored and discussed in order to develop strategies that address the imbalance and inform recruitment strategies. Highlighting the variety of roles and career opportunities for males within social work was part of a successful recruitment campaign in early 2020 by the Social Care Council working in partnership with the NI Degree in Social Work Partnership (NIDSWP)[9] and other stakeholders to attract more applicants into social work.

Almost 7% of the social work workforce or 429 (feb 2022) are employed within the voluntary and community sector. A survey carried out by NICVA every two

[8] Galley, D. (2020) "Social Work is women's work, right?" Amplifying the voices of male social work students entering into a female majority occupation: applying qualitative methods. Thesis (PhD). Bournemouth University.

[9] NI Degree in Social Work Partnership is an unincorporated association of education institutions and employing agencies –statutory and voluntary. Its main purpose is to ensure regional consistency in the delivery and development of agreed aspects of the Degree in Social Work in line with NISCC standards

to three years [10] collates data on the voluntary community and social enterprise sector and outlines, 71.4% of paid staff (entire sector)are female, with 55% of paid staff between 16-24 (NICVA State of the Sector report). One third sector social work employer, Barnardo's, reports that 83% of their workforce are female.

There is a significant difference in gender across the age groups (23% of registrants over the age of 50 are male compared to 11% under 39).

Analysis of HSC data also suggests that more women (proportionately) leave the profession in the younger age groups compared to men, pointing to a need to ensure women are supported to remain in the profession.

Key findings of a survey of 1000 women returning to work in the UK [11] highlighted that alongside flexible working, family friendly policies, and wellbeing initiatives, support and mentoring in returning to work can assist in retention of female staff.

2:3 Age

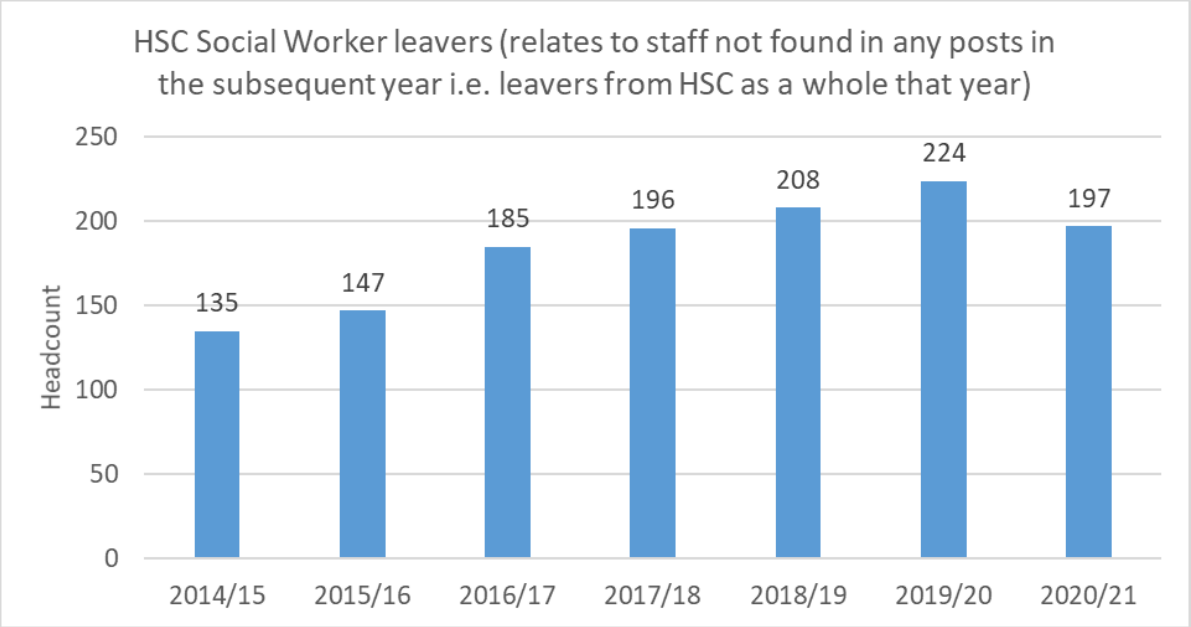
The table above illustrates that 37% of all registrants, (32% HSC), are aged over 50. The average age at normal retirement on the latest year's HSC data was 61.1 years, indicating that the potential impact of retirements over the next five to 10 years could be significant.

Analysis of HSC leavers in 2020/21 saw a slight reduction in terms of actual numbers and percentage of staff at 197 leavers (4.45%) the joiner's rate for the same period was 8.8%. Of the 2020/21 HSC leavers, 61% were aged 50 and over, 25% were aged under 40 and 13% were aged 40-49. These are not necessarily leavers from the profession and may not be permanent leavers from HSC either.

Building workforce business intelligence is one of the key themes of the HSC Workforce Strategy with the roll out exit interviews one of the actions planned to achieve this[12]. While this will assist decision making and workforce planning in the HSC, consideration should be given to gathering data on leavers from

[10] State of the Sector :NICVA report on the size, scope and finances of the voluntary, community and social enterprise sector
[11] A Guide for Employers 'Attracting and Engaging Women Returning to the Workforce' Robert Walters : empowering Women
[12] Action 23: Roll out of exit interviews for all staff leaving the HSC : HSC Workforce Strategy 2026

the social work profession to better understand trends and to inform future strategies on supply and retention.



PBNI report 53% of their workforce is aged over 45, with 28% of staff part time. With around 30 staff leaving per annum, of which around 84% are social workers, they need to replenish the workforce regularly and rely mainly on newly qualified social workers to fill vacancies.

YJA report that over 60% of the workforce is over 45 and 15% of the workforce is part time. A CJINI inspection report in 2018 commented on the ageing workforce particularly in the custodial services directorate.[13]

The working pattern in the HSC as at 31st December 2021 T was 82% of staff were full-time and 18% part-time.

As a relatively aging workforce there is a potential for a significant loss of knowledge and experience in the next 5-10 years across all sectors. As well as increasing supply, there needs to be a focus on retaining social workers including those who may wish to work past the average retirement age, with the appropriate supports to assist this.

Recently published research[14] 'Growing Older in Social Work' highlights the need to consider ageing as a critical matter for the social work profession, in

[13] An Announced Inspection of Woodlands Juvenile Justice Centre: June 2018 CJI :RQIA
[14] Growing Older in Social Work :Perspective on Systems of Support to Extend Working Lives –Findings from a UK Survey : Paula Mc Fadden, John Moriarty, Heike Shroder, Patricia Gillen, Gillian Manthorpe,&John Mallett

terms of workforce planning. The survey found that perceptions of structural ageism and a lack of support by line managers and organisations influenced retirement intentions by many respondents.

Research carried out in conjunction with Community Care exploring attitudes to ageing and retirement in social work reported that almost 50% of respondents suggested that opportunities for flexible working and /or opportunities to change role, could encourage retention of experienced staff.[15] Specific projects such as the 'Supporting Staff to Work Longer 'initiative,[16] undertaken in a NHS foundation Trust in England have been shown to reduce turnover of all staff as well as providing resources, tailored support and advice to staff and education for managers in helping to support staff to work longer.

Agencies such as Age UK and the Centre for Aging Better provide advice and guidance on the creation of 'age friendly' work places which may help to address the perceptions employees have of aging and assist in the retention of experienced staff.

2:4 Supply

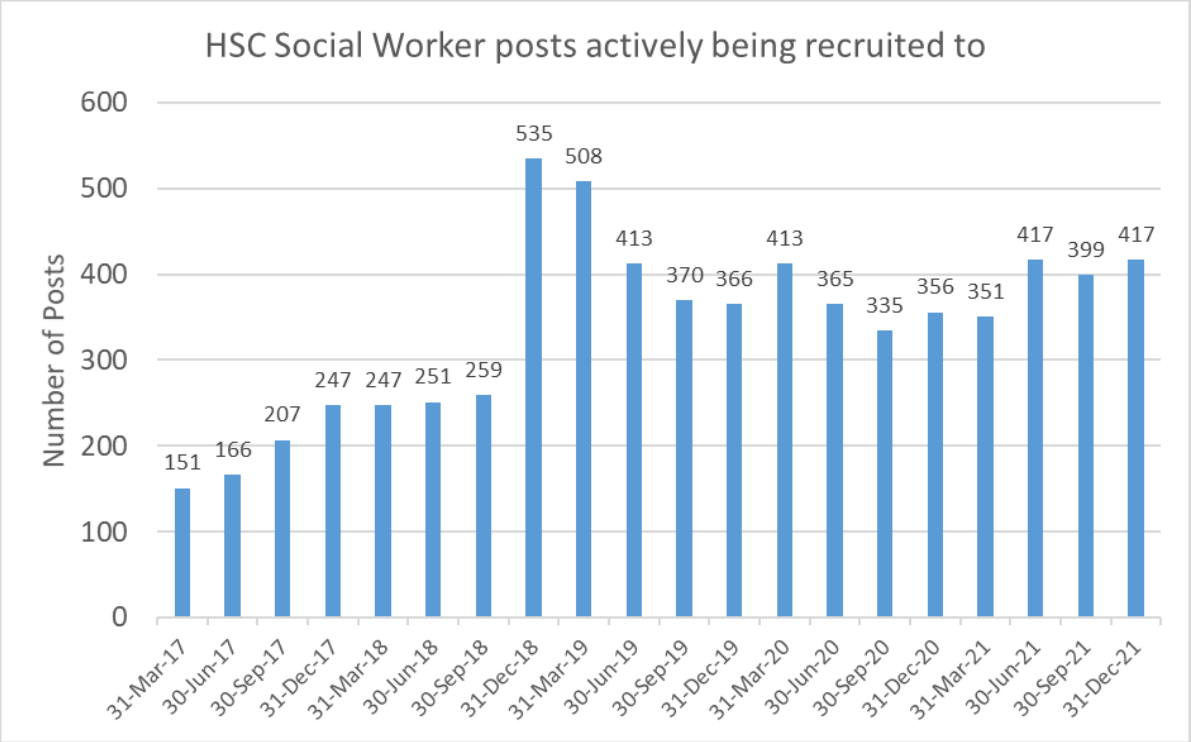
The number of social work students was reduced in 2011 from 300 to 260, due to economic constraints in the public sector at that time. The five year average of social work students completing the social work course is 239 each year (out of 260).They are eligible to join the workforce , (others defer and join at a later date) however it is likely not all join the NI workforce , and some may join the workforce in the Republic of Ireland or elsewhere.
An additional 15 OU places were approved in 2020, bringing the total number of student places to 275, however long term funding arrangements have not yet been agreed.

All sectors are reporting workforce issues with increasing difficulties in recruiting and retaining staff.

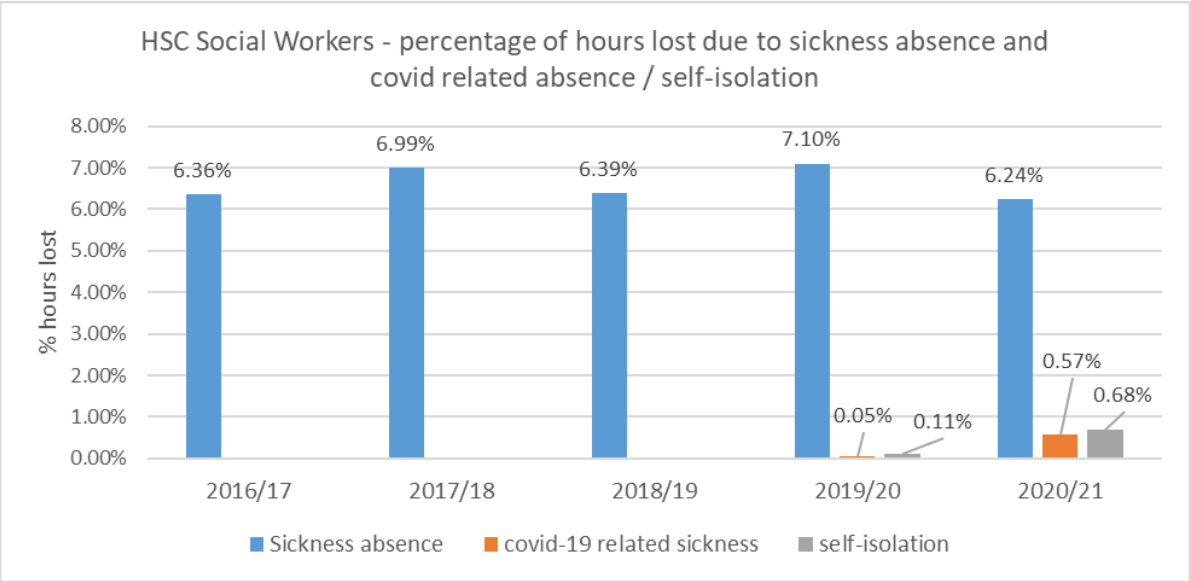
HSC Trusts have reported supply issues in DSF reports for a number of years, with the past three years showing a marked increase in (actively being recruited) vacancies in general.

[15] Aging and the Wellbeing of UK Social Workers :Dr P.Mc Fadden et al
[16] Supporting Staff to Work Longer project: University of Derby and Burton NHS Foundation :March 2020

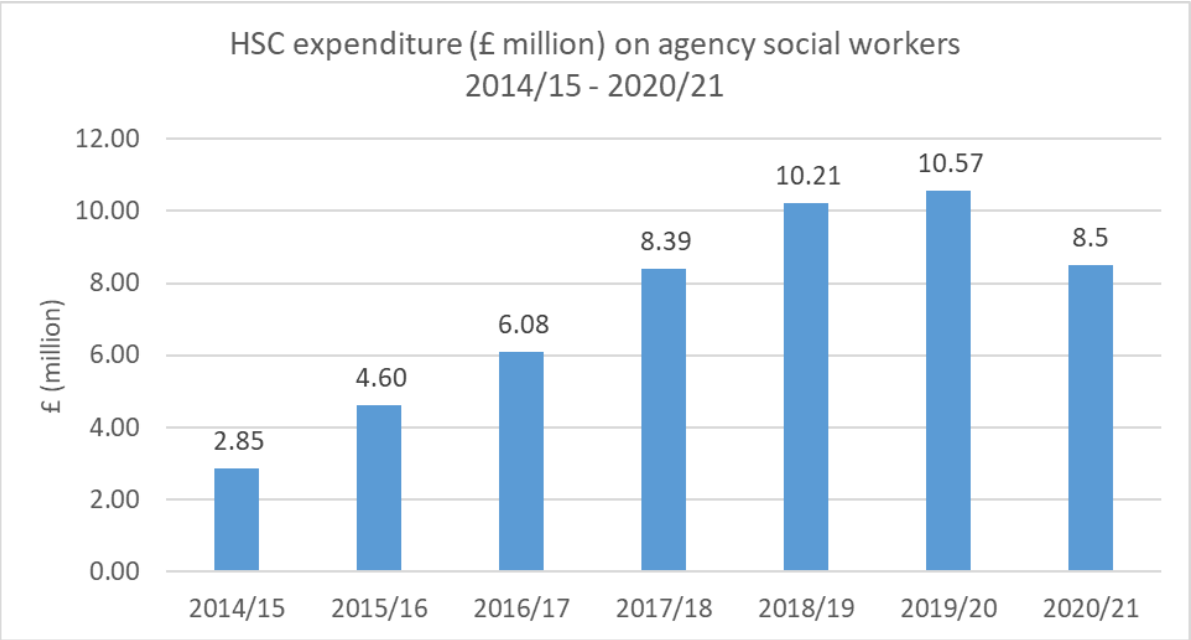
HSC vacancies in recruitment figures spiked dramatically in December 2018 (535) at more than three times those reported in March 2017 although this has since generally decreased and was 417 at December 2021.



<u>HSC sickness absence trends in the percentage of hours lost have ranged from 6.36% to 7.10% in recent years, however the pandemic has resulted in an elevated level of absence to 7.49% of hours lost io 2020/21 including covid related sickness and self isolation..</u>



HSC workforce data showed an increasing use of recruitment agency social workers over the past 3 – 5 years and an exponential growth in costs, however 2020/21 saw a marked effort to reduce this spend, as set out below:



Short term funding and budget uncertainties across the sector have led to a greater use of temporary staff employed by a recruitment agency. This in turn has contributed to unnecessary turnover of staff in some areas, with implications for the continuity and quality of care experienced by service users and carers.

Feedback from Trade Unions and staff surveys indicate that the vast majority of agency staff (and students) would prefer permanent appointments, if these were available in a timely manner, and for students, at a corresponding time to graduations.

Uncertainties regarding levels and sources of income in the voluntary sector require the use of short term or temporary contracts, which can lead to disruptions in service delivery and problems with retention and recruitment.

Within the HSC ratios of experienced to inexperienced staff have shifted with many experienced staff moving to newly created (Transformation) posts, at times leaving core teams with high numbers of inexperienced staff. Recurring

difficulties in some areas particularly in children's services have created 'hard to fill' posts or 'hotspots', with temporary posts particularly difficult to fill.

Children's Services in Leeds County Council, facing similar challenges, focussed on retention of staff and introduced a number of measure to stabilise teams and reduce dependency on agencies which included the introduction of an **advanced practitioner post**, part senior practitioner, part mentor, to co-work with inexperienced staff to support and develop their practice[17].They established a career pathway to offer tailored support and development opportunities at every level, with progression processes rooted in social work practice. The measures taken in Leeds took them from an 'inadequate' Ofsted rating to 'outstanding' with outcomes that included a reduction in agency social workers, higher levels of retention and improvements in recruitment.[18]

A review of the roles and deployment of senior practitioners (SPs) and principal practitioners (PPs) in the HSC Trusts carried out in 2014[19] found a lack of consistency in job descriptions and in the numbers and deployment of both senior practitioners and principal practitioners with variation in the amount of support and supervision provided to band 6 social workers.

The report also stated 'Of key importance is the need to examine the role of front-line managers' (band 7 as the review illustrated that these posts while having similar responsibilities to that of SPs, also had additional management duties. There is a need for appropriate weighting of posts at the same pay band' This is a critical post for assuring safe and effective care and remains difficult to recruit to given a senior practitioner is paid at the same band.

Standardisation of job descriptions of SPs and PPs is critical to ensure provision of support/mentoring for band 5 and 6 social workers .Addressing the roles and responsibilities of senior practitioners will assist in the retention and stabilisation of teams.

The use of Risk Retention Tools[20] (evidence based diagnostic tool) in some local authorities in England has enabled managers to get a baseline

[17] https://www.communitycare.co.uk/2019/02/25/retention-of-our-social-workers-has-been-key-to-unlocking-outcomes/
[18] Project entry form for Children and Young People Now Awards 2018
[19] DHSSPS :A review of the Roles and Deployment of Senior Practitioners and Principal Social Work Practitioners in NI.2104
[20] https://www.communitycare.co.uk/2019/11/27/social-worker-retention-risk-tool/

understanding of the retention challenges within teams, and to collaboratively identify risks and potential solutions .

Sustaining people in the profession and in their roles, including the promotion of self –care, is key to reducing dependency and spending on agency staff.

Social work managers in the HSC have expressed frustrations with delays in recruitment processes with vacant posts unfilled for a number of months. HR staff report a lack of consistency across organisations with a call for greater collaboration across the HSC to improve outcomes for all and to secure timely and permanent social work appointments.[21] Work was undertaken to address this, and with learning from initiatives introduced during the Covid pandemic, proposals developed for Student Streamlining and Collaborative Recruitment to speed up recruitment of newly qualified practitioners.

This led to a HSC Regional Recruitment exercise for band 5/6 social workers, which commenced in 2021.

Reports and analysis of the exercise highlighted more collaborative work was needed to improve recruitment outcomes. A report prepared by the Head of HSC[22] recruitment noted that 'without further external supply we are simply moving existing staff around the system'.

A report on the Professional Learning from the exercise prepared by Trust ADs echoed the recommendations within the Workforce Review on improving recruitment processes, including a focus on 'hard to fill posts', maximising outcomes for student recruitment, skills mix, and a review of pathways into social work.[23]

Lessons learnt from the 2021 Regional Recruitment are being taken forward by the Task and Finish (HR) group to improve and develop future recruitment exercises.

Historically, PBNI and the EA saw high levels of interest and applicants for social work posts, (including applicants from Trusts) .More recently this situation has changed and employers have concerns about being able to meet future demand due to challenges in recruiting qualified social workers. The

[21] The Strategic Resourcing Innovation Forum (SRIF) are working on this; TOR are 'to produce plans and recommendations about. Recruitment processes and HR Processes required to maximise the capacity of the workforce to deliver services regionally and ensure sustainability, consistency and retention.'
[22] Regional Social Work Recruitment Update Report : Karyn Patterson Head of HSC Recruitment
[23] Regional Recruitment :Professional Learning from January 2021

reliance on agency social workers, to staff projects funded on a short term basis has also revealed a shortage of agency social workers.

The voluntary sector has seen a drop in applicants and challenges in recruitment and retention due to difficulties competing with HSC pay scales, pensions and job security, and competition in border areas, particularly in the Western area with Tusla. The short term funding nature of many voluntary sector contracts can also have a negative impact on retention.

There needs to be a greater focus on retaining experienced social workers to help address the current supply challenges, and to retain knowledge, skills and expertise within the profession. It may also help to address specific retention challenges that are reported within front line children's services.

A Research in Practice paper on 'Recruitment and Retention of Social Workers' [24]discusses the 'push and pull' factors that social workers consider when deciding whether to stay or leave organisations or the profession. Minimising the 'push' factors and maximising the 'pull' factors, such as commitment to making a difference, high quality supervision(which includes a focus on health and wellbeing), opportunities for staff development, peer support, opportunities for career progression and organisational support for emotional well –being have been shown to strongly influence the decision to remain within an organisation. Loss of job satisfaction was cited as one of the biggest reasons social workers leave their profession.

All Ireland research recently completed on social work identity[25] provides further evidence of the 'push' factors and cited four factors which negatively impacted on social work identity as bureaucracy, workload pressure, insufficient time to spend in direct engagement with service users and media portrayal of social work.

Research has shown linkages between positive organisational culture and lower staff turnover, improved quality of service and outcomes for service users and increased job satisfaction.

2:5 Covid -19 Response

[24] Research in Practice :Social Work Recruitment and Retention
[25] Shaping Social Workers Identity, An All Ireland Study, Oct 2020 , BASW, IASW, NISCC, CORU

The impact of Covid -19 has presented unprecedented challenges to workforce planning. In response to an anticipated increase in demand steps were taken to increase the capacity of the workforce by expediting the registration and recruitment of newly qualified social workers (NQSWs) in 2020. HSC colleagues with the Social Care Council and others, worked collaboratively to accelerate and streamline processes, successfully resulting in the direct and timely recruitment of newly qualified social workers into the Trusts and the return of a number of lapsed social workers to the workforce.

Learning from this accelerated approach has been developed into proposals for streamlining student recruitment and collaborative recruitment processes which will reduce duplication and improve service delivery.

The impact for both newly qualified and experienced staff is yet to be fully understood, however, a survey of the health and social care workforce in the UK on the work experiences and coping of health and social care staff in relation to the COVID -19 pandemic confirmed the need for flexible working conditions, appropriate training and policies for working from home.[26]

A paper 'Testing Partnership and Preparedness in Northern Ireland During Covid-19 '[27] reflected on the processes and the impact on social work students and AYE social workers of 'entering the workforce in a time of flux'. Both point to a need for increased flexibility and adaptation with training and support to ensure a competent, confident and skilled workforce.

The crisis has highlighted the need for a workforce that is agile, responsive and equipped with transferable skills. Collaboration and innovation have been key to some of the responses to the pandemic that have included, role rotation and redeployment, flexible working arrangements, greater use of technology, increased cross-boundary working and more partnering with service users and carers.

To embed the learning from this innovative and collaborative approach to recruitment, the Department proposes to establish a reference group of representatives from HSC professions, HR Directors and BSO to develop collaborative, responsive and timely recruitment processes in future years.

[26] Health and Social Care Workers quality of working life and coping while working during the Covid -19 pandemic.May –July 2020: Dr. Paula mc Fadden, Dr.John Moriarity et al

[2727] Testing Partnership and Preparedness in NI During Covid-19 M O'Rourke, C. Maguire, J Molineaux & L Tanner.Social Work Education: The international Journal. Vol 39, 2020

2:6 Commissioned Professional Training

A Degree in Social Work is the threshold qualification for entry to the social work profession in NI and is a generic qualification which entitles social workers to practise across a range of sectors and settings including the statutory health and social care, justice, education and the third sectors.

Social Work education places in Northern Ireland are commissioned by the Department of Health (DoH) and providers approved by the Social Care Council. There are now **275** training places available in NI which include a recently approved Degree course provided by the Open University.

The number of student university/FE places was reduced from 300 to 260 in 2011 due to scrutiny of value for money across public spending, austerity measures and a reduction in available posts for new graduates at that time.

The Degree is provided as a three year undergraduate course (UGR) and a two year relevant graduate route. (RGR), the latter through QUB and the UU only. A part time route, which was an undergraduate five year programme, was available from 2010 but was discontinued in 2016/17 due to a low take up of places.

In March 2020 the Open University was 'approved with conditions'[28] by the Social Care Council to deliver 15 places on a flexible degree course, primarily to those currently working within the social care sector, (statutory and the third sector) as a career pathway for social care workers. The course has been oversubscribed with some Trusts exploring the possibility of funding additional places to help address supply challenges. (HSC Trusts are also exploring the option of supporting staff to complete the two year RGR programme) The voluntary sector would also welcome additional places and view this route as an opportunity for many experienced staff working in social care to gain a professional qualification while continuing to work and support themselves.

The OU route would also be suitable for staff in justice and education to obtain a professional qualification, if sufficient and recurrent funding could be secured.

Feedback from the engagement events and consultations have frequently referenced the need for an employment based route that would enable staff

[28] The approval is for a 5 year period subject to satisfactory quality assurance and annual monitoring

who are not social work qualified but experienced working in these sectors to obtain a qualification in social work. A work based route, or trainee programme, was previously available but discontinued a number of years ago.

There are now three approved providers, providing full time courses, as set out below:

Course Provider	Programme	Number of places
Queens University Belfast	Batchelor of Social Work Degree (UGR) Programme	72
	Batchelor of Social Work Degree (RGR) Programme	40
Ulster of University	Batchelor of Science Honours Degree (UGR) Magee	63
	Batchelor of Science Honours Degree in Social Work (RGR) – Magee	40
	Belfast Metropolitan College, Undergraduate (UGR) Programme (Yrs. 1 & 2 only)	30
	South West College (Dungannon) Undergraduate (UGR) Programme (Yrs. 1 & 2 only)	15
Open University (Approved March 2020)	NI Degree in Social Work	15
	TOTAL	**275**

The universities report that applications to both social work programmes are oversubscribed. Whilst there had been a decline in applications, for two years, for the UGR programme at the UU, this has been addressed, and applications to both universities increased in 2019/20 and 20/21.

Admissions data from the universities[29] shows that fewer males are applying to complete social work courses.

Admissions data is collated on age, sex and disability, but not race, religion, or sexual diversity. There is a perception that while the social work population is becoming more diverse, more could be done to improve diversity with both students and the social work workforce .Improving data collection on diversity would help inform future workforce planning and ensure the workforce reflects the population it serves.

In response to the decreasing number of applicants the Social Care Council, the NI Degree in Social Work Partnership, and representatives from the universities' and colleges academic staff and Admissions and Domestic Recruitment teams, worked to proactively promote social work as a career and review processes in order to maximise applications in 2020, increasing the number of successful applications by over 19% on 2019.

Analysis over the last five years shows that on average 239(out of 260) students complete the Degree and are eligible to join the workforce per year. (A number defer for personal or health reasons with the majority joining the workforce at a later date. Attrition rates would be between 2-3 %) Annual monitoring processes undertaken by the Universities (Continuous Assurance of Quality Enhancement (CAQE) at the UU and Continuous Action for Programme Enhancement (CAPE) at QUB) and ongoing work with the collaborative partnerships continuously review the quality and standards and seek to optimise successful completions.

Student social workers are required to complete two Practice Learning Opportunities (PLO's) or placements while training, and are required to be supervised by a qualified practice teacher, onsite, or an onsite supervisor and an offsite practice teacher. Positive learning opportunities are essential for the supply and development of the workforce, and must be adequately resourced

[29] https://www.ucas.com/data-and-analysis/undergraduate-statistics-and-reports/ucas-undergraduate-sector-level-end-cycle-data-resources-2019

to ensure we have a workforce 'fit for purpose' (Action 3: HSC Workforce Strategy).

Research findings from NI studies have identified the importance of PLOs being adequately resources, sustained and developed.[30]

There should be cross departmental discussions (DOH, DOJ &DE) to ensure practice learning opportunities are adequately resourced, sustained and developed across the profession.

In England the Open University has launched its Social Worker Degree Apprenticeship supporting more people into higher education and providing a new flexible route into social work. The Apprenticeships offer staff working within the care sector opportunities for qualification and career progression.

Scotland and the Republic of Ireland are addressing supply problems by considering options such as widening access to social work courses, particularly career pathways from social care into social work.

A Pathway Programme for widening participation is currently offered by Queen's University, in terms of supporting school leavers from disadvantaged communities, who meet the academic entry requirements. It is hoped that this will extend to the Bachelor of Social Work Degree (UGR) in 2023

A Domiciliary Care Workforce Review[31] completed in 2016 included a recommendation to create career pathways for social care workers to remain within the care sector and as a route into social work. This could both strengthen the social care workforce and potentially improve the supply of social workers.

Similarly, within the justice sector, there are experienced, motivated (unqualified) staff who may be interested in pursuing a career in social work if an appropriate route was available, which could assist in meeting future workforce needs across the justice sector.

There are currently 9 IQSWs registered with the Social Care Council (Feb 2022) Qualifications held by Internationally Qualified Social Workers (IQSWs) are assessed by the Social Care Council when they apply for registration. IQSWs are often required to complete a compensation measure before being accepted as suitable for practise in NI.

[30] https://pure.qub.ac.uk/en/publications/the-inside-story-a-survey-of-social-work-students-supervision-and https://pure.qub.ac.uk/en/publications/promoting-readiness-to-practice-which-learning-activities-promote
[31] Domiciliary Care Workforce Review NI 2016-21

Concerns have been expressed about the impact of Brexit on the recognition of qualifications and whether this will limit the opportunity to recruit EU social workers, which may also have to be factored into future workforce planning. Currently social workers working across the border are required to be registered in both jurisdictions.

Newly qualified social workers have restricted caseloads and are required to undertake an assessed year in employment (AYE) to ensure competency to practice in the workplace and for future career progression and professional development. Following their AYE all social workers are required to complete two requirements from the Social Care Council, Professional in Practice (PiP) Framework to maintain their registration. Professional in Practice Framework is the CPD Framework for social work in Northern Ireland
The Standards for Conduct and Practice for Social Workers require that, '*As a social worker, you must be accountable for the quality of your work and take responsibility for maintaining and improving your knowledge and skills'.* As a requirement of registration social workers must complete a minimum of 90 hours post registration training and learning in each three year period.

Although a requirement of their first year in employment, feedback from AYE staff, particularly in some Family and Childcare teams highlights that caseload protection is minimal and induction haphazard. Retention of staff into their second and third year, in the same post, should be a key organisational objective to break the problem of unnecessary turnover, in some teams. Including a recognition of and facilitation of AYE learning requirements.

Continuous Professional Development (CPD), professional supervision and supporting professional activities are essential for the maintenance and development of the workforce and frequently identified as essential factors in recruitment and retention of staff. CPD Is key to ensuring social workers are competent to practice and able to manage increasingly complex and challenging caseloads and must be promoted and protected.

The Learning and Improvement Strategy for Social Workers and Social Care Workers[32] sets out the strategic direction for learning and improvement to improve outcomes for people who use services, carers and communities.

A commitment to continuous improvement and the creation of a learning environment in which social work can thrive, are reported as factors that have

[32] A Learning and Improvement Strategy for Social Workers and Social Care Workers2019-27: DOH

contributed to 'Outstanding' organisations, in Ofsted[33] inspections. (See North Tyneside Inspection of Children's Social Care Services)[34]

The introduction of job plans which include time for CPD would ensure learning and development and other activities are recognised, prioritised and valued as an essential contribution to the delivery of high quality care. Recognition for CPD through the PiP Framework provides further opportunity for ensuring quality, consistency and transferability.

The Association of Executive Directors of Social Work in the Health Trusts has identified the need to adopt a regional approach to the leadership development and support for the social work profession in the context of ever increasing demands. The Association has endorsed a paper entitled ' A time for Change ' [35]which lays out a vision for a more centralised leadership model and the development of a regional learning hub for the profession .This proposal advocates the sharing of Trusts resources with a view to ;

- Promoting a strong confident and readily identifiable voice for the social work profession in Northern Ireland
- Fully implementing the strategic priorities contained in the Learning and Improvement strategy for Social Workers and Social Care Workers , the SW Research Strategy[36] and the Social Work Strategy
- Developing a drive within the social work/social care workforce which is focused on facilitating innovation and change at the front line, enabled by peer support and coaching, to address staff recruitment and retention issues.
- Removing the current barriers to securing a coordinated and coherent approach to all learning and improvement activity for social workers and social care workers, which maximises its efficiency and effectiveness.

[33] Office for Standards in Education, Children's Services and Skills :England
[34] Ofsted Inspection of Children's Social Care Services :North Tyneside Council March 2020
[35] A Time for Change :Creating a learning system for social work and social care in NI ?AD ?Directors of Social Work 2018
[36] Health and Social Care Board (2020) *Social Work and Social Care Research Evidence: Supporting Continuous Improvement in Service Outcomes Strategy 2020-2025*Available as SWSC-Research-Evidence-Strategy-2020-25.pdf (hscni.net)

Strategic Theme 1: Supply

Demand is outstripping supply and collaborative, proactive action must be taken to attract, recruit and retain students and social workers, with responsive and timely recruitment processes in place to provide a sustainable workforce (Recs 1, 3, 4 & 5)

2:7 Service Demand

Workforce issues in Health & Social Care have been reported in Delegated Statutory Functions[37] (DSF) reports since 2015. The 2019/20 Delegated Statutory Functions report[38] highlighted social work staff shortages across all five HSC Trusts and as having a significant impact on the Trusts ability to deliver their statutory functions.
Overall Trusts continue to report increased pressures due to rising demand and complexity of need across all Programmes of Care.
Emerging pressures related to the impact of Covid -19 also continue to present unprecedented challenges..

In children's services workforce difficulties are reported in recruitment and retention, caseload pressures, caseload size and complexity of cases, and rising numbers of unallocated cases which have impacted on service delivery .Rising numbers of children on the child protection register[39], rising numbers of looked after children, and placement availability across the spectrum ie fostering , residential care , post care and for children with a disability remain sources of significant pressures for Trusts.
As of the 31st March 2020, there were 3,383 Children Looked After. This is the highest number of children looked after since the introduction of the Children (NI) Order 1995
The number of children known to Social Services and whose names have been placed on the child protection register increased by 20% between 2014 and 2020, with 2,298 on the register in March 2020.

[37] Delegated Statutory Function reports are Trust reports to the HSCB on the statutory functions delegated to them by the HSCB .The Social Care Directorate carried out a review of the reporting process in 2021 and have begun work on an Outcome Framework which will assist and compliment the DSF process in future.
[38] Delegated Statutory Functions Report 2019/20
[39] Norhtern Ireland has the highest rate of children on the child protection register in the UK, at 52 per 100, 000

Concerns have been raised by the judiciary regarding delays linked to staff turnover in children's services and there have been increases in waiting lists for parenting capacity assessments in family centres.

There has been a rising trend in unallocated cases in children's services since 2013 with 804 children reported as awaiting a social work allocation in March 2020, compared with 236 in 2013.

HSC Trusts report increasing caseloads and increased complexity of need linked to addiction issues, poor mental health, domestic violence and poverty across all Trusts. The RQIA Review of Governance Arrangements for Child Protection in the HSC [40] noted concerns raised by staff about the increasing complexity of work, and unattended cases, and recommended that steps be taken to assess risk and support staff to mitigate the potential impact of work related stress.

HSC Trusts report that social work staff in children's services are working to capacity, with growing waiting lists, high staff turnover and high numbers of inexperienced staff within many children's services teams.

This prompted the successful submission of a business case in 2020 for an additional ten Band 7 peripatetic senior practitioners, ten social work assistants and five recruitment officers, to reduce the number of unallocated cases, provide greater levels of support for inexperienced staff, and enable social workers to spend more direct time with families, across the HSC. The additional capacity will be subject to review and evaluation on the basis of agreed measurable targets and objectives. Filling these additional posts will undoubtedly present further challenges making it imperative that supply is adequate to meet future demand.

Reducing unnecessary or unmanaged turnover and stabilising the workforce are critical to improving outcomes for staff and service users.

In Adult Mental Health all Trusts report pressures to varying degrees in terms of increases in service demands, acuity of need, management of waiting lists and challenges around the recruitment and retention of the skilled workforce, particularly Approved Social Workers (ASWs), needed to underpin and secure high quality, accessible and safe services.

[40] Review of the Governance Arrangements for Child Protection in the HSC in NI :Phase 1 .The Regulation and Quality Improvement Authority :May 2018

The phased roll-out of the Mental Capacity Act (Northern Ireland) 2016 commenced in December 2019, has placed significant demands upon Trusts, changing practice and requiring the development of new teams and protocols. The establishment of multi-professional panels to examine and authorise deprivation of liberty applications has placed an enormous demand on the wider HSC system and mental health particularly with regard to approved social workers

Improved understanding of the range of mental health needs of the population has led to the development of a wider range of new and targeted services and initiatives. Some of these will be described in the Mental Health Action Plan and will form part of the future Mental Health Strategy work. Trusts are reporting difficulties in finding experienced skilled staff to fill these posts.

In an effort to quantify both current and anticipated demand for ASWs a report was commissioned to provide an evidence based assessment of the number of ASWs required for Trusts to fulfil their statutory functions. Revised ASW Quality Standards are to be implemented which include a recommendation for an additional 64 ASWs.[41] While the QUB report included out of hour admissions in it's calculation, work on the model of delivery for the out of hours ASW service is still underway and may alter these numbers.

Recruitment and retention of social workers and social work team leaders, was reported as of concern in all service areas, and particularly acute in mental health services across NI.

In some areas across adult services social work team leaders, at Band 7, have responsibility for management of Senior Practitioners, Approved Social Workers and other professional leads, who are on the same Band (7) as well as responsibilities for decision making, caseloads and administration. They may also have to act as Designated Adult Protection Officer (DAPO) or ASW practice assessor unlike team leaders from other professions. Social Work leaders have expressed concerns these additional responsibilities may deter many from taking up the posts.

Adult Learning Disability reported challenges with the recruitment and retention of their workforce, specifically in relation to Approved Social Worker roles as well as Short term Detention Approvers and Social Workers assigned investigating Officer (IO) or Designated Adult Protection Officer (DAPO) roles.

[41] Approved Social Work Planning Estimates: July 2020 Prof Gavin Davidson & DR Claire Mc Carten QUB

The implementation of Deprivation of Liberty Safeguards (DOLs) under the Mental Capacity Act has also presented challenges for Trusts in meeting the required timescales.
Chief Officers in Trusts have called for regional consistency in bandings to ensure equity of opportunity and greater consistency in service delivery

A review of job descriptions and use and deployment of first line managers and Senior Practitioner posts could help to address perceived inequities and maximise the professional resource at Band 7 level. This should include opportunities for rotation and/or mobility to strengthen professional development and incentivise staff to take up management posts.

Strengthening professional leadership is one of the key priorities of the Social Work Strategy[42], and work has been ongoing to develop a Leadership Framework for Social Work.[43] This aligns with the HSC Collective Leadership Strategy launched in 2017 to create *'a culture of high quality, continually improving, compassionate care and support'*.

A framework to strengthen and support professional leadership and career progression should be progressed, supported by relevant development and CPD opportunities.

Effective leadership and management is also one of the six strategic priorities of the Learning and Improvement Strategy.[44]

Concerns have been raised in adult services at the variations of the social work footprint across programmes of care and Trusts. A multiplicity of job descriptions, or generic job descriptions, job titles, and job roles across teams, many of which are set up at a local team and service area level, can undermine the social work role, complicate identification and data collection and diminish visibility of the social work profession.

Greater regional consistency in job titles, including the use of the 'social worker' title in every day job names, would allow for easier and standardised collation of data and intelligence on the social work workforce to assist in workforce planning and decision making.

Delegated budgetary autonomy in the HSC enables service or senior managers, to determine the number of social workers within their service area and create

[42] Improving and Safeguarding Social Wellbeing: A Strategy for Social Work
[43] Social Work Leadership Framework
[44] Learning and Improvement Strategy:

new social work posts with new job titles and new job descriptions. This can lead to inequity in service delivery and disparity within and across Trusts particularly in the makeup of Integrated Teams.

Variations in terms and conditions along with perceived workload have exacerbated recruitment challenges across sectors. PBNI report high caseloads, increasing complexity and staff shortages that have impacted on staff morale. Difficulties in recruitment and retention are becoming more prevalent compounded by a growing pay differential with the health sector which may impact on future recruitment efforts and potentially increase leavers to the Trust posts.

Within the EA staff are increasingly focussing efforts on the welfare determinants of poor school attendance with the added stressors on young people and families created by Covid . A growing pay differential with the health service is also impacting on recruitment and retention.

It is difficult to quantify the impact of Covid -19 on service demand however there are reports from the NSPCC[45] , and others, of increasing levels of domestic violence, child abuse, social isolation , mental health difficulties and rising levels of poverty and deprivation which will require additional social work intervention and impact on current caseloads.

Strategic Theme 2: Safe Staffing

There should be regional consistency (using agreed workforce data) in the numbers, deployment and use of social work practitioners (including use of title), based on the development of a model to identify normative staffing/safe practice levels for social work services (Rec2B)

[45] https://learning.nspcc.org.uk/research-resources/2020/social-isolation-risk-child-abuse-during-and-after-coronavirus-pandemic

SECTION 3: Mapping Service Change

3:1 Drivers for change

There are a number of strategic drivers shaping the delivery of future social work services and requiring effective coordinated and timely workforce planning.

Delivering Together and the Draft Programme for Government 2016-20 set out the road map for significant change to improve the health and wellbeing of the population. Making Life Better[46], the annual Commissioning Plan Direction,[47] the Children and Young People's Strategy: 2017-27, and the Social Work Strategy are all drivers for change highlighting the need to ensure connectivity with workforce planning.

Work is also underway to develop a Future Planning Model based on an Integrated Care System approach and includes the development of a Strategic Outcomes Framework which will detail the strategic direction for the Department in future.

The Outcomes Delivery Plan [48]sets out the headline actions that departments have put in place and includes the development of a problem solving approach to crime reduction. The DOJ Corporate and Business Plan 2020-21 sets out objectives to improve community safety in which PBNI has a key role in 'Improving Outcomes for individuals by helping them address the root cause of offending behaviour and reduce the rate of reoffending'[49]

YJA will have a key role in caring for vulnerable children with complex needs in the proposed secure care and justice centre and in further developing early interventions for children encountering the justice system.

There are a number of new policies or initiatives within the education sector that will impact on the social work workforce of the future, including the joint (with the DOH) Looked After Children Strategy, the New Special Educational

[46] Making Life Better 2013-23 is the strategic framework for public health designed to provide direction for policies and action to improve the health of people in NI and reduce health inequalities.
[47] The annual Commissioning Plan Direction sets out Ministerial priorities, key outcomes and objectives and related performance indicators , prepared by HSCB in
[48] Outcomes Delivery Plan :Executive Office :2019
[49] DOJ Corporate and Business Plan 2020-21

Needs (SEN) Framework, the Newcomer Policy/Vulnerable Persons Relocation Scheme (VPRS) and the Emotional Health and Well Being Framework. Developments of services in EWS and Children Looked After (CLA) and more general opportunities within education for social work may see further demand for social work qualified staff in the future. Multi-agency approaches whereby social workers with experience in education are working alongside social workers in health have proven very successful. This will be a big driver for change going forward as more traditional service delivery models are changed to reflect the increasing importance of and broadening role of social workers within education. This is particularly so for children and young people with trauma and attachment difficulties and the staff providing their education. Support from social workers in education with the unique understanding of the impact of trauma and attachment difficulties on the child/young person has yielded significant outcomes.

The 'State of the Sector' document reports on issues facing the VCS with levels and sources of income and withdrawal from the EU, and consequent impact on the workforce and service delivery, as of significant concern in the future.

The voluntary sector report that the current procurement culture destabilises the contribution of the sector generally due to limited , often short term funding and resources , but given sufficient funding and resources they could make a full contribution to the training and development of the social work workforce.

The ongoing Covid-19 crisis has presented further challenges, setting out a need to rebuild or reconfigure services in many areas. A Strategic Framework for Rebuilding Health and Social Care Services was launched in June 2020 which along with complementary plans from the Health Trusts will set out how services will be delivered in the future. The crisis has highlighted the need for a workforce that is responsive and prepared to meet surges in demand which must also be considered in workforce planning for social workers.

New models of service delivery, new or pending legislation, ongoing reviews and investigations, developments in technology and changing demographics are placing new and additional demands on the social work workforce. It is essential that steps are taken now to ensure there will be a workforce of the right size with the right skills deployed in the right way to deliver safe effective and high quality social work services in the future.

Ongoing and emerging issues include increasing demand for services, insufficient capacity to meet demand across many areas of health and social care, workforce challenges across the spectrum of children's services and in particular the retention and availability of social workers, growth in the numbers of children and families in need and requiring early intervention services; increased demand for placements for children in the care of the state, an aging population, particularly those over 85, including frail elderly, and an increase in people with co-morbidities and long term conditions. [50]

Safe staffing legislation for HSC professionals is currently being considered which may also impact on staffing levels in the future.

3:2 Population statistics and health profile

Changes in age composition of the population will affect needs and demand for health and social care, will impact on service provision and place increased pressure across the social work and social care system. Life expectancy is rising and greater numbers of people with significant disabilities or complex needs are living longer.[51] Care needs are not evenly divided among age groups in the population and cost per capita tends to rise sharply with age. These changes inform the commissioning of services at regional and local level. This is likely to place considerable pressure on the social care sector, including care home provision, and access to domiciliary care, and consequently on social workers.

The latest published mid-year estimates for 2020 show ;

- There are approximately 1.90 million people living in Northern Ireland.
- 83% of the population are aged 0-64 years
- There are an estimated 441,108 children aged (0-17 years) living in Northern Ireland.
- Approximately 17% of the population (314319,) are aged 65+ years
- 2% of the population (39,488) are aged 85+ years

[50] Draft Commissioning Plan2019-20
[51] Improving and Safeguarding Social Wellbeing :A Strategy for Social Work in NI (2012-2022)

The NISRA 2020-based interim population projections show that the population of Northern Ireland is projected to increase by 2.1% to reach 1.935 million by 2031.

In particular the population projections show that the population aged 65+ years will increase from 319,949 (2020)to a projected 409,620 by 2031, an increase of 89,671, people or 28%.

Further ahead projections are for an increase to 1.93 million by 2045 (an overall 2.3% projected rise from 2020).

Again some of the most significant increases are amongst the older population (65+), which is set to rise by 50.5% by 2045 to 481,473 people.

As the population of N Ireland continues to increase, this will have a direct impact on the number of social workers required to meet the needs of the population.

In addition, it is generally accepted that NI has a population with a significant proportion adversely affected by high levels of trauma, deprivation and division, with detrimental impacts on physical, mental and emotional health and wellbeing. Northern Ireland is reported to have a 25% higher overall prevalence of mental health problems than England.

A 2014 study on the impact of the 'Troubles' on the population, found that the prevalence of Post-Traumatic Stress disorder in N.I. was the highest of the 27 countries in a World Mental Health Study[52].

The number of deaths by suicide in NI was 209 in 2019 a rate of 11 per 100,000 per year. Studies such as 'Mental Health in Northern Ireland: Research and Information Service Research Paper' published in 2017 have reported that mental health problems are the largest cause of ill health and disability in NI.[53]

At the time of writing the Covid -19 pandemic is having a devastating impact on the health and social wellbeing of populations around the world.

[52] Traumatic events and their relative PTSD burden in NI: A Consideration of the Impact of the 'Troubles'.F .Ferry, B Bunting, S Murphy, S.O'neill,D Stein, K Koenan 2014

[53] NI Assembly Research and Information Service Research paper: Mental Health in NI. Betts &Thompson 24/1/2017

The full extent of the impact may not be fully understood for some time, however, it is becoming increasingly evident that a social response to the pandemic is needed, as well as a medical response. The World Bank have reported that half a billion people could be pushed into destitution as a result of Covid - 19 and that the outbreak will have long lasting economic and social impacts stemming from the direct and indirect impact of illness.[54]

Reports and research[55] on the direct and indirect impact of Covid-19 on health and wellbeing highlight the long term impacts on physical and mental health, the increase in reports of domestic violence and family breakdown and of isolation and loss .

Social workers will be required to carry out a wide range of 'promotive, preventive and responsive'[56] roles to both mitigate the impact of Covid -19 and assist in the management of the long term consequences on societies.

Social Work has an essential front line role, working with other health professionals in delivering services to Covid-19 patients their families and carers and also in delivering services to vulnerable, isolated at risk adults and children to protect and promote social wellbeing.

SECTION 4: Defining the Required Workforce

4.1 Mapping New Service Activities

This section outlines some of the key developments, including Transformation projects that will impact on the social work workforce of the future. Where known, projected workforce numbers associated with new developments or changes have informed the modelling of future numbers of social workers required. However, some of the developments have yet to quantify the

[54] The World Bank: Poverty and Distributional Impacts of Covid -19:Potential Channels of Impact Mitigating Policies
[55] Direct and indirect impacts of COVID-19 on health and wellbeing: Rapid Evidence Review July 2020 Health and Equity in Recovery Plans Working Group
[56] International Federation of Social Workers: Social Service Workforce Safety and Wellbeing During the Covid 19 Response:

potential impact on staff numbers and there may be a need to review projections going forward when more definite information is known.

Multi-Disciplinary Teams (MDTs)

A new model for primary care has been developed and is being piloted in five GP Federations across Northern Ireland to enhance the services available at primary care level, with a greater focus on prevention and early intervention. Social Workers will work alongside other health care professionals on the management of ill health and the physical, emotional and mental wellbeing of communities. To date (March' 21) 67.7 (wte) Band 7 social workers (against a target of 127.4) have been recruited, representing 67.7 % of what is required. Initial calculations indicate that 18 Band 8A social work managers, 380 Band 7 social workers and 180 social work assistants will be required when the MDTS are fully implemented (8-10 years) across all 17 GP federations in NI.

Around 200 Mental Health Practitioners will also be required and potentially up to 50% of these may also be social workers. Evaluations are currently underway to determine future rollout.

Social Work recruitment into these posts has been impeded by the lack of availability of staff and is significantly lower than the other professions. The maximum impact of this model will only be realised with full staffing and the limited supply of social workers is putting this at risk.

Mental Capacity Act (NI) 2016

The implementation of the Mental Capacity Act[57] (MCA) has placed additional responsibilities on social workers particularly in respect of Deprivation of Liberty Safeguards (DOLS)and increased demand for Approved Social Workers (ASWs) as well as the workload for social workers in both hospital and community settings.

A report was commissioned by the DoH in 2020 to provide an evidence based estimate of the number of Approved Social Workers required by Trusts to fulfil their statutory duties under the Mental Health (NI) Order 1986. The report , prepared by Professor Gavin Davidson and Dr Claire Mc Cartan has

[57] Mental Capacity Act (NI) 2016 /Mental Health (NI) Order 1986

recommended an additional 64 ASWs are required to meet current and anticipated need. [58]

As outlined above all HSC Trusts have reported the roll out of the MCA requirements have added significantly to workforce pressures across adult services.

Reform of Adult Social Care

The Reform of Adult Social Care is considering different approaches to care and support to ensure the long-term sustainability of the adult social care system, including proposals for all aged over 75 to be entitled to a social assessment. The demographic trend towards an increasingly older population including people with a learning disability, greater numbers of people over 85 + and fewer people of working age in society is impacting on demand and requiring a review of how services are delivered and funded in the future.

There are a range of proposals currently out for public consultation, (March 2022) that if progressed will impact significantly on the social work workforce and require additional social work posts such as a focus on locally based, collaborative and community based service provision, supporting people to live well in their own home in connection to their families, social networks and communities and support for preventative and early intervention models.

Social workers alongside multi-disciplinary colleagues, working in integrated teams, are playing a key role in supporting people to live independently at home and ensuring they are safeguarded from abuse or exploitation. Additional numbers of social workers will be required to maintain the current level of service to the anticipated population increases. Any changes in service delivery need to be quantified and factored into future workforce planning.

Review of Urgent and Emergency Care

A Review of Urgent and Emergency Care is underway to establish a new sustainable, high quality regional care model, the most appropriate arrangements for assessment and admission of older people, and the best, appropriate care for people of all ages to reduce Emergency Department (ED)

[58] Approved Social Worker Workforce Planning Estimates 2020:Prof G Davidson and Dr C. Mc Cartan :QUB

attendances and hospital admissions. Combined with the roll out of 7 day working in hospitals, to improve patient flow, and service delivery to patients and their carers, the role of the hospital and community social worker will become even more pivotal in discharge planning, and in the provision of rehabilitation services in the community. This includes a consideration of how the Regional Emergency Social Work Service (RESWS)[59] could be utilised to prevent unnecessary admissions. Implications for the social work workforce will become clearer as the review progresses.

Adoption and Children's Bill

The proposed Adoption and Children's Bill will place new duties on Trusts and introduce new processes for social workers, partly as a consequence of the introduction of new legal orders, and the strengthening of existing provision in relation to looked after children, care leavers and adopted children. It is anticipated that there will be additional staffing requirements in relation to some of the new duties under the Bill.

Adult Protection Bill

The Adult Protection Bill is currently being drafted including a business case relating to the costs involved, which will include workforce implications.

The draft Adult Protection Bill will include the establishment of an Independent Adult Protection Board to oversee adult protection in Northern Ireland which will need to be appropriately staffed. It will also legislate for the availability of independent advocates, which will have resource implications for the HSC Trusts, who will be responsible for implementing new powers and duties on the ground.

The full extent of the impact on the workforce has not yet been quantified but future projections should include any emerging workforce data.

Problem Solving Justice

PBNI are involved in delivering a number of the Problem Solving Justice initiatives, aimed at creating safer communities and reducing reoffending, which subject to funding from the DOJ, will be rolled out over the next 5-10

[59] The Regional Emergency Social Work Service (RESWS) consists of a mixture of permanent and locum senior practitioner social workers and managers to provide an emergency out of hours social work response across the five Trusts.

years. When completed, it is estimated the workforce would need to expand by up to 75 social work qualified staff to deliver the initiatives which include the Substance Misuse Court, the Promoting Positive Relationships project, the Mental Health Court, the Domestic Violence Court arrangements, and the Enhanced Combination Order Project.

Encompass

The development of a digital health and care record for all citizens**,** Encompass, will introduce new ways of working to improve efficiency and productivity. Implementation and ongoing maintenance will require professional staffing and support. Social Work must be engaged in the design to ensure it supports front line practice, a reduction in bureaucracy and an increase in digital capacity.

Third (Voluntary) Sector

As outlined throughout this report staffing levels within the voluntary sector are impacted by a number of factors, however it is unlikely that current numbers will reduce, with expectations, that due to increasing demand for mental health services in particular, and if funding is available, that workforce numbers may need to increase.

Strategic Theme 3: Workforce Planning

Workforce planning and projections must be a compulsory element of all new service developments to ensure future workforce needs are identified and appropriate planning /strategies put in place to address (Rec 2A)

4:2 Social Work Register Projections

Social Work Register projections

The number of NISCC registered social workers at February 2022 was 6,417 not including students. Of this, approximately 5,398 were self-declared with employment in NI.

Additional requirements for the social worker workforce up to 2031 have been estimated as follows:

Increase HSC Older People's Social Workers to maintain the current ration per population aged 65+ years into 2031, plus an additional factor for an increased proportion of 85+ years.	197
Stabilise Children's Services by funding posts on a 52 week service basis i.e. account for planned absence, study leave, annual leave.	534
Primary Care Multi-disciplinary Team (MDT) social workers	380
Primary Care MDT mental health practitioners	93
Approved Social Workers	63
Probation Board for NI	75
TOTAL	1,351

***The above table is mainly based on HSC-derived assumptions. Further data/information from the non-HSC sector and universities may cause this figure to be revised.*

This estimate of a further 1,351 social workers required would represent an increase of 25% on the February 2022 count of 5,398 registrants in employment. Based on assumptions of a 2.3% retirement rate and 90% of the 5 year average of graduates entering the workforce as social workers, the register may be short around 458 social workers on the 1,351 additional estimate required.

A front-loaded approach of an additional 60 places for 5 years could help to bridge that gap, in conjunction with other measures.

This would bring the total places to 320 (260+60), a 23% increase, which is potentially the limit of how many more could be accommodated in placements for students.

2020/21 HSC agency expenditure on social workers was £8.5m (a decrease from £10.57m in 19/20). The NISCC register at February 2022 shows 142 social workers self-identifying with agency employment. Current HSC social worker vacancies in recruitment were 417 at December 2021. The number of current vacancies in recruitment has not been specifically used in the calculation for the recommendation on additional undergraduate places as this requires a more immediate solution. However, long-term it is expected that the main recommendations will help lower future vacancy levels.

Strategic Theme 4: Workforce Business Intelligence

An agreed regional data set (and processes) to inform policy making and decision making at a strategic level and to inform the development of workforce initiatives, should be developed. (Rec 2a)

4:3 Stakeholder Engagement

Stakeholder engagement is key to effective workforce planning and the delivery of high quality health and social care. Key stakeholders were members of the Project Group, which met regularly and contributed to the development of the review, until restrictions were imposed in response to the Covid-19 outbreak. Engagement events detailed below, and engagement on social media, took place, prior to the restrictions, to ensure the review was informed by the principles of co-production and co-design.

Two key stakeholder events were scheduled, a real time e-participation Stakeholder Engagement Event held at the Ulster University in March 2020, and the 3rd Annual Social Work Strategy Workforce Workshop held in March 2020.

The discussions focussed on the main themes of **supply, recruitment and retention** and future delivery of social work services

A wide range of over 100 participants, from the statutory, independent and voluntary sector, education providers, staff side, and service users, attended the Engagement Event in the Ulster University on 28.2.20. The aim of the event was to seek views on the social work workforce of the future and to consult on the development of the draft report, which was circulated before the event.

The methodology used combined the live aspect of a small scale discussion with information and communication technologies, using information and in-depth investigation, small group discussion, reflection and polls.

Participants were asked to discuss and prioritise responses to the following the following three questions:

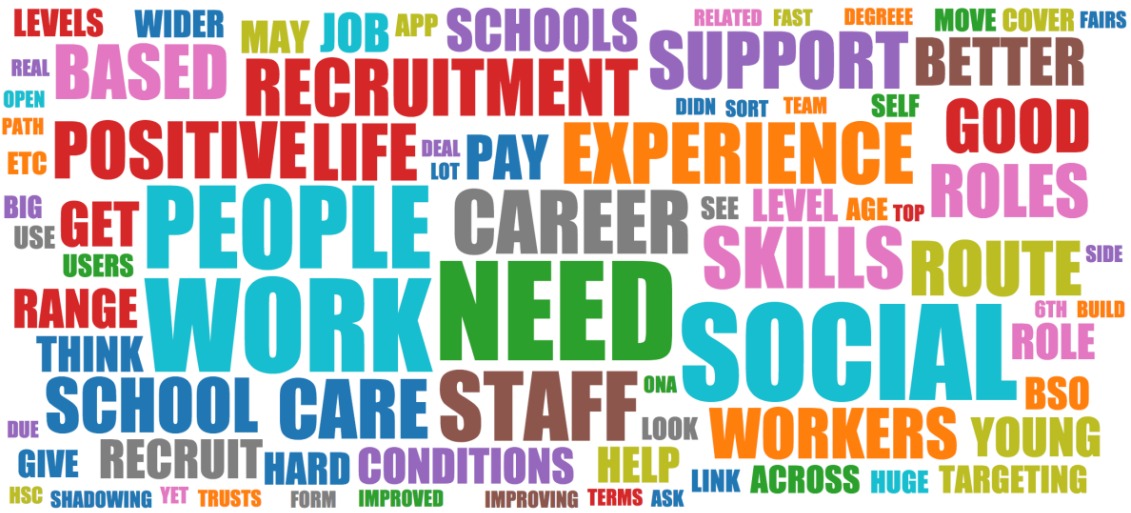
Q1: Recruitment-What needs to be done to attract the right people with the right skills into social work?

Q2: Retention-What needs to be done to retain social workers in the work force?

Q3: The future of the service you deliver or the service you receive - How should it develop and be delivered in the future?

Below is a cloud map of the responses in respect of Question 1 on Recruitment:

'What needs to be done to attract the right people with the right skills into social work '



A summary of the responses to all three questions was as follows:[60]

Recruitment & Supply

- Alternative routes into social work should be explored
- Positive branding and awareness raising of social work is needed
- Highlight the opportunities within the social work profession
- Improvement needed in recruitment processes

[60] Social Work Workforce Review Engagement Event Instant Report :Engage UU Feb 2020

Retention

- Manageable caseloads are essential
- Reduction of bureaucracy is required
- Enhance career progression and CPD opportunities
- Focus on health and wellbeing and support for all staff

A second consultation event took place at the **Annual Social Work Workforce Workshop** on 12th March 2020.

The following are some of the key messages from the discussions:

- Need for flexible pathways into the profession to increase diversity in the workforce
- Workplace conditions, keeping people in work and keeping social workers well are a priority.
- The gender imbalance in the workforce remains an issue (predominately female)
- Workforce data trends indicate women are more likely to leave during their 30s and in their 50s; this suggests that there is a need for more family friendly policies and flexible job design including at senior levels to maintain women in the workforce during different stages of their careers i.e. allowing for people to manage personal/professional life commitments while at the same time offering continuity and consistency for service users.
- There is a lack of intelligence about why people leave and their future employment destinations; more extensive use of exit interviews would provide more insights.

Strategic Theme 5: Retention

Effective retention strategies should be developed and implemented to secure and retain a stable, skilled and motivated workforce resourced to deliver safe and high quality social work services (Recs 5&6)

4:4 Social Work Workforce Planning: UK & Ireland

Reports[61] highlight challenges across Europe in respect of the social care and social work workforce that have also been raised in the course of this review, predominantly in respect of supply, recruitment and retention.

Workforce reports from across the UK and the Republic of Ireland identify similar concerns and provide information on initiatives that are being developed along with examples of innovative practice that could be considered within the NI context

Workforce planning in England, Scotland and Wales is based on common data sets[62] which provide the data, intelligence and information used to analyse social work workforce trends, inform the commissioning of social work training and shape policy and decision making. There is no common data set for the workforce in NI.

The Scottish Social Services Council (SSSC) undertake two workforce data collections per year using a Core Minimum Data Set (CMDS)[63] and publish two reports each year which provide data, information and intelligence to inform workforce planning.[64] The data and information is available on the SSSC website for use by the sector and stakeholders.

Additionally, they produce a report every two years on 'Demand for Social Workers'[65] which analyses available information, provides forecasts, highlights areas to address and sets out suggestions for action. The 2019 report identified similar concerns to those identified in this review including a growing gap between demand and supply and concerns regarding retention. Responses to address this include work on widening access to social work courses, a five year longitudinal research study of NQSWs and development of a national model for a supported and assessed first year in practice.

In England, Skills for Care[66] collate data in respect of the adult social care workforce via an online data collection service using an agreed Adult Social

[61] Social Services Workforce in Europe: state of Play and Challenges. Federation of European Social Employers: June 2019
[62] Scotland use Core Minimum Data Set (CMDS), England use Adult Social Care Workforce Data Set (ASC-WDS)
[63] The Core Minimum data set was created to address the need for standard workforce data covering the whole of the sector using common data standards for key or core data items.
[64] Scottish Social Services Workforce Data Report & Mental Health Officers Report
[65] Demand for Social Workers :SSSC May 2019
[66] Skills for Care are the strategic body for workforce development in adult social care in England

Care -Workforce Data Set (ASC-WDS) and produce an annual report that provides workforce intelligence, analysis and forecasts. The data is used to develop interactive dash boards for local use, to inform policy making and decision making at a strategic level and to inform the development of workforce initiatives. The data collated via the ASC-WDS is also being used to develop 'machine learning'[67] models to identify key factors that influence turnover rates, Care Quality Commission (CDC)[68] scores and to understand the impact that workforce variables may have on the quality of care.

Skills for Care also undertake research and impact projects (largely funded by the Department of Health and Social Care) to provide evidence to assist with strategic workforce planning. Research conducted with adult social care employers with low turnover rates, of less than 10%,[69] concluded that '*investment in learning and development , a positive workplace culture, recognising, supporting and celebrating the strengths of the workforce and the use of values based recruitment all impacted positively on recruitment and retention'*.[70]

The Department for Education (DfE) (England) collate data in respect of the Children and Family Social Work Service in England, based on an annual statutory census collection and produce an annual statistical report.[71] Concerns regarding supply, recruitment and retention are common themes in the workforce reports. The DfE has commissioned a five year longitudinal study to collate robust evidence on recruitment, retention and progression in child and family social work with the aim of building a better understanding of the issues facing local authority social workers and factors affecting job satisfaction and retention. Findings from the first year highlight a need to focus on social workers with 2-3 years' experience as they move from the protection of the AYE, a need for flexible working, reductions in unnecessary bureaucracy and the importance of organisational culture and peer and management support in building a healthy workforce.

[67] Machine learning is the study of computer algorithms that improve automatically through experience
[68] Care Quality Commission is the independent regulator of all health and social care services in England
[69] This included 1426 'standalone' organisations , 157 'parent' organisations & 40 Local Authorities
[70] Skills for Care :Recruitment and Retention in Adult Social Care: Secrets of Success: learning from employers what works well: May 2017
[71] Department for Education (DfE):Official Statistics: Children and Family Social Work Workforce in England

A number of national initiatives are underway in England to improve recruitment and retention, including the use of 'Risk Retention Tools'[72] and 'Return to Social Work' [73] programmes. Other initiatives have focussed on supporting newly qualified social workers, improving technological support in the workplace, providing personal assistants to support social workers with administrative and non-professional tasks, and an Innovation Programme to support and promote examples of good practice

More broadly, the NHS has identified retention of staff as a key issue and a crucial factor in securing a skilled and sustainable workforce for the future[74]. Key themes such as building line manager capacity, shaping organisational culture, flexible and predictable working, development and career planning, supporting new starters, staff engagement, health and wellbeing and the use of data to understand and evaluate the workforce have all been identified as critical in reducing staff turnover rates. In addition the NHS has developed a Retention Hub[75] to facilitate the sharing of best practice resources and learning to improve retention.

Social Care Wales[76] work in partnership with the Local Government Data Unit, the Association of Directors for Social Services and the Welsh Government to collect analyse and report on social worker workforce planning data to inform the commissioning of social worker training and to underpin planning for future workforce needs. They produce an annual report[77] of the current workforce which also considers the projected demand for social workers. Projections in the report indicate that the local authority social work workforce will increase by 6% by 2021/23.

Republic of Ireland: Significant concerns have been reported by TUSLA (Child and Family Agency) in the retention and recruitment of social workers in Ireland. Major gaps between supply and demand have prompted the

[72] Evidence-based diagnostic tool that helps senior leaders of children's services understand the risks they face within social worker retention – and what the solutions are.

[73] The Local Government Association (LGA) in association with the Government Equalities Office (GEO), in England, have been running a free return to social work scheme , since 2017, for social workers who have been out of practice for between 2-10 years, providing training and support to enable re-registration .

[74] NHS: Retaining our People: A Practical Guide to improving retention of clinical staff.

[75] The NHS online Retention Hub is a platform for Trusts to share initiatives and resources and to implement best practice

[76] Social Care Wales is the regulatory body for social work and social care in Wales

[77] Social Worker Workforce Planning 2018-19: A national report on the social worker workforce e for Wales

development of a range of initiatives to increase supply and improve retention, some of which may impact on supply in NI.

Currently (2020) there are 230 social work training places across nine educational centres in Ireland. Ireland has a population of almost 5 million and it is widely recognised the number of places is insufficient to meet demand. Proposals to address the growing deficit include increasing the number of 3rd level social work places, development of alternative pathways into professional training, development of a career pathway for social care workers, technical administrative roles to support frontline social workers alongside consideration of protected caseloads, the role of senior practitioners and enhanced supervision to improve retention.

Similar to the HSC, Tusla had experienced difficulties with a high number of agency social workers and associated instability within the workforce. In 2019 they converted 400 agency jobs to permanent posts. They have also taken steps to facilitate easier transfer/mobility of the workforce through the development of a National Transfer Policy.

As our closest neighbours there have been concerns about the potential impact on the pool of social workers in NI. A survey completed in January 2019 of new CORU (Ireland's multi professional health and social care regulator) applicants showed that 19 of 100 new applicants were from NI. This represents less than 10% of the average number of new social workers each year, however it is not known if this is an established trend each year.

83 social workers registered with the NI Social Care Council are domiciled in the ROI.

Recent (Feb'21) announcements of public sector pay increases in the ROI may potentially attract more of the NI social work workforce, particularly in border areas.

Strategic Theme 6: Workforce Development

Ongoing investment and support of leadership, improvement and continuous development are essential to maintain and retain a skilled, stable and motivated workforce able to deliver quality services and meet future challenges (Recs 5&6)

SECTION 5: Conclusion

It is evident that demand is outpacing supply for the social work profession and urgent action must be taken to address this and ensure there are the 'optimum number of people in place to deliver treatment and care and promote health and wellbeing to everyone in Northern Ireland with the best possible combination of skills and expertise'[78]

Health and social care services are facing rising demand which is being driven by demographic change, advancing medical science and new technologies. Transformation is essential to ensure a Health Service that is able to meet the challenges of the future.

Different approaches within justice and education and the development of new initiatives are increasing demand for social workers and it is imperative to ensure there is a skilled, competent and confident workforce in place able to deliver safe, high quality care

HSC data, the ASW review, reports from the Trusts and all social work employers indicate a growing gap between demand and supply of social workers that must be addressed to ensure the delivery of safe and effective professional social work practice in the future.

Social Workers have played a key role in responding to the Covid-19 pandemic and will have a crucial role in public health and wellbeing strategies of the future. The long term impact of the Covid-19 pandemic is becoming more evident with increasing evidence and reports of mental, physical and emotional ill health and concerns that require a social work response. This will require a workforce that is flexible and mobile, with transferable skills.

Responses from the Stakeholder Engagement events concurred with many of the key themes identified throughout the review and with those identified in other jurisdictions of supply, safe staffing, recruitment and retention.

Safe staffing legislation for professionals within the HSC is currently being considered and it may also impact on demand.

[78] Obj 1 Action Plan: Health and Social Care Workforce Strategy ;2026

Student numbers were reduced to 260 from 300, in 2011, and it is likely the cumulative impact of this reduction has contributed to a growing gap between supply and demand. The calculations and predictions contained within this report make a clear case for a n additional **60** student places in order to ensure there will be a workforce with the capacity to meet future demand.

The route to achieving this number needs further exploration and agreement but may include more work based opportunities, the retention of the Open University Degree course, reductions in student attrition rates, return to social work schemes, and increases in university places.

Widening access to social work courses to improve supply, alongside development of retention schemes and strategies to retain experienced and newly qualified staff were identified as key factors in ensuring we have a fully trained and motivated workforce with the capacity to meet future challenges.

Proactive, collaborative approaches to recruitment difficulties are already underway and need to be developed further, to ensure an adequate supply of social workers and improve and strengthen the workplace supports and practice for every social worker irrespective of where they work.

A focus on health and wellbeing, support for staff, manageable caseloads, opportunities for CPD, career progression and flexibility were all consistently identified as factors that positively impacted on staff retention.

Urgent action is required now to ensure there is a sufficient supply of social workers to meet future need.

SECTION 6 Recommendations

Recommendations and action plan

Based on the findings of the review the key recommendations are set out below, these have been structured under key headings and will inform the Action Plan.

COMMISSIONING	**1**	**Analysis of future anticipated demand, current and future workforce demographics indicate that an additional 60 social work places will be required to maintain a stable social work workforce.** **Education provision and supporting learning arrangements should be reviewed to produce plans and timetable for increased capacity .**

WORKFORCE PLANNING	2 a	There should be a process to collate, analyse and report on the state of the social work workforce, using agreed regional minimum workforce data , to monitor workforce trends , forecast future needs and inform workforce planning and decision making
	2b	There should be regional consistency (using workforce data) in the numbers deployment and use of social work practitioners, including use of title, based on the development of a model to identify normative staffing/safe practice levels for social work teams
SUPPLY	3	To increase supply, appropriate measures should be taken to promote social work as a career choice, to review the routes into the profession and to develop options for leavers to return

RECRUITMENT	4	Develop recruitment processes and practice to be responsive, timely and cost -effective, to secure workforce stability.
RETENTION	5	Develop a strategy to secure and retain a stable, skilled and motivated workforce, with a specific focus on retaining NQSWs(1-3yrs) in post, to ensure the appropriate mix of staff with the appropriate skills to deliver safe and high quality social work services
WORKFORCE DEVELOPMENT	6	CPD (through PiP) should support effective practice, career aspirations, workforce mobility, new developments and changing requirements.

STRATEGIC OVERSIGHT	7	There should be strategic oversight to monitor workforce trends, share good practice and agree regional actions to strengthen the workforce

SOCIAL WORK WORKFORCE REVIEW – ACTION PLAN FOR IMPLEMENTATION

	Recommendations	Action	Lead, assisted by and timescale
	1 COMMISSIONING Analysis of future anticipated demand, current and future workforce demographics indicate that an additional 60 student social work places will be required to maintain a stable social work workforce. Education provision and supporting learning arrangements to be reviewed to produce plan and timetable for increased capacity.	1. **Agree** a cross departmental (DoH/DoJ,DE) strategic plan to resource, develop and sustain additional PLOs with all providers. 2. **Secure** engagement, investment and support of senior level managers in all provider organisations to resource and enable PLO development/sustainability 3. **Review** NIPTTP/Refresher training to respond to need for additional PLOs 4. Consider wider context of 'resourcing the partnership' for additional students ie admissions selection processes/teaching/marking/assessment/PLO coordination & delivery 5. Consider alternative models of P/L in days required 6. Consider the role of voluntary and community organisations in the provision of additional PLOs.	OSS OSS OSS OSS NISCC/OSS OSS
	2. WORKFORCE PLANNING There should be a process to collate, analyse and report on the state of the social work workforce, using agreed regional minimum workforce data , to monitor workforce trends, forecast future needs and inform workforce planning and decision making	7. A working group of key stakeholders should be set up to develop a regional workforce data set that for use in workforce planning and decision making, across all sectors 8. A specific HSC workforce planning report should be developed using data collected from the DSF reporting process. 9. Establish a strategic oversight group of senior social work and HR leaders to review annual workforce data and trends and agree on local and regional actions	

	There should be regional consistency (using agreed workforce data) in the numbers, deployment and use of social work practitioners (including use of title), based on the development of a model to identify normative staffing/safe practice levels for social work services .	10. Ensure workforce planning and projections are a compulsory element of all new service developments to be shared with strategic oversight group. 11. Develop and agree a model for normative/safe staffing standards, 12. Review numbers, deployment and use of social work practitioners to ensure regional consistency in capacity linked to normative staffing /safe practice levels 13. Review use and deployment of senior practitioners and principal practitioners to ensure support for managers 14. Agree a regional approach to creation of new posts at Band 7 and 8a level to maintain regional consistency and equity in career progression opportunities. 15. Consider regional standardisation of job titles and bandings to promote regional consistency and improve accuracy of workforce data	
	3: SUPPLY To increase supply appropriate measures should be taken to promote social work as a career choice , to review the routes into the profession and to develop options for leavers to return	16. **Key bodies to work collaboratively to** promote social work as a positive career choice offering opportunities for development and progression. 17. **Target** post primary schools and develop work-experience/ learning opportunities for young people. 18. **Review** pathways into social work, including, a career progression pathway for social care workers that includes access to a social work qualification. **19. Develop** a strategy to improve diversity within social work workforce 20. **Develop** a pathway and supports for those who leave social work to return including consideration of a Return to Social Work programme	NISCC

		21. **Key bodies** to work collaboratively to minimise attrition rate of social work courses	
	4: RECRUITMENT Improve recruitment processes and practice to be responsive, timely and cost -effective, to secure workforce stability.	22. Develop and implement a regional co-ordinated approach to recruitment of NQSWs to secure timely and permanent appointments in HSC. 23. Introduce a transfer policy to enable movement and redeployment of staff within Trusts. 24. Consider a regional Job Rotation scheme, within HSC, to support development and career succession planning 25. Consider standardisation of social work practitioner job titles , to include the title of 'social worker' and agreed core professional tasks for use as basis of job descriptions for comparable posts across Trusts 26. Develop strategies and actions to address challenges of hard to fill/unfilled posts that address both recruitment and retention issues. 27. Introduce a Childcare recruitment Support Officer for Family and Children's Services in each Trust 28. Consider how to enhance and strengthen total student experience during practice learning as part of proactive	

		recruitment policy for HSC aligned with the HSC Careers Service	
	5: RETENTION Develop a strategy to secure and retain a stable, skilled and motivated workforce to ensure the appropriate mix of staff with the appropriate skills to deliver safe and high quality social work services	29. Review the Assessed Year in Employment (AYE) to strengthen supports for NQSWs including structured rotation that develops capacity and capability to work across different settings and helps inform career choice and pathways. 30. The retention of staff into their second and third year in the same post, should become a key HSC objective, to address preventable turnover in some teams. Once recruited, all staff need to be adequately supported to remain in their role. Newly qualified SWs especially, should be mentored by more experienced staff and the achievement of AYE should be formally recognised by an Award from NISCC. 31. Agree a regional framework that can be used by all social work employees to strengthen supports for new starts in individual organisations and includes the promotion of self-care. 32. Implement a career planning framework setting out pathways for career progression supported by relevant development and CPD opportunities. 33. Consider a job rotation scheme for all social workers including opportunities for inter-organisational /sectoral exchange. 34. Build capacity and capability of leaders at all levels to support succession and career planning in social work 35. Introduce job plans for social workers to include time for CPD and professional supervision. 36. Strengthen capacity and capability of first line managers, senior practitioners and principal practitioners to provide professional leadership and supervision. 37. Implement revised supervision policy	

		38. Develop coaching and mentoring schemes for social workers including senior leaders. 39. Introduce flexible working and family friendly policies, well- being initiatives and policies to help retain experienced staff. 40. Consider a Retire and Retain policy in social work 41. Review job design and flexible working opportunities for staff in senior posts to retain experience and expertise 42. Introduce exit interviews to inform local and regional retention strategies. 43. Ensure planning for introduction of ENCOMPASS in community settings meets the need of social workers 44. Consider introduction of skills mix into social work teams 45. Increase use of technology to improve efficiency, reduce bureaucracy, and increase time for professional practice 46. Pilot use of administrative support for first line managers	
	6. WORKFORCE DEVELOPMENT CPD, (thorough PiP) should support effective practice, career aspirations, workforce mobility new developments and changing requirements.	47. Review and update CPD to support career planning framework and workforce mobility and to ensure staff are supported and prepared for new business working models including technology and changes in legislation. 48. Service user feedback should be used to inform and improve practice 49. Review and update supervision training to support implementation of revised supervision policy 50. Promote evidence-informed decision making to improve and support practice decisions and outcomes	

	7:STRATEGIC OVERSIGHT There should be strategic oversight to monitor workforce trends, share good practice and agree regional actions to strengthen the workforce	51. Establish a strategic oversight group of senior social work and HR leaders to review and monitor workforce data and trends, share good practice and agree regional actions to strengthen the workforce. 52. Create and extend opportunities to showcase good practice initiatives that have strengthened the workforce and agree and support regional adaptation and spread. 53. Build capacity and capability of professional leaders at all levels to build healthy work environments and contribute to local and regional workforce planning.	DOH

Appendix 1: Project Group Membership

Carol Diffin BHSSC T

Karen O'Brien WHSCT

Linda McConnell SEHSCT

Rhoda Mc Bride BHSCT

Anita White NHSCT

Peadar White SHSCT;

Suzanne Mahon WHSCT

Michaela Glover HSCB

Myra Weir SEHSCT.

Damien Maguire Staff side

Marian O'Rourke NISCC

Carolyn Ewart BASW

Danielle Turney QUB

Paul McStravick, YJA

Colin Reid EA

Gillian Robinson, PBNI

Lynne Stevenson Barnardos

Catherine Donnelly, Catherine DoH

Dunwoody, Alison DoH

Christine Mclaughlin WHSCT

Ann Moir SHSCT

Maxine Gibson HSCB

Catherine Maguire NISCC

Judith Mullineux UU

Jill Brown YJA

Elaine Craig EA

Christine Smyth / Jackie McIlroy /Andrew Dawson DOH Co-Chairs

Eithne McIlroy DOH Project Coordinator

Appendix 2: Terms of Reference

Terms of Reference

Social Work Workforce Review

Purpose: To plan for a Social Work workforce of the right size, with the right skills, and deployed in the right way to deliver safe, effective and high quality social work services within available resources, based on data, evidence and analysis of current and future needs.

A Project Group will be established to undertake a workforce review to support strategic workforce planning within the HSC and criminal justice, education and independent sectors.

The workforce review will:

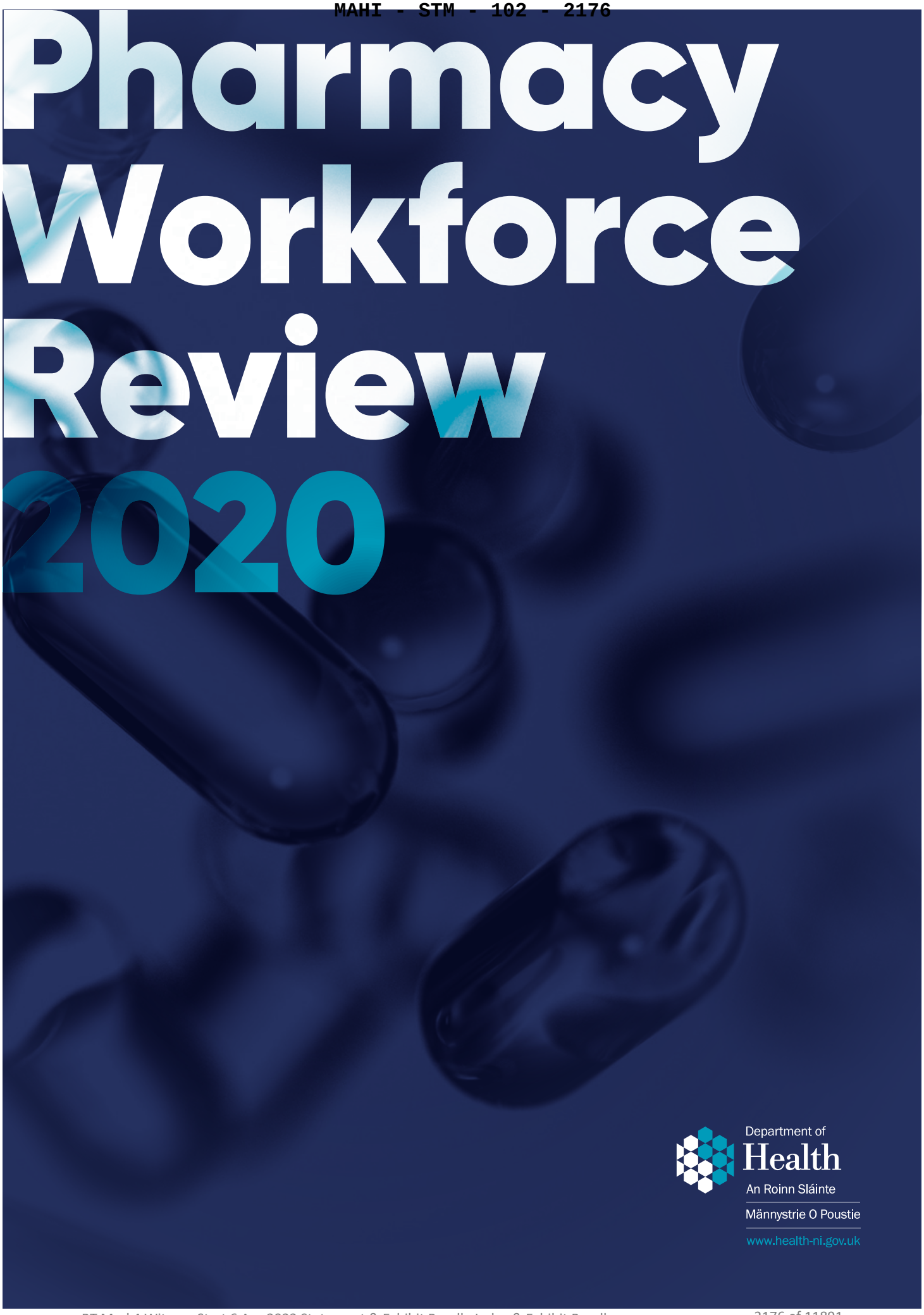
(a) **Produce information, data and analysis on**:
- Current capacity and availability of social workers in Northern Ireland;
- Strategic developments/changes that will impact on future social work workforce requirements (e.g. demographics, transformation, service changes, emerging need, education pathways to professional qualification);
- The numbers and profile (e.g. skills, roles, practice area etc.) of social workers needed to deliver safe, effective, person-centred services in the future.

(b) **Produce plans and recommendations about:**
- The workforce profile required to ensure sustainable social work services regionally;
- Recruitment and HR processes required to maximise the capacity of the workforce to deliver services regionally and ensure sustainability, consistency and retention;
- Professional and workplace supports required to improve retention, reduce absenteeism and ensure safe, effective, high quality social work practice and interventions
- The commissioning of pre-registration training places for social workers and education pathways to professional qualification;
- The commissioning of post registration training and education for social workers.

Appendix 3: Social Work Workforce Engagement Event: Instant Report

DoH HSC Social Work Workforce Strategy Engagement Jordanstown 28_02_20 Instant Report Release.pdf

Pharmacy Workforce Review 2020



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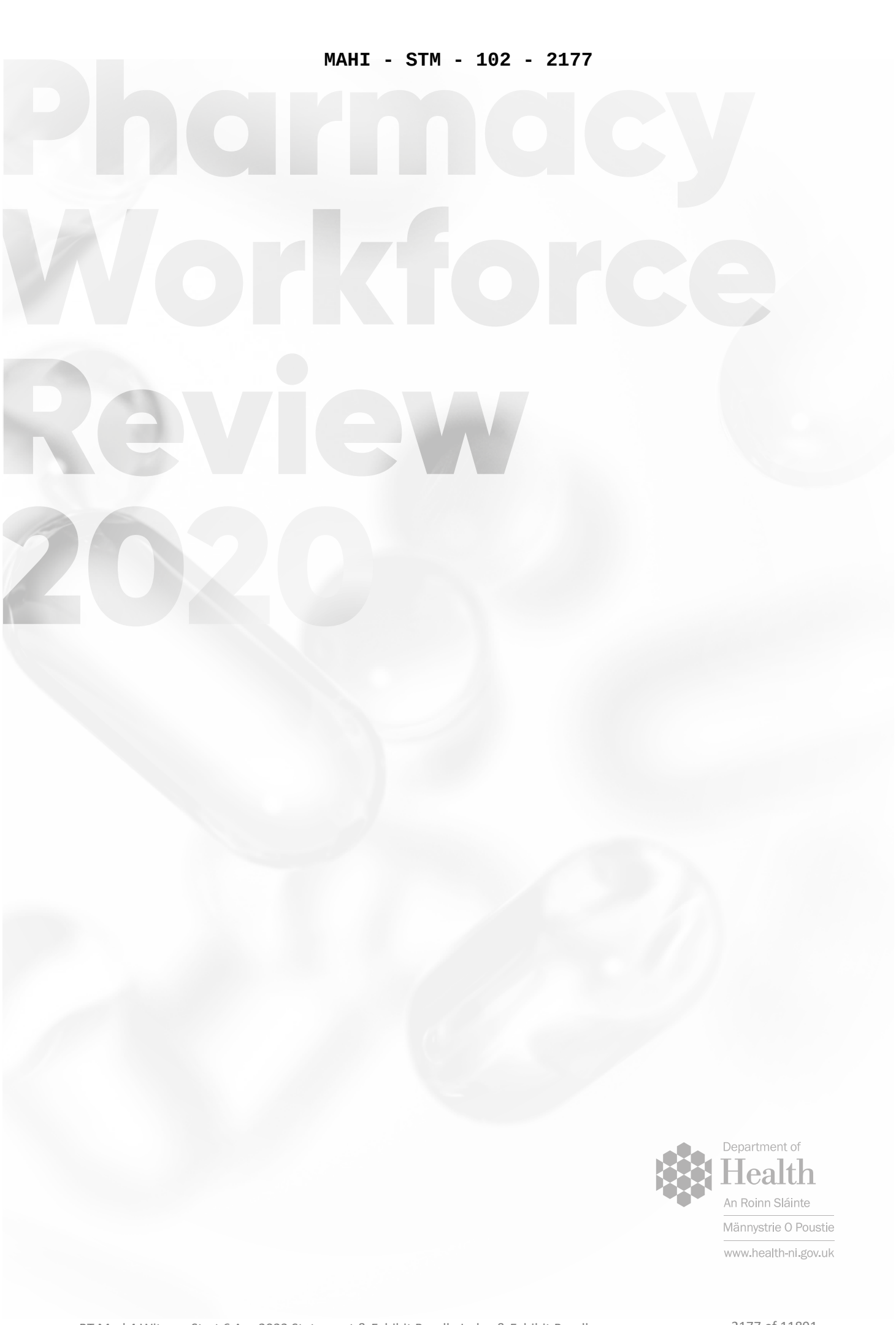
Pharmacy Workforce Review 2020



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Foreword

I welcome the publication of the Pharmacy Workforce Review, which comes at a critically important time for both the pharmacy profession and Health and Social Care Service (HSC) in Northern Ireland.

Pharmacists, pharmacy technicians and their teams have had a vital role in caring for patients and protecting public health throughout the COVID-19 pandemic. Across all HSC sectors they have risen to the challenges posed by the emergency to ensure the optimal and safe use of medicines. They have adapted and maintained services and provided essential support, underpinning the effective rollout of the COVID-19 vaccination programme.

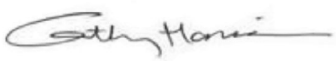
As we rebuild the HSC after the pandemic, the skills of pharmacy teams will be in high demand. With a large number of people waiting to access treatment and an aging population, the HSC will be caring for increasing numbers of people with complex medical needs, taking multiple medicines. To make real progress, the unique skills and knowledge of the pharmacy team as medicines experts will need to be developed and deployed effectively across all sectors.

This Review considered the full scope of pharmacy practice in Northern Ireland and there was wide engagement with the workforce during its development, including in community pharmacy, general practice and hospitals. This enabled people to share their views and experiences and I acknowledge the very real concerns raised around capacity, career development and a sense of professional isolation in some areas.

The Review dovetails with UK-wide reforms for the initial education and training of pharmacists which aim to prepare young pharmacists to take on increasingly clinical roles across all sectors. It also commits to a clear career pathway that will enable individuals to develop their knowledge and skills throughout their professional lives. A central theme of the Review is the need to develop the role of pharmacy technicians in Northern Ireland as registered professionals in their own right.

The recommendations contained within the report are ambitious and have the potential to be transformational for the pharmacy profession in Northern Ireland. There is much to be done, but by working together we can achieve sustainable change.

I would like to thank Professor Colin Adair and Ms Jill McIntyre for their leadership in completing this Review, and to all of those who contributed to its development. The Department has committed to implementing the recommendations of the Review and has developed an Action Plan to take this forward over the coming months and years.



Cathy Harrison
Chief Pharmaceutical Officer,
Department of Health

Defining the plan

Step 1

Step 1 – Defining the plan

1.1 Purpose of this review

Pharmacists and pharmacy technicians are pivotal in ensuring the safe and effective use of medicines. As Health and Social Care (HSC) in Northern Ireland (NI) continues to evolve, new services and models of working, together with a multi-professional approach to providing care is needed to meet the health needs of the population. Accordingly, the widening clinical role of pharmacists, supported by pharmacy technicians and adoption of automation, has resulted in greater effectiveness. Consequently, these professional groups are in high demand.

Health and Social Care Workforce Strategy 2026: Delivering for Our People[1], described the importance of workforce planning in enabling HSC to monitor workforce trends and address issues proactively. Subsequently, the DoH Chief Pharmaceutical Officer commissioned the Northern Ireland Centre for Learning and Development (NICPLD) to undertake a review of the pharmacy workforce to inform their pharmacy workforce development plan for the period 2019-29.

1.2 Need for this review

Population estimates for NI show that by 2026, the number of older adults (those aged ≥65 years) will exceed that, of children (those aged <16 years). Moreover, by 2039, one in four people will be aged over 65 years[2]. Whilst this demographic change is a medical, economic and public health success story, one consequence is an ageing population with complex health needs. Ageing is typically associated with an increased prevalence of multimorbidity (the presence of two or more long-term conditions) and polypharmacy (the prescribing of multiple medicines), which increases the demand for the health and social care services and practitioners generally. The ten-year vision for healthcare in NI describes a model of healthcare based on multidisciplinary teams working across the primary-secondary care interface[3]. Importantly, pharmacists and pharmacy technicians were seen to play a central role in this model, highlighting the need for a skilled pharmacy workforce across all settings.

The Medicines Optimisation Quality Framework[4], a roadmap for improving the use of medicines across the HSC, advocates the optimisation of medicines by a multidisciplinary workforce that includes pharmacists at each stage. This emphasises the need to advance the role of pharmacists through wider adoption of prescribing rights, development of clinical leadership and expansion of consultant roles in primary and secondary care.

[1] https://www.health-ni.gov.uk/publications/health-and-social-care-workforce-strategy-2026
[2] https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf
[3] https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together
[4] https://www.health-ni.gov.uk/sites/default/files/consultations/dhssps/medicines-optimisation-quality-framework.pdf

1.3 Aim of this review

The aim is to undertake a review of the pharmacy workforce, specifically pharmacists and pharmacy technicians, to inform HSC workforce development needs for the period 2019-2029. The scope focuses on the three main employed sectors; community, hospital and general practice pharmacy.

The review considered:

- Characteristics of the current pharmacy workforce
- Factors that will influence workforce development over the next 10 years
- Current recruitment and retention challenges
- Future requirements related to workforce numbers and development needs.

1.4 Approach used in this review

This review was planned and reported in accordance with the Regional HSC Workforce Planning Framework[5], which is a practical approach to ensuring a workforce of the right size and with the right skills. Figure 1.1 provides an overview of the six steps to integrated workforce planning. As with other professional groups, this review focuses on steps one to five; step six occurring at a later time following adoption of the review and implementation of its recommendation by the DoH.

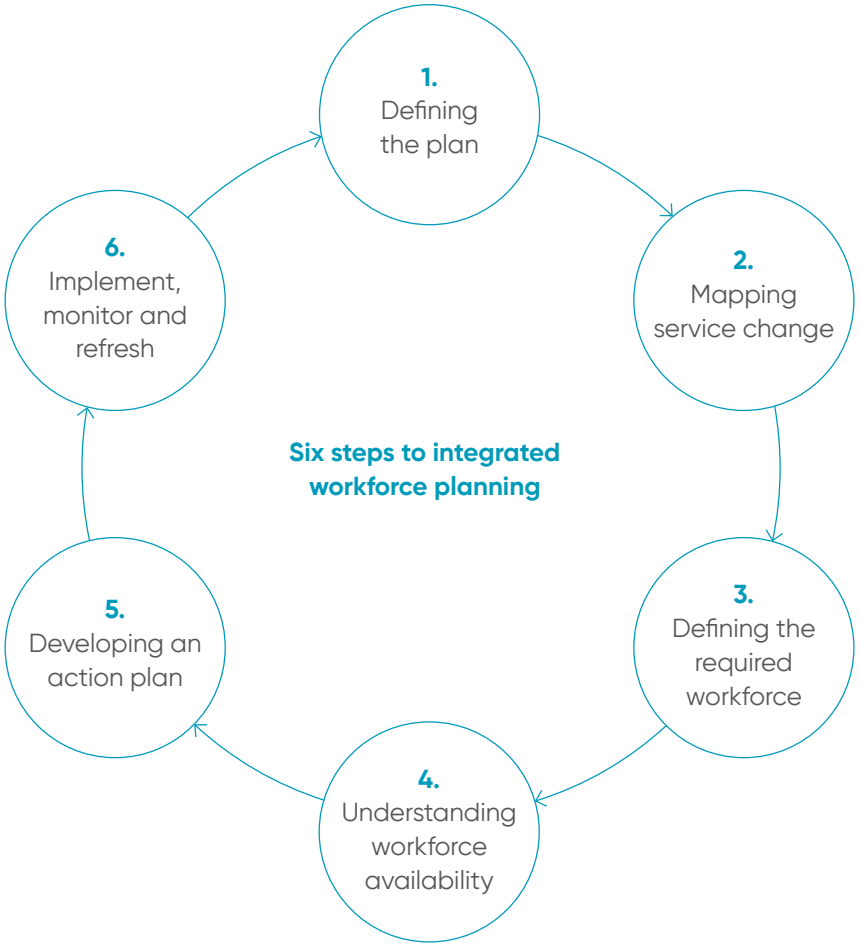


Figure 1.1 Six steps to integrated workforce planning.

[5] https://www.health-ni.gov.uk/publications/regional-hsc-workforce-planning-framework

This review was authorised by the DoH through the Medicines Optimisation Steering Group. A Project Board, consisting of key stakeholders, was formed to oversee the review and ensure input from their respective organisations and sectors. Members of the Project Board are listed in Appendix 1.

The recommendations made in this review were informed by qualitative research undertaken with key stakeholder organisations (see Appendix 2) and data collection from an anonymous questionnaire, circulated to all pharmacists and pharmacy technicians registered with the NICPLD. Data collection tools are shown in Appendix 3 (focus group topic guides) and Appendix 4 (questionnaire). Overall 690 questionnaires were completed, with 55% of responses from community pharmacists, 29% from hospital pharmacists, 18% from general practice pharmacists and 10% from pharmacists working in other sectors. These responses are in-line with the composition of the pharmacy profession by sector. A small number of responses were received from pharmacy technicians and these will be addressed in a separate report.

Mapping service change

Step 2

Step 2 – Mapping service change

2.1 Expansion of pharmacy services

Over the last 30 years the profession of pharmacy has been on a transition from the compounding of medicines to a more central, patient facing clinical role. Changes to professional practice have been driven by policy which have had implications for workforce development. Such policy has consistently sought to engage pharmacy in a more clinical role. For example, the 1999 Crown Report on the Review of Prescribing, Supply and Administration of Medicines[6] recommended the extension of prescribing rights to nurses and pharmacists. This was followed by the 2001 Audit Commission report, A Spoonful of Sugar[7], which described best practice for contemporary medicines management services in the hospital sector. This report envisaged pharmacists devoting less time to the medicines supply function and more time on clinical services.

Specifically, the report highlighted that pharmacists should:

- undertake medicines reconciliation on admission (particularly on older patients)
- provide medication review clinics
- develop their unique role contributing to medicines safety
- pro-actively implement clinical pharmacy services
- undertake a prescribing role.

Whilst this report focused on hospital pharmacy, the principles are generalisable to the wider pharmacy workforce.

Transforming Your Care (2011)[8] set out a broad new model of care tailored to today's needs that would better support patient-centered care. Its most substantial proposal was to develop quality alternatives to hospital care, focusing on primary, community and social care services.

These themes, and in particular a greater clinical role for community pharmacy, have been reinforced by Making it Better Through Pharmacy in the Community 2014[9], Making Life Better: Strategic Framework for Public Health 2013-2023[10] and the Northern Ireland Medicines Optimisation Quality Framework 2016[11]. Most recently, the need to continue with transformational change was emphasized in Health and Wellbeing 2026: Delivering Together[12]. While this document highlighted the progress already made with general practice pharmacists, it advocated more needed to be done to support and expand the role of community pharmacy.

[6] https://webarchive.nationalarchives.gov.uk/20130105143320/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4077153.pdf
[7] http://www.eprescribingtoolkit.com/wp-content/uploads/2013/11/nrspoonfulsugar1.pdf
[8] http://www.northerntrust.hscni.net/pdf/Transforming_Your_Care_Report.pdf
[9] https://www.health-ni.gov.uk/publications/making-it-better-through-pharmacy-community
[10] https://www.health-ni.gov.uk/articles/making-life-better-strategic-framework-public-health
[11] https://www.health-ni.gov.uk/consultations/medicines-optimisation-quality-framework
[12] https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together

2.1.1 Community pharmacy services

Community pharmacists are the most accessible healthcare professional to patients. There are currently 531 community pharmacies in NI and it has been reported that, on average, 45% of the population used a pharmacy 10 times or more within a year[13]. Overwhelmingly, patients report a high level of satisfaction with the pharmacy service. Over the last decade, the average monthly dispensing volume per pharmacy has increased by 22%[14]. This underestimates actual workload, given the increase in multiple dispensing that has occurred over this time.

Following the publication of Making it Better Through Pharmacy in the Community – five-year strategy 2014[15], the services provided by community pharmacy were extended to enhance the role of the pharmacist in managing medicines and contributing to health and wellbeing in the community. Despite the expansion in services, dispensing still remains the core function of community pharmacy. Agreed expansion in community pharmacy services are outlined in the following framework:

1. Practice quality system • Clinical governance • IT infrastructure • Access/opening hours • Practice-level services (Pharmaceutical waste, sign posting, advised self-care, Living well, emergency supply service)	**2. Core services** • Dispensing (including repeat and instalment dispensing) • Medicines adherence
3. Additional services • Medicines use review • Pharmacy first • Smoking cessation • Pre-registration pharmacist training	**4. Locally required services** • Palliative care • Opiate substitute dispensing • Needle/syringe exchange • Oxygen

Figure 2.1 Draft community pharmacy framework.

Whilst the policy-driven enhanced clinical role for community pharmacy is a positive step, successful implementation will be dependent upon appropriate funding and optimising pharmacist capacity through, for example, improved service design, better skill-mix and wider adoption of automation.

[13] http://www.hscboard.hscni.net/download/PUBLICATIONS/pharmacy_and_medicines_management/reports-and-publications/Survey-of-Community-Pharmacies-December-2016.pdf
[14] http://www.hscbusiness.hscni.net/services/2980.htm
[15] https://www.health-ni.gov.uk/publications/making-it-better-through-pharmacy-community

2.1.2 Hospital pharmacy services

Each hospital pharmacy department provides key pharmacy services[16]. Hospital pharmacists progress through their career following the Royal Pharmaceutical Society (RPS) roadmap from Foundation to Advanced practice. Aligned to this, National Health Service (NHS) Employers National Profiles for Pharmacy[17] describes the roles and responsibilities associated with each NHS pharmacy staff profile title. Figure 2.2 provides an overview of the Agenda for Change (AfC) banding within the NI hospital pharmacy sector.

Band 8d/9
Head of Pharmacy and Medicines Management

Band 8b/8c
Consultant Pharmacist

Band 8b/8c
Pharmacist Team Manager

Band 8a
Highly Specialist Clinical Pharmacist

Band 7
Specialist Pharmacist

Band 6
Rotational Pharmacist

Band 5
Pre-registration Pharmacist

Figure 2.2 Overview of the Agenda for Change banding for pharmacy.

2.1.3 General practice pharmacy services

Making it Better through Pharmacy in the Community also recommended the development of pharmacists in primary care. The general practice pharmacist initiative was announced in December 2015 and supported a five-year programme that aimed to embed approximately 300 whole time equivalent (WTE) pharmacists within general practices in NI by 2020. The effectiveness of this role has been investigated extensively[18] and, consequently, general practice pharmacists are being incorporated into general practice teams in countries such as America, Australia, Canada and Great Britain (GB)[19]. Their core roles and responsibilities are focused on improving safety, quality, efficiency and cost-effectiveness, as well as governance and record keeping. Pharmacists in general practice manage caseloads of patients, review medications, audit prescribing and build effective working relationships to contribute to optimisation of medicines across HSC.

The integration of pharmacists into general practice teams is one component of a bigger programme aimed at transforming general practice into multidisciplinary teams. These teams will include physiotherapists, mental health specialists and social workers, the intention being to identify opportunities for early intervention and support patients in managing their long-term conditions thereby reducing overdependence on secondary care. This ethos aligns with the objectives set out in Health and Wellbeing 2026: Delivering Together[20].

[16] Other key pharmacy services in this context include aseptic, patient services, procurement, medicines governance and patient safety, quality assurance, radiopharmacy, interface and medicines information.
[17] https://www.nhsemployers.org/~/media/Employers/Documents/Pay%20and%20reward/Pharmacy.pdf
[18] Hazen ACM, de Bont AA, Boelman L, Zwart DLM, de Gier JJ, de Wit NJ, et al. The degree of integration of non-dispensing pharmacists in primary care practice and the impact on health outcomes: A systematic review. Res Social Adm Pharm. 2018;14:228-40.
[19] Tan ECK, Stewart K, Elliott RA, George J. Pharmacist services provided in general practice clinics: A systematic review and meta-analysis. Res Soc Adm Pharm. 2014;10:608-622.

2.2 Constraints to provision of pharmacy services

The qualitative research undertaken as part of this review has identified a number of themes relating to constraints impeding the delivery of current and future pharmacy services. These issues are discussed below.

2.2.1 Recruitment challenges

In keeping with other healthcare professions, pharmacy is experiencing challenges in recruitment, putting increased demands on an already pressurised workforce. This makes delivery of existing services more challenging and limits the development of new pharmacy services and access to those services. The need to attract, recruit and retain staff was a key theme to emerge from the Health and Social Care Workforce Strategy 2026[21] prompting a recommendation to establish an HSC careers service by December 2020. Similarly, resources should be allocated to support a similar workstream for pharmacy, which depends heavily on the independent sector.

Data provided by the Pharmaceutical Society of Northern Ireland (PSNI) show that, over the last ten years, there has been a steady increase in the number of registered pharmacists (Figure 2.3). Nonetheless, over this period demand for pharmacists has increased as hospitals introduced seven day working and new roles have been created in the hospital and general practice sectors, many of which have been filled by experienced community pharmacists. Moreover, an increasing number of pharmacists are registering with the Pharmaceutical Society of Ireland to work in community pharmacy in the Republic of Ireland.

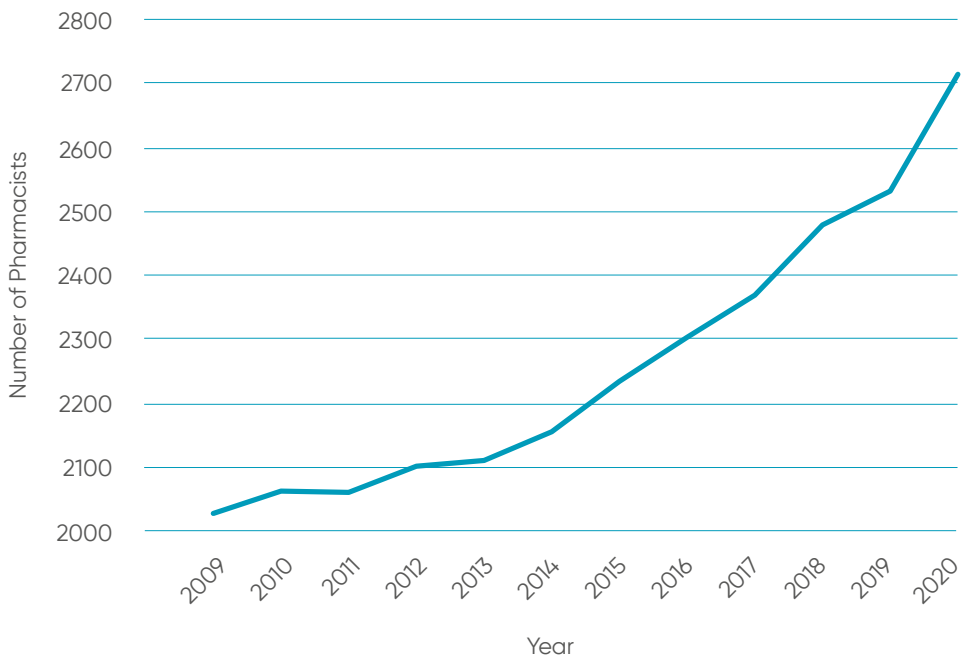


Figure 2.3 The increase in number of registered pharmacists in Northern Ireland since 2009.

There are a number of issues inherent to the ongoing recruitment of pharmacists that must be addressed. More needs to be done generally to promote pharmacy as a career choice, attract people to job vacancies in Northern Ireland and retain people in their posts. In the hospital sector there have been some delays in the recruitment process now that Regional Support Services (RSS) are managing the recruitment process.

[20] https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together
[21] https://www.health-ni.gov.uk/publications/health-and-social-care-workforce-strategy-2026

2.2.2 Capacity

In-line with the increasing concerns for safe staffing across the health professions, safe staffing standards for pharmacy staff must be developed to ensure patient safety.

Community pharmacist dissatisfaction with their role has been increasing over the last 10 years[22]. This has arisen, in part, because of increased dispensing pressures, limiting the time available for patient engagement and opportunities for a greater clinical role. Unsustainable workloads also fuel the fear of errors in which the pharmacist rather than the employer is generally held to account.

Other sources of dissatisfaction include:

- anti-social and inflexible working hours
- increasing difficulty in securing annual leave
- legislation requiring pharmacists to be present in the pharmacy at all times
- lack of appropriate breaks.

These issues are considered, by this survey, to increase work-related stress, decrease staff morale and cause pharmacist burnout which, in turn, can compromise patient safety. Whilst all sectors of pharmacy reported issues around balancing workload, feeling overwhelmed by patients' expectations and difficulty in balancing new roles with existing responsibilities, these were more pronounced amongst community pharmacists, resulting in low morale across the sector and a feeling that they are not valued by HSC (Figure 2.4a, 2.4b, 2.4c, 2.4d and 2.4e). Both employees and employers in the community sector had the perception that they are not valued by HSC, views which were not mirrored by the other sectors (see Figure 2.4e). This disparity, undoubtedly, has contributed to large numbers of community pharmacists seeking to practice in other areas. Thus, these issues must be addressed to ensure a viable community pharmacy network that is able to contribute to the transformation agenda.

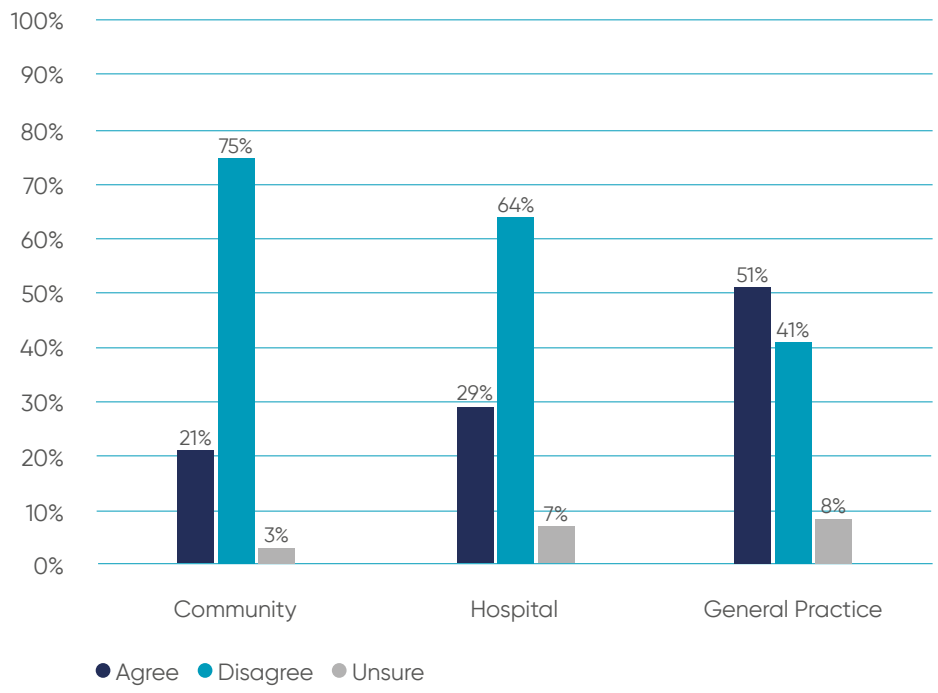


Figure 2.4.a Able to control workload.

[22] Lea VM, Corlett SA, Rodgers RM. Workload and its impact on community pharmacists' job satisfaction and stress: a review of the literature. Int J Pharm Pract. 2012;20:259-271.

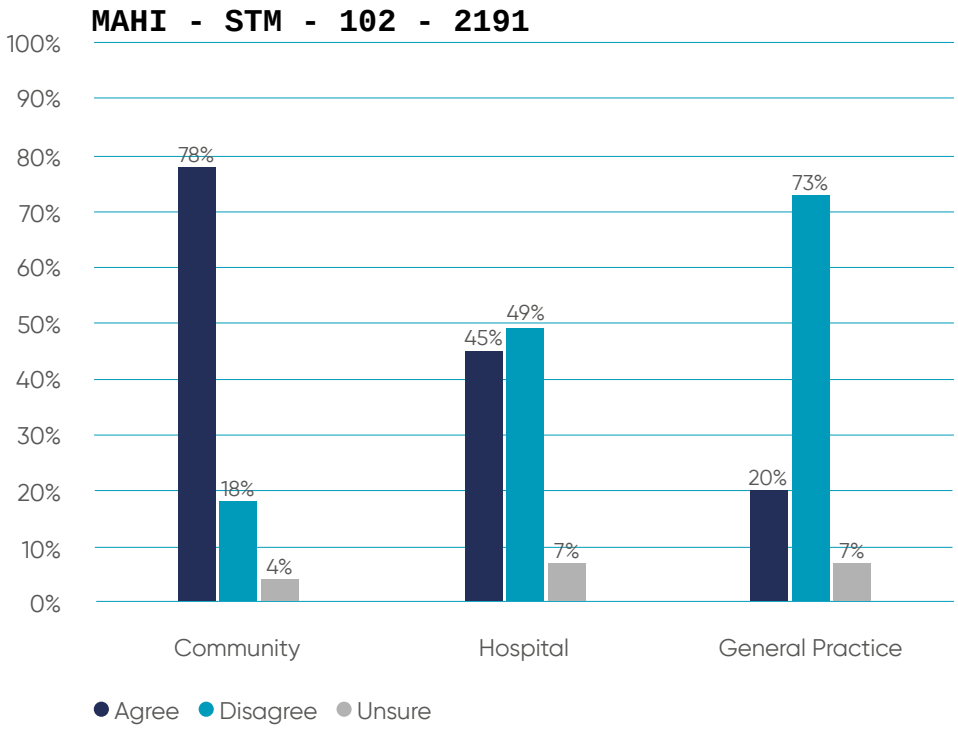


Figure 2.4.b Overwhelmed by patients' expectations.

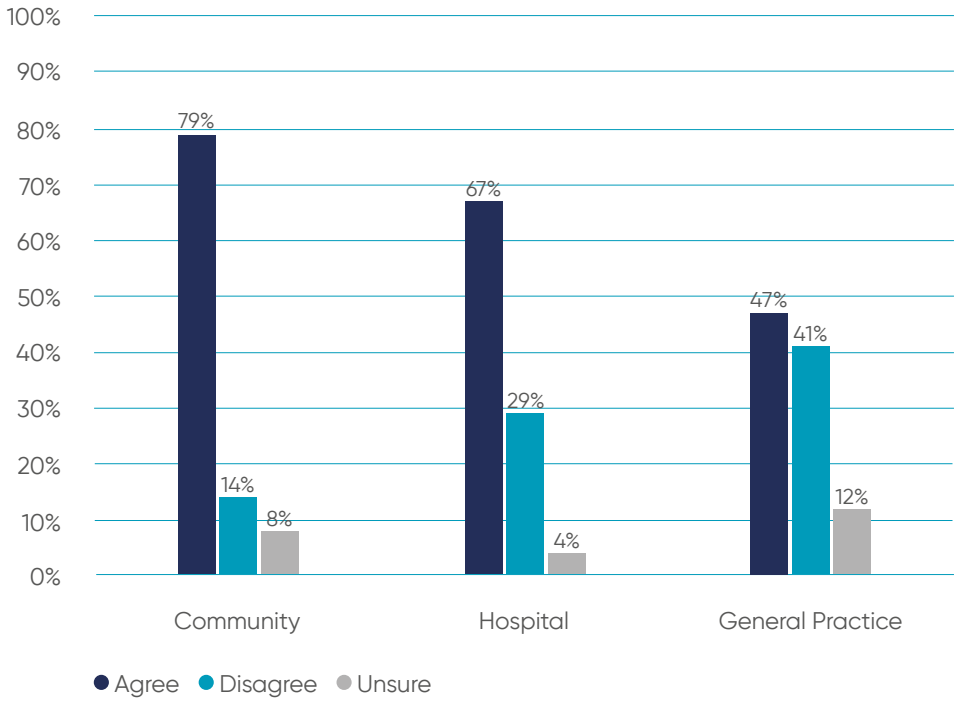


Figure 2.4.c Unable to balance new roles with existing responsibilities.

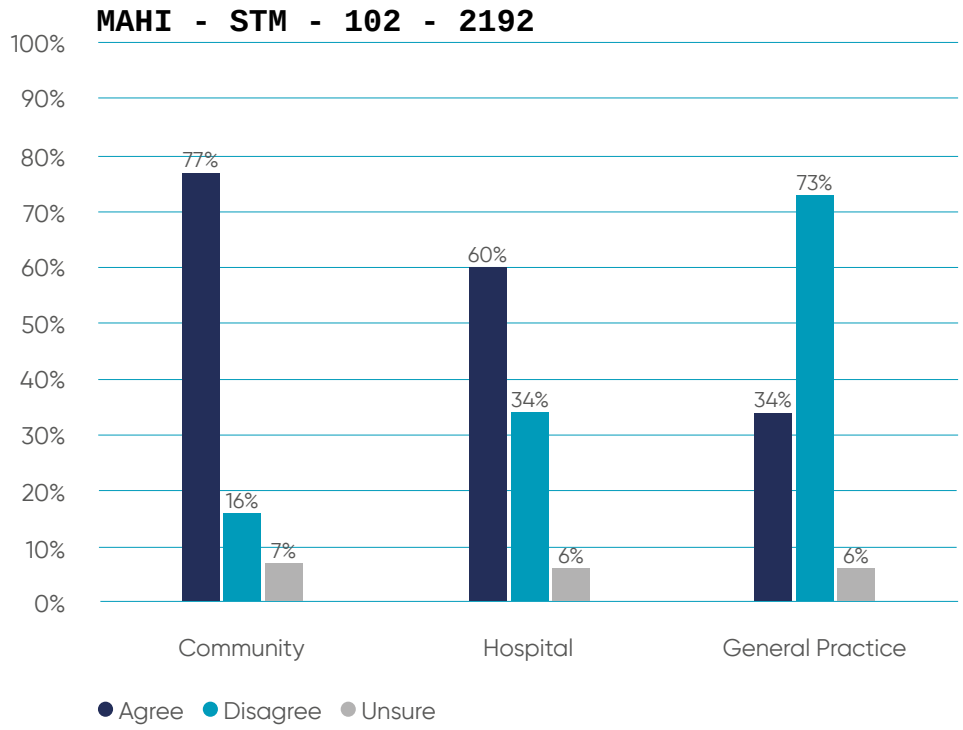


Figure 2.4.d Feel stressed they will make a mistake.

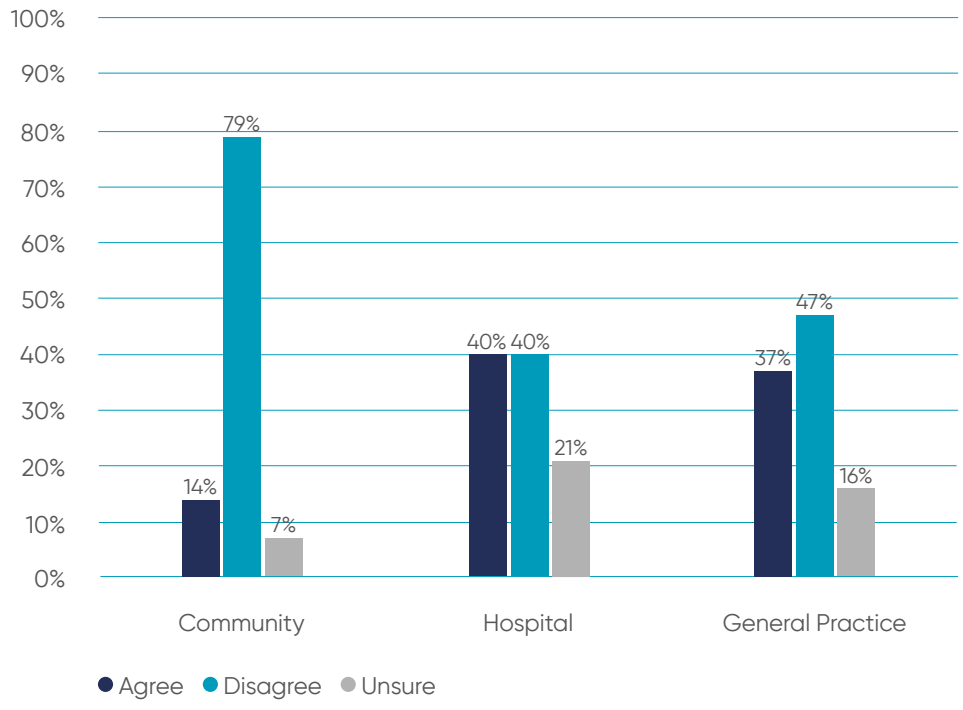


Figure 2.4.e Feel valued by Health and Social Care.

The Carter Report (2016)[23] recommended that 'NHS Trusts should use at least 80% of their pharmacist resource for direct medicines optimisation activities, medicines governance and safety'. Furthermore, the report advocated increasing the number of pharmacist prescribers and urged Trusts to ensure pharmacists and clinical pharmacy technicians spend a greater proportion of their time on patient-facing roles.

The National Institute for Health and Care Excellence (NICE) guidance on Medicines Optimisation[24] advocates that all patients (target 95% of patients) should have their medicines reconciled within 24 hours of an acute admission to hospital. This role is typically completed by pharmacists as they are regarded as the experts in medicines use. Admission and discharge ('book-ending' the patient) accounts for around 70% of the current clinical pharmacy workforce, which limits pharmacist availability throughout patients' in-hospital stay, thereby increasing the likelihood of medication problems. Thus, to manage increasing workloads, experienced pharmacists are having to undertake medicines reconciliation at admission, a task better suited to lower banded pharmacists. This represents an inefficient use of resources and impedes the provision of clinical pharmacy services. It is therefore imperative that appropriate numbers of pharmacy staff are recruited to allow stratification of the workforce, enabling staff to undertake the roles and responsibilities appropriate to their band and experience.

Additionally, when a new medical service is set up, it does not always include the cost of pharmacy services, even though pharmacy staff and resources are needed for the service to operate. Furthermore, the funding for other key pharmacy services[25] required to support these new clinicals services, has not kept pace with the expansion and subsequent increased funding of clinical pharmacy services. This has increased work-related pressures on staff. Issues around balancing workload, feeling overwhelmed by patients' expectations and difficulty in balancing new roles with existing responsibilities (Figure 2.4a, 2.4b and 2.4c) were reported more frequently by pharmacists at Band 6 and 7 rather than those at Band 8a and above.

As the role of general practice pharmacists becomes an established part of general practice in NI, the workload associated continues to increase. Overall, general practice pharmacists were the most positive of the three sectors (Figure 2.4a, 2.4b and 2.4c). They recognised at this formative stage not all aspects of their role would have been fully embedded. Nevertheless, there was an expectation that issues relating to career development, AfC banding and scope of practice would be addressed in a timely manner.

[23] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf
[24] https://www.nice.org.uk/guidance/ng5
[25] Other key pharmacy services in this context include aseptic, patient services, procurement, medicines governance and patient safety, quality assurance, radiopharmacy, interface and medicines information

2.2.3 Professional isolation

Professional isolation has been a long-standing issue within community pharmacy[26]. Following analysis of data collected for this review, almost 60% of community pharmacists stated that they feel professionally isolated, compared to just 21% and 14% of hospital and general practice pharmacists, respectively (Figure 2.5).

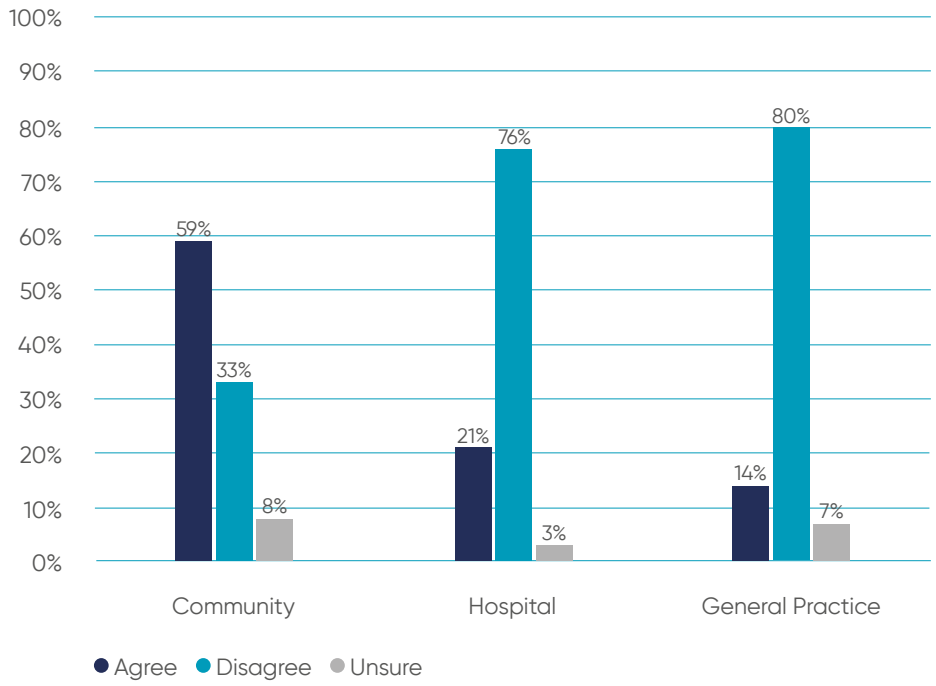


Figure 2.5 Perceived professional isolation.

There are a number of reasons for this perceived professional isolation in community pharmacy. Firstly, in many cases, a single pharmacist bears sole responsibility for all daily dispensary activities, staff management and answering medicines-related queries. Without adequate skilled support staff this can be particularly challenging for young, inexperienced staff. Secondly, poor communication and collaboration between community pharmacy and GPs further augments community pharmacists perceived isolation. Thirdly, pharmacists in this sector do not have the level of career development opportunities of counterparts in hospital and general practice.

Fourthly, lack of access to patient information systems, e.g. the electronic care record (ECR), isolates community pharmacists from other healthcare professionals and is a barrier to their professional involvement in patient management, limiting utilisation of their clinical skills. Research has shown that shared access to ECRs has benefits for healthcare organisations, patients, healthcare professionals and third parties. Such benefits include, improved patient safety, reduced errors, facilitation of integrated care pathways, better transition of care and more effective multidisciplinary team working[27]. Arrangements to enable community pharmacy access to the ECR are being progressed as a matter of urgency and are expected to be in place by 2020.

[27] http://www.ehr-impact.eu/

2.2.4 Skill-mix

The predominance of tasks related to supply in the community sector limits the pharmacist's capacity to utilise their clinical skills to their fullest extent (Figure 2.6). This is compounded by the inability to control the workload reported earlier (Figure 2.4a).

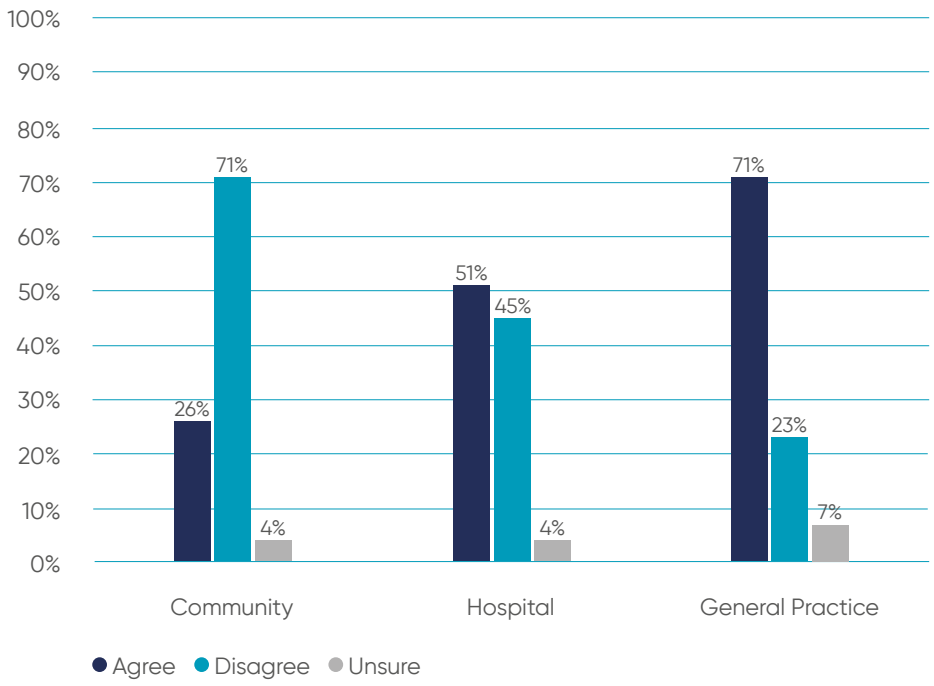


Figure 2.6 Utilise skills to the fullest extent.

Community pharmacists have a key role to play in educating patients about their medicines and engaging with the public to improve public health, thereby reducing pressure on other parts of HSC. If the full potential of this is to be realised, there is a need to address access to ECRs, better utilisation of pharmacy technicians and support staff as well as wider adoption of automation. Better use of the pharmacy technicians already employed within the community sector, underpinned by regulation, is central to affording community pharmacists confidence in support staff and the time needed to undertake enhanced clinical roles.

Likewise, there is also a need to diversify the skill-mix within hospital and general practice through expansion of the role of pharmacy technicians, pharmacy support staff and non-pharmacy staff. For example, pharmacy technicians could support pharmacists managing patients in care homes. These roles should be explored and defined.

2.2.5 Career development and succession planning

Unlike the hospital sector, a defined career pathway for community pharmacy is lacking and 66% of community pharmacists report they have no opportunities for advancement in their career; Figure 2.7.

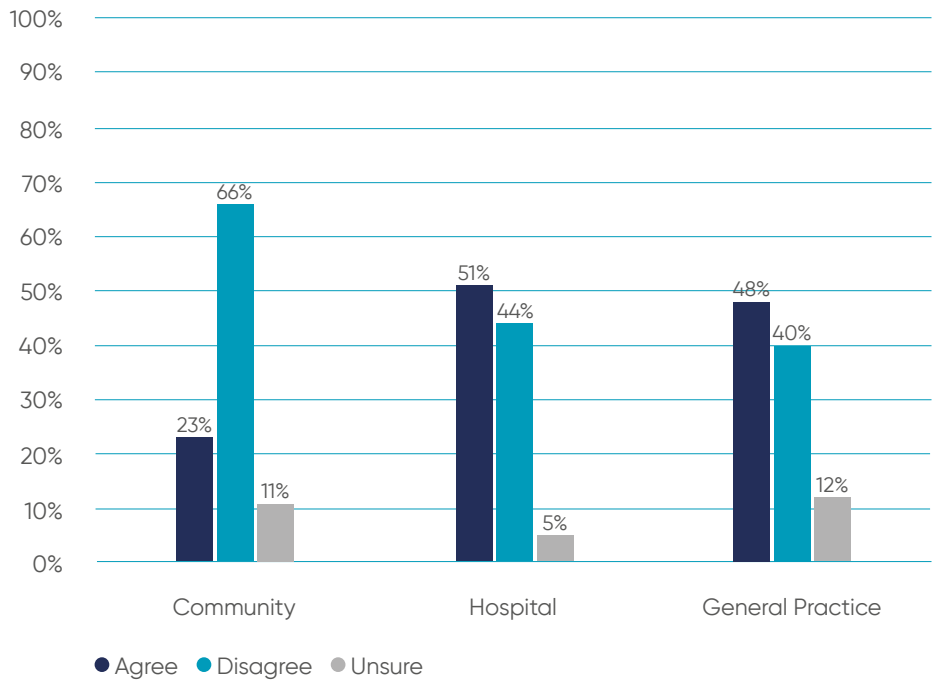


Figure 2.7 Opportunities for advancement in career.

In relation to opportunities for career advancement, there were differing views within the hospital sector (Figure 2.7). For example, those at Band 6 and 7 were more likely to agree with the statement, 'I have good opportunities for advancement in my career', whilst those at Band 8a and 8b (i.e. more experienced pharmacists) were more likely to disagree with this statement, reporting that they found it difficult to have time to develop themselves and support pharmacists undertaking Foundation training. Training to support career development was more limited in areas other than clinical pharmacy, this was viewed as a disincentive to practice in these areas. There needs to be greater equity in funding arrangements for career development across hospital pharmacy services.

There is a need to expand the scope of practice for both lead and general practice pharmacists, yet the absence of a career development pathway does not reflect this. Foundation training for general practice pharmacists was introduced in 2019, after which pharmacists may train as independent prescribers. Whilst most pharmacists in this sector report that they enjoy their role, opportunities for grade progression and advanced clinical practice, central to a career in hospital pharmacy, are absent in general practice pharmacy.

Postgraduate training and development of pharmacists should be harmonised across all sectors, allowing progression from foundation training (including independent prescribing where appropriate) to advanced practice. This will require additional investment to move from a continuing education (CE) model to a workforce development model. Moreover, it is anticipated that a large number of senior and experienced pharmacists will retire in the coming years and the mechanisms for succession planning need to be established now to ensure business continuity in an expanding environment.

2.3 Pharmacy technicians

2.3.1 Service provision

Research published by the University of East Anglia, in collaboration with the Association of Pharmacy Technicians United Kingdom (APTUK), identified the roles of pharmacy technicians in the United Kingdom (UK)[28]. This work showed considerable overlap in practice between hospital and community pharmacy. Tasks undertaken by pharmacy technicians include:

- dispensing prescribed medicines
- calculating quantities and doses
- providing information to patients on using their medicine
- providing advice on over the counter (OTC) medicines
- accuracy checking of dispensed medicines
- assessing patients own drugs
- undertaking medicines reconciliation
- manufacturing ointments and mixtures
- stock procurement and control
- maintaining electronic patient medication records.

Currently, some of these tasks may only be undertaken after appropriate training programmes e.g. Medicines management accredited programme (MMAP) and Accuracy checking pharmacy technician (ACPT). A recent pilot has explored the potential for pharmacy technicians to take on medicines administration roles within Trusts in the view of the shortages of the nursing workforce. Given the limited number of pharmacy technicians this may simply displace shortages in one sector to another.

Experience in secondary care has shown that less than 60% of patients are seen by a member of the pharmacy team. Thus, opportunities for pharmacy intervention are missed in around 40% of cases. Better use of pharmacy technicians leads to a more appropriate skill-mix, allowing pharmacists more time to focus on patients with multiple and complex needs. In community pharmacy, technicians are ideally placed to manage and oversee the running of the dispensary, thereby creating capacity to allow the pharmacist time to focus on the delivery of enhanced services.

2.3.2 Constraints

Following the analysis of focus group and questionnaire data, a number of themes emerged relating to constraints faced by the pharmacy technician workforce. These constraints are discussed below.

Registration and regulation: Pharmacy technicians in NI are not regulated healthcare professionals, unlike their counterparts in GB who have been a regulated profession since 2011. One consequence of this is that pharmacists are still professionally accountable for all regulated activity in the pharmacy, including that which they may not ordinarily be directly involved in. Therefore, they tend to be reluctant to delegate some of their dispensing and management responsibilities in the absence of another registered professional, which limits the potential for service development. Full benefit of any alternative regulatory model designed to support maximum utilisation of skill-mix may only be realised with registration of pharmacy technicians, ensuring the full capability of the workforce is optimally utilised, whilst maintaining patient safety and public confidence.

[28] https://www.uea.ac.uk/documents/899297/15294873/Identifying+The+Role+Of+Pharmacy+Technicians+In+The+UK/d6d60e7b-f527-481a-8f16-9f3f04037b6c

Recruitment: Better terms and conditions and a defined career pathway in the hospital sector have been cited by community pharmacy employers and pharmacy technicians as factors leading to a change in employment sector. Nevertheless, a consistent approach is needed across the hospital sector in respect of post-qualification training and AfC Band. Expansion of pharmacy technicians to general practice is likely to place further recruitment pressures on the community sector. Thus, more needs to be done to make the community pharmacy sector more attractive as a career option.

A standardised approach to the recruitment and utilisation of pharmacy support staff (pharmacy technicians and pharmacy assistants) throughout HSC Trusts is lacking and contributes to difficulty in filling vacancies. This limits optimal skill-mix and leads to individuals undertaking tasks for which they may be over- or under-qualified. The introduction of seven-day working has compounded this problem. Furthermore, workforce supply issues negatively impact on staff morale, increase the potential for errors and compromise patient safety.

Defining the required workforce

Step 3

Step 3 – Defining the required workforce

3.1 Undergraduate pharmacist requirements

Like the rest of the UK, NI is experiencing a decline in number of applications to study pharmacy (Figure 3.1). Pharmacy has seen significant fluctuations in undergraduate numbers in the last ten years, with periods of shortage and over supply. The opening of a second School of Pharmacy at Ulster University in 2009 resulted in an overall increase in the number of pharmacy training places and thus pharmacy graduates. The number of Schools/Departments of Pharmacy has rapidly increased in GB over the last 10 years as these universities are not restricted by the maximum student number mechanism experienced by universities in NI. This resulted in large numbers of qualified pharmacists flooding the market in GB between 2007 and 2011, leading to an overall under employment of the workforce in NI. This created a negative perception of the opportunities of a career in pharmacy. Simultaneously, market forces, funding for community pharmacy and over supply of pharmacists across NI forced employers to reduce salaries, particularly in community pharmacies. This may help explain why the number of students enrolling for the Master of Pharmacy (MPharm) has declined each year since 2011.

While the number of undergraduates from NI studying pharmacy is declining, the Schools of Pharmacy have maintained their overall student numbers by recruiting overseas students (this includes the Republic of Ireland) and expanding the number of undergraduate pharmaceutical science degree programmes offered. Estimates indicate that approximately 20% of pre-registration trainees are from outside NI and choose to practice in their home country following registration. In addition to changing employment opportunities, evidence suggests low morale across community pharmacy, together with its perceived limited career prospects is putting-off prospective students (and their parents) from applying to study pharmacy.

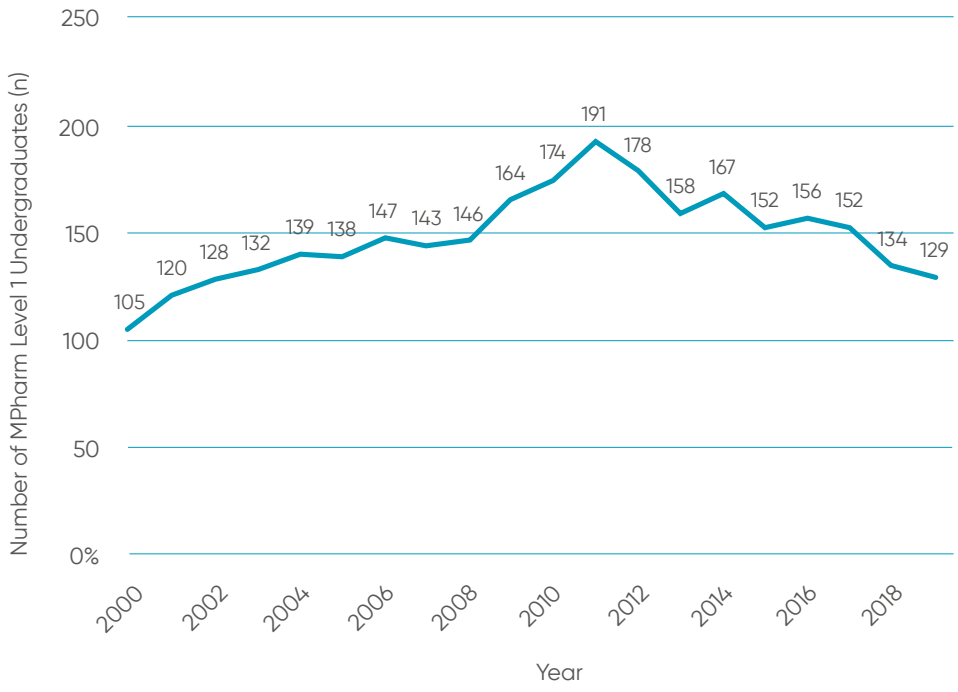


Figure 3.1 Trend in MPharm level 1 undergraduate numbers in Northern Ireland (2000–2019).

To ensure availability of the necessary pharmacy workforce, there is a need to better engage with post-primary schools, prospective students and their parents to promote pharmacy as a career and market NI as an attractive place to live and work.

The public generally associate a career in pharmacy with dispensing and they have limited awareness of wider roles such as, clinical pharmacist, consultant pharmacist, aseptic pharmacist, medicines information pharmacist and general practice pharmacist. Consequently, there is a need for the strategic leadership within pharmacy to broaden the public's understanding of pharmacy.

When presented with the statement, 'I would choose pharmacy again if I could start my career over', only ~23% of the current pharmacy workforce agreed (Figure 3.2). This does not create a positive view of pharmacy likely to attract more students into the profession. Thus, promotion of pharmacy as a career by current pharmacists, needs to occur in conjunction with addressing the issues with each sector.

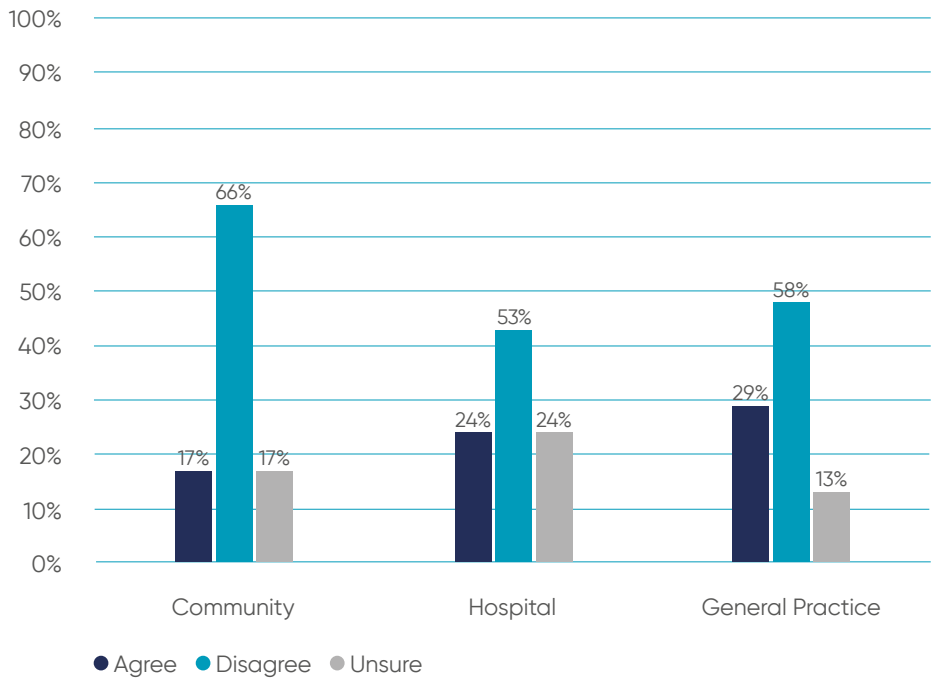


Figure 3.2 Percentage of pharmacists that would choose pharmacy again as a career.

3.2 Pre-registration requirements

Currently, pharmacy pre-registration training occurs after graduation from the four year MPharm course. In January 2019, the General Pharmaceutical Council (GPhC) consulted on new standards for the initial education and training (IE&T) of pharmacists, in collaboration with the Pharmaceutical Society of Northern Ireland, ensuring a UK wide perspective. The consultation highlighted the need to prepare pharmacists for increasing clinical roles in a multi-sector health environment with closer integration of academic study and learning in practice. It sets out learning outcomes and revised draft standards for education providers aimed at ensuring students benefit from a coherent and connected five years of education and training with greater application of science in practice and development of skills in decision-making, risk management and consultation.

In addition, the UK-wide Education Governance Oversight Board (EGOB) has been developing views on post-registration foundation training for pharmacists. These two important areas of work are expected to inform changes in pre-registration training across the UK, starting during 2021. This work will require Higher Education Institutions, Deaneries and employers to work together in new ways, with a clear set of accountabilities and with oversight on outcomes from the regulators.

Whilst most pre-registration trainees spend 12 months in community pharmacy, a small number (n=23) undertake their training across two sectors (community and hospital), spending six months in each. The provision of multi-sectoral experience for all pre-registration trainees is increasingly being regarded as a better approach to current practice[29]. Given the establishment of general practice pharmacists, it has been proposed that multi-sectoral training should embrace three sectors and that all trainees are appointed at AfC Band 5. Multi-sectoral pre-registration training is being implemented in Scotland and Wales and in parts of England. Evaluation of this training pathway has demonstrated benefits in preparing trainees for practice and therefore implementing this approach should be taken forward in Northern Ireland. It should be noted that legislative change would be required to allow implementation.

3.3 Post-registration requirements

This review has highlighted that there is no single system to monitor vacancies in community and general practice. The data presented in this review are self-reported, thus, there is a need to develop a more robust model to track vacancies in these sectors.

3.4 Community pharmacy requirements

Currently, 1522 pharmacists are employed in the community pharmacy sector, equating to around 900 WTEs. It has been reported that almost 400 pharmacists have left community pharmacy since 2016 to take up posts in hospital trusts (18%), general practice (44%), the Republic of Ireland or GB (17%). Only 69 pharmacists on the pharmaceutical register are designated as locum and a high proportion of pharmacy contractors report difficulty in sourcing locum cover. These staff movements together with a reduction in new pharmacy graduates have resulted in community pharmacies reporting difficulty in filling vacant posts. Moreover, some community pharmacies have been unable to open due to lack of pharmacist availability. This movement has been evidenced by recruitment data from hospital and general practice and has created workforce pressures that are under active consideration by the DoH and HSCB in conjunction with CPNI. It is more appropriate to consider those pressures separately from longer-term strategic recruitment requirements because mitigating action is needed in the short-term. Should these mitigating actions not be achieved a revision of the figures in Table 3.3 would be required.

Estimates of the number of additional pharmacists needed in the community pharmacy network is given in Table 3.3. Employers anticipate that the introduction of new pharmacy services, over and above those outlined in the draft framework, could require an additional 0.5 pharmacist per pharmacy. However, some of this additionality could be

[29] http://www.nwssp.wales.nhs.uk/sitesplus/documents/1178/abstract_for_integrated_pre-reg_pharmacists_posts_final1.pdf

provided by pharmacy technicians, but would be contingent on their professional regulation. While relatively few community pharmacists are qualified independent prescribers, employers estimate that, depending on the type of new services introduced, each community pharmacy would require one pharmacists to be trained as a prescriber. At the time of publication of this report there are no models of practice that would warrant large scale training of community pharmacists as prescribers. Such training may be confined to local need for locally commissioned services. Nonetheless, as pressure continues to increase in primary care, it is possible to envisage a scenario in which repeat prescribing and medication review are managed by pharmacist prescribers for patients registered with their community pharmacy, dispensing services being supported by better skill-mix and automation.

3.5 Hospital pharmacy requirements

Heads of Pharmacy and Medicines Management for all five HSC Trusts have projected pharmacist, pharmacy technician and pharmacy support workforce requirements over the next three and five years (see Table 3.1 and Table 3.2). These estimates are based on the NHS benchmarking exercise which all Trusts undertook in 2017. Trust are working with commissioners to address gaps in the service compared to other comparable Trusts in the UK (see also section 2.2.2).

Pharmacist agenda for change band	In post (WTEs*)	Projected requirements in three years (WTEs)	Projected requirements in five years (WTEs)
Band 9	5	5	5
Band 8d	1	4	4
Band 8c	25	36	42
Band 8b	38	51	64
Band 8a	126	176	207
Band 7	200	264	308
Band 6	119	174	216
Total	514	710	846

Table 3.1 The number of pharmacist WTEs needed over the next three and five years.

*WTE, Whole time equivalent.
Data to the nearest whole number.

These data include pharmacists employed to provide pharmacy services to prisons but do not take into account the additional number of pharmacists that will be needed as a result of ongoing workstreams linked to oncology, Inquiry into Hyponatraemia-related Deaths and wider adoption of consultant posts. Moreover, these data are estimates based on admission figures and could change depending on future service development.

Pharmacy support title	In post (WTEs*)	Projected requirements in three years (WTEs)	Projected requirements in five years (WTEs)
Pharmacy Technicians Band 8b	0	1	2
Pharmacy Technicians Band 8a	0	2	5
Pharmacy Technicians Band 7	4	10	13
Pharmacy Technicians Band 6	29	44	53
Pharmacy Technicians Band 5	136	201	241
Pharmacy Technicians Band 4	182	241	288
Pre-registration Trainee Pharmacy Technicians Year 2	16	46	56
Pre-registration Trainee Pharmacy Technicians Year 1	15	47	57
Pharmacy Assistant Band 3	33	66	81
Pharmacy Assistant Band 2	92	126	143
Total	507	784	939

Table 3.2 WTE pharmacy support requirements over the next three to five years.

*WTE, Whole time equivalent.
Data to the nearest whole number.

3.6 General practice pharmacy requirements

While pharmacists have been working in general practice for more than 20 years, it tended to be a niche area involving relatively few pharmacists. The funding provided by the DoH in 2015 supported near universal adoption of pharmacists within general medical practice throughout NI. GP Federations have projected workforce requirements over the next five years based on planned recruitment to achieve full implementation of the initial five-year plan and potential natural churn. However, a significant number of additional posts could be required in the future due to service and career development. In order to optimise the pharmacy skill-mix in general practice these posts would range from foundation to advanced practice. Given that this sector is still in its infancy, the number of pharmacists that will be required in the future is difficult to determine at this stage and thus is not reflected in Table 3.3.

3.7 Summary of pharmacy requirements

Table 3.3 provides an overview of the projected retirement and anticipated recruitment across all pharmacy sectors over the next five years. The raw data presented in Table 3.3 are summarised in Table 3.4 as the net number of new pharmacists entering the PSNI register and the anticipated need arising from retirement/removal from the PSNI register and creation of additional posts.

	2020	2021	2022	2023	2024
Pre-registration trainees[1]	152	156	152	134	130
Pre-registration trainees available to practice in NI[2]	122	125	122	107	104
From GPhC/EEA[3]	22	22	22	22	22
Recruitment (community)[4]	64	64	64	64	64
Recruitment (hospital)[5]	64	64	64	68	68
Recruitment (general practice)[6]	60	20	20	20	20
Retirement (hospital)[7]	5	10	5	14	7
Retirement (other)[7]	0	2	2	5	4
Retirement (community/locum)[7]	24	21	18	17	21
Removal from register (other)[8]	14	14	15	15	16
Hospital vacancy rate (8%)[9]	40	44	48	51	56

Table 3.3 Projected retirement and anticipated recruitment over the next five years.

[1] Based on number of graduates currently training as pharmacists in NI.
[2] Accounts for overseas pre-registration trainees who do not progress to practice in NI following registration.
[3] Based on PSNI previous registrations.
[4] Projections from CPNI based on new services to support the transformation agenda.
[5] New posts from Table 3.1.
[6] Data for 2020 represent planned recruitment, thereafter the data represent natural turnover.
[7] Assumes a retirement age of 65 years.
[8] Typically, 7-10 pharmacists were removed from the PSNI register annually for fitness to practice or non-payment of fees. A smaller number requested they be removed from the register for unspecified reasons.
[9] Based on hospital trust current and past vacancy rates across NI.

	2020	2021	2022	2023	2024	Total (needed)	Total (available)
Net number of pharmacists added to the pharmaceutical register	144	147	144	129	126		690
Net number of new posts and number of pharmacists leaving the pharmaceutical register	271	239	236	254	256	1256	–
Deficit	-125	-90	-90	-127	-132	-566	

Table 3.4 Summary of all pharmacist data from table 3.3.

Since 2015, 101 pharmacists have registered with the General Pharmaceutical Council and Pharmaceutical Society of Ireland. Such registrations tended to be higher in 2015 when pharmacy jobs were scarce in NI. However, with greater employment opportunities these registrations have reduced considerably to around three per year, with most pre-registration pharmacists choosing to remain in Northern Ireland upon qualifying.

A number of factors may affect the deficit of pharmacists outlined in Tables 3.3 and 3.4. For example, the data assume full-time working, whereas Section 4.1 highlights the prevalence of part-time working and, thus, actual workforce availability may be lower than predicted. Expansion in the role of community pharmacy beyond those envisaged may have workforce implications. CPNI suggest this could equate to an additional 0.5WTE pharmacist per pharmacy, increasing the potential deficit from 556 to over 800. Given the declining number of pharmacy graduates, some of this requirement could be mitigated through the wider use of qualified pharmacy technicians and their professional regulation.

Quantifying the number of pharmacy technicians working in Northern Ireland is more difficult as there is no register of qualified technicians. The GPhC currently defines a pharmacy technician as possessing Pharmaceutical Science Level 3 (City & Guilds / BTEC / SQA) and NVQ Level 3 (Pharmacy Service skills). This will be replaced in 2020 by a new qualification, the Level 3 Diploma in Principles and Practice for Pharmacy Technicians. Currently there are 351 WTE pharmacy technicians working in hospital practice, with the requirement rising to over 600 WTE by 2024.

The wide variation in support staff qualifications in the community sector makes it difficult to provide accurate estimates of the current workforce. The 400 pharmacy technicians reported by CPNI as working in this sector is probably an overestimate, arising from confusion around the definition of a pharmacy technician. As such, these data likely represent a combination of all support staff with some qualification. The PSNI estimate, from premises returns, that 262 pharmacy technicians are employed in the community sector. Anecdotal evidence suggests some pharmacy technicians employed in the community sector move to hospital practice. However, the number of staff involved is small and most of this movement arises from unqualified staff. Nonetheless, CPNI have projected that 600 qualified pharmacy technicians will be needed across the community pharmacy network by 2024.

3.8 Future career development

3.8.1 Future pharmacist career development

Following a review of frameworks across the UK (led by the RPS), it is envisaged that independent prescribing will become part of the Foundation Programme from 2021/22. This approach will allow greater focus on further developing prescribing practice during the advanced practice phase. Whilst the NICPLD and NHS Education for Scotland Pharmacy (NES) have been at the forefront of developing and delivering such programmes, there is national acceptance that this is how the profession should be developed, and this approach is being adopted in Wales and in England. Internationally, these programmes are part of the International Pharmaceutical Federation Workforce Development Goals[30] as best practice for how the pharmacy workforce should be developed.

Increasingly, healthcare is delivered by multi-disciplinary teams, yet much of the training is provided in professional silos. This was recognised in Scotland as being disadvantageous to overall service development, leading to the establishment of NES in 2005. A similar approach was taken in Wales with the creation of HEIW in 2018. Health Education England also provides multi-disciplinary learning. Thus, the move of NICPLD to NIMDTA in 2019 and their intended merger, is similarly viewed as a positive move that supports people who work together also training together.

3.8.2 Future pharmacy technician career development

The role of the pharmacy technician should be promoted and the national career framework (APTUK Foundation Pharmacy Framework[31]) adopted to support expansion of the role of pharmacy technicians and better skill-mix (Carter Report 2016)[32]. This model would also make the World Health Organisation goal of reducing medication harm by 50% over the next five years, (Medication without Harm[33]), an attainable one.

Upskilling the workforce would require increasing availability and uptake of post-registration training for pharmacy technicians. Currently, professional development opportunities exist in the form of the ACPT qualification, the MMAP and pre- and post in-process checking accredited programme. Registering the workforce would allow the true value of these qualifications to be realised.

[30] https://www.fip.org/www/streamfile.php?filename=fip/PharmacyEducation/2016_report/2016-11-Education-workforce-development-goals.pdf
[31] https://www.aptuk.org/static/pdf/1d828536f790c7b842907dc23096d62a.pdf
[32] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf
[33] https://www.who.int/patientsafety/medication-safety/en/

3.8.3 Funding requirements

The NICPLD was originally established as a provider of CE for the pharmacy profession, but it has evolved over the past 17 years into an organisation for developing the pharmacy workforce in-line with national career frameworks. However, the infrastructure needed for workforce development programmes requires funding at a higher level. Moreover, the current funding arrangements cannot accommodate the significant increase in number of trainees recruited to the hospital sector in recent years. A similar picture has emerged with general practice pharmacists and expanding the training infrastructure to support early career community pharmacists will be more difficult still. Although the pace of staff development can be slowed to live within the available funding, pharmacists, like their medical and dental colleagues, have an expectation of being able to progress from foundation (through independent prescribing) to advanced practice. Importantly, Government policy on extending the clinical role of pharmacists is dependent on expanding postgraduate training opportunities.

The extended role of pharmacy technicians in both dispensary and (increasingly) clinical roles has ably demonstrated the impact of a better skill-mix on patient care. This has been made possible by post-qualification training opportunities and should continue at an accelerated pace if technician regulation and registration is introduced into NI. The NICPLD has been innovative in the design and implementation of transformative programmes, which, in turn, have supported the greatly expanded clinical role of pharmacists and pharmacy technicians. However, its budget has remained broadly static over the last decade and more funding is required to continue developing the pharmacy workforce in line with HSC transformation.

Under-standing workforce availability

Step 4

Step 4 – Understanding workforce availability

4.1 Current pharmacist workforce

As of January 2020, the PSNI report there are 2715 pharmacists registered in NI, of which 55% practice in the community pharmacy sector, 24% in the hospital pharmacy sector and 12% in the general practice pharmacy sector. In addition, 10% of registered pharmacists work in other sectors such as academia, the Health and Social Care Board (HSCB) and other public sectors. The breakdown of the pharmacy workforce by area of practice is shown in Figure 4.1.

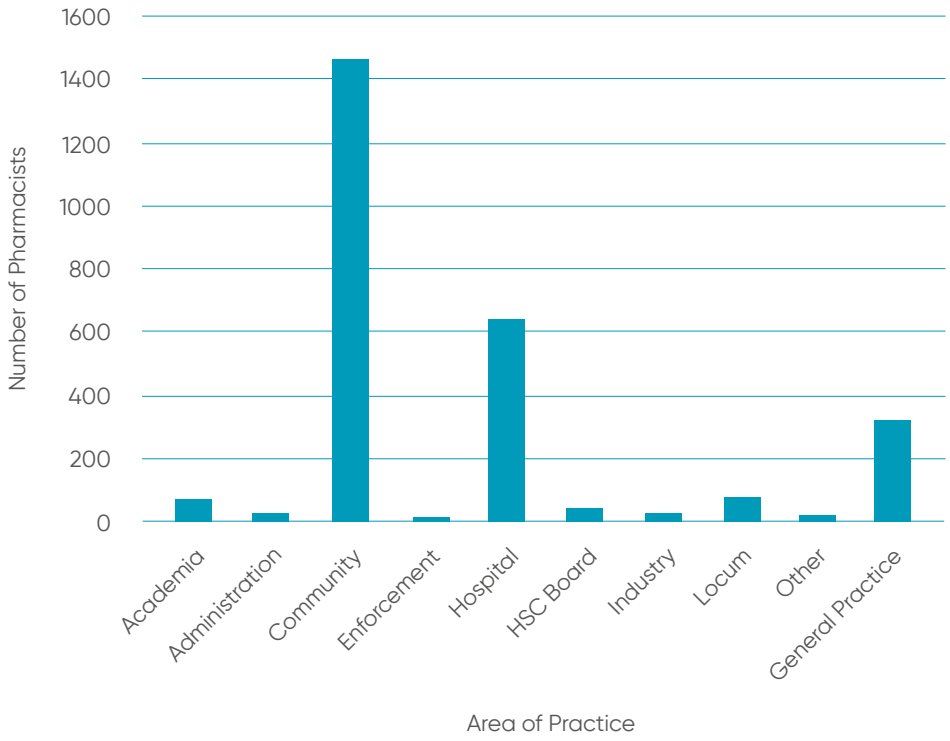


Table 4.1 Number of pharmacists in Northern Ireland according to area of practice.

The pharmacy profession is characterised by a predominantly young female workforce (Figure 4.2 and 4.3). For example, 68% (n=1843) of pharmacists are female and 52% (n=693) are less than forty years of age. Additionally, whilst women make up 68% of the Pharmaceutical Register, they comprise 79% and 78% of hospital and general practice pharmacists, respectively.

Age profiling of the workforce shows that pharmacists aged 30-39 years represent the largest category in hospital and general practice pharmacy, whereas the largest age group in the community pharmacy sector are those under the age of 30 years. Employers raised concerns at the focus group that the change in demographics means that younger, less experienced pharmacists are now managing community pharmacies.

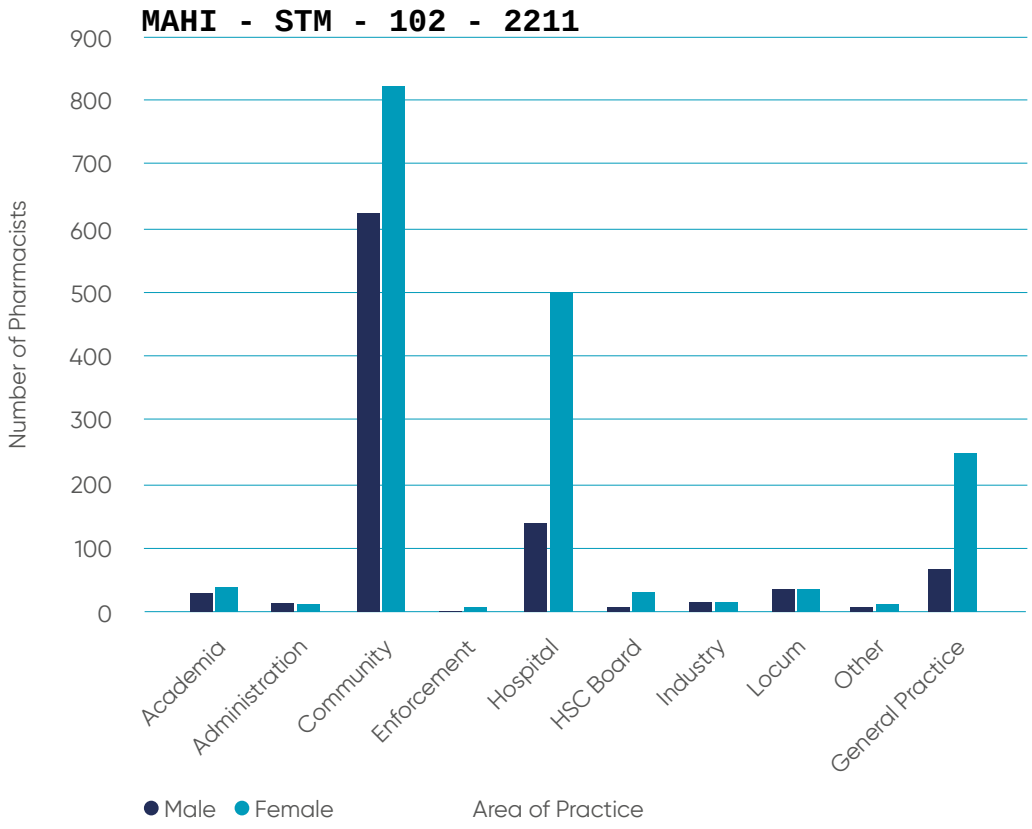


Table 4.2 Gender distribution of pharmacists by area of practice.

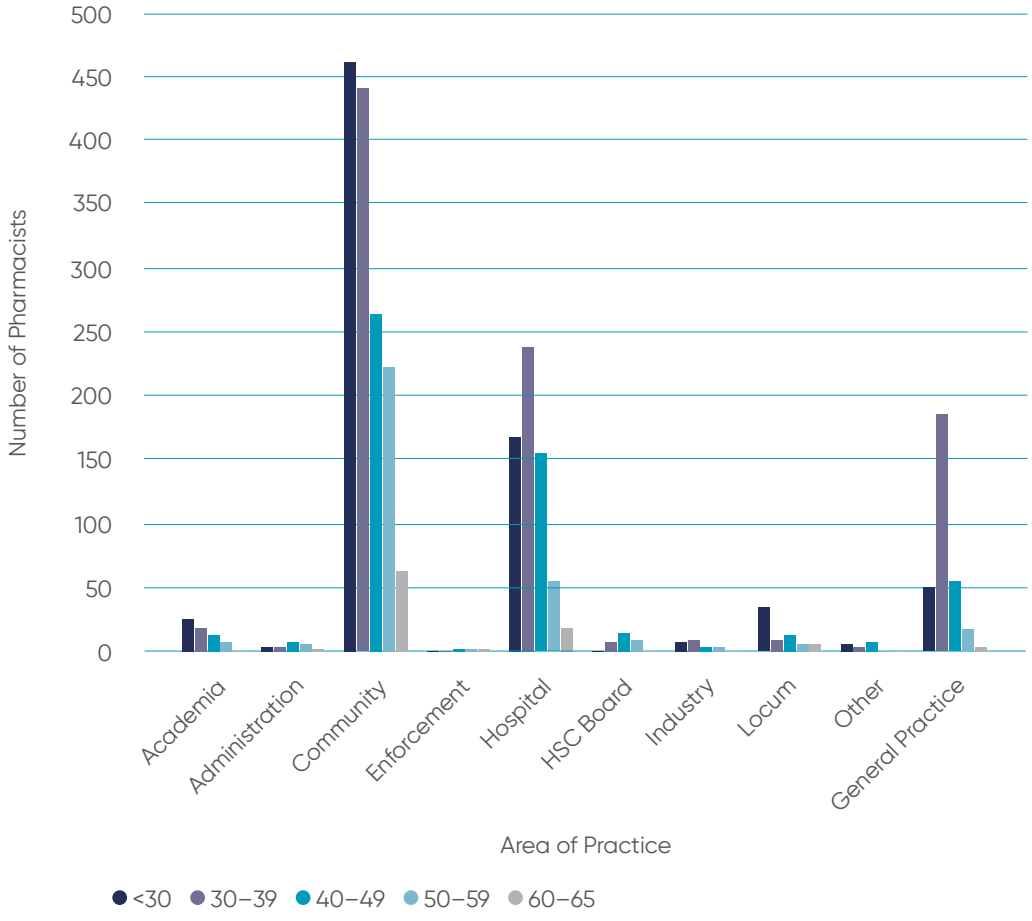


Table 4.3 Age distribution of pharmacists by area of practice.

Figure 4.4 illustrates the patterns of part-time and full-time working of pharmacists by age and gender. There is an element of part-time working for both genders and in the youngest age group these tend to be broadly equal. However, in older age groups there is a higher percentage of pharmacists who work part-time, and this tends to increase with age.

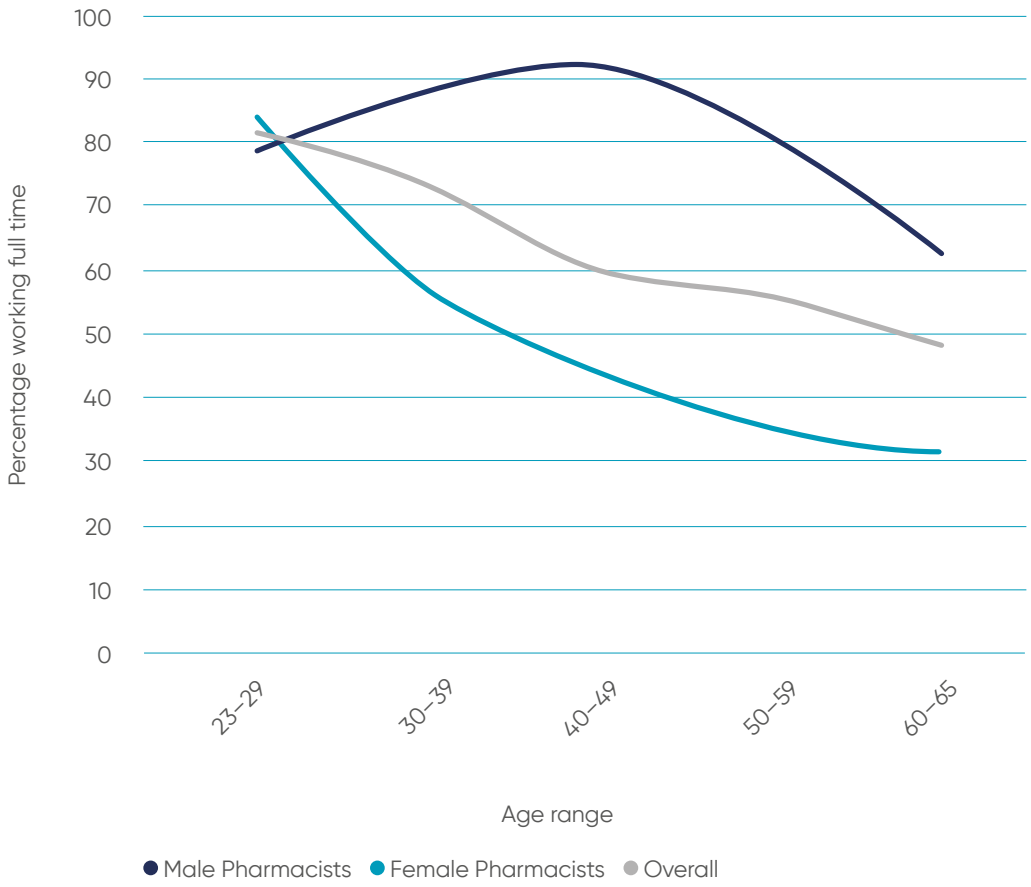


Table 4.4 Patterns of part-time/full-time working by age and gender.

4.2 Current pharmacy technician workforce

Quantifying the number of pharmacy technicians working in Northern Ireland is more difficult as there is no register of qualified technicians. Accurate numbers are known for technicians working in the hospital sector and none are currently working in general practice. However, the general confusion around qualifications has probably resulted in overestimation, the reported numbers likely representing a combination of all support staff with some qualification. This aspect will be dealt with in detail in a separate report.

4.3 Current pharmacist training arrangements

4.3.1 Foundation training

While undergraduate degree programmes have adapted to reflect a more clinical role for the pharmacist, their funding model has remained unchanged which has constrained overall development. Unlike the medical profession, pharmacy has had no mandatory postgraduate training to support workforce development beyond pre-registration training, which further limits expansion in this clinical role. Consequently, personal development was largely a matter for the individual.

Exhaustive research by the Competency Development Group and Joint Programmes Board demonstrated that foundation training is the vital step beyond pre-registration training that supports acquisition of clinical skills in early career pharmacists. Further work by the Royal Pharmaceutical Society, International Pharmaceutical Federation (FIP), NES, NICPLD and others has reinforced this view, which is supported by the four UK Chief Pharmaceutical Officers. Foundation training develops the knowledge, behaviours, skills and values that collectively form the building blocks for all pharmacists across all sectors. Research repeatedly demonstrates that, in contrast to traditional taught postgraduate programmes, a structured work-based approach to developing the knowledge, behaviours, skills and values leads to early, effective and persistent behavioural change in the practitioner. Importantly, practitioners are less likely to focus on semi-professional activity and are more confident in adopting extended roles.

The NICPLD has been accredited as a Foundation School of the Royal Pharmaceutical Society since 2016, demonstrating that the NICPLD's Foundation Programme meets the national standard. Figure 4.1 shows the pharmacy education continuum, from initial education and training, through foundation to advanced practice.

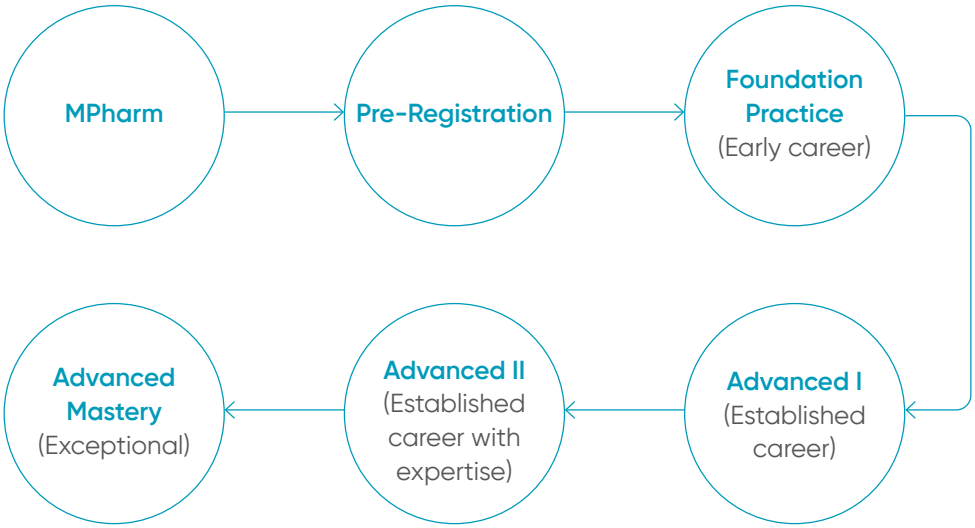


Figure 4.1 Pharmacy education continuum.

The NICPLD Foundation Programme is the standard training pathway for all hospital and general practice pharmacists. For community pharmacists, clinical training is almost exclusively confined to undergraduate study and the pre-registration year. A lack of career and postgraduate training pathway means training can be inconsistent and unstructured. By contrast, in general medical practice, trainee GPs engage in a well-established, centrally funded training programme that is underpinned by an infrastructure of tutors and peer support. This is considered vital to developing competent independent practitioners with the capacity to deliver high-level clinical services.

In order to prepare early career community pharmacists to meet the challenges of a modern health services, access to well-funded, supported, foundation training is needed. Given the anticipated introduction of a new community pharmacy contractual framework, there is a need to revitalise and increase the number of community pharmacists if these services are to be delivered and contribute to the overall transformational change envisaged in the Bengoa Report[34].

By incentivising the workforce, it can serve to attract and retain pharmacists into the community sector by overcoming professional isolation, enabling collaborative working, offering peer support and fostering the acquisition of professional skills necessary to practice to a high level. As with the hospital and general practice sectors, the support and vision of employers will be vital to the success of such a programme.

For widespread availability of foundation training for early career community pharmacists, additional funding is needed that can provide the training infrastructure (including trained educational supervisors) and protected study time necessary.

4.3.2 Independent prescribing

Following publication of the Crown Report, legislation was introduced to NI in 2003 enabling pharmacists to prescribe as supplementary prescribers. That same year NICPLD developed a postgraduate certificate to train pharmacist prescribers and in 2006 legislation was amended to allow independent prescribing. Currently, over 600 pharmacists in NI are independent prescribers, the majority of whom practice in secondary care, although this is rapidly changing as the role of the general practice pharmacist becomes established.

Prescribing by community pharmacists has been more limited. Nonetheless, exemplars have consistently demonstrated the feasibility of prescribing by this sector and access to the electronic care record by community pharmacists will make prescribing a realistic extension to practice across the community pharmacy network. Results from the workforce questionnaire (Section 2) demonstrated that pharmacist prescribers, regardless of practice sector, were more likely than non-prescribers to report being satisfied in their job, able to use their skills to the fullest extent, and less likely to feel professionally isolated or overwhelmed by patient's expectations.

4.3.3 Advanced practice

Whilst pharmacists have traditionally identified with the medication-related aspects of the role, becoming an effective practitioner requires a broader skillset. Thus, the RPS Advanced Practice Framework encompasses six competency clusters: Expert professional practice, Collaborative working, Leadership, Management, Education/developing others, Research.

The APF is intended for use once foundation training have been completed. It forms a supportive framework to gather evidence of continuous advancement across the core competencies, encouraging practitioners to progress from:

- Advanced Stage I: Early stages of specialisation and advancement beyond foundation years
- Advanced Stage II: An expert in an area of practice who routinely manages complex situations and is recognised as a leader locally/regionally
- Mastery: Recognised as a leader in an area of expertise (nationally often internationally), alongside a breadth of experience.

In Northern Ireland, hospital pharmacists completing their foundation and prescribing training progress to train as advanced practitioners (to Stage II) via NICPLD's MSc in Advanced Practice. It is intended that this training should be extended to all pharmacists.

[34] https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report

4.3.4 Consultant pharmacists

This role was first identified in 'A Vision for Pharmacy in the New NHS' (2003) and was seen as an opportunity to build on the success of clinical pharmacists and make a greater difference in patient care. The guiding principles in developing this role are that:

- benefits to patients are identified when designing posts
- the title consultant pharmacist has real meaning
- there is a uniform approach nationally
- there will be a high level of transferability across organisations.

The title consultant pharmacist applies to those appointed to approved posts who meet the appropriate level of competence. It is not conferred solely in recognition of excellence or innovative practice. Neither are consultant pharmacists advanced level practitioners renamed. A consultant pharmacist is a pharmacist who has developed and demonstrated high level expertise in their area of practice and across the four pillars: 1. clinical practice, 2. leadership, 3. education and 4. research. They have been credentialed as such and have been appointed to an approved consultant post.

As leaders in their field and the profession, consultant pharmacists provide expert care to patients with the most complex needs as well as providing advice to the teams caring for patients. Their influence spreads across organisational and professional boundaries to support the health of those accessing services in their area of practice as well as the wider population. They develop the knowledge-base in their area of expertise through research and innovation and share these developments through their educational role to develop the wider pharmacy workforce, thereby improving patient care.

4.4 Current pharmacy technician training arrangements

Traditionally, Further Education (FE) colleges have been the main training providers for pharmacy technicians in NI, although a greater number of private providers are entering the market with a more flexible distance learning approach that some employers prefer. In the UK, an apprenticeship employer's levy of 0.5% exists for organisations with an annual wage bill above £3 million. In NI, the Department for the Economy (DfE) funds apprenticeship training through the Apprenticeships NI programme, although this is only available to private sector employers for Level 3 apprenticeships. Public sector employers are still liable to pay the levy but have no means of benefitting from the funding. The DfE are reviewing the current arrangements with a view to extending the Apprenticeship NI programme to both private and public sector employers.

Developing an action plan

Step 5

Step 5 – Developing an action plan

5.1 Pharmacy workforce review recommendations

As detailed in Step 2 of this report, focus group and questionnaire data revealed several constrains to the provision of current and future pharmacy services. To overcome these constraints and ensure the workforce can deliver on the wider transformation agenda, a number of recommendations, specific to each pharmacy sector, have been identified (see Table 5.1).

Table 5.1 Pharmacy workforce review recommendations.

Sector	Recommendations
All Sectors	Work should be undertaken with the Department for the Economy, universities and FE colleges to ensure the necessary number of pharmacy graduates and pharmacy technicians are available to meet workforce demands.
	Pre-registration training for pharmacists should be reformed to ensure that students are prepared for increasingly clinical roles in a multi-sector health environment..
	All pharmacists should be supported to undertake foundation training, progressing to independent prescribing and advanced pharmacy practice aligned to service and patient need. This will be subject to appropriately resourced post-graduate pharmacy training and expansion of the current training infrastructure.
	Advanced and consultant pharmacist roles should be defined and developed to support clinical leadership across all pharmacy sectors.
	Appropriate training pathways and opportunities should be devised which support succession planning for senior positions across all pharmacy sectors.
	Pharmacy technicians should be encouraged to practice at the top of their skillset through appropriate pre- and post-registration training. This should be resourced and supported through pharmacy technician education and development leads across all sectors.
Community	Urgent action is needed to ensure the community pharmacy network has adequate workforce capacity to deliver current and future pharmacy services aligned to the wider transformation agenda. This should be reviewed on an ongoing basis.
	Utilisation of pharmacy technicians and technologies should be optimised to enable pharmacists to spend more time on patient-facing clinical activities and manage capacity.
	Flexible working, adequate breaks and safe staffing levels should be addressed to encourage recruitment and retention of pharmacy staff and promote their well-being.
	A career pathway should be developed for community pharmacists.

Cont'd

Sector	Recommendations
Hospital	Safe staffing standards for pharmacy staff must be developed to ensure patient safety.
	The cost to provide all pharmacy support services should be included in any business case for new clinical services. This must also take into account seven day working and headroom.
	A consistent approach needs to be taken across HSC Trusts in respect of job banding and recruitment procedures should be shortened to ensure service continuity.
General Practice	A career pathway should be developed for general practice pharmacists. Moreover, strategic direction needs to be given as to how this sector will develop and how this will affect further recruitment.
	A model for core general practice pharmacy services should be delivered consistently across GP Federations with scope to allow for variation in specialist/additional services according to local need.
	A path-finder study should be undertaken to explore the role of pharmacy technicians in supporting the work of general practice pharmacists.
Pharmacy Technicians	A career as a pharmacy technician should be promoted, particularly to school leavers. The HSC careers services should also be utilised as a means of promoting the pharmacy technician role.
	To maximise the benefit of skill-mix, work should be urgently progressed to enable the registration and regulation of the pharmacy technician workforce in NI in step with the rest of the UK.

5.2 Conclusion

This report has been written to inform HSC pharmacy workforce development for the period 2019-2029. Data collected for this report has demonstrated the need to increase workforce capacity through necessary changes to policy, legislation and funding arrangements, and ensure workforce development is supported. Effective workforce planning and full implementation (to include a formal midterm evaluation of actions taken) of the recommendations in Table 5.1 will ensure we have the right people, in the right place at the right time to ensure efficient and effective delivery of the wider HSC transformation agenda over the next ten years.

Appendices

Appendices

Appendix 1 Project Board members

Colin Adair, (Co-chair) Northern Ireland Centre for Pharmacy Learning and Development, School of Pharmacy, Queen's University Belfast

Jill Macintyre, South Eastern Health and Social Care Trust

Karen Cardwell, Northern Ireland Centre for Pharmacy Learning and Development, School of Pharmacy, Queen's University Belfast

Kate McComiskey, Northern Ireland Centre for Pharmacy Learning and Development, School of Pharmacy, Queen's University Belfast

Peter Barbour, Department of Health

Cathy Harrison, Department of Health

David Lennox, Department of Health

Joe Brogan, Health and Social Care Board

Dianne Gill, Northern Health and Social Care Trust

Louise Brown, Belfast Health and Social Care Trust

Lyn Watt, Southern Health and Social Care Trust

Anne Keenan, Western Health and Social Care Trust

Peter Rice, Community Pharmacy Northern Ireland

Marie Smith, Community Pharmacy Northern Ireland

Aileen Crossin, Community Pharmacy Northern Ireland

Glynis McMurtry, GP Federation

Karen Briers, General practice Pharmacist

Roisin O'Hare, Hospital Pharmacist

Trevor Patterson, Pharmaceutical Society of Northern Ireland

Julie Greenfield, Pharmacy Forum Northern Ireland

Kathy Burnett, School of Pharmacy, Ulster University

Sharon Haughey, School of Pharmacy, Queen's University Belfast

Warren Francis, Association of Pharmacy Technicians UK

Tess Fenn, Association of Pharmacy Technicians UK

Appendix 2 Focus group participants

Hospital Trust Heads of Pharmacy and Medicines Management

Clinical Leads, Medicines Governance and Medicines Information

Aseptics, Radiopharmacy, Quality Assurance and Industry

Patient Services and Procurement and Interface

Community Pharmacy Northern Ireland

GP Federation Lead Pharmacists

Pharmacy Technicians

Ulster University MPharm Level 4 students

Appendix 3 Focus group topic guides

Appendix 3.1 Generic topic guide

Mapping service change

1. How do you see pharmacy services developing in the next two, five and ten years that will impact upon future workforce requirements?

Prompt questions

- What are the benefits of these changes to the HSC?
- What are the drivers for change?
- What factors might prevent this from happening?
- What collaboration do you see across sectors/disciplines?

Defining the required workforce

2. What is the likely impact on the type and number of staff needed to deliver the new service model(s)?

Prompt questions

- Which types of staff will you need to develop the service?
- What new skills will be needed?
- To what extent do you have the right skill-mix?
- What needs to be done to address the skill-mix?
- How could you reduce the cost associated with implementing change/improving the service?

Understanding workforce availability

3. What are the issues around workforce availability that need to be addressed to make change/service development sustainable?

Prompt questions

- What options are open to you for staffing, including issues of skill-mix?
- What training/redeployment considerations need to be addressed?
- How might this be best done?
- What is the likely increase in staff numbers needed for the service in the next short (two years), medium (seven years) and longer (ten years) term?

Developing an action plan

4. A plan for delivering the right staff, with the right skills in the right place needs to be developed. What is the most effective way of ensuring the availability of staff to deliver services?

Prompt question

- What would be your first priority?

Appendix 3.2 Technician topic guide

Service development

1. How do you see pharmacy services developing in the next 2, 5 and 10 years?

Prompt questions

- How will these services benefit the HSC and patients?
- What factors will help drive forward these developments?
- What factors might prevent these developments?

Workforce requirements

2. What type and number of staff do you think will be needed to deliver these new services?

Prompt questions

- What type of staff do you need?
- To what extent do you have the right skill-mix?
- What needs to be done to address skill-mix?

Workforce availability

3. What issues around workforce availability need to be addressed to make service development sustainable?

4. How could we address issues of recruitment and retention of staff to ensure service development is sustainable?

Prompt questions

- Career pathway
- Training issues that need to be addressed?

Action planning

5. What three priorities should be addressed first to achieve the right staff, with the right skills in the right place?

Prompt questions

- Are you in favour of professional registration for pharmacy technicians in NI?
- How would you like to see technician registration be implemented?

Appendix 3.3 Undergraduates topic guide

Choosing pharmacy as an undergraduate degree

1. Why did you choose pharmacy as your undergraduate degree?

Prompt questions

- What attracted to you to pharmacy as a career?
- Was there a particular sector of pharmacy within which you wanted to work?
- Have your views towards a career in pharmacy changed since starting your degree, and if so how?
- If you could go back and make your choices again, would you choose pharmacy as an undergraduate degree?

Development of pharmacy services

2. Have you any opinions on how pharmacy services might develop in the next two, five and ten years?

Prompt questions

- What developments do you see/would you like to see in the provision of pharmacy services?
- How would these developments be of benefit to the HSC?
- What is needed for these developments to happen?
- What factors might prevent these developments from happening?
- What collaboration do you see/would you like to see across sectors/disciplines?

Delivery of pharmacy services

3. In relation to developments in the provision of pharmacy services, how do you think this will impact on the type and number of staff needed?

Prompt questions

- Which types of staff would be needed to provide these developed services?
- What new skills will be needed?
- To what extent do you have/are you developing the right skill-mix?
- What needs to be done to address the skill-mix?

Appendix 4 Questionnaire

General information

1. What is your gender?

- ◯ Male
- ◯ Female
- ◯ Other
- ◯ Prefer not to say

2. Whats is your age?

- ◯ <25
- ◯ 25–34
- ◯ 35–44
- ◯ 45–54
- ◯ 55–64
- ◯ 65+

3. Do you work full time or part time?

- ◯ Full time
- ◯ Part time

4. What is your job description?

- ◯ Pharmacist
- ◯ Pharmacy Technician

5. Are you a Pharmacist Independent Prescriber?

- ◯ Yes
- ◯ No
- ◯ N/A (i.e. Pharmacy Technician)

6. In what sector(s) do you practice? Please tick all that apply.

- ◯ Academia
- ◯ Community Pharmacy
- ◯ Hospital Pharmacy
- ◯ HSCB/DH/Other public sector
- ◯ Practice-based Pharmacy
- ◯ Other

7. Which sector do you consider to be your main area of practice?

- ◯ Academia
- ◯ Community Pharmacy
- ◯ Hospital Pharmacy
- ◯ HSCB/DH/Other public sector
- ◯ Practice-based Pharmacy
- ◯ Other

Community pharmacy

8. Which category do you fall into?

- ◯ Contractor
- ◯ Employee Pharmacist
- ◯ Employee Pharmacist and Staff Manager
- ◯ Employee Pharmacist and Area Manager
- ◯ Locum Pharmacist
- ◯ Pre-Registration Pharmacist
- ◯ Pharmacy Technician

9. For those whose main role does not currently include management, do you see yourself moving into management?

- ◯ Yes
- ◯ No
- ◯ N/A

10. What type of community pharmacy do you work in/represent?

- ◯ Single independent
- ◯ Small multiple (2–5 pharmacies)
- ◯ Medium multiple (6–10 pharmacies)
- ◯ Large multiple (11+ pharmacies)

11. Where is the community pharmacy in which you work located?

- ◯ Rural
- ◯ Semi-rural
- ◯ Urban
- ◯ Town/City centre
- ◯ All of the above

12. Within which country do you practice? Please tick all that apply.

- ◯ Northern Ireland
- ◯ Republic of Ireland
- ◯ Great Britain

Hospital pharmacy

13. What is your current pharmacy grade?

- ◯ Band 4
- ◯ Band 5
- ◯ Band 6
- ◯ Band 7
- ◯ Band 8a
- ◯ Band 8b
- ◯ Band 8c
- ◯ Band 8d
- ◯ Band 9

14. What is your main role?

- ◯ Administration
- ◯ Clinical
- ◯ Dispensary
- ◯ Management
- ◯ Quality Assurance/Aseptic
- ◯ Regional Specialist Services (e.g. MI, Interface Antimicrobial, Medicines Governance)

15. For those whose main role is not currently management, do you see your future career moving into management?

- ◯ Yes
- ◯ No
- ◯ N/A

Practice-based pharmacy

16. What is your job title?

- ◯ Federation Lead Pharmacist
- ◯ Practice-based Pharmacist

17. What is your main role(s)? Please tick all that apply.

- ◯ Clinical patient-facing
- ◯ Clinical non-patient facing
- ◯ Management
- ◯ Administrative

18. For those whose main role is not currently management, do you see your future career moving into management?

- ◯ Yes
- ◯ No
- ◯ N/A

The future

19. Thinking about the future, how likely is it that you will be working in your current area of practice in each of the following time frames? (Highly likely/likely/unlikely/highly unlikely)

In one year

In three years

In five years

20. If you answered highly likely/likely for any of the above, for what reason(s) are you not considering a change? Please tick all that apply.

- ◯ Approaching retirement
- ◯ Defined career pathway
- ◯ Enjoy working in this area of pharmacy
- ◯ Financial incentives
- ◯ Limited opportunity to practice elsewhere
- ◯ Multiprofessional environment
- ◯ Opportunities for professional development
- ◯ Professional automony
- ◯ Team working
- ◯ Use full range of my skills
- ◯ N/A
- ◯ Other (Please specify)

21. If you answered unlikely/highly unlikely for any of the above, for what reason(s) are you considering a change? Please tick all that apply.

- ◯ Approaching retirement
- ◯ Considering working in a different area of pharmacy
- ◯ Considering working outside pharmacy
- ◯ CPD requirements
- ◯ Financial disincentives
- ◯ Finding pharmacy unrewarding
- ◯ Having to work too many hours
- ◯ Lack of defined career pathway
- ◯ Unsustainable workload
- ◯ Unmanageable levels of stress in current role
- ◯ N/A
- ◯ Other (Please specify)

22. What do you consider to be the biggest challenges facing your area of pharmacy over the next 3–5 years?

23. If you could change one thing to improve your area of practice or role, what would that be? (Optional)

Work related stress

24. How often are you concerned about the level of stress you experience in your working day?

- ◯ Every day
- ◯ Most days
- ◯ About once or twice a week
- ◯ About once or twice a month
- ◯ Less than once a month
- ◯ Never
- ◯ I don't know

25. Can you tell us what impact your stress levels have on your practice and on you personally?

26. Different approaches have been tried to support wellbeing in the workforce. Do you engage in any activities to manage your stress or support your wellbeing, such as peer support, or does your employer provide help/training in stress management?

- ◯ Yes
- ◯ No

If yes, please specify which activities you engage in.

27. If you felt your working environment was unsafe, would you feel able to communicate your concerns?

- ◯ Yes
- ◯ No

If yes, please comment on how you would communicate your concerns.

Job satisfaction

28. Please rate your response to the following statements.

I have good opportunities for advancement in my job

I feel overwhelmed tryning to meet patients' expectations

I am not paid enough for my level of responsibility

I am able to use my skills to the fullest extent

I do not feel I am challenged by my job

I feel professionally isolated

I am able to control my own worklload

I find it difficult to balance new roles with existing responsibilities

I often feel stressed that I will make a mistake in the treatment of a patient

I am satisfied in my job

I do not receive respect or recognition from the general public

I feel the role of pharmacy is valued by HSC

I would choose pharmacy again if I could start my career over

Department of Health

Workforce Review Report

Music, Art, and Drama Therapies

2019 – 2029

BAMT BRITISH ASSOCIATION FOR MUSIC THERAPY

ba at the british association of art therapists

The British Association of Dramatherapists

HSC Health and Social Care

DoH Department of Health www.health-ni.gov.uk

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Foreword

Since October 2016, Health and Social Care workers and the Department of Health have been cooperating to deliver the transformation set out in ***Health and Wellbeing 2026: Delivering Together***. This ambitious ten-year plan was our response to the report produced by an Expert Panel led by Professor Bengoa, who were tasked with considering how best to re-configure Health and Social Care Services in Northern Ireland.

The aim is a health and social care system that helps people to stay well for longer, with services delivered in the community or at home, where possible. Allied Health Professions (AHPs) will play a key part in responding to this challenge, particularly as we expand the role of innovative, multidisciplinary teams across a range of integrated care pathways within health and social care settings. No matter how or where AHP staff work, they will continue to maintain their clear professional focus: ensuring that people, who are ill, have disabilities or special needs, can live the fullest lives possible.

Since these AHP Workforce reviews commenced the landscape across Health and Social Care has changed considerably. Opportunities for AHPs have been created across a range of primary care multi-disciplinary teams. These are to be welcomed but it is important to have the highly skilled workforce required to take these opportunities as they arise. This series of workforce reviews are written with a view to identifying and quantifying the workforce required to meet these challenges and help drive the transformation agenda forward.

The AHP Workforce reviews will help to address one of the immediate priorities set out in the “New Decade New Approach” document published at the time of the establishment of the new NI Executive. The commitment being that the Executive will transform HSC services through reconfiguration of services.

The Covid-19 pandemic challenged us in many ways including the immense pressures placed on our workforce, but there are others pressures challenging us to think and act differently and to consider as to how we currently work and as to how we may work in the future.

In this changing environment, it is even more essential that we have an understanding of our workforce needs, so that we can plan effectively to maintain and develop our services into the future. This was recognised in ***Health and Wellbeing 2026: Delivering Together*** and appears as a key theme in the associated ***Health and Social Care Workforce Strategy 2026: Delivering for Our People.*** Recognising that the HSC is a changing environment and will continue to evolve, this series of workforce reviews are "living documents" which will be reviewed throughout the period of the reviews.

This report and the clear recommendations it contains are the result of a wider Workforce Review Programme covering all thirteen AHPs in Northern Ireland. Since March 2017, Project Groups comprising representatives from across the health and social care service, professional bodies, staff side representatives and the Department of Health have been meeting regularly to consider how these professions / services are likely to develop in the period 2018 – 2028. Their work has been overseen by the AHP Workforce Review Programme Steering Group and applies the ***Regional HSC Workforce Planning Framework's*** six-step methodology.

This process and its resulting workforce review reports are the products of active co-design and co-production, delivering together to ensure the workforce needs of the HSC are met. Project Groups have engaged with their stakeholders including service users and carers, both in formal engagement events and through ongoing involvement with relevant individuals and organisations. Their input has been invaluable in producing this final document and its recommendations. We would like to thank everyone who has contributed to the work of the AHP Workforce Review Programme.

Our vision is that to Northern Ireland has an AHP workforce that has the capacity and capability to deliver the best possible care for patients and clients and has the leadership skills and opportunities to lead and transform services to improve population health. This Review Report and its recommendations set us on course to do just that for this profession.

Professor Suzanne Martin
Chief AHP Officer
Department of Health

Philip Rodgers
Director of Workforce Policy
Department of Health

Executive Summary

This workforce review for Music Therapy, Art Therapy and Dramatherapy has been initiated and guided by the Department of Health and completed by a working group comprising representatives of all three professions and in consultation with wider representation of therapists.

The aim of the review is to ensure that the three arts therapies workforces are adequately positioned in terms of numbers, training provision, and recruitment and retainment to meet the anticipated demands on the profession over the next 10 years, and to ensure that the workforce is suitably equipped to meet the changing needs and demands of the population in that time.

The Music Therapists, Art Therapists and Dramatherapists making up the collective 'arts therapies' workforce in Northern Ireland number approximately 90 highly specialised and skilled healthcare professionals, holding a primary degree in their strand of the arts plus further Masters-level specialised training in their therapy profession in line with HCPC registration requirements. Although there is Art Therapy Masters training at the Ulster University, no training is currently available in Northern Ireland for Music Therapy or Dramatherapy which has an obvious impact on the recruitment and retention of staff. However, standards for Arts Therapies apprenticeships at Masters level were approved for England in April 2019. This represents the first government-funded training route for art, drama and music therapists in England and lays the ground to enable new arts therapies apprentices to contribute to enhancing health and social care.

Furthermore, as there are no Music Therapists or Dramatherapists currently employed in Trusts, and just one Art Therapist in WHSCT, this review has taken a slightly different perspective, including both HSC Trust-funded and non-Trust services also in order to give a representative view of the professions overall. A scoping exercise was carried out in each profession of both independent therapy organisation employees and independent and freelance therapists, and a stakeholder engagement event was held in September 2018. This report has been structured with a colour-coded section for each of the three professions, and subsequently divided into sections on the main drivers and constraints for each professions and specific information of provision to different service user groups. Each profession has highlighted its own conclusions, and the broader, shared issues for the three workforces have been collated into shared recommendations in the final section.

The role of the arts in people's lives to enhance their health and wellbeing is indisputable. We have a very human instinct to turn to the arts to make our lives better, to improve our quality of life, and this instinct is not impaired by illness, injury, impairment or disability. The arts therapies are the healthcare professions that can effectively harness this human quality to help meet specific healthcare needs, working to enhance the impact of other health professionals, provide cost-effective, high-quality, evidence-based and ethical therapy services, deliver outcomes and, most importantly, improve the health and wellbeing of the population.

The clinical evidence base for these professions is solid and increasing, and references to the most relevant sources are made throughout the report. But perhaps more importantly in the current climate of transformation and change, the approach of the three arts therapies is a compassionate and collaborative one. The valuable contribution of these professions is highlighted through a range of case studies throughout the document, giving qualitative descriptive examples of therapy work with a range of service users of different ages and conditions.

This workforce review has highlighted the current position of Music Therapy, Art Therapy and Dramatherapy as Allied Health Professions which are under significant stress in seeking to meet the demand for their services in independent services and thus meet the needs of service users throughout Northern Ireland. Services have evolved organically and as a result are fragmented and lacking in clear strategic direction, and the consequence of this is a drastic inequity of access to services across service user groups and geographically across the region. Service provision is not as effective or efficient as it could or should be. Despite being professions that are person-centred and driven by co-production at their heart, the services currently in place in Northern Ireland are entirely dictated by funding limitations. As a result, it has been recommended that a review of Arts Therapy services be carried out, with a view to developing a strategic approach to the three professions in Northern Ireland, and that the three professions be more actively included and involved as appropriate in service reviews and relevant groups, with a network group to be created across the three professions as a point of contact and to encourage effective communication and liaison between the three professions collectively and with relevant HSC bodies.

Strategic Context

In December 2016 the Department of Health (DoH) Northern Ireland began a series of workforce reviews across the thirteen Allied Health Professions, including Music Therapy, Art Therapy and Dramatherapy. While three separate professions, these are often collectively referred to as the 'Arts Therapies'. The aim of these reviews is to evaluate the current and future workforce requirements of these professions in order to ensure their sustainability and suitability to deliver AHP services across Northern Ireland capable of meeting the needs and demands of the population in the coming years, and to ensure that such services are delivered to the required standard.

It is widely recognized that the Northern Ireland health and social care system is undergoing a period of transformation in response to the challenges it faces, and the need for an integrated, well-supported, adaptable and resilient workforce to achieve this has never been greater. Art, Music and Dramatherapists, representing three of the thirteen Allied Health Professions, are well placed in terms of their skill set and clinical expertise to support this process and become an integral part of it. All three arts therapies help a wide range of service users to achieve outcomes which broadly improve their health, wellbeing and quality of life, as will be outlined in this report, and as such are well place to support a systemic rather than single-structure approach. Drama, Art and Music therapy services at present are not mainstreamed, being almost exclusively provided by external organisations and freelance individuals. As a result service delivery is irregular and fragmented, and the implementation and development of services is severely limited by the restraints of this funding model. This has also presented challenges in completing this review, as both the professions themselves and their stakeholders state that *current* service needs are not yet being met, before consideration can properly be given to assessing future demands and consequent workforce requirements. The instability and insecurity of current service and funding models significantly hinders the planning of a workforce that is as efficient and effective as it could be.

The 10-year strategy launched by the Department of Health in October 2016 - 'Health and Wellbeing 2026: Delivering Together' - was developed to ensure that Health and Social Care services in Northern Ireland can adequately meet the predicted needs of our

population over the next 10 years and beyond. The main focus of this strategy was to put the service user, the person, at the centre of services:

- Improving the health of our people
- Improving the quality and experience of care
- Ensuring sustainability of our services
- Supporting and empowering staff

The arts therapies should be integral to a health service following this strategic direction given the value they add to health and wellbeing outcomes, and the integral role the arts play in our lives. The All-Party Parliamentary Group on Arts, Health and Wellbeing Inquiry Report "Creative Health: The Arts for Health and Wellbeing"[1] (hereinafter referred to as the 'APPG Creative Health report 2017') was published in July 2017 and states (p.11):

> "Millions of people in the UK engage with the arts as part of their everyday lives. As we demonstrate in this report, arts engagement has a beneficial effect upon health and wellbeing and therefore has a vital part to play in the public health arena. At the same time, this report shows that the arts have a significant role in preventing illness and infirmity from developing in the first place and worsening in the longer term. Added to which, engagement in the arts is consistently seen to enhance wellbeing and quality of life in people of all ages. In short, the arts can help to address many of the challenges the health and social care system is facing and improve the humanity, value for money and overall effectiveness of this complex system."

[1] http://www.artshealthandwellbeing.org.uk/appg-inquiry/Publications/Creative_Health_Inquiry_Report_2017.pdf

Music Therapy

1. Music Therapy

The overview that follows of music therapy services in Northern Ireland shows that the service delivery model currently in place is not fit for purpose and does not meet the health and wellbeing needs of service users, and services are not as efficient or cost-effective as they potentially could be. The existing music therapy workforce does however already have the skills and qualities needed to actively engage with and support the transformation agenda. It is therefore essential at this stage that a properly integrated and supported workforce be facilitated in order for us to play our role in this process as one of the 13 Allied Health Professions and to contribute fully to improving the health and wellbeing of the local population.

A scoping exercise was carried out in early 2018 to gather data from the current workforce throughout Northern Ireland, including both music therapists delivering services funded by Health and Social Care Trusts (HSC Trusts) as well as those delivering services elsewhere that have been sought from providers or by the NI population in order to have their health and wellbeing needs met. In this way we have aimed to give as full a picture as possible of current music therapy provision in Northern Ireland.

Definition of Music Therapy

The NHS England website states that, "Music therapists engage clients in live musical interaction so as to promote an individual's emotional wellbeing… …this established psychological clinical intervention utilises their unique connection to music and the relationship established with their therapist to help: develop and facilitate communication skills, improve self-confidence and independence, enhance self-awareness and awareness of others, and improve concentration and attention skills."[2]

Music therapy is both an evidence-based clinical treatment and at the same time innovative, creative and person-centred. Individually-defined psychological, emotional, cognitive, physical, communicative, sensory or social outcomes can be achieved. This takes place through the creative processes of music, facilitated by a duly trained and registered therapist.

[2] https://www.england.nhs.uk/ahp/role/#music

Music therapists work with people of all ages, from neonatal care to end-of-life, and in a range of settings including hospitals, hospices, residential care homes, rehabilitation, community settings, day centres, nursery, mainstream and special schools, and in clients' own homes. Client groups include people with learning, developmental and physical disabilities, neurological disorders (including stroke, Parkinson's, MS, MND) and acquired or traumatic brain injury, mental health conditions, dementia, in palliative care or with emotional, behavioural or wellbeing issues.

A list of publicly available video links showing some examples and case studies of music therapy work are included in Appendix 1.

The current music therapy workforce

All of the data contained herein is based on information gathered during a scoping exercise completed in May 2018. Due to the nature of the profession in Northern Ireland today, specific data may have changed to a degree in the interim period until publication of this review. HCPC data states that 30 music therapists are registered in Northern Ireland, and 29 therapists are known to be working here, 24 female and 5 male. The Department of Health does not hold data on the music therapy workforce. 19 responses were received to the scoping exercise carried out and so the information contained herein is the best indication available based on the information received. Six of the 29 therapists are working full time, with the average being 0.67 WTE. Only a small number (11) are employed with permanent contracts, with others either working freelance or with time-limited contracts.

Service user group	No. of music therapists in this area
Adults with Learning Disabilities	1.22 WTE (B & NHSCT)
Adults with Physical Disabilities	0.3 WTE (BHSCT)
Children with Disabilities	4.8 WTE (All Trusts)
Child and Adolescent Mental Health	0.3 WTE (BHSCT)
Children with social, emotional and behavioural difficulties	1.12 WTE (B, SE, N & WHSCT)
Adult Mental Health	<1 WTE (sessional) (BHSCT)
Dementia	0.2 WTE (B & WHSCT)
Forensic settings	0.3 WTE (B, SE & WHSCT)
Acute Medical settings	0.16 WTE (BHSCT)
Brain Injury	0.3 WTE (B & WHSCT)
Neurological conditions	0.2 WTE (B & SHSCT)
Palliative care	1.2 WTE (B & SHSCT)

Table 1: Number of WTE music therapists working in each clinical area in Northern Ireland.

Drivers and constraints to music therapy services and workforce in Northern Ireland

Drivers:

Effectiveness and evidence base: Music therapy outcomes show long-term benefits and improvements in transferable life skills, enhancing and improving the health and wellbeing of the population. Measurement of outcomes can be challenging due to the nature of the outcomes and the client groups in question, but this is being actively addressed within the music therapy profession with developing measurement tools which are an excellent fit for the overall shift in our health services towards value-based commissioning, outcomes-based accountability, and person-centred practice.

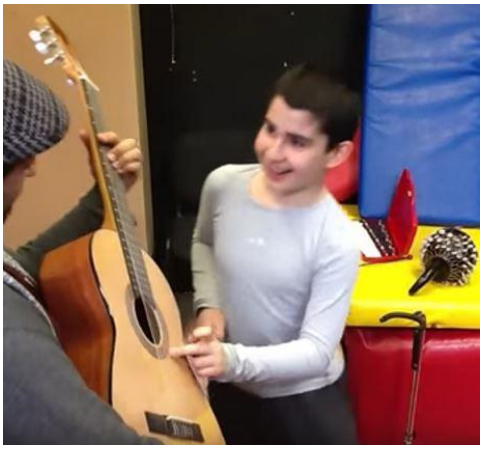
The evidence base for music therapy is strong and growing, with an increase in quantitative and mixed methods research in addition to qualitative evaluation. A database of evidence

by the Nordoff-Robbins music therapy organisation was last updated in 2016 and contains an overview of research evidence for the profession[3].

Flexibility and adaptability in meeting clients' needs: Music therapy has an inherent adaptability, which is why it is a viable intervention for such a wide range of service users and across the full span of life.

There is an innate human ability to respond to music, and this remains intact regardless of illness, injury or disability.

In the hands of trained and registered music therapists, this can become a form of therapeutic support that can be accessed by those with the most complex needs, needs that are difficult to address in other settings or by other professions.



Music therapy is a person-centred discipline, service users are always involved directly in the development of their treatment. Identification of objectives and outcomes is a dynamic process that begins in the initial assessment and runs throughout the therapy, especially and most importantly through service users' musical responses. In short, co-design is at the heart of every single music therapy session, from the roots up.

PHOTO FROM 'EITAN'S MUSIC THERAPY' - HTTPS://YOUTU.BE/PYPJNC645N8

Demand for services: Awareness is steadily growing among the general public of the extent to which music therapy can contribute to improving health and wellbeing. This is demonstrated by the high number of unsolicited enquiries received. Interest is also high from stakeholders in healthcare and education who have directly observed the impact of this therapy. Where services are funded, demand for them is usually such that referrals are only actually accepted when there is known availability and referrers are forced to prioritise service users resulting in a funding-dictated rather than a needs-based service.

[3] https://www.nordoff-robbins.org.uk/ResearchAndResources

High engagement and motivation of service users: with uniformly high attendance, compliance with treatment and low cancellation rates across all client groups and age groups.

Service feedback consistently positive: consistently positive feedback about the outcomes of services is received from families, staff, and service users themselves across all areas of work.

Constraints:

Funding: The lack of funded services was unanimously identified by the profession as the main constraint to music therapy in Northern Ireland. Clients and families regularly report that they are unable to access services, other healthcare professionals report that service users request this service and are unable to access it, and music therapists report their difficulty in setting up any regular, sustainable long-term provision. Music therapists' clinical recommendations for ongoing support for service users are generally not met, and potential partnerships and collaborations with other healthcare professionals, allied health professionals, or education professionals cannot be effectively implemented.

Instability of contracted services: With a handful of exceptions, services are mainly short-term contracts (up to 1 year) resulting in a highly unstable working environment with a lack of job security. This also has a clear impact on service planning, service improvement and on service users themselves.

Knowledge is significantly lacking of our profession as one of the 13 Allied Health Professions capable of providing a clinical intervention comparable to a psychological therapy, not only among the general public but also within our health services themselves. There is a lack of distinction made between music *therapy* with clinical aims for directly improving health and wellbeing, and music for general wellbeing, recreational or teaching purposes. The current rise in Arts for Health practices, both within the general public and within statutory services, is in itself positive, and increased engagement in the arts will only benefit the general population. There is, however, a need for due caution when such services are expected to have 'therapeutic' outcomes and musicians or artists with no health-related training or indeed any governance responsiblilty are employed to deliver these without the protection for the public brought by HCPC registration and its related

standards of proficiency, good governance and professional practice. It is important and in the absolute best interest of service users that awareness be raised appropriately of the importance of employing a health professional when this is required and a good musician at other times when clinical responsibility is not an issue.

Inequity of services: Across geographical areas and across clients groups, as is evident in the service mapping summary below.

Communication: The present service delivery model hinders effective liaison with other professionals and with families and carers, as well as preventing participation in care team, annual review or multidisciplinary team meetings. This means that music therapists miss out on vital information about clients, but also that other involved professionals miss out on the clinical perspective and insight a music therapist can bring.

Required workforce:

The manner in which music therapy services in Northern Ireland have developed and evolved to the present time means that it is impossible to predict workforce requirements for the coming ten years or to properly evaluate matters of training requirements, recruitment and retainment until such a time as there is a strategic approach and infrastructure in place for the arts therapies. The following areas are, however, basic requirements of such a workforce:

Professional regulation

The HCPC is an independent body responsible for setting and maintaining the standards of proficiency, performance, conduct and ethics of the health professions it regulates, of which music therapy is one. Only those with a professional qualification from a Masters-level training course approved by the HCPC can register with the regulatory body and practice in the United Kingdom as a Music Therapist. As mentioned above, the lack of awareness of this need for registration, along with the current rise in more generic 'arts in health' practices without protected title or training requirements results in frequent misuses of the protected title in the public realm.

Supervision

Music therapists and independent organisations work in line with current guidelines and recommendations for supervision, including the 'Regional Supervision Policy for AHPs – Working for a Healthier Future (2014)'[4], even when not employed in HSC Trust contracts, in the interests of effective governance and professional accountability. Music therapists fully recognise the need for regular supervision and reflective practice to consistently deliver the highest level of quality, safe and effective services that properly meet the psychological, emotional and neurological rehabilitative needs of services users.

1.1 Service Mapping – Music Therapy in Northern Ireland, May 2018

The following section maps out music therapy services in place in Northern Ireland as determined by the scoping exercise completed in May 2018. Services are provided to a wide range of client groups, but consist mainly of short-term sources of funding which leads to high variability and changeability of services. Thus, the information outlined below acts as a snapshot of those services in place in May 2018, in a highly fluctuating service model, based on the responses of 20 of 29 music therapists working in Northern Ireland at that time. It can, however, be considered as generally representative of music therapy provision in Northern Ireland at the present time. All calculations are based on a 37-hour full time week, 7.4 hours per day.

The table below summarises services currently funded by Health and Social Care Trusts, which account for approximately 40% of the working time of those therapists who responded to the scoping exercise (the actual figure will be considerably lower). Services are shown by Trust area, and the inequity of provision across the Trusts is evident.

[4] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/regional-supervision-policy-ahp-2014.pdf

	BHSCT	SEHSCT	SHSCT	NHSCT	WHSCT
	Adult Learning Disability	-	-	-	-
HSCB	*Children with Disabilities*	*Children with Disabilities*	*Children with Disabilities*	*Children with Disabilities*	*Children with Disabilities*
	Children with Disabilities (residential)	-	-	Children with Disabilities (CDC & Complex Care)	-
	Adult Physical Disability	-	-	-	-
	CAMHS	-	-	-	-
	Brain Injury	-	-	-	Brain Injury
	-	-	-	-	Dementia / Adult mental health
	-	Forensic	-	-	-

Table 2: Areas where music therapy services are funded by HSC Trusts

Services and related workforce implications are presented below in greater detail, subdivided by client group. For those identified as 'non-Trust', the funding has been obtained from a range of sources including:

- private payment by families/carers
- fundraising by families/carers
- charitable grants
- lottery funding
- self-funding by schools

1.1.1 Adults with learning disabilities

Area	Funding	Venue/setting	Provision/ week	Service users	Waiting list
BHSCT	BHSCT	5 Day Centres, inpatient setting, residential	5.6 days	73	215+
BHSCT	BHSCT – social worker	Home visit	1 hour	1	0
BHSCT	Non-trust	Home visit/residential	3 hours	13	0
NHSCT	NHSCT – social worker	Home visit	1 hour	1	0

Under contracted services with the BHSCT music therapy is provided in five day centres for adults aged 18 and above with learning disabilities, 0.5-1 day per week in each centre, for a total of 0.75 Whole Time Equivalent (WTE) music therapists. On average 55 service users receive music therapy each week, with approximately 200 more service users in these venues identified as potential beneficiaries of the service if it were possible.

In inpatient and residential settings for adults with severe learning disabilities including ASD, mental health needs, forensic needs and challenging behaviour, a total of 0.47 WTE posts are providing music therapy to approximately 32 service users, with current waiting lists of 15. Demand is extremely high and all therapists stated that they receive more referrals than they are able to see. In summary:

- 1.2 WTE therapists
- approximately 88 service users each week
- Northern Ireland population of adults with learning disabilities estimated at 30,814 (Source: Mencap, 2017[5]).

All but one service user are in the greater Belfast area and so there is huge inequality of access to music therapy services for adults with learning disabilities across the region.

[5] https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/how-common-learning-disability

Music therapy is widely accepted as providing a valid therapeutic support for adults with learning disabilities, in particular in developing communication, social skills and interaction, and providing a highly accessible form of emotional and psychological support. Attendance is traditionally very high, with service users highly motivated to take part. With appropriately integrated services facilitating multidisciplinary partnership working, including co-treating where appropriate, music therapy could also significantly enhance the impact and outcomes of physiotherapy, occupational therapy and speech and language therapy for these service users. In one HSC Trust service in 2017, attendance at therapy sessions over a six-month period averaged 78.8%, with only 8.8% lost to DNA (did not attend), despite the highly complex and often challenging needs of this population.

Sample Outcomes In 2017, 22 service users showed an average 12% increase in their ability to interact and relate to others in the music therapy session over just a 12-week period of music therapy.

Case example

S attends a Day Centre in Belfast. She has received regular periods of individual music therapy over the last number of years, time-limited due to the high demand for music therapy in the centre. S has profound and multiple learning disability with an extremely limited range of movements and facial expressions. She is non-verbal, and her participation in group activities in the centre is extremely limited. However, when she plays an electric piano keyboard in music therapy sessions, she lights up and the change in her is remarkable. She makes a tremendous effort to bring her hands onto the instrument and, despite the extremely limited range of movement she has, she will manage to play through minimal finger movements. The therapist creates a musical structure around her sounds that is adapted and changed in the moment to support whatever S is playing, enabling her to enter into a 'dialogue' with another person. This represents a vital form of self-expression that S cannot access elsewhere. During these exchanges she makes her pleasure known through smiling, laughing aloud, making eye-contact and turning towards the therapist. Staff report that these positive outcomes continue in S long after each session has finished – her joy at being able to interact in this way is clear and lasting.

1.1.2 Adults with Physical Disabilities

Area	Funding	Venue/setting	Provision / week	Service users	Waiting list
BHSCT	BHSCT	3 X Day Centres	1.5 days	23	30

There are no known music therapy services for adults with physical disabilities in any other area of Northern Ireland - inequality of service provision is evident.

In the Belfast area services are provided in three day centres for adults with physical disabilities.

- 0.3 WTE therapists
- On average 23 service users each week

Demand for the service is extremely high and all therapists stated that they received more referrals than they were able to see. In one HSC Trust service in 2017, attendance at therapy sessions over a six-month period averaged 85.8%, with only 2.5% lost to non-attendance (DNA) (the remaining 11.7% due to cancellation of sessions).

Sample Outcomes Five service users over just a 12-week period of music therapy showed an average 7% increase in their ability to interact and relate to others in the music therapy session (obtained using a music-therapy specific outcomes tool measuring communication-relationship goals). The services in question focus mainly on group social skills, communication and interaction with peers, but a fully integrated service for this client group could potentially work in close partnership with speech and language and physiotherapists to use specific music therapy techniques to develop vocal, verbal and motor skills, thus enhancing the outcomes and impact of other allied health professions as well.

Service user voice –comments from unanimously positive questionnaires completed by eleven service users at a Belfast day centre in 2017

'It made me more outgoing'

'It helps my speech, my words are clearer'

'It makes me happy'

'It's good for my hand coordination'

1.1.3 Children with Disabilities

Provision for children with disabilities is by far the most widespread music therapy service in Northern Ireland, and yet evidence shows that there is significant unmet demand with only approximately 0.03% of children with disabilities in Northern Ireland able to access services at any given time. Of those services in place approximately 20% are funded by HSC Trusts while the remaining 80% are funded through charitable grants, private funders, parent fundraising, paid for privately or from school budgets (and this is an overestimation as based only on the respondents to the scoping exercise carried out). It is clear that demand is extremely high both among parents and from professionals working directly with the children in question. This is an area where collaboration with the Department of Education is essential as the majority of these services are delivered in school settings.

A single music therapy organisation provides a regional family support music therapy service across all 5 Trusts for children with disabilities. This Health and Social Care Board funding covers a minimum of six sessions per week in each Trust area for children aged 0-19 with disabilities, severe communication difficulties and challenging behaviour. There is extremely high demand and HSC Children's Disability teams hold and manage the waiting lists and prioritise for available spaces.

In addition to this regional service, a contract with the NHSCT covers one day per week split across a Child Development Centre focussing on early intervention and family support for children with ASD aged 2-4 years, and in 'complex care home visits' for children with profound and multiple learning disabilities and complex medical needs. Due to demand, in both of these settings only very short-term interventions are possible.

Area	Funding	Venue/setting	Provision/week	Service users no.	Waiting list
Regional	HSCB	Home visits and schools	7.5 days per week	c. 64 (variable)	Unknown
Regional	Non-Trust	Home visits and schools	3 days per week	c. 18	Unknown
BHSCT	BHSCT	Residential setting	0.5	5	10

BHSCT	BHSCT – social worker	Home visit	1 hour	1	0
BHSCT	Non-Trust	Special school /community/residential	3.5 days	c.98	85
BHSCT	Non-Trust	Early years	0.5 days	6	unknown
SEHSCT	Non-Trust	Special and mainstream schools/home visit	1.3 days	c. 36	100+
SHSCT	Non-Trust	Special school	2.2 days (including short-term contracts)	c. 40	180++
NHSCT	NHSCT	Child Development Centre and home visits	1 day	6	22
NHSCT	NHSCT – social worker	Home visit	1 hour	2	0
NHSCT	Non-Trust	Special and mainstream schools	1.8 days	20	80+
WHSCT	WHSCT – social worker	Home visit	0.3 days	2	0
WHSCT	Non-Trust	Clinic/community	5.9 days (including short-term contracts)	53	75

Table 3: Overview of music therapy provision for children with disabilities

In the HSCB-funded service over a 6-month period in 2017, attendance at therapy sessions averaged 82.8%, with only 1.2% lost to non-attendance at sessions (DNA) (the remaining 16% are due to cancellations).

Sample Outcomes Over just a 12-week period of music therapy 83 service users showed an average 14% increase in their ability to interact and relate to others in the music therapy session (obtained using a music-therapy specific outcomes tool measuring communication-relationship goals).

Case examples:

A. began to receive sessions in his mainstream school, at a time when he was struggling with this placement. The therapist was able to establish a secure therapeutic relationship with A. at this time, giving him an outlet to express himself emotionally and a sense of control at a time when he was overwhelmed and anxious. The therapist was able to adapt to his preferences, recognising and facilitating his need for control at this time. The flexible nature of the service meant that the therapist was able to continue to support A. through the summer and as he transitioned to his new school placement the following year, thus providing consistent therapeutic support during this period of change.

Parent/carer voice: "We are delighted to report that, whilst it took A. time to settle into his new school, he is now happy and engaged both socially and academically. He sings, dances, chatters non-stop and enjoys playing with his friends – and we can't tell you how thankful we are for that. It's all to the good that he can continue to express himself through music, and in other ways, whatever he is feeling."

P. is a 9-year-old girl with ASD who attends a special school where she is in a class on her own. Cognitively P. understands language and verbal interaction, but is herself non-verbal and does not generally use her voice unless at times of severe distress. P. received a 10-week period of music therapy through lottery-funding and during this time not only was she able to sustain engagement and attention with the therapist in shared interactions, she also began to make increased vocal sounds through shared singing. As this was an extremely time-limited intervention, the therapist put together a programme based on neurologic music therapy techniques which the teaching staff could implement subsequently in order to continue to support development of P.'s controlled and directed vocalisations.

Benji – A Journey to Speech (Nordoff-Robbins Australia):
https://www.youtube.com/watch?v=a1xiG29UMOA

"And he starts to discover that he can use music to connect with others…and that he might enjoy it!! …Now he starts to connect with intention…"

With appropriately integrated services facilitating multidisciplinary and partnership working, music therapy could significantly enhance the impact and outcomes of physiotherapy, occupational therapy and speech and language therapy for children with disabilities.

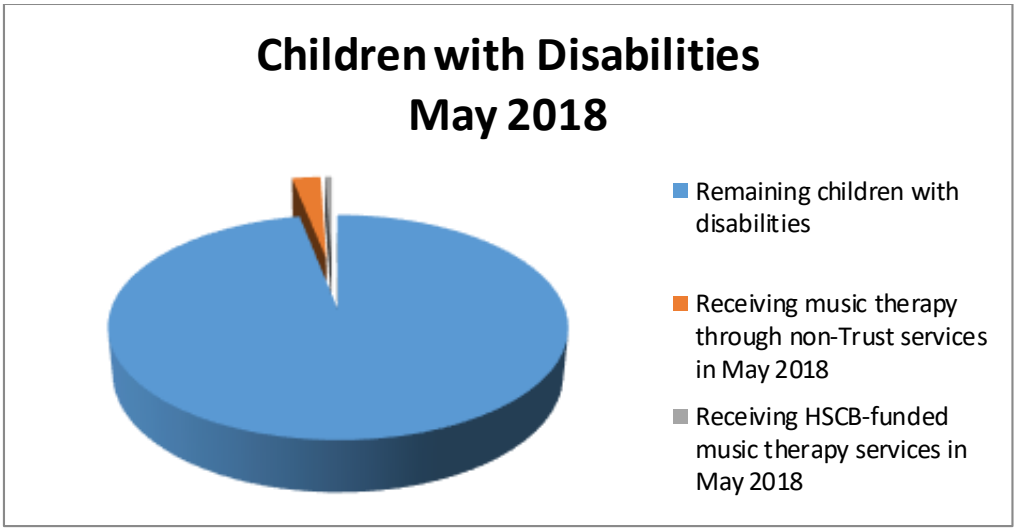
Trust and HSCB-funded services account for 1.86 WTE therapists currently working with 64 children. In this service waiting lists are not generally held as demand is so high that sessions are offered only when there is known availability.

Non-Trust services account for 2.94 WTE therapists currently working with 271 children, with at least a further 520 identified by therapists as potential referrals. The proportionately higher number of children treated per WTE in non-Trust services is dictated by the fact that self-funded services on the whole tend to favour group settings due to the need for venues such as schools to show that the service is shared as equitably as possible among all service users. This is therefore a funding-constrained, not person-centred service delivery model.

In summary:

- 4.8 WTE therapists
- 335 service users currently
- Northern Ireland population of children with disabilities estimated at 10,889 (Source: Mencap, 2017[6]).

There is a high turnover of referrals in this service, but even so only a tiny proportion of the overall Northern Ireland population of children with disabilities are able to access music therapy at any given time, and a significant proportion of this is highly dependent on variable grant and charitable funding. It is worth bearing in mind that this represents by far the best funded music therapy service at present.



1.1.4 Child and Adolescent Mental Health Services

One day per week is provided in a mental health inpatient unit for young people aged 12-18. 6 clients are seen per week with a further 15 not accessing music therapy, and 0.5 days per week in a mental health clinic for 10-18 year olds where 2 clients are seen per week. Psychologists in this setting have expressed that they would be keen for most service users

[6] https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/how-common-learning-disability

to receive at least a music therapy assessment. The services in question are both in the greater Belfast area, with no provision in the rest of Northern Ireland.

Area	Funding	Venue	Provision / week	Service Users	Waiting list
BHSCT	BHSCT	Inpatient unit/clinic	1.5 days	8	15

The 'Music in Mind' study was completed in Belfast in 2014 and published in 2016[7]. This was a multicentre, single-blind, randomised controlled trial in which young people, aged 8-16 years old, with Social Emotional and Behaviour Difficulties (SEBD) were allocated randomly to 12 weekly sessions of improvisational music therapy in addition to usual care or to usual care alone at six community care facilities within the Child and Adolescent Mental Health Service in Northern Ireland. This was internationally the largest ever study of its kind to date, involving 251 young people. It showed that young people between eight and 16 years of age who received music therapy had significantly improved self-esteem and reduced depression compared with those who received treatment without music therapy. The study also found that young people aged 13 and over who received music therapy had improved communicative and interactive skills, compared to those who received usual care options alone. Music therapy also improved social functioning over time in all age groups.

The most common approaches to treatment for this client group are costly medications and psychotherapy, both of which have an insufficient evidence base for use with children and adolescents. A cost-effectiveness analysis (publication pending) was conducted alongside the Music in Mind trial, with costs examined in relation to improvements in communication and quality-adjusted life years. It demonstrated a net benefit value for each child/young person based on the observed costs and effectiveness of music therapy.

The findings from the Music in Mind trial support the integration of music therapy into routine clinical practice within child and adolescent mental health services. However, since the completion of this Belfast-based study and publication of its findings, there have been no further developments in related services in Northern Ireland.

[7] https://doi.org/10.1111/jcpp.12656

Recent media reports have stated that 'almost half of Northern Ireland young people have mental health problems'[8], and that 'Northern Ireland has catastrophic levels of mental ill health' with the highest suicide level in the UK[9]. According to the 'Mental Health in Northern Ireland' report[10] published in 2017 'while data on the prevalence of mental ill health in children and young people in NI is scarce, it is estimated that around 45,000 of children and young people in NI have a mental health need at any one time' (p. 32). Despite locally-provided and internationally-accepted evidence, current service provision is equivalent to just 0.3 WTE for the whole of the region, with approximately 8 young people able to access services.

- 0.3 WTE therapists
- 8 service users
- Estimated that 'around 45,000 children and young people in Northern Ireland have a mental health need'.

1.1.5 Children with social, emotional and behavioural difficulties

These are services provided, most often in school settings, for children recognised as having a need for additional emotional, psychological or behavioural support. The APPG Creative Health report 2017 recognised the "arts as a form of evidence-based and cost-effective treatment of childhood behavioural problems and conduct disorders" (p. 90). As in CAMHS services, music therapy is ideally placed as an accessible service to provide high quality, high impact psychological and emotional therapeutic support as part of an early intervention or prevention model, especially as it is a trauma and developmentally-informed practice. It is particularly relevant for these children as it is not only effective but also immediately appealing, accessible and engaging for children for whom verbal or talking therapies may not be possible or accessible.

8 https://www.belfasttelegraph.co.uk/news/northern-ireland/almost-half-of-northern-ireland-young-people-have-mental-health-problems-study-reveals-36776120.html (5th April 2018)
9 https://www.amh.org.uk/wp-content/uploads/2018/02/Briefing-Mental-Health-Crisis-in-Northern-Ireland.pdf (20th February 2018)
10 Betts and Thompson, http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2016-2021/2017/health/0817.pdf

Area	Funding	Venue/setting	Provision/week	Service users	Waiting list
BHSCT	Non-Trust	Mainstream schools	3 days	c. 45 (variable)	67++
BHSCT / NHSCT	Non-Trust	Clinic	2 days	10	unknown
SEHSCT	Non-Trust	Special school/Private /home visit (LAC)	1.6 days	9	30
WHSCT	Non-Trust	Mainstream school	0.5 days (short-term)	5	3+++

Services are provided across 11 different venues with 1.12 WTE therapists working with a total of 69 children and upwards of 100 on waiting lists and many more recognised as potential referrals, representing just a tiny proportion of the Northern Ireland population of children and young people who may need additional support of this nature.

The numbers given above are particularly striking given the severe lack of CAMHS services previously described, as this area of work is often considered as a form of 'pre-CAMHS' early intervention. The demand for these services is evident, given that those outlined are entirely self-funded. Again collaboration is clearly needed with the Department for Education in this area to provide appropriate support for these children in the right place at the right time.

1.1.6 Adult mental health: Specialist psychiatry services, general emotional/psychological support

Area	Funding	Venue/setting	Provision/week	Service users	Waiting list
BHSCT	BHSCT (sessional)	Inpatient wards Outpatient primary care	Up to 2 days	Up to 25	unknown

"According to the Northern Ireland Health Survey 2014/15, 19% of individuals show signs of a possible mental health problem… Similar rates of poor mental health were reported in a 2013 study into the prevalence of mental health disorders in Northern Ireland, which suggested rates of 23.1%" (source: Mental Health Foundation report 'Mental Health in Northern Ireland: Fundamental Facts 2016'[11]).

PHOTO FROM "MEET ALI" HTTPS://YOUTU.BE/LNSBYAOEYZC

As noted earlier in this report, there is universal recognition of music as a means of enhancing our mental and psychological wellbeing as part of the human condition. This capacity of music is part of the reason why it is so powerful as a therapeutic tool in the hands of a trained and registered therapist, and music therapy is ideally placed to play a vital role in any programme of social prescribing for this and other client groups. While music is widely recognised as integral to mental health services, it is music therapy that is particularly well-evidenced, for example, the APPG Creative Health report 2017 stated that "A Cochrane review of RCTs found that individual music therapy combined with standard care (psychotherapy and medication) tended to show more significant improvements in mood than standard care alone"[12] (p. 103). It is noted that as well as treating patients with complex psychological needs in a detailed, multi-layered way, enabling increased insight into symptoms for ongoing monitoring of illness, music therapy has also been instrumental in patients' return to taking an active part in their community.

Within adult psychiatry, one music therapist has been working closely with psychiatrists for a decade, within a BHSCT specialist psychotherapy service for adults with complex, severe

[11] https://www.mentalhealth.org.uk/file/1610/download?token=vOtlEP36

[12] Maratos, A., Gold, C., Wang, X. & Crawford, M. (2008). Music Therapy for Depression. Cochrane Database of Systematic Reviews

disturbance (12-16 hours per week). The input of this therapist has covered ward settings (including low secure wards, two acute admission wards and a medium secure forensic unit) and two specialist BHSCT psychological therapies outpatient facilities for patients with complex needs (dual/triple diagnoses). This is a rolling contract, usually reviewed every 2 years but, in spite of this, services for adults with diagnosed mental health issues currently have less than one WTE treating only up to 25 patients at any given time via one sessional BHSCT contract and a grant-funded time-limited service. This work has received much recognition and support but further funding to expand the service has been absent and no such services have been provided in the rest of Northern Ireland.

Case example:

A patient in their twenties had availed of significant CAMHS and community services for more than 7 years and then attended music therapy in an outpatient setting, having presented with ongoing, complex difficulties in terms of capacity to manage independent living. The patient was prescribed a significant amount of psychiatric medication and was extremely isolated, taking no part in society and deteriorating, suggesting in-patient services might be required. The music therapist initially worked at a more concrete level, offering the patient a means of discovering how the instruments might help link up with and express experiences. Over time the patient became able to put words onto these experiences, and then to use the instruments as a means of spontaneous self-expression, for working out difficulties, and for identifying the roots of what was difficult. This was delicate, complicated and careful work, because of the risk of self-harm that was present. After 4 years of weekly sessions, the patient was discharged, no longer taking psychiatric medication, living independently and working. This shows how cost-effective an investment in music therapy can be: the patient no longer required psychiatric treatment and medication, contributing fully to society and unlikely to break down and need specialist help.

In relation to older age psychiatry, there is no provision in N. Ireland, while in the Republic of Ireland music therapy is provided 2 days per week in Tallaght hospital with older adults and adult psychiatry services. In the rest of the UK there are innovative services across the age range that have survived in spite of funding cuts. Despite the immense need, there are only rare examples of music therapy services within psychiatry in Northern Ireland, even for generalized emotional or psychological support for adults. Given the multifaceted difficulties arising out of the legacy of the Northern Ireland conflict, music therapy is an established

method and means of treatment[13] and thus a relevant – and necessary - intervention to meet the current complex needs of many psychiatric patients.

1.1.7 Dementia

Area	Funding	Venue/Setting	Provision/week	Service Users
BHSCT / SHSCT	Non-Trust	Care homes and own homes	0.5 days + 1 hour	16
WHSCT	WHSCT	Hospital (dementia and adult mental health assessment)	0.5 days	8

Under a WHSCT contract, renewed every two years, approximately 8 patients aged 60 and over are seen in a hospital setting for 0.5 days per week. There is high demand for the service as staff would like as many seen as possible in the time available.

KATH - HTTPS://YOUTU.BE/SWT8J_FNUO4

Music therapy is again widely recognised as an important and effective means of therapeutic support for people with all forms of dementia. A report published in January 2018 summarising the work of the Commission on Dementia and Music[14] states that that music helps to minimise some of the symptoms of dementia, such as agitation, and can help to tackle anxiety and depression, and that we can also observe the considerable value of music in improving the quality of life for people with dementia, by helping to increase social interaction and decreasing stress hormones.

Sample Outcomes In a HSC Trust service, outcomes are measured using the Music in Dementia Assessment Scales (MiDAS[15]). In the most recent quarter April-June 2018,

[13] Sutton, J. (2002) Music, Music Therapy & Trauma. International Perspectives. London, Jessica Kingsley

[14] http://www.ilcuk.org.uk/index.php/publications/publication_details/what_would_life_be_without_a_song_or_dance_what_are_we

[15] https://www.musictherapy.aau.dk/midas/

patients showed an average 48% improvement across the five outcome areas, (Level of Involvement, Response, Interest, Enjoyment and Level of Initiation). It should be noted that these scores assess the patients' presentation at the beginning of the session (before music therapy input) and their 'peak' response, and so they indicate a baseline and a maximum response.

NICE guidelines recommend that older people engage in creative activities, and that 'people with all types and severities of dementia who also experience agitation may be offered 'therapeutic use of music'. Once again, the APPG Creative Health report states that "A 2013 DH report on dementia in England made passing reference to the beneficial sensory aspects of arts engagement in general and music therapy in particular. An RCT comparing standard care with music therapy over six weeks found that agitation increased in the first group and decreased in the second, leading to a diminution of medication in the group receiving music therapy. NICE advises that people with all types and severities of dementia who also experience agitation may be offered 'therapeutic use of music and/or dancing'." (p. 133)

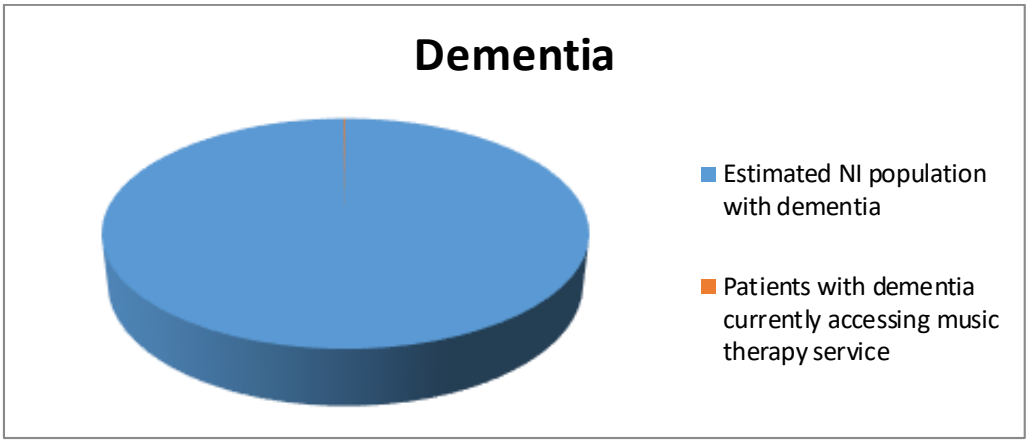
Recently there has been increasing awareness and recognition in the public eye of the dramatic impact that appropriate engagement in music can have on the health, wellbeing and quality of life of people with dementia, including in the mainstream media[16]. Secretary of State for Health and Social Care, Matt Hancock, recently stated that more people with dementia should be given music and dance therapy in a bid to prevent them being "over-medicalised", saying "This is the kind of personalised care that I fully endorse as a key part of our NHS long term plan"[17], and in a presentation to the Creative Health conference in June 2019, NHS Chief Executive Simon Stevens recognised that music therapy reduces agitation and the need for medication in 67% of people living with dementia[18].

- 0.2 WTE music therapists
- 24 service users currently accessing music therapy
- Over 20,000 people estimated to be diagnosed with dementia in Northern Ireland (source, Alzheimer's society NI[19]), a figure set to increase given our increasingly

[16] 'Miriam's Dead Good Adventure, BBC2, 21st April 2019 https://www.bbc.co.uk/programmes/m0004gpl
'Our Dementia Choir' series, BBC1, from 2nd May 2019 https://www.bbc.co.uk/programmes/m0004pyg
[17] https://www.telegraph.co.uk/news/2019/04/05/dementia-patients-should-offered-music-dance-therapy/
[18] https://www.rhinegold.co.uk/classical_music/southbank-centre-holds-first-creative-health-conference/

19 https://www.alzheimers.org.uk/about-us/policy-and-influencing/national-policies/dementia-strategy-northern-ireland

aging population.



1.1.8 Forensic settings

Area	Funding	Venue/Setting	Provision / week	Service users
SEHSCT / WHSCT	SEHSCT	Prison	1 day	30
BHSCT	PBNI	Bail hostel	4 hours	10

Prison population numbers in Northern Ireland and those with mental health issues or addiction are estimated as follows: "On 17 November 2016, the prison population totalled 1,533. Of these, 417 were recorded as having a mental illness, and a further 740 prisoners were recorded as having an addiction. That amounts to just over 75% of the prison population."[20] And yet, currently 0.3 WTE posts provide services in forensic settings to 29 people, and there is very high further demand for this service providing support into the mental health teams in these settings.

[20] https://www.theyworkforyou.com/ni/?id=2016-11-21.2.1&p=13821

In November 2018 the Arts Council of England published 'Arts and Culture in health and wellbeing and in the criminal justice system'[21] which strongly supports arts and arts therapy interventions in this area and in particular references the AHRC Cultural Value report[22] saying "The Cultural Value report argues, on the basis of its own evidence review, that the arts can facilitate 'personal insight, increasing empathy and respect for others' and can 'change how we perceive ourselves, relate to others, and make sense of our world': These attributes contribute to what we understand as factors predicting desistance from crime..."

This is an area of work where collaboration with the Department of Justice is essential.

1.1.19 Acute Medical Settings

Area	Funding	Venue/setting	Provision / week	Service users	Waiting list
BHSCT	Non-Trust	Paediatric acute medical	0.8 days	5	unknown

In a paediatric acute medical setting in Northern Ireland, funded by a charitable grant, for 0.16 WTE just 5 children receive this service of all those in long-term hospital care in Northern Ireland. There is very high demand for increased services in this venue, and no known services anywhere else in Northern Ireland.

As a benchmark, in Our Lady's Children's Hospital, Crumlin, Dublin music therapy is available 3 days per week (0.6 WTE) specialising in neurology, oncology and the transitional care unit. In the Temple Street Children's University Hospital, Dublin music therapy is available 2 days per week

[21]https://www.artscouncil.org.uk/publication/arts-and-culture-health-and-wellbeing-and-criminal-justice-system-summary-evidence
[22]https://ahrc.ukri.org/documents/publications/cultural-value-project-final-report/

(0.4 WTE) specialising in neurosurgery and neurology. In the Tallaght Hospital Paediatric Music Therapy is available 1 day per week (0.2 WTE). There is currently a new children's hospital being built in Dublin which will replace the 3 hospitals above. As part of workforce planning, the Deloitte group recommended that there should be 5.0 WTE music therapists based on an international benchmark of The Royal Children's Hospital, Melbourne, Australia.

Case example:

A teenage boy was receiving care for the end-of-life stage of muscular dystrophy. Medical staff had administered pain relief and the physiotherapist had sought to re-position him but he continued to suffer extreme pain. He was aware that his body was deteriorating and he had been afraid to fall asleep for a number of days. During a 2-hour music therapy session, the therapist used simple guitar music to attune to his inner state and physical presentation, matching his breathing and crying vocalisations and gradually engaging him and guiding him to a place of calm where he was finally able to relax. He began to express himself vocally, resulting in a drastic change in his mood and wellbeing. He became calmer and was gradually able to fall asleep. In subsequent sessions, two of which were in the PICU, he himself engaged and focussed on the music much more quickly in order to relax and overall was much more settled physically and mentally. The effect on the level of pain perceived, on the child's physical comfort and also his emotional state was plainly evident to all involved and during and after subsequent sessions he was able to find peace and find sleep.

Another area of interest is music therapy in Neonatal Intensive Care Units which takes place in a number of hospitals worldwide, especially in the USA[23]. In 2018 Chiltern Music Therapy, who provide music therapy services across the south-east of England, completed a pilot music therapy project at the Portland Hospital for Women and Children in London with infants from 32 weeks onwards which incorporated Developmental Multimodal Techniques, skin-to-skin care, infant-directed singing and psychological support to mothers. A number of further NICU projects across the UK are planned for 2019 as well as programmes for babies and parents following discharge from the NICU to help parents continue to bond with their babies, and to support important developmental milestones over

[23] https://katfulton.com/hospitals-with-nicu-music-therapy-programs-around-the-world/

the first 2 years of their lives. Such services are not currently available anywhere in Northern Ireland. Specialist training is available in this area in 2019 two local music therapists travelled abroad to complete this training in the hope of bringing this service to Northern Ireland.

1.1.10 Brain Injury

Area	Funding	Venue/setting	Provision/week	Service users	Waiting list
BHSCT	BHSCT	Hospital	1 day	6	unknown
WHSCT	WHSCT	Hospital	0.5 days	4	4

A 0.3 WTE service is provided into 2 inpatient settings for adults (age 14+) with ABI/TBI, treating 10 patients per week. These patients have no further access to music therapy services after discharge from the settings. According to the RQIA Review of Brain Injury Services in Northern Ireland published in September 2015, it is estimated that approximately 2,000 people a year in Northern Ireland sustain and are living with the long-term effects of a brain injury. Patients could benefit both in acute hospital settings and in the community.

There is a significant and steadily growing evidence base for this area of work in particular coming from the specific area of neurologic music therapy. Neurologic music therapy is a specialized training which uses specific techniques such as rhythmic auditory stimulation, therapeutic instrument performance and pattern sensory enhancement for movement and gait objectives, or melodic intonation therapy, rhythmic speech cuing, oral motor respiratory exercises for speech-related goals. It is very difficult to access for Northern Ireland therapists. There are currently 4 music therapists in Northern Ireland who hold this training, although general music therapy can still be provided by any music therapist. The APPG Creative Health Report 2017 states that “Listening to music, singing and music therapy aid physical and cognitive recovery from brain injury” (p. 104), and that “A Cochrane Review of studies combining music therapy with standard care, on its own or in combination with other

therapies, found that rhythmic auditory stimulation improved the speed, rhythm, stride length and symmetry of patients' gait following an acquired brain injury." (p. 105)[24]

Sample Outcomes In one HSC Trust service where patients attend for short periods of time, outcomes are measured within each individual session, showing patients' initial presentation and maximum response during the session. In the most recent quarter April-June 2018, there was an average 43% improvement across 4 outcome areas (Level of Alertness and Responsiveness, Supporting Emotional Needs, Level of Engagement and Participation, and Level of Communication), with staff and therapist observations aligned. This indicates the patient's baseline at the start of sessions and the moment of their 'peak' response to music therapy during the session, and is indicative of the level of response music therapy can evoke. The most common behavioural responses observed were increases in vocalisations and physical movement, suggestive of the potential benefit of collaborations between music therapists, physiotherapists and speech and language therapists in this area.

1.1.11 Neurological conditions

Area	Funding	Venue/setting	Provision/week	Service users	Waiting list
BHSCT	Non-Trust	Hospital	1 day	8	?
SHSCT	Non-Trust	Home visit	1 hour (short-term)	1	0

0.2 WTE therapists currently provide services to just 9 patients, mainly in an inpatient medical setting. These patients usually attend for short-term respite care and the therapist has stated that patients would benefit from ongoing long-term service in their permanent care setting or home. This area of work covers is a very wide spectrum of conditions

[24] References: Bradt, J., Magee, W., Dileo, C., Wheeler, B. L. & McGilloway, E. (2010). Music Therapy for Acquired Brain Injury. Cochrane Database of Systematic Reviews.; and Magee WL, Clark I, Tamplin J, Bradt J. Music interventions for acquired brain injury. Cochrane Database of Systematic Reviews 2017, Issue 1.

including Multiple Sclerosis, stroke, Lewy body dementia, Huntington's disease, Parkinson's, cerebral palsy, and multiple system atrophy.

The MS Society estimates that there were 3,188 people living with MS in Northern Ireland in 2012.

Parkinson's UK estimates that there are more than 3,000 people in Northern Ireland with Parkinson's.

The Stroke Association reports that 4,416 people in Northern Ireland suffered a stroke in 2013/14.

There is significant and wide-ranging evidence for the effectiveness of music therapy in this area, especially if implemented as an integral part of the care plan from the earliest stages of rehabilitation. The Academy of Neurologic Music Therapy website in its research section lists 31 pages of references to research papers and clinical evidence.[25] In addition to providing a form of emotional and psychological support, for example, in stroke rehabilitation, music therapy is also reported in the evidence to improve gait, upper and lower limb increase of repetition and range of motion for hemiplegia, fine and gross motor controls for grip strength, supination and pronation repetitions and quality of movement, apraxia, and dysarthria. Music therapy's holistic approach in a ward setting is also reported to support the multidisciplinary approach throughout the setting, for example working with AHP colleagues to enhance and support their impact on attention, executive function, movement or communication goals.

Across the UK, neurologic music therapy has been growing in private and NHS healthcare settings, and within the medico-legal setting. One of the larger providers of neurologic music therapy, Chroma, currently provides NMT into the following healthcare settings: The Portland Hospital (HCA Healthcare UK), The Wellington Hospital (HCA Healthcare UK), Charing Cross Acute Stroke Unit (NHS), Great North Children's Hospital (NHS), Central England Rehabilitation Unit (CERU, NHS), York General Hospital (NHS), Birmingham Children's Hospital NeuroRehab Ward (NHS). In addition, PR and media coverage about neurologic music therapy (NMT) as a clinically effective and cost efficient medical intervention is increasing[26]. Neurologic music therapy is increasingly been used as it is an

[25] https://nmtacademy.co/research-publications/clinical/
[26] http://attoday.co.uk/index.php/could-new-therapy-be-music-to-stroke-and-dementia-patients-ears/ http://www.acnr.co.uk/2018/06/taking-music-therapy-into-the-mainstream/

approach based in evidence, which is also cost efficient.

In 2015, Chiltern Music Therapy in England provided a pilot Neurologic Music Therapy service to a NHS in-patient acute and hyperacute stroke ward. Following the success of the pilot, an ongoing weekly service was established, with 6 more hospitals expressing an interest in their services. This stroke service provides full day Neurologic Music Therapy services in all stroke settings: in-patient; outpatient and community. Chiltern Music Therapy have created a pathway for treatment across all stages of patient care, and within these services offer one-to-one, small group and larger group sessions. They also provide one-off assessment sessions and design appropriate home programmes for patients and their families or carers. The service supports the meeting of guidelines set out in the National Stroke Standard, NICE Guidelines and National Clinical Guideline for Stroke, alongside inputting data for SSNAP. This also ties in with Cochrane's review of 'Music interventions for acquired brain injury'[27] (2017) and 'Interventions for improving upper limb function after stroke'[28] (2014).

The Royal Hospital for Neuro-disability[29] in London provides support and rehabilitation for over 200 people who have become disabled due to brain injury, illness or neurological conditions. They provide music therapy in their rehabilitation and special care services and currently employ 2 full-time music therapists, 1 part-time music therapist and 1 assistant, for 3.4 WTE. Approximately 2/3 of patients can access music therapy treatment.

Patients with these neurological conditions are currently unable to access any music therapy support whatsoever in Northern Ireland, despite the clear recognition of the impact of such services across the rest of the UK.

https://www.nrtimes.co.uk/single-post/2018/01/26/Reframing-rehab-through-the-arts

[27] https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006787.pub3/full?highlightAbstract=withdrawn%7Cmusic%7Cstroke%7Cstrok

[28] https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010820.pub2/full?highlightAbstract=withdrawn%7Cmusic%7Cstroke%7Cstrok

[29] https://www.rhn.org.uk/what-makes-us-special/services/music-therapy/

1.1.12 Palliative care or associated support

Area	Funding	Venue/setting	Provision / week	Service users	Waiting list
BHSCT	Non-Trust	Children's and Adult Hospice	2 days	12-16	12
SHSCT	Non-Trust	Cancer charity for children	4 days	20	Many

There are three palliative care services in place:

- 1.2 WTE music therapist
- Approximately 36 patients per week
- Around 8000 people in Northern Ireland receive palliative care support per year[30].

In addition to the APPG Creative Health Report 2017 which states that "In the palliative care environment, researchers have found that music therapy reduces anxiety, pain, tiredness and drowsiness and increases wellbeing." (p. 142)[31], a feasibility study was also completed here in Northern Ireland in 2017 with a view to carrying out a UK-wide multicentre phase III randomized control trial with 5 sites across the UK, with a Northern Ireland music therapy organization in partnership with QUB, Marie Curie, University of Bournemouth and Chroma Arts Therapies (UK).

The systematic review that formed part of this feasibility study showed promising evidence for the effectiveness of music therapy in improving the quality of life of palliative care inpatients, with a need for further studies to be completed. In a critical realist evaluation[1] also completed (pp. 6-8) the following comments were highlighted:

[30] https://www.mariecurie.org.uk/globalassets/media/documents/policy/policy-publications/june-2015/triggers-for-palliative-care-northern-ireland-summary.pdf

[31] References: Horne-Thompson, A. & Grocke, D. (2008). The Effect of Music Therapy on Anxiety in Patients Who Are Terminally Ill. Journal of Palliative Medicine, 11 (4), pp. 582–90; Wlodarczyk, N. (2007). The Effect of Music Therapy on the Spirituality of Persons in an In-patient Hospice Unit as Measured by Self-report. Journal of Music Therapy, 44 *(2)*, pp.113–22; and Warth, M., Keßler, J., Hillecke, T. K. & Bardenheuer, H. J. (2015). Music Therapy in Palliative Care: A randomized controlled trial to evaluate effects on relaxation. Deutsches Ärzteblatt International, 112 (46), p. 788.

'Music therapy had a way of helping patients surpass their current position and find peace'

The music therapy process 'helped me see my life has been worthwhile'

Music therapy improved the sense of community within the setting, reduced isolation, was calming and pleasant

Music therapy 'helped humanise the hospice setting'

Patients who found it difficult to verbalise feelings found that music therapy could 'ease psychological anguish'.

Case example:

A patient received just three music therapy sessions in a hospice setting. In the first session she requested that the therapist play for her to help her relax. The therapist improvised music in a classical style adapted to attune to the tempo and intensity of the patient's presentation. In this session the music played a supportive role, transporting her to another place and helping her relax. In between songs she spoke candidly and philosophically about her life – the joys of having children and grandchildren, that she had had a good life.

During the second session the therapist played a known piece of music which evoked a specific memory and emotional response from the patient which she shared with the therapist. In this session the focus of the therapy was communication, music therapy providing a link to emotional expression and support. In her third and last session the patient's son was present. During this session she closed her eyes and sang with the therapist, and this was a special moment to share with her son.

Over the course of just 3 sessions, this was used the therapy space for different purposes from physical and psychological support, through emotional expression and reminiscence leading to a shared experience with her son.

1.2 Music Therapy Training

The minimum training required to register and practice as a music therapist in the UK is a Masters in Music Therapy, usually following a primary degree in music. The recommended entry level for music therapists employed in the NHS is Band 6[32]. Qualified music therapists are adequately prepared to work with all of the client groups described above. Music therapy training is not available in Northern Ireland, and the only course on the island of Ireland is at the University of Limerick. There are 7 music therapy courses in the UK (Queen Margaret University, Edinburgh; Anglia-Ruskin University, Cambridge; Nordoff-Robbins, London; Guildhall School of Music, London; Roehampton University; University of the West of England, Bristol; University of South Wales, Cardiff), with an estimated 8 students from Northern Ireland enrolled in the last three years. This affects the potential workforce as many graduating music therapists remain living in the area where they have qualified, and a great many third-level students show an interest in training but are not able to move to other parts of the UK or Ireland in order to complete their training. Three therapists are known to have left the profession in the last 2 years, although specific reasons for this are not known.

In April 2019 the standard for Arts Therapies Apprenticeships at Masters level was published, approved for delivery by the Institute for Apprenticeships and Technical Education. This represents the first government-funded training route for art, drama and music therapists in England and will enable new arts therapies apprentices to contribute to enhancing health and social care[33].

Further training and Continued Professional Development

As for all Allied Health Professions, Continued Professional Development is a requirement of HCPC registration, and in order to meet this requirement music therapists and music therapy organisations have to provide training at their own expense. Despite the fact that it is absolutely essential in order to continually guarantee safe and effective therapy practice, this is not covered within currently funded contracts. There is therefore an ongoing burden, both financially and logistically, in sourcing appropriate training. There is of course an ethical practice-related implication of therapists having proper access to adequate governance and training which cannot be underestimated.

[32] https://www.bamt.org/
[33] https://haso.skillsforhealth.org.uk/news/arts-therapist-approved-for-delivery/

Additional specialist music therapy training

4 therapists in Northern Ireland hold additional training as Neurologic Music Therapists. This is a highly specialised training which further qualifies music therapists to work with specific techniques in populations such as people with ABI/TBI and neurological conditions. This training has never been available in NI, and so therapists have to travel in order to complete it at their own expense.

Other specialised training is available internationally for NICU music therapy (neonatal intensive care), MATADOC (Music Therapy Assessment Tool for Awareness in Disorders of Consciousness), GIM (Guided Imagery in Music), but these are again not available in Northern Ireland unless international experts are specially brought in making costs prohibitive on a small scale. Two therapists from Northern Ireland travelled abroad in February 2019 to complete the NICU music therapy training. For work with patients with personality disorders, the MBT (Mentalization Based Treatment) model has been recommended and shown to be of use. There is currently only one music therapist who has this training, as well as holding an additional training in Operationalised Psychodynamic Diagnostics.

1.3 Cost Effectiveness

Benefit analysis in financial terms or Social Return on Investment information is lacking in the music therapy profession as a whole, both nationally and internationally. Despite the growing evidence base, economic impact often remains unclear or unspecified in studies, perhaps also because 'nor… has wellbeing been rigorously conceptualised' (APPG Creative Health Report, pg. 5). Indeed, accurately assigning financial equivalence to the wide range of outcomes that music therapy can effectively address or contribute to is clearly problematic. The social, psychological, or emotional value of our interventions, improvements made to communication skills, relationships with others, or improvements in quality of life are difficult to satisfactorily quantify in monetary terms. Estimating the long-term future impact of this, or impact on others presents additional problems. And this is further enhanced by the wide range of client groups we work with, many of whom cannot easily self-report the benefits they experience. In short, the value added to quality of life does not match up easily with standard cost-benefit analysis, and this is an ongoing problem for the music therapy profession as a whole.

Beyond its own clinical outcomes, music therapy can both add value to and reduce burden on healthcare services as a whole through enhancing the outcomes of other healthcare professionals (other AHPs, but also colleagues in psychiatry, mental health, learning disability, and so on), reducing burden on staff, strengthening prevention thus avoiding costs in other services, reducing re-admissions into acute medical or mental health services, reducing absence from work, maintaining people's independence to enable them to stay at home for longer, improving the lives of children and young people to become positive members of society, able to engage in education and employment, and so on. Indeed, the APPG Creative Health report stated that "evidence here shows that arts can save money in HSC by strengthening prevention, reducing demand for medication and clinician's time, reduced hospital stays, reducing absence from work. It is universally recognised that the arts are good for health and wellbeing, and more healthy people reduce costs and burden on the health service" (pg. 55).

In relative terms music therapy is a low-cost high-impact intervention, the only real investment being in the person of the therapist themselves and relatively little additional equipment required, in comparison to the wide range of health and wellbeing outcomes it can achieve. It is also an extremely flexible and transferrable service in terms of location, timing and length of intervention required, and of course in terms of adaptability to meet the unique needs of different service users. It should be noted that many of the service users referred to clinical music therapy are among the most complex, particularly in psychiatric and mental health services, and so investment in longer term weekly treatment is recommended. However, the cost of this can be offset against the potential outcomes of patients who no longer require the same level of ongoing support, such as lengthy rehabilitation programmes, costly medication and/or acute services.

1.4 Conclusion

The above detailed service mapping and analysis of the current workforce provides numerous examples of good practice in Northern Ireland that could and should be scaled up to properly support the population in line with the 2026 Delivering Together strategy.

Music therapists in Northern Ireland advocate constantly for their profession, in an ongoing cycle of funding applications and contract renewal, and in a working context of great instability. Music therapy services are currently provided in a highly inequitable, changeable and inconsistent service model. The stakeholder engagement event held in September 2018 was attended by and received written feedback from representatives of education, both mainstream and SEN settings, adult day care services, nursing, CAMHS, the community and voluntary sector and the two universities in Northern Ireland, as well as from music therapist themselves. The input received (briefly represented in Appendix 3) fully supports the description of services given above, giving further demonstration that music therapy should be integrated across the board as a viable option for the client groups in question, and as such should be appropriately involved in and considered during reviews of services. It has also become clear from this engagement and review process that the profession is suffering from the lack of any coordinated or integrated strategic approach to the Arts Therapies across the health service in Northern Ireland. The profession has evolved organically over the last 30 years, and is limited by non-recurrent sources of funding, rather than being person-centred and driven by compassion, listening and the desire to meet the needs of the population. Alongside the need to develop the workforce for future provision of adequate services for the Northern Ireland population, we currently already have the right people with the right skills - there is an existing workforce of allied health professionals in place whose potential remains untapped.

Appendix 1 – publicly available videos illustrating music therapy work with different client groups

British Association for Music Therapy website - https://www.bamt.org/music-therapy/music-therapy-on-video.html#

- ‘Music therapy unlocks a child’s potential – Initial music therapy sessions of a young boy with delayed development’: https://www.youtube.com/watch?v=oZlimD-Ua-8&fs=1&hl=en%5FGB
- ‘Eitan is diagnosed with Autistic Spectrum Disorder and has complex needs. His main difficulties are to develop social relationships and to communicate with others around him. For a long time Eitan had his hands tucked away inside his shirt and refused to use them’: https://youtu.be/pypjnC645n8
- Ronan’s music therapy: https://youtu.be/FUPhiOLdgkA
- Music therapy with a young girl with autism: https://youtu.be/TP_G52zRj7A

Nordoff-Robbins Music Therapy website - https://www.nordoff-robbins.org.uk/Stories

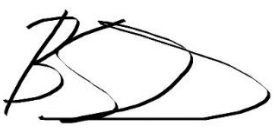
- Sadru’s story – Sadru received music therapy support during treatment for cancer in London: https://www.nordoff-robbins.org.uk/case-study/sadru%E2%80%99s%C2%A0story%C2%A0%C2%A0
  Listen to Sadru’s song here: https://youtu.be/rQYERoOBl_U
- Omolara’s story - Omolara is 16 years old and has severe learning difficulties and physical disabilities. She is non-verbal, and relies on Makaton, a simplified form of sign language, to communicate: https://youtu.be/2WOpsX07sj8
- Ali’s story – Last Christmas was Ali’s first in the UK. He was forced to flee his home in Iran fearing for his life after facing severe persecution: https://youtu.be/lnSbYAOEYzc
- Eddie’s story - Eddie lived with dementia. A gifted musician and previously a drummer in a band, music therapy helped Eddie reconnect with his passion and communicate where words failed him: https://youtu.be/fZBdiIILTdw
- Meet Alfie and Louie - Alfie and Louie are now ten years old, and have autism. “*To put it simply, music has opened a big window and a light has come on.*” - https://youtu.be/jp3m3mkhR98
- Betty’s story – “*Music therapy has been amazing for Mum, it’s turned a light on that we thought was long gone. She’s 95 and has always loved music and now it’s being used to help her unlock happy memories and communicate with loved ones.*” - https://youtu.be/c27GTBGx4aE
- Suffering from advanced dementia, Kath couldn't speak and was isolated from the world. Watch how music therapy helped Kath find a connection. https://youtu.be/SwT8J_fNUO4
- Bemji – A Journey to Speech (Nordoff-Robbins Australia): https://www.youtube.com/watch?v=a1xiG29UMOA

Appendix 2 - statement from BAMT

- Based on the most recent information in the BAMT membership database, there are **151** music therapists working in NHS settings making up 21% of the full practitioners. There are currently **729** Full practitioner members registered with BAMT.
- Music Therapists have a recognised Agenda for Change salary scale in the NHS and our bandings range from Band 6 to Band 8.
- There is mounting evidence that providing a range of psychological therapies which include arts therapies helps to improve Patient Reported Experience Measures (PREMs), an important indicator of quality of care in all Trusts.
- As HCPC registered professionals, Music therapists are members of the Allied Health Professions and contribute to consultations on and strategic planning of services. They also access all the opportunities for leadership and research careers offered by the National Institute for Health Research.
- Although, no training is currently supported in NI and trainees have to travel or move to RoI or UK, there has been the commencement of a new course in the UK. The lack of training available in NI will undoubtedly have a significant impact on recruitment and retainment however.
- The contribution Music Therapists can make to wider MDT (AHPs and wider disability, mental health and social care colleagues) is significant due to the nature of the nonverbal nature of music therapy and its ability to impact any individual regardless of age or ability.
- Music therapy is often called upon to intervene when all other supporting services have failed due to users having difficulties accessing existing services. These may be due to an unwillingness to engage in verbal therapy or an inability to express appropriately in the services on offer.
- The BAMT has supported the development of a range of evidence-based approaches to music therapy such as GIM, psychodynamic principles, person-centred approach, etc. and music therapists understand the importance of working in a client-centred way and as active team members.
- Music therapists also take on generic tasks such as risk or triage assessments and participate fully in extending knowledge and skills required by their employers.
- Importantly, music therapists can engage service users who experience emotional or physical conditions preventing them from participating in verbally-based intervention but do need psychological interventions.

I hope this helps define our current professional status and approaches.

Yours faithfully



Ben Saul, Chair of Trustees, British Association for Music Therapy

Appendix 3 - wordcloud and thematic analysis of feedback from Stakeholder Engagement Event – 7th September 2018

Thematic analysis of stakeholder feedback (no. of mentions in brackets)

Preliminary question – 'best things about the profession'

- outcomes/benefits for service users (37)
- support it can provide for others (24) (other professionals – 11; families – 10)
- person-centred practice (13)
- transferability of skills/accessibility/flexibility/innovative (8)
- range of service users who can benefit (8)
- strong evidence base (1)

Question 1 - Recruitment

- Secure job posts (16)
- Advocacy (increasing awareness, support from others, feedback) (10)
- Music therapy training (5)
- CPD (3)
- Governance/infrastructure/strategy (3)
- skillset of music therapists (3)

Question 2 - Retention

- Secure job posts (13)
- Governance/infrastructure/strategy (6)
- CPD (5)
- Advocacy (increasing awareness, support from others, feedback) (4)
- Service development (4)

Question 3 - Future Development

- Secure job posts (7)
- Advocacy (increasing awareness, support from others, feedback) (5)
- Governance/infrastructure/strategy (3)
- CPD (1)
- integration into existing services/structures (6)

Art Therapy

2. Art Therapy

The definition on the NHS England website states that 'Art therapists use art as a form of psychotherapy to encourage clients to explore a variety of issues including emotional, behavioural or mental health problems, learning or physical disabilities, life-limiting conditions, neurological conditions or physical illnesses. People of all ages from children to the elderly, regardless of artistic experience, use art therapy in this way as an aid to supporting them with their particular concern. It is not a diagnostic tool but rather a mode of communication and expression'[34].

The definition reflects the breadth and diversity of populations with which art therapists work.

Since art is a universal expression, the media available can be familiar and also tailored to individual need. The absorbing nature of play with art materials allows a reverie to occur in the containing safe space provided by the art therapist. Here, art engages the senses, stimulating and encouraging the inherent need and urge to create an individual expression. Visual communication, a pre-cursor of verbal communication, gives form to thoughts or feelings whose expression may be unavailable in the usual currency of words, whether through physical or emotional reasons. This visual language creates a communication which brings the possibility and relief of a shared understanding – an antidote to despair.

2.1 Overview of Current Art Therapy Workforce

The following data is based on information received from a survey of the NI Regional Group of Art Therapists' Professional Body, the British Association of Art Therapists (BAAT). Carried out over the period December 2018 - March 2019, it reflects an up-to-date picture of art therapy provision. Emergent themes include a lack of mainstream funding, and the prevalence of sessional and short-term contracts whose consequences limit the therapeutic

[34] https://www.england.nhs.uk/ahp/role/#art

value of intervention. Major factors in the working environment are the lack of knowledge about the nature of art therapy as an AHP, and subsequent lack of employment opportunities where art therapy could bring contributory benefits to a multi-disciplinary working environment.

The effect of the nature of current employment, with its precarious funding and a short-term focus would be a demoralised art therapy workforce, were it not for the commitment which these professionals bring to their everyday practice, knowing that the activity of mark-making in a safe environment nourishes and sustains the individual spirit in adverse circumstances. This 'knowing' derives from personal experience – a motivating force to enter training; built upon theoretically and experientially during training, graduates apply to register with HCPC as practitioners, supported by BAAT and undertaking Continuing Professional Development (CPD) to merit ongoing HCPC registration.

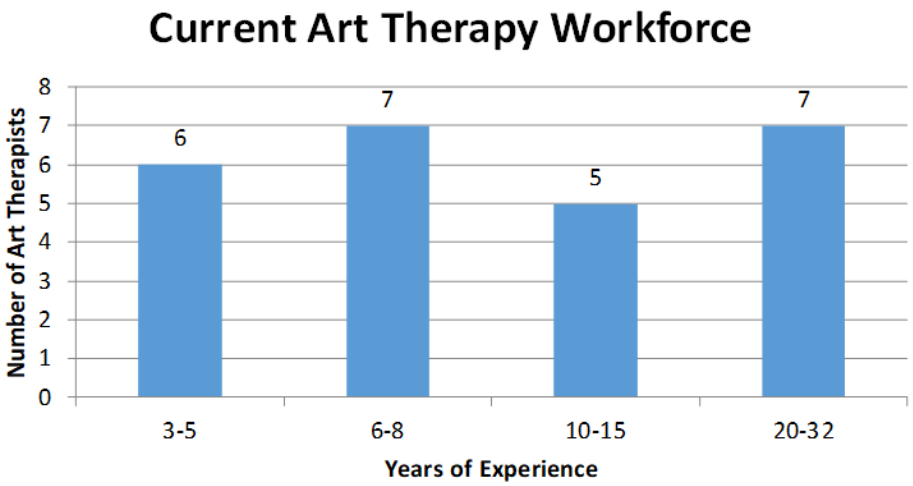
Commitment and passion are best demonstrated however, in secure employment and where complex needs can be met with an assurance of a consistent and guaranteed presence for service users.

2.2 Service Mapping of Art Therapy in Northern Ireland - March 2019

The survey yielded 25 responses (18 female and 5 male) from the 35 members of the Professional Body with a rewarding amount of information regarding aspects of employment, delivery of service to diverse client groups, views on drivers/constraints on the profession and opinions on how a comprehensive and strategic plan for its future development can maximise its potential for the benefit of service users and organisations providing their care.

The graph demonstrates a continuum of over a quarter century's professional experience.

Years of Experience	Number of Therapists
3-5	6
6-8	7
10-15	5
20-32	7



2.3 Drivers & Constraints to Art Therapy Services & Workforce in NI

2.3.1 Drivers

Respondents cited a number of factors as 'drivers' to the art therapy profession in NI including the following:

An increasing demand for the service and its breadth and scope of practice as a specialist psychotherapy; local HCPC approved training; adaptability of the method; effective outcomes and evidence base.

Demand and scope of practice

There is a significant and increasing level of interest in and demand for specialist art therapy services, evidenced in waiting lists. Art therapy is flexible and adaptable, featuring a breadth and depth of scope of practice, with its focus on symbolic and creative processing meaning ensuring a useful form of psychotherapy for people of ages from age approximately four upward – a valuable modality for early intervention as well as postvention. Art therapy offers a wide scope of practice, including those people who find verbal communication difficult, or whose issues do not lend themselves to verbal processing. Art therapists' training ensures therapeutic competence in verbal as well as symbolic communication.

Specialist psychotherapy

Art therapy is a specialist form of psychotherapy featuring multi-sensory and symbolic processing, particularly salient to working with children, young people and older people, and with issues which feature bodily and projective dimensions, and especially relevant where verbal approaches may be insufficient.

The modality is an attachment and developmentally-informed practice, featuring a synthesis of 'bottom-up' and top-down' approaches consistent with the Neurosequential Model of Therapeutics. As a trauma-informed modality, it is particularly relevant for addressing trauma, abuse, developmental disorders, a range of complex mental and physical conditions, offending behaviour, and a wide range of other issues. Symbolic and art-based processing is an innate human capacity with an evolutionary function.

Dynamic local HCPC approved training.

Art therapy master's level training in NI commenced in 2002 at Queen's University Belfast and has continued to evolve as an HCPC approved programme now within Ulster University. This training has provided numerous placements in statutory, community and voluntary sectors, a service which has been valued by organisations, some of which have been able to create jobs: sessional, part-time and full-time. It has also led to a number of Doctoral degrees researching art therapy. Currently, the training includes students from NI and the Republic of Ireland and is attracting international applicants. The art therapy training in Northern Ireland is relational, attachment-based and psychodynamically informed. It is grounded in trauma-informed care principles and the biopsychosocial paradigm, promoting evidence-based practice informed by contemporary common factors and neurobiological research.

Adaptability

Art therapy training in Northern Ireland promotes a trauma-informed and pluralistic approach: pluralistic art therapy is an ethical stance featuring inclusivity, where person-centred and relational practices form a collaborative and partnership approach by which therapy is tailored to the client's needs. Service users are actively involved throughout their

art therapy, including in the routine systematic evaluation of practice outcomes and the therapeutic alliance.

Effective outcomes and evidence base

Art therapy typically demonstrates its effectiveness as measured by robust outcome measures commonly used across agencies employing art therapists. Feedback from clients and others is normally extremely positive, typically demonstrating high attendance and retention rates. Art therapy training in Northern Ireland promotes competence in therapeutic skills consistent with psychotherapy common factors research; skills which are shown to be more likely to foster effective outcomes.

The evidence base for art therapy is growing and the UK professional body, the British Association of Art Therapists (BAAT), hosts an online Research Library which collates research across a range of topics, e.g.: Depression, Severe mental distress, Autism, Personality Disorders, Learning Disability, Older Adults, Organisations and Art Therapy, Post Traumatic Stress Disorders, Children and Young People, Forensic and Prison Services, Cancer and Palliative Care, Group-based Interventions, Physical Conditions, Neurology, Strokes, Substance Misuse, Research methodology, Evidence-based practice. BAAT also has a long-standing Art Therapy Practice Research Network which fosters evidence-based practice and practice-based evidence.

2.3.2 Constraints

Without exception, a lack of knowledge about art therapy as an AHP was cited as a main constraint of art therapy's development in NI resulting in:

Lack of commissioning; inadequate funding; protection of the public; co-ordination in services; research.

Commissioning

A key constraint is lack of commissioning for art therapy posts and trainees, despite it being one of the HCPC regulated allied health professions.

Funding and sustainability

Lack of funding and appropriately paid jobs is a key constraint, resulting in growth of services which then deplete due to gaps in new funding. Clients and families regularly report difficulty in accessing services, a frustrating irony since a trained workforce exists and is growing. Within statutory services, a disparity of work conditions exists, with only a very few art therapists banded under Agenda for Change, whilst others are still paid sessionally for similar work, this inequality being a contributory factor to some art therapists leaving statutory sessional work.

Protection of the public

The regulation of art therapy by the HCPC has a vital function to protect the public and this, backed up by the evidence of risk, is a key reason to employ art therapists. Understanding can be lacking, even within the health services and wider services, that art therapy is an HCPC regulated profession, one of the allied health professions, and has an HCPC approved local training. There is a lack of distinction made between art therapy with clinical aims and risk management for directly improving health and wellbeing, and art for recreational or teaching purposes. There have also been instances where non art therapists are practising, using art for psychological/ wellbeing purposes or using titles such as creative therapist or similar, but without HCPC registration. This has several consequences:

Firstly, there are missed opportunities to employ specialist regulated professionals who also offer effective specific competences relevant to key areas of public health need: children's mental health, trauma, complex mental health, abuse, dementia, cancer care, etc.

Secondly, employing art therapists promotes competent risk assessment and risk management, a key function of HCPC regulation. Art therapists / art psychotherapists have competence in assessing and managing psychological and "art-based risk" (Springham, 2008). The concept of "art-based risk" highlights a serious risk of "arts-based injury" which was noted under a tort law case which established arts practitioner and organisational negligence when art activities were used by a non art therapist for psychological purposes with populations who are vulnerable. This case also showed how psychological risk and art-

based risk can be intertwined. There have also been legal cases of art-based injury in which an organisation was found in breach of health and safety regulations when a young person was damaged by inadequate risk assessment and management of art materials (HSE, 2007).

Co-ordination in Services

Due to marginalisation of art therapy within statutory settings, difficulties in communication across service teams arise with a lack of inclusion of art therapy insight in wider services. Interestingly, such insight is reported as highly valuable by teams where art therapists are employed or where art therapy students are in placement.

Research

While art therapists are trained at Master's level and thus have research competences currently underutilised by statutory services, there is a lack of inclusion in research: art therapists, however, are engaging in routine systematic outcome evaluation, but since many are practising in community organisations and in schools, their practice outcome results are often subsumed under counselling / therapy service figures. Much valuable data exists from a number of Doctoral degrees and numerous Master's level studies researching art therapy.

2.4 Service Mapping by Client Group and Employing Agencies

2.4.1 Case Studies 1 to 9

Case Studies 1 and 2
(Demonstrating Art Therapy Services as Trusts Provision)
WHSCT

Adult mental health (Day Facility)

WHSCT employs a full-time art therapist in a community-based Adult Mental Health facility. A graduate from the initial training cohort (2005), the art therapist has been in a 0.5 post for the past 11 years; the post has recently been made full-time (potentially for a year). The contract is permanent and equivalent to Pay Band 6 and the service is delivered on both an individual and group basis. Full-time provision was based on an increased demand for the

service and a widely-held recognition on the part of management of the value of art therapy as an integral part of mental health provision, maximising the choice offered to acute, chronic and long-term conditions. The art therapist has provided a valuable and consistent learning experience and clinical supervisory role for trainee art therapists, currently and over previous years of HCPC approved post-graduate training in NI. This arrangement has been fully supported by the art therapist's managers and the role will extend as further placements occur within the Trust's clinical premises, providing a model for the future and offering one which other organisations can emulate.

Case Example 1 - adult mental health setting

Synopsis

The clinical context is an Adult Mental Health Day Facility where the service user, an adult male, was referred to art therapy for PTSD, depression and anxiety, and historical sexual abuse. Referral by a psychotherapist indicates recognition of how trauma may be approached more appropriately by giving visual form to thoughts and feelings in order to heal and integrate. The art therapist adopted a psychodynamic approach and was witness to the art-making process, central to the sessions. The sensory aspect of the art materials was an important trigger to the client's ability to re-visit the difficult events of his childhood, the opportunity to share those events bringing him 'catharsis'. Integration, in the form of 'forgiveness' was achieved through reflection on others' possible motivations for actions. Through examination of the past, afforded by the therapeutic context, the service user was able to move forward with an understanding previously absent.

Key Concepts: WHSCT, Trauma, visual exploration of trauma, sexual abuse, PTSD, violence, catharsis, depression

Tom (not his actual name) was a 59-year-old male referred to Art Therapy by a Psychotherapist. Reasons for the referral included anxiety, depression, PTSD and child sexual abuse. It was hoped that creating imagery around past traumas would give shape and healing to those traumas.

Perusing the art materials in session one, the smell of the crayons struck a chord with Tom. Their scent immediately cast him back to the December day when his father, aged just forty-one, died suddenly from a heart attack in the family home. The rippling effects from that

event were huge. As his mother struggled to rear Tom and his siblings, she became an angry and often violent woman. The physical abuse meted out by his mother was compounded by that which he experienced at the hands of senior teaching staff at the secondary school he attended. The abuse suffered at school forced Tom to leave at sixteen. This session was difficult for both Tom and myself. He admitted at the following session that it had left him physically and mentally drained. However, he also said that he had found it cathartic.

In the second session, Tom created images around the memories of his father's wake. He contemplated how life would have been if his father had not died. He wondered would his mother have been more gentle and loving. Would he not have suffered the same level of abuse at school? At the close of the session Tom commented that he was finding the Art Therapy therapeutic, adding that he was getting a lot from the process.

Session three and Tom was 12 years old again. He vividly recalled through drawing, the moment a teacher viciously beat him, before kicking him as he cowered on the floor of the classroom. A junior member of staff attempted to intervene, but was advised by this senior teacher to be mindful of his position within the school. As Tom explored his picture, I found myself becoming one of Tom's classmates, witnessing this brutality, appalled and fearful. This event had stayed with him, but having finally found the courage and mechanism to explore and share it, he had gained some healing.

If I thought Tom's trauma and pain could not get much worse, I was wrong. In session four he described the horrific events of his last day at school. Having left the exam hall, he was approached by the same teacher who had physically assaulted him previously. He forced Tom into nearby toilets where he again beat him, before then going on to sexually abuse him. As he picked his way through the carnage he had experienced and now drawn, the emotions were raw. The scene, the smells, the abuse and the humiliation were still fresh, still real. It was a story Tom had longed to share and seeing it laid out before him was tough viewing. It impacted upon me as a fellow human being. I felt so helpless. As an adult, I now wanted to protect that child. Hearing Tom and supporting him, I was doing my best to do that. At the time he told no-one about this incident. He would not have been believed. To share it now, and be believed, was huge for Tom.

At the end of session five, I felt that Tom and I had taken the process as far as we could and as far as was needed. In the session he drew a picture depicting the day he grabbed his mother and demanded that the beatings stop. She was being violent towards Tom's sister when he finally snapped. The violence came to an end. It was with regret that it had come to that. Looking back he could acknowledge that what his mother did was wrong, but as an

adult and though Art Therapy he now has a better understanding as to why she became the person she did. Through art and reflection he could forgive her.

Session six confirmed to both Tom and me that Art Therapy had served its purpose, as he drew and talked about issues relating to his family in the present, the type of issues that other families could well be experiencing. Having explored through imagery, traumas from his past, gaining some healing to the wounds, Tom was now in a better position to examine the here and now. He was now better placed to move forward.

Case Example 2 – BHSCT adult mental health

Synopsis

BHSCT employed an art therapist in an out-patient centre between 2005-2016 offering a service to individuals experiencing a wide range of complex mental health problems as detailed below. The art therapist's clinical framework was person-centred, flexible to presenting needs and responsive to patients' particular stage of creativity, as a means to achieve a therapeutic alliance and address individual need. Outcome measures (CORE, SDQ as examples) were utilized to evaluate both quantitative and qualitative information and typically showed improvements over many areas. Positive staff feedback indicated the value of the art therapy service as a means of expressing, containing and processing material which was difficult to access verbally.

Key Concepts: BHSCT, complex mental health issues, improvement in coping strategies and decision making, tailored treatment plan, non-verbal processing, CORE, SDQ

The client group for art psychotherapy was diverse and included: individual adult female and male clients, age group 20-69, in an NHS outpatient complex mental health setting. The reasons for referral included complex mental health issues, suicidality, self-harm, psychotic symptoms, abuse, trauma, sexual offending, autism, eating disorder, addiction, transgender issues etc. The service was provided regularly between 2005 and 2016, working with up to six clients per week and was paid sessionally. The art materials and process were risk-assessed and media selected as suitable for each client and setting and these included: paint, oil pastels, chalk pastels, natural media, found objects, modelling clay, fabric, pencils, papier maché and art journaling. The rationale for therapeutic process and art media depended on each case assessment and formulation and a tailored treatment plan was

established and adapted as needed. Clinical supervision was with a Consultant Psychoanalyst and art therapist.

Client outcomes were increasingly evaluated using CORE, SDQ and other relevant measures and typically showed positive improvements. Patients also typically reported "strongly agree" for all the following benefits from art therapy (CORE) – improved: Personal insight/understanding, Expression of feelings/problems, Exploration of feelings/problems, Coping strategies/techniques, Access to practical help, Control/planning/decision making, Subjective well-being, Symptoms, Day to day functioning, Personal relationships. CORE other comments included: "I feel (the art psychotherapist) was always easy to talk to and empathetic to my needs. I felt the time we had created a safe place for me to think about my feelings and express them through different media. I am very happy with the level of care I have received."

Qualitative evaluations were undertaken and patients also typically reported "strongly agree", or for an occasional entry, "agree", for the dimensions of the "About the Working Relationship with your Therapist" section (NHS patient feedback form). Patient feedback (NHS patient feedback form) examples include: "My time here has been invaluable. Being able to process things at my own pace and in a caring safe environment with a wonderful mentor has helped in more ways than I could express in here." "Thank you very much for all your help and particularly patience when listening to my frustrated monologues and rants. You have helped me and educated me a great deal, and I am very close to being who I wish to be now."

Staff reported valuing the art therapy service and that clients benefitted from art therapy. They reported that art therapy helped contain clients, enable work when psychotherapy may not be possible, improve general functioning and enable symbolic processing of material and particularly material not easily accessed verbally.

Case Examples 3 and 4

(Demonstrating Art Therapy Services offered by Counselling Centres)

Counselling agencies which provide psychological services to both children and adults, employ art therapists, usually under the designation of 'counsellor'. Art therapy services are delivered to adults, young people and children in the community and potential service users are referred on the basis of art-making as an accessible and creative method of accessing thoughts and feelings which may be beyond words. Many referred cases are complex and in need of longer term support than funding provision allows, with attendant concerns.

Case Example 3 – counselling agency setting

Synopsis

Mark is a fourteen-year-old male who presented as depressed, anxious and angry. He had recently suffered a serious illness which had left psychological scars. Mark engaged in 8 weeks of art therapy, using clay field sensorimotor art therapy and painting. During the sessions he was able to process his past events in a meaningful way for him. Using clay in a therapeutic setting is beneficial as it helps the troubled brain to regulate through haptic perception.

Key Concepts: ME, sensorimotor, frustration, anger, depression, insomnia, improved mental health/sleep, isolation/integration, voice of service user.

The following are extracts from a letter written to the funders of the project by his mother……

"My son Mark has had a very difficult journey over the past year and a half. In November 2016 after competing in a swimming competition and gaining a podium finish, he took ill with a crushing headache. He lost the ability to walk and talk and was admitted to hospital. He underwent various tests and the consultants were stumped as to what was wrong. Mark began to talk again two weeks after admission and was sent home to recover. He was discharged in a wheelchair.

Being an athlete and competitive swimmer, Mark was headstrong and battled his debility and learned to walk again. The most heart-breaking moment for me was when I took him in swimming and he couldn't even float. But Mark being Mark, he asked for the aqua- belt and we together began his rehabilitation under the guidance of the physio.

Mark gave us the best birthday present ever. And walked unaided. It was around then that he was diagnosed with ME. Although Mark could now walk unaided and looked 'cured' to the naked eye, the psychological journey took so much more time.

Mark went from excelling in sport and academic life to just surviving due to being off school for 2 months and then the ME diagnosis. It was almost like he felt insignificant. He was no longer at the top of his game (as he would say). Mark became frustrated, angry, depressed, withdrawn and anxious. One main issue was sleeping at night. He was afraid to go to sleep because he might waken up the way he was before, although Mark's thoughts were so much

more, which we will never know. Looking at Mark and knowing I couldn't resolve his feelings as he was struggling, I asked for help.

It was then that we were referred for Art therapy. I wasn't sure what to expect at first. The art therapist explained what was to be done over the next 8 weeks.

Well, Mark has gone from not wanting to go to sleep and from us having to sleep beside him to actually going to his bed, chilling out and sleeping the full night. Not only have we noticed the difference in his sleeping pattern but his general overall mental health has greatly improved. We can actually see a part of the old Mark, pre-ME. He is beginning to be a teenager and enjoy the craic and banter again without lashing out and becoming guarded

It so hard to explain the exact change in Mark but it's like I can now see the fun-loving, carefree Mark he always was. The art therapy process has really and truly done wonders."

This case was filmed by the BBC and aired in November 2018 on Countryfile as part of the Children In Need Appeal.

https://www.youtube.com/watch?v=x3uOiFnuwGM

Case Example 4 – counselling agency setting

Synopsis

Joe presents as a 6-year-old boy who witnessed domestic violence in the family home. Joe's father, who is reported as the abuser, has left the family home and Joe now lives with his grandmother and mother. His mother describes his behaviour as increasingly challenging and states that he has regular outbursts and is becoming increasingly aggressive towards her. His school teachers report that Joe is being disruptive during class and is hitting out at his peers.

His mother feels that this change in behaviour is linked to his experience of domestic violence but when she tries to discuss his feelings around this subject, he becomes silent and withdrawn. "For a victim of domestic violence, often the impact of the abuse is too difficult to verbalize through words alone and impacted by strong feelings of shame, humiliation, guilt, and fear around speaking about the abuse". (Malchiodi and Miller, 2011).

Key Concepts: Domestic violence, aggression, trauma, metaphor, symbolic enactment, non-verbal to verbal.

Joe was offered 8 art therapy sessions and he was able to use art and metaphorical meaning to break the silence that can surround experiences of violence, reassembling his experience to create a sense of safety.

During this time, he used paints to create a volcano and family of dinosaurs. Each image was created on individual A4 pages. Using blu-tac, he placed each image on a wall starting with the volcano. He described this as being "dangerous" and "scary" saying "it could explode at any time". He then placed the dinosaurs around the volcano saying, "They are all in danger" and explained how frightened the dinosaurs felt. When given the option to move the dinosaurs to a safer place, Joe originally declined. As the sessions continued, he gradually moved each dinosaur to a safe place starting with the 'mummy' dinosaur. At this time Joe briefly acknowledged that he had to protect his mum when his dad got angry, saying 'I had to become a superhero and fight back'. Joe chose to leave the baby dinosaur by the volcano, saying "he is always in danger and cannot move". However, he always displayed excitement that he was able to move the mummy & brother dinosaur to a safe place.

As the sessions continued, Joe moved the baby dinosaur around the volcano saying he was trying to move it to a safe place. However, he never succeeded in moving the baby dinosaur far enough away from the volcano and always described it as feeling frightened. Eventually he decided to add grass and water to the top of the volcano stating, "The fire is gone now and the volcano is no longer dangerous".

The volcano could be read as a symbolic introduction of dad or the 'danger' which J was reluctant to talk about. At the time of the sessions, Joe had no contact with his father and displayed confusion over not being able to see him. His inability to move the baby dinosaur, which could be symbolic of Joe, may have mirrored his feelings or loyalty towards wanting to be near his dad but also acknowledging unsafe feelings linked to his father. Through art he was able to discuss feelings of danger at a safe distance & move family members to a safe place. By adding grass & water to the volcano, Joe was able to create a sense of safety & remain close to the volcano.

As a direct result of this Art Therapy intervention Joe's mother reported positive changes in his behaviour, saying that he is now talking about his feelings more and, since starting the therapy sessions, he has stopped being aggressive towards her. She also stated that the

school reported that they noticed positive changes in his mood and behaviour describing him as being a lot calmer.

Case studies 5 and 6

(Demonstrating the effectiveness of Trauma-informed Art Therapy)

Case Example 5 – trauma agency setting

Synopsis

C is a male in his 40's who self-referred to a specialist organisation for victims and survivors of the Northern Ireland Troubles. The organisation provides a range of welfare, justice, counselling, and health and well-being support services. C had witnessed and been affected by many Troubles-related incidents including the loss of friends to suicide. C was diagnoses with PTSD, depression, (over a span of ten years)), anger, bereavement and social isolation. C also reported he had attempted suicide on two occasions. C had previously attended "talking therapy" but felt it had not worked for him resulting in apprehension regarding counselling services. While attending an intensive group therapy programme for PTSD held in England which offered art therapy as part of the programme, upon returning to Northern Ireland C sought out the services of an art therapist.

Key Concepts: PTSD, suicide, bereavement, social isolation, trauma, anger, NI Troubles, CORE, voice of service user.

In the past, C had attended many 'talking therapy' counselling services and was apprehensive about counselling as it had not worked for him previously. He had attended an intensive group therapy programme for PTSD in England which had also included participation in art therapy.

At the assessment meeting with the art therapist, C discussed his goals for attending art therapy. He stated he wanted to address his anxiety and hyper-vigilance and aim to reduce his symptoms of PTSD (sleeping difficulties and distressing, unwanted and intrusive memories) while maintaining a sense of well-being.

In initial art therapy sessions, C used drawing to explore and affirm his strengths, support systems and self-care strategies. In the first phase, he chose chalk pastels to create artwork which he commented gave him time to grieve for friends.

In further sessions, the client used drawing materials to create an artwork to map his 'Pathway to Recovery' and in a final series of sessions, he used collage materials to create

artworks on the theme of 'Past, present and future'. A broad range of art media were offered and he used materials which he liked and was familiar with.

Overall, the client attended 15 sessions and was highly motivated, committed to attending and engaged very well. As the sessions approached an ending, the client began to use art outside the therapeutic context, commenting that he would be interested in further art activity – a painting course or project.

Evaluation of the impact of art therapy was measured through the art therapist's observation, the client's self-reporting, client and art therapist's discussion of sessions and artwork. Core Outcome measures (measuring subjective well-being, problems, symptoms, life functioning and risk/harm) were used throughout.

The client reported: Art therapy encouraged him to speak about his own early childhood and family relationships, old routines, patterns of behaviour and his difficulties in expressing his feelings. At the end of therapy, the client reported that he felt the sessions had been very beneficial, had given him time to grieve for friends and a safe space to speak about Troubles-related trauma. He commented that he was also able to 'open up more', to express his feelings to others; he felt a positive change in outlook and it had encouraged him to think about future hopes and plans.

Later the client stated: 'I would encourage anyone who is suffering mental ill-health to try art therapy and use it as coping mechanism, and as a therapeutic tool and as an aid to recovery'.

The art therapist observed: C had made good progress, engaging in art therapy and encouraging emotional expression. In particular, the art therapy space supported him in the safe expression of anger. Sessions also encouraged changes in his thought patterns, while supporting him in developing coping strategies to regulate his feelings.

Core measures indicated: good progress with a reduction in symptoms (including those of PTSD) from moderate/severe on commencement to mild at the final session.

The organisation's Health and Wellbeing Lead reported: "During the period of the client attending Art Therapy, I noticed a steady change in his motivation and general outlook on his life. During sessions, he was able to open up about his life goals. The client mentioned to me that he would like to return to work and would like to help others. Art therapy allowed the client to talk about difficult subjects, enabling him to build on his resilience and develop his self-belief and motivation to the point that he indeed secured a position within a Trauma treatment organisation, providing groupwork facilitation to others suffering from similar experiences as himself"

A small number of art therapists work in private practice in Northern Ireland. Although there does not appear to be a culture of personal payment for treatment in Northern Ireland, some people are prepared to use the services of an HCPC-registered therapist.

Case Example 6 – trauma - art therapy

Synopsis

'Kevin' presented as a fifty-year-old male with Chronic Post Traumatic Stress Disorder, back pain, eczema, depression and suicidal ideation. He was unable to concentrate and unable to get a good night's sleep. He had previously had a successful career but was now unable to find employment. The approach used in this case was psycho-dynamic and client-led and used the physical, hands-on, 'touchy-feely', aspects of paint and clay, (sensorimotor), to create an intuitive language, which the client was unable to express in words. In doing this the client was able to push beyond conscious awareness and tap into the unconscious, which is particularly valuable where trauma renders our thinking problematic and unhelpful.

Key Concepts: Chronic PTSD, Enduring Personality Change, relief of somatic PTSD symptoms, visual processing, voice of service user.

"I was diagnosed with Chronic PTSD in 2005 and Enduring Personality Change. This was due to the Troubles and what I experienced.

In 1981, 3 of my colleagues were murdered by the IRA in separate terrorist incidents.

In 1982, I stood beside bombs as they exploded. I have witnessed shootings and people being killed and injured, and I was involved in numerous terrorist-related incidents over the many years of the Troubles.

I had continuous and repetitive nightmares and flashbacks which started in the 1980s. I was able to cope when I was younger because I played a lot of sport, but as I grew older the nightmares, flashbacks, hypervigilance etc all intensified. My behaviours and emotional numbness badly affected my relationships with friends and worst of all my family.

By 2011 I had tried several talk therapies, including CBT, EMDR, reliving traumas. None of these worked and they left me in a state where I had lost all hope of recovery and I had made a plan to end my life, just to get rid of the pain and the pain I was causing my family.

As a last resort I tried Art Psychotherapy. I immediately felt a sense of safety and thought that maybe this therapist knew what they were doing. The nightmares ceased almost immediately and gradually all the other symptoms faded away.

The therapy was very intense at times and lasted about 4 years of weekly sessions. Because all the events I was involved in were visual, the therapy involved finding visual ways of properly processing these events. They now appear to be stored in the correct place in my brain. The benefits to me are that I have not had a nightmare or distressing thought since 2011. Gradually my back pain has gone- I can now raise my arms above my head- couldn't do that before! My eczema has gone, I sleep like a baby and I feel that I have got my old self back with interest. I have got my life back and look forward to trying to repair the damage done to my family. Thanks to a really good Art Therapist!"

('Kevin' has since completed a Master's in Art Psychotherapy and is now employed as a therapist working with traumatised children.)

Case Example 7 – acquired brain injury setting

(Demonstrating the effectiveness of Art Therapy with Acquired Brain Injury)

Synopsis

The setting is a Charity providing a community-based service for adults with Acquired Brain Injury. The art therapy offered follows an open-studio model where individuals can attend once or twice a week. Individuals can self-refer as can their family. The art therapist's approach is eclectic drawing upon psychoanalytic theory within a humanistic framework.

Key Concepts: Brain Injury, cognitive impairment, chronic fatigue, impatience/patience, frustration, insight, voice of service user.

B is a young man who sustained a brain injury at 24 years of age due to a traffic accident. Prior to this he had worked full-time, but has been unable to return to work. In his own words he is easily frustrated, has poor memory, his concentration is severely affected; he suffers from chronic fatigue and much frustration with his limitations which results in a notable lack of patience or understanding for those around him.

In January 2016 the art therapy service in the agency commenced and he attended from the first group. He has continued to attend weekly (Jan 2016-Nov 2018). At the end of October 2018, his request to attend twice weekly has been respected.

The client's insight into his frustrations and limitations has been 'strengthened' as evidenced by his ability to translate aspects of his thinking or behaviour beyond the therapy situation e.g. finding perspective in another's viewpoint. He is more able to make connections between his condition and his impatience or intolerance of others and is coming closer to an understanding and acceptance of his limitations while continuing to 'stretch' beyond them. He is able to respond to other group members' need for quiet when absorbed in their work just as he has needed on occasions.

Voice of Service User

Significant developments since commencing art therapy as identified by him (now 26) are as follows:

"Greater patience, I can sit for longer periods, capacity to concentrate has gone from 15- 20 minutes in 2016 to 1.5 hours twice weekly in November 2018.... He adds ("Now maybe not even go to the toilets in that time!)"

"When I found out about art therapy, I was unsure at first. It took the first 1-4 sessions and then I got into it and realised I fell in love. For me art therapy is my life line since I was landed down with my brain injury. Takes you away from life troubles and you're only worried about your drawing. Without art therapy I would be lost as I look forward to doing it every week. I even go to two groups now. From my experience I think art therapy should be available to everyone who is a member, survivor, or carer. Everyone can get something different out of it."

Case Examples 8 and 9

(Demonstrating Art Therapy Services in Forensic Settings)

A full-time art therapy post (1987-2011) in the Probation Board for Northern Ireland (PBNI) was followed by a model of provision where a Counselling Agency (employing art therapists) successfully accessed PBNI's 'ring-fenced' funding. This 3-year model delivered a province-wide art therapy service to male and female offenders assessed as high-risk of causing harm, referred by PBNI. Belfast-based art therapy provision for male and female offenders continued for a further year with renewed funding from a different source.

The contribution of arts therapies in the treatment of offenders is aptly summarised in the following excerpt, where 'acting-out' harmfully against others, is discussed:

'It is the task of the therapeutic relationship, by achieving a therapeutic alliance, to understand this propensity to destructive acting-out, and to be able to get it into words and to discuss it rather than it needing to be endlessly actually repeated. It is also the case that many offender patients find talking, rather than acting, either different or quite beyond their capacities. There may be relative degrees of incapacity to symbolise and a ''concretisation'' of thought. In these cases, the arts therapies – whether art, music or drama – may be particularly helpful in allowing a therapeutic alliance to grow ''without words''. (Mc Murran, M. (Ed) 2002. *Motivating Offenders to Change. A Guide to Enhancing Engagement in Therapy*. London: Wiley)

The forensic field is a fruitful area for the employment of art therapists elsewhere in the UK: two art therapists in NI are employed as art teachers/assessors in forensic educational settings because of the non-availability of art therapy employment. Feedback indicates an appreciation by the organisations and service users that the therapeutic application of art in these roles is of significant value and that prior qualifications and experience were considered to be of benefit in selection for the posts.

Case Example 8 – forensic setting

Synopsis

A thirty-seven-year-old male deemed to be a high risk of causing harm to others was referred to art therapy as part of his probation supervision in the community. Already on an intensive cognitive programme for serious and violent offenders, the referral by his supervisory team aimed to 'reduce emotional blockages' so that he could participate more fully in the cognitive programme, the focus of which was the examination of thoughts and feelings leading to offending behaviour. A non-directive approach allowed the client to play symbolically with the risk and fear of giving up his identity, and his alarm about its total loss, even if small changes were to occur. Consistent attendance over a six-month period of weekly sessions (22 in total), ended with a presentation of his artwork and his developing insights, to his supervisory team. His writing (with his emphasis) indicates his dawning discoveries about the possible transferable skills between art therapy processes and the expectations of the cognitive programme:

Key Concepts: Forensic, violence, cognitive change and transformation of life-skills, loss of and reconstruction (through art making) of self-identity, voice of service user.

Voice of Service User

'A significant effect of art therapy was a very informal, relaxed and comfortable atmosphere to talk about problems I was having with my picture and without noticing, making a direct comparison with some of the problems I have with my attitudes, and doing this in a non-analysing way made it easy and interesting. So, this made the taking-in or understanding of this very easy. It was a positive consequence of the sessions.

Looking at the problem on the canvas was, although a bit frustrating at times, it wasn't serious. So that made it easier to come up with solutions and try different ways of overcoming them. And then the realization I could try this with my New Thinking Plan (an aspect of the cognitive programme) came, through talking about these 'ways' with (art therapist). If I can come up with solutions (and sometimes fail) for problems I haven't encountered before (first canvas), and got a satisfactory result, then that's a positive and actual experience I have achieved and might be able to translate this into my New Thinking Plan.

Realising all of a sudden through talking with (art therapist), the connection between Art Therapy and (name of programme) e.g. talking through problems – hurdles, in relation to my picture, a direct or indirect comparison to the problems I have to face in my behaviour and attitude'.

Case Example 9 – forensic setting

Synopsis

The context is a secure forensic setting for adult male clients experiencing complex mental health issues. The 12-week group project, funded by a Government department, was led by a forensically experienced art therapist and co-facilitated by an arts practitioner providing technical skills in the main medium of ceramics. This co-working model enabled an individual approach to group participants as well as shared perceptions of the group's dynamics, facilitating satisfactory working relationships through combined therapeutic attention. Evaluation at the beginning and end of the project was key: quantitative evaluation (WEMWBS) yielded positive changes in wellbeing; feedback from stakeholders rated the project as successful; qualitative information from participants indicated their wish for further sessions and reflected important insights gained through their involvement in art processes.

Key Concepts: Forensic, group art therapy, WEMWBS, problem solving, coping strategies, team work, imagination, voice of service users.

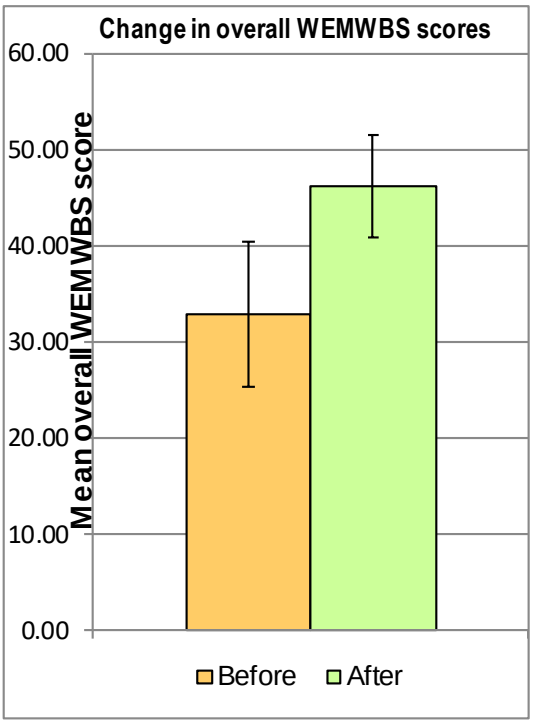
This project featured a group of adult male clients, age group 25-39, in a secure forensic setting. Reasons for referral included mental health issues, addiction and suicidality. The service was provided over 12 weeks and funded by a Government department. The art materials and process were risk-assessed and media selected as suitable for the client group and setting and included: paint, pencils, chalk pastels, papier maché, modelling clay and art journaling. The group was led by an art psychotherapist who provided the therapeutic assessment and competence and forensic setting experience. A senior art therapist, experienced in forensic practice provided clinical supervision for the art psychotherapist. Group clay work was also co-facilitated by an arts practitioner who added technical moulding skills and access to firing technology.

The most important feedback came from group participants themselves and quantitative data gathered showed a statistically significant improvement in wellbeing, as well as specifying varying types of improvement for those who completed start and end evaluations. This was consistent with the qualitative data gathered which noted boosts in confidence and personal skills including coping, problem solving, teamwork and greater discovery of imagination and art skills. Feedback from other stakeholders such as the funder, co-ordinator and relevant forensic setting staff also rated the project as successful.

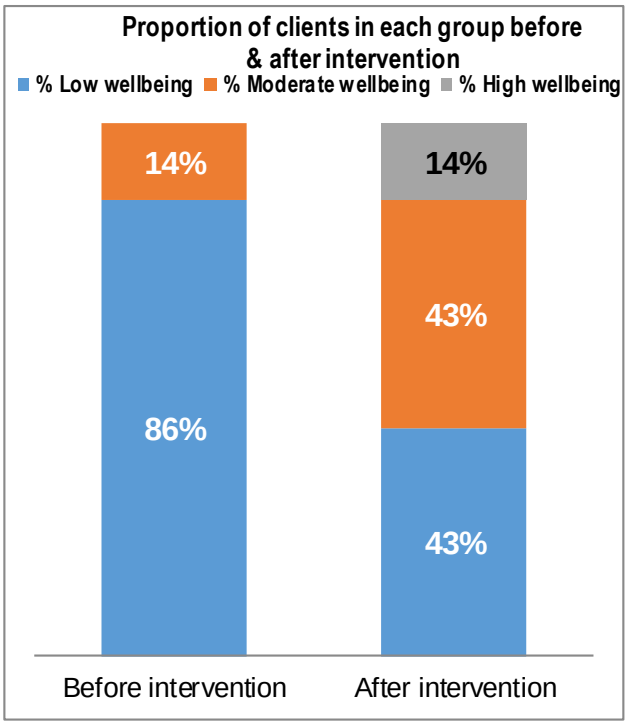
The art therapy project was evaluated, including using the WEMWBS (Warwick-Edinburgh Mental Well-being Scale) at the start and end of the group.

The change in the overall WEMWBS wellbeing scores from Before to After the intervention is shown in graph 1 below. The % of clients in each group (Low wellbeing, Moderate wellbeing & High wellbeing) Before and After the intervention is shown in the graph 2 below.

Graph 1



Graph 2



In the qualitative evaluation, participants reported: "I would like more (art therapy)", "I would like art therapy", "please put my name down for (more)." Participants reported wider benefits: "it's helped me deal with problems", 'I couldn't really talk about anything before – I've got a broader perspective now', "learning to cope better", "kept me out of mischief", "manage to express myself in my work and I feel that I am good at using my imagination", "managing better", "did help me coping with some personal problems, some days(before session)I didn't feel like do anything but after (the session), get to it!" "Discovering I have capacities I didn't know", learned "teamwork", "confidence boost", "feel better".

One participant worked for weeks creating a clay construction, building and linking strands together, and being helped to manage strong emotions when pieces got broken. Reflecting later, he stated that initially he had not known what this piece represented, then he reflected how the art therapy helped him think better and realise he could make more constructive choices for himself:

"I realized that this is a head and then I realized that it is a mind, it is my mind", and "It represents the twists and turns in the experience I've had." He added feeling other benefits: "perseverance", "learning to fit pieces together and design and proportion", "stimulated my interest", "learning to use my imagination", "I am working to have a job set up for me when I get out and I don't want to re-offend".

Table of Art Therapists' Employment

Context	Art Therapists Employed	Client Group	Type of Contract	Presenting Issues	Total Art Therapists Working	Approx. WTE
WHSCT	1	Adult Mental Health (Day Facility)	Permanent, Full-Time	PTSD, Depression, Addiction	1	1.0 WTE
BHSCT	0.5	Adult Out-Patient, CYP In-Patient	Permanent, Part-Time, Sessional	Complex Mental Health issues, Behavioural	1	0.5 WTE
Counselling Centres	12	Adults, Families, Child, Parent Groups	Permanent, Full-time (1), Sessional (7), Part-time, Sessional	Suicide Ideation, Sexual Abuse, Family Relationships	12	5.3 WTE + 1 sessional staff (hours unknown) + 2 staff (hours unknown)
Trauma Centres	4	Children and Adults affected by 'the Troubles'	Sessional	Trauma Related Issues, PTSD, Suicide Ideation	4	0.37 WTE + 1 sessional staff (hours unknown) + 2 staff (hours unknown)
Schools Counselling Services	5	Children in Primary, Secondary and Special Sector	Permanent (term-time), sessional	Emotional and Behavioural Difficulties, Bullying, ADHD	5	1.3 WTE + 3 staff (hours unknown)
Brain Injury Services	2	Adults with Acquired Brain Injury	Sessional	Reduced mental and physical ability, cognitive impairment	2	0.26 WTE
Cancer Services	8	Children, adults and families affected by cancer	Permanent, Full-time (1), Sessional (7)	Psychological and Physical Effects of Cancer	8	1.0 WTE + 7 sessional staff (hours unknown)
Private Practice	5	Personal Therapy, Clinical, Supervision	Private	Psychological Issues, Mandatory supervision for practice	5	0.05 WTE + 4 staff (hours unknown)

Academic	7	Trainee Art Therapists	Permanent Part-time (2), Sessional (5)	MSc Art Therapy, Post-graduate Training	7	1.0 WTE + 5 sessional staff (hours unknown)
Agencies Employing Bank of ATs	5	Adoption support, Physical illness, Services for Autism	Sessional	Behavioural	5	5 bank staff (hours unknown)
				Total	**50**	**10.78 WTE ***
	***** 10.78 WTE + 14 sessional staff (hours unknown) + 5 bank staff (hours unknown) + 11 staff (hours unknown)					

2.5 Main Working Contexts for Art Therapists

Art Therapists / Art Psychotherapists work in diverse settings (as shown in the table on p.72) and an overview of some key current areas is given below.

2.5.1 Trauma Services

A Trauma Centre in NI employs 4 art therapists who work sessionally, including outreach provision. A historical overview helps to create the context:

Artist Adrian Hill, when recovering from tuberculosis in hospital during the Second World War and through sharing his skills, motivated fellow patients (soldiers who had served on the frontline) to experience the sustaining effects of creative activity in times of stress. Unwittingly an 'art therapist', it was however in 1946, that the term 'art therapist' was first used when Edward Adamson was appointed to Netherne, a State Psychiatric Hospital in Surrey. Both were involved in a Working Party set up by the National Association for Mental Health (NAMH) in 1951, whose conclusion was that an Art Therapy Panel should exist to assist those hospitals wishing to employ art therapists. Rita Simon (pioneer art therapist and co-founder of BAAT) worked in these early days with Hill and Adamson to bring art therapy into hospitals, and on arriving in NI in the 50s developed art therapy services in Purdysburn (now Knockbracken Health Care Park). During Rita Simon's second period in NI (1969-1984), she developed art therapy services in a variety of contexts, and in 1976 founded the **NI Group for Art as Therapy** (NIGAT), a Charity which is a portal for aspiring art therapists and those interested in creativity in its various forms.

From these early beginnings, and after many years' work, BAAT was formed in 1964, one focus being to determine standards of professional practice and conditions of service with a view to the professional training for art therapists currently existing throughout the UK.

This historical context indicates that art therapists have been practising in NI since the 1970s with a backdrop of clinical experience and support derived from the origins of the profession. It is recognised and demonstrated that art therapy is ideally placed to help war veterans heal the psychological scars that war can bring, since a number of art therapists are employed by veterans' charities in England – but none in NI!

Essentially a visual modality, art therapy can effectively heal the damage which trauma causes to the brain as most sufferers have a series of horrific visual images within. Art therapy can regulate, normalise and heal the neurological damage caused by the effects of trauma.

Art therapy as a profession, therefore, is perfectly placed to help heal the psychological injuries caused by 'the Troubles' to thousands of people here in Northern Ireland. A total of 4 art therapists currently work on a sessional basis for a Trauma Centre while 12 others are employed by Counselling Centres where presenting issues are 'Troubles' related. We consider this to be a drop in the ocean compared with the thousands of people still living who have been badly affected by 'the Troubles'. The evidence we have presented shows that trauma can be healed by art therapy and not just managed, as other professions would advocate. Why settle for half measures?

2.5.2 BHSCT - Secondary care adult psychiatry in an outpatient setting

An Art Psychotherapist worked sessionally in an outpatient adult psychotherapy department from 2005-2016, now providing clinical supervision for art therapy practice in this setting and in a CAMHS setting.

An art therapist has worked in the context of an outpatient setting providing primary care adult psychiatry, initially as a trainee art therapist on placement (MSc Art Psychotherapy), since 2012 as an Honorary Therapist, and since 2014 as a contracted sessional Art Therapist. Over ten years of art therapy provision, a variety of presenting problems has been met, with multiple symptoms of personality disorders (including borderline personality disorder) and dissociative disorders, depression, anxiety, self-harm and suicidal thoughts. Referral to the art therapist may be based on a patient's difficulty in verbalising feelings associated with this wide range of complex mental health problems of both psychotic and neurotic origin.

The art therapist has a psychodynamic approach, where the process of symbolic art-making in a contained environment is at the centre of the psychotherapeutic relationship. Art therapy may be the primary psychotherapeutic method offered or part of a multi-

disciplinary treatment plan. Observable changes and improvements over patients' period of therapy are communicated to the staff team and involvement in art therapy may lead to further participation in 'talking therapy' or group processes.

Referral to Art Therapy may be the primary intervention; length of treatment here is variable, is reviewed periodically and may continue for a number of years. Observable outcomes include patients' experience of change or reduction in symptoms associated with their difficulty; patients presenting as more settled in their day to day lives; a lessening of the impact of maladaptive coping behaviours such as thoughts of self-harm or suicidality. These positive outcomes lead to an enhancement in lifestyle, an increased ability to socialise, a better experience of work, improved quality of life and relationships.

Where art therapy is part of a multi-stepped treatment plan, the patient's initial engagement, and the experience of a therapeutic process, may over time lead to participation in one-to-one talking therapy or a group setting within the service or transfer to another service which the patient is now more equipped to use.

2.5.3 Child and adolescent inpatient care

An art therapist has been employed since 2015 in The Child and Adolescent Mental Health Service (CAMHS) which provides specialist multi-professional support in the community for children and young people (CYP), experiencing mental health problems, aged up to 17 years. The Hospital Unit is the base for Inpatient and Regional Specialist Services and also houses specialist teams for family trauma, drug and alcohol misuse, eating disorders and intensive support and assessment in emergency departments/GP surgeries.

Referral to the Unit is made through the community CAMHS as a voluntary patient, or depending on needs and presentation, a patient may be detained under the Mental Health (Northern Ireland) Order 1986. CAMHS in Northern Ireland is structured according to a stepped care model which aims to enable CYP to achieve their full potential, through improved provision of co-ordinated care across child health, social care and specialist CAMHS care services thus reducing the impact of mental health and emotional problems

A weekly open Art Therapy Group for CYP as well as individual 1-1 Art Therapy sessions have been established over those years on the two inpatient wards in the hospital with the

support of the multidisciplinary team. There has been art therapy provision in the past in the form of trainee placements. Statistics indicate an increase in patient engagement in the service year on year until end April 2018 since its regular introduction in Sept 2015.

CAMHS in Northern Ireland is structured according to a stepped care model which aims to enable CYP to achieve their full potential, through improved provision of co-ordinated care across child health, social care and specialist CAMHS care services thus reducing the impact of mental health and emotional problems. Such problems include depression, isolation and withdrawal, eating disorders, addictions, anti-social behaviour, effects of loss or bereavement.

The Unit comprises an Assessment Ward, a Treatment Ward and an Intensive Care Unit. Art Therapy provision takes the form of an open group on each ward as well as the choice of individual sessions. An open group (capacity 6-8) is open to any child or young person who wishes to attend without prior referral. Findings from the trialling of a closed group format (formal referral, capacity 6-8, for a fixed number of weeks) indicated that patients found attendance very difficult.

Both group and individual sessions are non-directive: materials and the nature of the patient's exploration in art are self-chosen. Within the last year and in response to patients' feedback, an optional theme has been introduced in the group context, in addition to a non-directive approach. The theme may be proposed by the art therapist or by the group itself, the aim being to provide focus, if necessary, and maximise choice.

Art Therapy in both contexts provides a means of communication, allowing others an awareness of how the patient may be feeling. In providing a means of expression, it gives the patient a means to 'self-regulate' their thoughts and feelings in the difficult circumstances of a hospital admission and lack of control because of illness. The necessity to search for verbal language is removed and seeing their thoughts and feelings in their art work appears to feel easier than to manage the thoughts and feelings in their own bodies. The art work forms a 'bridge' to others without the necessity of verbal explanations until the patient is ready to reflect upon it, over time, with the art therapist, either verbally or non-verbally with further creative work.

Art therapy provision in the Unit forms an integral part of a multidisciplinary approach to the care and support of children and young people admitted to hospital, providing a visual and non-verbal means of communication, self-expression and exploration of their personal situation. Feedback has indicated the importance of 'choice' in relation to attendance at groups, perhaps highlighted by finding themselves in a situation where choices are limited through illness.

Evaluation of outcomes of art therapy interventions are tracked using the ICCE Outcomes and Alliance Measures and Graph, an accessible, mark-making evaluation tool for self-report and session feedback.

2.5.4 Cancer Services

Art therapy started sessionally in a palliative setting in 1997, in a cancer charity in 2000 and in a hospital cancer care setting in 2001. The cancer charity setting evolved into a placement for the MSc Art Therapy in 2002. An art therapist has been employed full time by a Charity for the past 11 years, delivering art therapy services to those who have been affected by cancer. Patients may be adults, children who are ill, or whose parents have cancer or any person who has been bereaved by cancer. This inclusive and accessible service also has a 'bank' of 7 art therapists providing outreach services throughout NI. Currently, due to demand for the service, funding is being sought for 2 p/time posts for N/W and S/W areas as well as funding for sessional art therapists. Accessibility is a feature of the Charity's work and while a service is delivered in hospital and hospice settings, it also occurs in other premises which are accessible and familiar to potential users. This frequently involves the networking and negotiating skills of Trusts' personnel to secure appropriate and confidential spaces.

A range of provision is offered including: an art therapy studio in the Charity's central premises where children and adults can be seen individually; an open, drop-in facility in a Hospital for Sick Children where 8-10 children attend weekly; a 'bedside' opportunity for patients admitted to the isolation ward. Closed and open groups, provision for carers, families and friends are on offer.

Art therapy in this context provides an opportunity to give form to feelings which may unthinkable, unacceptable or impossible to express verbally, as a consequence of this

devastating illness, where the patient may feel the need to 'protect' family. The age range is wide, from tiny children to a patient of 84 years, whose art helped her to be 'seen' by medical staff in an otherwise potentially anonymous clinical situation. The art therapist's role here is that of 'quiet witness', holding a safe space for emotional expression associated with the experience of life-changing illness. A wide range of art media is offered including the important therapeutic medium of journaling, while animation and the digital age have been embraced for younger patients!

The Charity provides patient-centred care and values art therapy as an important means of reducing negative psychological symptoms as evidenced by two participants in a group: "*Art therapy improves your mood and your outlook on life. It also helps with feelings of stress and to keep you emotionally stable"; "the (art therapy) sessions don't ignore your diagnosis – they try to integrate it in a positive way. It is extremely therapeutic – you can lose yourself with the paintbrush. I like how you can completely immerse yourself in the art. It boosted my confidence and pride, and gave me a sense of well-being, determination and something else to focus my thoughts on".*

Over the years and currently, the Charity is a placement provider for trainee art therapists from the HCPC approved training. Trainees conduct individual and group sessions under the art therapist's Clinical Supervision.

2.6 Art Therapy Training

A skilled and experienced art therapy workforce is already available through HCPC approved training in Belfast. This was established in 2002 and has run in Queen's University Belfast and then the Belfast Health and Social Care Trust until 2016. This evolved explicitly into a trauma-informed MSc Art Therapy, with the current HCPC approved training from 2018 being located at the Belfast School of Art, Ulster University where 19 students are registered - 14 undertaking a 3-year part-time training while 5 have chosen a 2-year full-time option. New graduations will occur in 2020 and 2021. Graduates will be eligible to apply to the HCPC for registration in order to practice as art therapists/art psychotherapists. Interviewing in underway for the September 2019 intake and the course is always heavily oversubscribed.

The HCPC approved training promotes 'an evidence-based, trauma-informed and integrative, pluralistic theoretical stance, founded on a relational and person-centred way of being, underpinned by working within ethical and professional requirements'35.

The training has enabled the development of Master's level research and a number of tutors and graduates have undertaken doctoral / PhD research.

Demand for places has far outstripped UU's resources and the following considerations have emerged:

Accessible post-graduate training should be preceded by foundation courses providing a firm knowledge base for potential post-graduate students.

Recognition is needed of the essential elements in a post-graduate training for therapeutic purposes i.e. adequate student/staff ratios with resources to match, enabling successful graduates to become confident practitioners.

There are expectations of employment opportunities on registration with a salary structure commensurate with art therapists' skills and experience, and matching their ability to work with a complexity of problems and issues which have not responded to verbal interventions.

2.6.1 Further opportunities provided by MSc Art Therapy training in NI

There are multiple opportunities for the mutual advantage of UU and agencies considering employing art therapists:

Provision of clinical placements in statutory agencies during art therapists' rigorous training – an opportunity to introduce and evaluate its benefits to service users

Teaching 'slots' available for agency staff within academic modules, connecting theory and practice to work 'in the field'

[35] www.ulsteruniversity.ac.uk

Opportunities for experienced and registered therapists to be available for the mandatory requirement of personal therapy during students' training

CPD availability within agencies for qualified art therapists

Registered and highly trained art therapists as potential employees

Possible secondment for agency staff who fulfil the entry criteria for the MSc Art Therapy, resulting in those agencies having an in-house art therapist, akin to the current opportunities for secondment which BHSCT are offering to trainee psychotherapists – in England!

These beneficial relationships can only serve to promote the understanding and development of effective art therapy provision within statutory agencies. Positive consequences of such informed and enhanced multi-disciplinary working include appropriate referral systems, effective treatment and reliable evaluation of interventions, all leading to improvement in clinical services and opportunities for further academic research.

2.7 Retention of the Art Therapy workforce

Retention of this workforce and the proper utilizing of its skills require properly paid employment with adequate contracts and salaries aligned to other AHP professions with a structured career progression which acknowledges professional experience and seniority. The future of the art therapy service will depend upon appropriate finance being made available for secure tenure of employment otherwise a 'brain drain' of competent, experienced art therapists will occur as has happened in past years.

Art therapists' professional qualifications need recognition as falling within 'essential criteria' as advertised by DoH, so as to maximise employment opportunities here. This includes the identification of art therapy as a 'standalone profession' rather than being subsumed under the title 'counsellor'.

Recognition of art therapists' contribution to the effective functioning of a multi-disciplinary team with the patient/client

at its centre needs reflected in appropriate DoH resources for their employment, ideally an arts therapies unit within statutory services.

DoH's role as educator requires exploration, so that art therapy as a profession is understood, named and supported, affirming art as at the centre of the service user/therapist relationship. Many opportunities exist for education of the public, including service users and service providers, to highlight the depth, breadth and scope of the profession and its practitioners' experience and qualifications.

A priority is protection of the public by employing only HCPC registered art therapists thus guarding against other art practitioners offering an unregistered and potentially damaging service.

Funding for evaluation and research which demonstrates art therapy's effectiveness in situations of complexity would lead to it becoming part of mainstream provision, accessible and responsive at the point of delivery, thus extending its present 'niche' identity. The development of opportunities for CPD and research to further the profession's profile and capabilities would be to the advantage of service users, organisations and the profession.

An effective art therapy service is best delivered as an integral part of organisations' Business Plans where the service is targeted in a specific, defined manner and evaluation methods are employed with a view to exploring, improving and enhancing outcomes.

2.8 Art Therapists' Professional Body (BAAT)

The BAAT[36] has extensive experience in supporting its members and their employers in many and varied contexts and its role in consultation and the exploration of solution-based approaches is well-documented. (See)

BAAT's NI Regional Group has an overview of HCPC Registered Art Therapists, their areas of expertise, geographical locations and availability. It provides a conduit for representation of members' views and interests, guidance on professional issues and contribution to the development of the profession locally. Close connections are maintained between the

[36] www.baat.org

Regional Group and BAAT's Central Body: NI is represented on BAAT Council in London and two Regional Coordinators respond to members' needs and agencies' queries about art therapy availability (baatni@gmail.com)

Please see Appendix 1 for an outline of BAAT's professional status and approaches including statistics on NHS employment of art therapists, Agenda for Change salary scales, evidence of art therapy's inclusion in Patient Reported Experience Measures (PREMs), and the Professional Body's involvement in research to evidence effectiveness of its method.

2.9 Cost Effectiveness

Samples of the effectiveness of art therapy demonstrate its capacity to reach individuals who have experienced other forms of therapies without satisfactory outcomes. Participation in art therapy, either individually or in groups, harnesses the innately creative aspects of the patient/client in the service of health and wellbeing, contributing positively to overall case management. The costs of art therapists' time and basic materials must be balanced against lengthy hospital stays, recurring medical appointments, expensive drugs – and the costs of inability to contribute to society – when examining the nature of 'effectiveness', both short-term and long-term. A most important aim is to integrate service users' voice and experience into the design, delivery and evaluation of services.

2.10 Conclusion

The information outlined above details the current situation in relation to art therapy services in Northern Ireland, including numerous examples of practice delineating its specific contribution to a wide range of populations. It demonstrates that no specific strategy or process is in place either regionally or within individual Trusts for actual or potential art therapy provision indicating the urgent necessity for a HSCB review to develop and implement a strategy for its development.

Art therapy is ideally placed to further the objectives of a multi-disciplinary team whose commitment is to the care of the patient/client. The physical and emotional needs of a hospital patient, vulnerable child or ageing adult are myriad, and experienced at an unconscious as well as a conscious level. Providing an effective means to process this experience has positive effects on the individual, enabling both physical and psychological needs to be met, thus enhancing the individual's care plan. The evidence we have

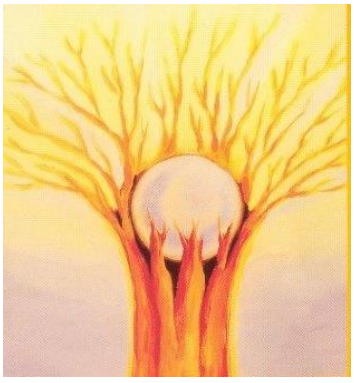
presented shows how Art Therapy can help people stay well, recover faster, heal long-term conditions and experience a better quality of life, as an alternative to medication.

As a profession, we are calling for an informed and open-minded willingness to accept that art in a therapeutic setting i.e. Art Therapy, can make a significant contribution to addressing pressing issues faced by the population of Northern Ireland and by our Health and Social Care Systems. We would like to see the inclusion of Art Therapy as a treatment modality included on the list of approved treatments for depression and anxiety used by GPs, enabling service provision to a much wider public.

We welcome the fact that Art Therapy will be involved in the forthcoming review of Mental Health services, considering the current demand, existence of an experienced workforce and accredited local training, which ensures ongoing professional capacity to respond to such demand.

As a profession, we feel under-valued, under-utilised and overlooked. We have a highly educated and highly skilled workforce, not utilised at present to best serve the needs of this 'post-conflict' region, where the effect of 'the Troubles' is demonstrated through trans-generational trauma, evident in the extent of identified mental health needs. The contribution of arts therapies is vital as a 'way in' to somatically-held psychological injury, enabling the service user to connect creatively with sensory materials and helping to activate, repair and heal areas of the brain that trauma has damaged - key to healthy emotional development. Our service gives young people a therapy to repair their emotional distress which does not depend on words or cognitive thinking.

A workforce of HCPC registered art therapists provides an evidence-based service mainly through the Charitable Sector. We would press the DoH to use its capacity to make this AHP more widely available to the general public i.e. inclusion of art therapy in the list of psychological therapies recommended for the treatment of adults and children (NICE guidelines), naming Art Psychotherapy as a recommended service. We would also like to see the inclusion of Art Therapy as a treatment modality included on the list of approved treatments for depression and anxiety used by GPs, ensuring its availability for a much wider public.



Appendix 1 – information from the BAAT

24-27 White Lion Street
London N1 9PD
Telephone: 020 7686 4216
Email: info@baat.org
Web: www.baat.org

4th March 2019

TO WHOM IT MAY CONCERN: Art Therapy Professional Status

This letter sets out several points which support the employment of art therapists in Health Services.

- The BAAT has recently run a workforce survey in the UK. This evidenced that the NHS continues to be a significant employer of art therapists (a total of 42% of respondents were employed in the NHS).

- Art therapists have a recognised Agenda for Change salary scale in the NHS and our bandings range from Band 6 to Band 8.

- There is mounting evidence that providing a range of psychological therapies which include arts therapies helps to improve Patient Reported Experience Measures (PREMs), an important indicator of quality of care in all Trusts.

- As HCPC registered professionals, Art therapists are members of the Allied Health Professions and contribute to consultations on and strategic planning of services. They also access all the opportunities for leadership and research careers offered by the National Institute for Health Research.

- The recently HCPC validated Belfast art therapy training will be an asset to the Northern Ireland Health Service as it will provide practice placements for trainees who are mature students with considerable prior work experience. These practice placements enable provision of art therapy in a wide range of services.

- The BAAT has actively prioritised research to evidence the efficacy of art therapy with a wide range of client groups and conditions. Some of this evidence has been included in the All Party Parliamentary Group on Arts in Health 'Creative Health' report. http://www.artshealthandwellbeing.org.uk/appg-inquiry/Publications/Creative_Health_Inquiry_Report_2017.pdf

- The BAAT has supported the development of a range of evidence-based approaches to art therapy such as mentalization, psychoeducation, brief approaches, EMDR, etc. and art therapists understand the importance of working in a client-centred way and as active team members.

- Art therapists also take on generic tasks such as risk or triage assessments and participate fully in extending knowledge and skills required by their employers.

- Importantly, art therapists can engage service users who experience emotional or physical conditions preventing them from participating in verbally-based intervention but do need psychological interventions.

I hope this helps define our current professional status and approaches.

Yours faithfully
Dr Val Huet (PhD),

Chief Executive Officer

The British Association of Art Therapists Ltd, A company limited by Guarantee.
Company No: 1326920
(England and Wales)

Dramatherapy

3. Dramatherapy

3.1 Introduction

As one of the Allied Health Professions Dramatherapists engage with a wide range of service users to achieve outcomes which improve their health, well-being and quality of life.

Dramatherapy has been grouped with music therapy and art therapy in this workforce review. While it is important to define and review dramatherapy as a stand-alone arts therapy it is also crucial to acknowledge it as an important member of an arts therapy coalition in order to establish standards of professional training and practice. This review of current dramatherapy services will include information gained from a scoping exercise carried out in April 2019 to try to discover the numbers and activity of dramatherapists in Northern Ireland. It will also include the statements from the Allied Health Professions Workforce Review Stakeholder Engagement Day held on 7 September 2018, an essential part of the co-design and co-production process for these workforce reviews. Questions were designed to facilitate and guide discussion with the view to focusing thoughts. The views of all participants were considered and are to play an important part in helping inform the future of the three arts therapies reviewed.

3.2 What is Dramatherapy?

At the Workforce Review Stakeholder Engagement day it became evident that there is little knowledge in Northern Ireland of what Dramatherapy is which is not surprising as our numbers are small, physically evidenced on the day by dramatherapy occupying only one table in the room.

As far back in history as Aristotle 'theatre' has been a medium through which society has examined itself in an attempt to make understand and make sense of human existence. For Aristotle the cathartic experience was brought about by a "combination of vicarious participation and suspension of disbelief". (Aristotle in Jones, 1996: 44) The use of drama as therapy in Europe can be traced back to the 18th century: theatres were known to exist within psychiatric hospitals where patients engaged in creating plays to explore their own psychoses. However, there is evidence that dance, rhythm, storytelling and rituals were used much further back in time.

From the late 19th century onwards new perspectives on mental health, theories of the mind and the emotions had been developing. During this same period “a spirit of experimentation radically altered the ways in which drama and theatre were used”. (ibid: 46). However, it was not until the 20th century that western society made connections between theatre and its ability to create personal and societal change and a focus on theatre as therapy became more defined. The convergence of the new developments in psychology in relation to treatment of mental health and the realisation of the inherent healing properties of theatre created the conditions for the gradual development of dramatherapy from the 1960’s onwards.

The British Association of Dramatherapists (BADth) is the professional body for Dramatherapists in the United Kingdom. It was established in 1977, is formally constituted with Officers and an Executive Committee and has its own Code of Practice. BADth has the legal status of a non-profit-making company, limited by guarantee. The following is the British Association’s Definition of Dramatherapists (BADth) and a more detailed description of its processes and where it’s used:

Dramatherapy has as its main focus the intentional use of healing aspects of drama and theatre as the therapeutic process. It is a method of working and playing that uses action methods to facilitate creativity, imagination, learning, insight and growth.

Clients who are referred to a Dramatherapist can be any age, from very young children right through adulthood, and do not need to have previous experience or skill in acting, theatre or drama. Dramatherapists are trained to enable clients to find the most suitable medium for them to engage in group or individual therapy to address and resolve or make troubling issues more bearable.

Dramatherapy is a form of psychological therapy in which all the performance arts are utilised within the therapeutic relationship. Dramatherapists are both artists and clinicians and draw on their trainings in theatre/drama and therapy to create methods to engage clients in effecting psychological, emotional and social changes. The therapy gives equal validity to body and mind within the dramatic context; stories, myths, playtexts, puppetry, masks and improvisation are examples of the range of artistic interventions a Dramatherapist may employ. These will enable the client to explore difficult and painful life experiences through an indirect approach.

Dramatherapists work in a wide variety of settings:

- schools
- mental health
- general health social care settings
- prisons
- the voluntary sector.

Thus, the clients they work with will have differing needs: from children on the autistic spectrum to older people with dementia; adolescents who self-harm, people with histories of sexual and/or physical abuse, those suffering from a mental illness and women with post-natal depression.

3.3 Dramatherapy Training

Dramatherapy has never been taught in NI. There was a course in the South of Ireland at Maynooth for approximately 10 years, but this course was removed from the university's curriculum in 2018. At present there are 4 dramatherapy courses in mainland UK: as a postgraduate Masters at the University of Derby[37], the University of Roehampton[38], Anglia Ruskin University[39], and Central School of Speech and Drama[40].

Dramatherapists can be members of The British Association of Dramatherapists (BADth), and are registered with the Health and Care Professions Council (HCPC)

3.4 Service Mapping of Dramatherapy in Northern Ireland 2019

Dramatherapists in Northern Ireland generally work freelance because they are not included in job specifications set out by Health and Social Care Trusts or other statutory organisations. However, this is not the case in mainland UK where specific posts for dramatherapists and arts therapists are available within Health Trusts, Education and Forensic Services.

[37] https://www.derby.ac.uk/postgraduate/therapeutic-practice-courses/dramatherapy-ma/
[38] https://www.roehampton.ac.uk/postgraduate-courses/dramatherapy/
[39] https://www.anglia.ac.uk/study/postgraduate/dramatherapy
[40] https://www.cssd.ac.uk/course/drama-and-movement-therapy-ma

The current workforce:

Data has been collected from the scoping exercise previously mentioned and has been integrated with the data obtained from the Stakeholder Engagement Day. The purpose being to try to establish the activity of the current workforce, the type of client groups who receive delivery of service, views on its drivers and constraints, opinions on how the service needs to be developed and to provide recommendations which could enable it to do so.

The scoping exercise yielded 6 responses: 2 dramatherapists preferred not to state their gender and 4 identified as female. This information can only be taken as a snapshot as there may be dramatherapists who were not aware of the scoping exercise or chose not to respond. The following 3 tables show the makeup of the current dramatherapy work force and their employment using the information gained from the 6 therapists who responded.

TABLE 1

	Age Band	Training	Years of practice	Avg hours / week as dramatherapist	Avg hours / week to supplement income
1	40-49	MA Drama & Movement Therapy (registered with HCPC)	15 years	30	0
2	50-59	MA in Social Work, MA in Dramatherapy (registered with NISCC & HCPC Sensorimotor Psychotherapy Level 1	22 years as social worker, 18 years as dramathera pist	On average 1 hour per week with occasional sessional project work for e.g. 21 hours on project 8/2018	37.5 as Senior Practitioner in Social Work in CAMHS using dramatherapy skills
3	20-29	MA in Dramatherapy	Currently completing MA	7 hours in dramatherapy placement	Works as a nanny
4	30-39	MA in Dramatherapy (IACAT registered & pending HCPC registration)	3 years including student practice	0 in N.I. as waiting on HCPC registration	Activities therapist in mental health, using skills as DT, and paid minimum wage.
5	N/A	PGDIP	30 years	N/A carer	N/A
6	60+	MA in Dramatherapy	22 years	1	12 hours per week as learning mentor

TABLE 2

	Service type	Client group & age range	Area located	Type of funding	Contract type & length	Pay band equivalent
1	Voluntary organisation working community and schools Home visits	Young people & families Autism & complex needs	Belfast Belfast	Various Belfast trust	Various contracted 25 hours per week for 5 years Ongoing contract of 5 years	Band 7
2	Tessa (adoption roots)	Parents & children adoption support Children up to age of 12	Northern trust area	Lottery	Sessional	Band 7
3	N/a					
4	Voluntary organisation in community centre	Children on the autistic spectrum aged 5-10	Newry	Various	6 hours per week for 8 weeks as student placement	N/a
5	N/a					
6	Private practice in community centre	1 adult	Belfast	N/a	I hour per week for contracted for 75 hours	Band 7

TABLE 3

	Avg clients per week	Demand for DT services	Drivers	Constraints	Collaboration with DTs or professionals
1	14	Work alongside other therapists as part of multidisciplinary team	Community need	Limited funding or constraints to preferred types of therapy procured within this service.	DTs, other AHPs, other therapists & counsellors.
	Various	Same as above	Support for clients who don't leave their house	No coordinated approach to these services. Families organise it themselves	I work with DTs, other therapists, social workers and nurses
2	Various	With an organisation supporting adoptive parents and children, big need for DT but not enough funding	Helping families to stay together and preventing the need for further resources and support from Health Trusts	Limited funding	Other arts therapists and counsellors are employed by this service but usually we work on an individual basis
3	N/A				
4	8	Big demand for individual & group therapy as organisation supports children & families on the autistic spectrum	Community need	Limited funding or constraints to the preferred types of therapy procured within the service	Occupational therapists
5	N/A				
6	1	Low, sporadic	DT qualification	Low client nos	No

Brief Summary of Tables:

Dramatherapists working in Northern Ireland together have over a quarter of century's professional experience. However, numbers are small, and the practice is **mainly in the Belfast area**. Only 1 therapist works the equivalent of a 4 day week employed as a dramatherapist, 1 works full time in NHSCT within CAMHS as a senior practitioner in social work using dramatherapy skills and has sporadic sessional work as a dramatherapist either on a private basis or for a charity. Another works full time in a charity using dramatherapy skills. 2 dramatherapists have just finished their training but are "nervous about the prospect of getting work" once they are registered with the HCPC. Another dramatherapist only has work as a dramatherapist for 1 hour per week and supplements her income as a learning mentor and another is not currently working due to carer responsibilities but hopes to work again in the future.

This scoping exercise shows that dramatherapists in Northern Ireland work in community centres, schools and homes and there is limited funding for their practice. Some work alongside other dramatherapists, AHPs, nurses, social workers, other types of therapists and counsellors. One of the main drivers behind the organisations they work in is community need and the main constraints are lack of funding and preferred types of therapy procured within the service. When dramatherapists are employed within organisations either by contract or on a sessional basis it appears to be the equivalent of a Band 7 salary.

The following 'drivers' section of this report is comprised from the scoping exercise and the icebreaker question on the Stakeholder Engagement Day regarding Dramatherapy: What is the best thing about the service you provide or the service you receive?

3.4.1 Drivers

- The desire to use Dramatherapy training which is underpinned by the belief and evidence that dramatherapy can effect positive transformation and healing for those who have an opportunity to access this therapy;
- The evidence base for dramatherapy is growing due to the ongoing development by dramatherapists in UK of appropriate measures that have the ability to capture both

qualitative and quantitative data: for example the following offers three versions of outcome measures http://www.psychlops.org.uk/versions. ;

- Dramatherapists have historically been successful in promoting their work and finding openings in schools and trauma recovery specialisms;
- Dramatherapy does not rely on only verbal communication and can provide a safe space for the individual to express, explore and understand their thoughts and feelings;
- Dramatherapy is a person-centred therapy in which the therapist enters the world of the service user in order to guide them;
- Dramatherapy is flexible and adaptable in meeting client needs: it can be used in a variety of settings with a range of clients and issues; relieving stress for individuals
- families are supported to stay together at a time of crisis
- containing people and helping them manage complex issues
- holistic approach to linking users and providers, co-designing solutions as a conduit
- working as part of a multidisciplinary team
- making a significant change in people's lives
- goes beyond narrow definitions of health into well-being at personal, family and social levels
- much of the work is preventative

Dramatherapy was recently included in the NICE guidelines for treatment of psychosis - www.nice.org.uk/sharedlearning/dramatherapy-in-early-intervention-in-psychosis

The above statements indicate how dramatherapy has within its modality the qualities to play an integral role in the transformation agenda for health and wellbeing enabling people to stay well for longer.

The following constraints section of the report were the responses of dramatherapists to the scoping exercise:

3.4.2 Constraints

- A lack of knowledge and understanding about the specialism of Dramatherapy as an AHP and its versatility/benefits regarding different client groups was cited as the main constraint by dramatherapists resulting in the lack of its development/promotion in NI;
- A lack of commissioning/openings for Dramatherapy posts and placements for students, for example in healthcare, to be a widely felt presence even though Dramatherapy is one of the HCPC regulated AHP's;
- A limited/lack of funding and sustainability;
- A lack of local training;
- As a society there is still a stigma towards therapy;
- There is an inequity of service across geographical areas and across client groups as the tables above show.

3.4.3 Case Example

Due to the small number of dramatherapists in NI, lack of funding for posts in statutory services and research, and limited time frame to gather information for this report there is only one case study within the Northern Ireland context.

Dramatherapy Group within Specialist CAMHS (July to September 2016) NHSCT

The young people in the group were aged between 15 and 17 years old and were attending CAMHS due to experiencing low mood and or anxiety.

Rationale - To provide a non-threatening, playful environment that facilitates the development of individual and group skills. These skills, in turn, promote self-confidence and self-esteem along with an awareness of and appreciation for the qualities of co-participants. This creative expressive structure is based on a health model as the strengths and healthy parts of the young person are elicited. Qualities such as expressiveness, playfulness, creativity, spontaneity, humour and aliveness are nurtured.

Aims

1. *To promote positive change in young people by means of a brief dramatherapy group intervention duration of 8 weeks of 90-minute sessions. It is hoped these can run consecutively when possible.*

2. *To provide a programme structure to facilitate group processes that according to research contain twelve 'therapeutic factors', which contribute to positive change in the condition of an individual. Some of the more important are the following:*
    - *Self-understanding.*
    - *Interaction.*
    - *Universality: member's realisation that his problems are not unique.*
    - *Instillation of hope: belief that participation in the group will be beneficial.*
    - *Altruism: benefit derived from recognition that group members can help each other.*
    - *Guidance*
    - *Identification*
    - *Cohesiveness: the degree to which each member feels accepted and valued.*
    - *An 'existential' factor: being authentic, taking responsibility for self.*

Objectives

To promote the following positive change in young people with low mood and or anxiety:

- *increase self-confidence*
- *improve self-image*
- *Improve communication skills*
- *reduce anxiety*
- *raise mood*
- *enable discharge from Specialist CAMHS or medication only review*

Out of the 7 participants only 2 were on medication. One of them had been engaged in therapeutic work in CAMHS for a number of years and after the group was able to attend only for medication review and then was discharged. The other participant who had been in crisis when referred to CAMHS was discharged into the care of his GP. Out of the other 5 participants another 3 were discharged and 2 remained within CAMHS for further individual therapy. Feedback was obtained from the participants and parents. These are some of the comments from 2 young people and 2 parents:

What changes, if any, did you notice in the group from week to week?

"Everyone got more involved and confident".
"I felt more engaged with the people around me".

Did you feel safe in the group?

"Yes, I felt I could trust everyone".

In what way did you feel you contributed to the group?

"I took part in all the activities".

"I felt like I participated a lot".

Did your participation in the group increase from week to week?

"Yes"

"I was pretty engaged every week".

Has anything in your life changed since being in the group?

"I am more confident with people and I talk to more people".

"Yes, I'm much happier and enthusiastic now".

What is your attitude to the future?

"I hope to improve more".

"That if things aren't going your way, just stick with it".

What have you learnt from taking part in the group?

"That everyone feels the same".

"How to break out of the old me and be more sociable"

Parent feedback:

What changes, if any, have you noticed in your son/daughter since attending the group?

"Improvement in her well-being straight after the group, started to look forward to going to the group, big achievement".

"Brighter, more upbeat about things, not spending as much time on his own/in room. Gets out more with friend and more independent and confident

Would you change anything about the group?

"No"

"No he seemed to enjoy the group meetings".

Would you recommend this type of group to other parents?

"Absolutely"

"Definitely helped him grow in confidence – so yes".

The following excerpt is from the 2019 United Kingdom Advancing healthcare awards: Allied health professionals & healthcare scientists. These dramatherapists/winners won the Guardian Jobs Award for Innovation in Mental Health Services.

WINNER

Young Persons' Dramatherapy Group

Clare Hubbard, dramatherapy Lead and Marina Morgan, dramatherapist, Hertfordshire Partnership University NHS Trust

With an increase in referrals for younger adults who experience social anxiety as part of their mental health difficulties, Clare and Marina felt that group therapy could be more beneficial than the one-to-one therapy that was currently being offered.

Many had experienced bullying at school which had had a severely detrimental effect on their confidence in interacting with others, being out in the community and going to college or work. It was decided that group therapy could help them find peer support, work through their fears and build their confidence. To help them engage in their community, the therapy took place at a local theatre.

The group, comprising eight members, ran for 12 months from October 2017. All had had some individual sessions prior to the group. Of the seven people who completed the group, three were ready to be discharged from the mental health services and two were under a psychiatrist only.

Being away from the health centre for a whole year, the group talked a lot about how they felt defined by their mental health diagnosis. But being in a studio situation working creatively, allowed them space to work through this self-view, and define themselves differently. They had the potential to be something other than their illness and diagnosis.

One member said: "I actually feel hopeful for the future and instead of feeling suicidal I feel more invigorated and want to live my life."

"The impact on individuals – all young people – allowing them to grow in confidence and personality was stunning."

3.4.4 Research

Measuring the effectiveness of Dramatherapy is an ongoing and evolving process. Standardised outcomes have not been deemed to fit well due to their quantitative background. Nevertheless, it is essential that arts therapies find appropriate forms to evaluate their effectiveness as our healthcare system promotes talking therapies such as CBT. Dramatherapists employed in health trusts in England are developing outcome measures that have the ability to capture both qualitative and quantitative data. PSYCHLOPS Kids mentioned earlier in the report is a routine outcome measure specifically

created at the *Institute of Psychiatry* with the help of *Roundabout Dramatherapy*[41], a London based Dramatherapy charity. Another useful measure for keeping therapeutic goals in mind is goal-based outcome measures (GBOM)[42]. When working with children especially, the use of teacher and parent evaluations are a great addition to capturing the whole picture. It is therefore vitally important that research remains an important conversation within arts therapies in general. Jones in 2005 states "if health services are not satisfied change is occurring in a way they understand, or at a pace they find satisfactory, then the Arts Therapies will dwindle into abandonment as viable options of client care" (p.211). It is vitally important that the Arts Therapies Community continues to build an evidence base to meet registration standards and clinical commissioning for treatment.

3.4.5 Cost Effectiveness

This report has provided 2 examples of groupwork with young people experiencing mental health difficulties. These are good examples of cost effectiveness with positive therapeutic outcomes: Working with people in a group frees up more time therefore enabling services to treat more people within a given time frame. It frees up more time for working with clients who are unable to engage in groupwork.

As mentioned previously Dramatherapy is an effective preventative intervention and improves well-being.

3.5 Conclusion

Dramatherapists ranked their top priority for the AHP workforce reviews to deliver: "to recognise the role of all AHPs in delivering core HSC services by creating an integrated pathway from training to employment". This would include "parity of terms and conditions with other AHP professionals commissioned under HCPC and" and "inclusion within the AHP governance structure, including maintaining a register of recognised practitioner status".

[41] http://www.roundaboutdramatherapy.org.uk/

[42] https://goalsintherapycom.files.wordpress.com/2018/03/gbo-version-2-march-2018-final.pdf

Collective Recommendations

for Music Therapy, Art Therapy and Dramatherapy

4. Collective recommendations - Music, Art and Dramatherapy

The above three professional reports highlight a number of common issues – the arbitrary and unstructured model of service delivery that has evolved over the years leading to inconsistent funding for short-term or limited services which hinders the sustainable impact they can have on service users. The potential benefit that the arts therapies could bring to the health and wellbeing of the Northern Ireland population is not being achieved, despite consistently good outcomes and feedback on services across all three professions and across the full range of service user groups.

There is a small, but impactful workforce in place with a highly specialised skillset that is not being capitalised on as well as it could and should be. It has been shown that there is significant untapped potential for the arts therapists to support other healthcare professionals in achieving their outcomes for patients more effectively and more efficiently, thus leading to cost savings overall. The impact of the current service delivery model on the workforce is that it leads to difficulties in retaining therapists to the professions they have trained for, due to the lack of secure jobs and proper career pathways, and those highly specialised skills are being lost. Recruitment can also be challenged by the lack of secure posts and also, at least for music therapy and dramatherapy, by the fact that there are no training courses for these professions in Northern Ireland.

Feedback from the stakeholder engagement event held on 7th September 2018 was collated and integrated with the findings of the above reports, resulting in the following recommendations for Music Therapy, Art Therapy and Dramatherapy (collectively known as the 'Arts Therapies'):

	RECOMMENDATIONS	
WORKFORCE STRATEGY	1	The development of an Arts Therapies strategy for Northern Ireland by carrying out a review of Arts Therapies services, in collaboration with the Department of Health, Health and Social Care Board and 5 HSC Trusts, in order to support the transformation agenda with the development and improvement of services across the region.
INVOLVEMENT IN STRATEGIC REVIEWS AND RELEVANT GROUPS	2	Ensure that the three Arts Therapies are involved in the upcoming review of Mental Health services.
	3	Ensure that the three Arts Therapies are involved and included appropriately throughout the design and implementation of the new AHP strategy.
	4	Ensure that the three Arts Therapies be given proper consideration in all relevant service reviews, and be appropriately included as a treatment option, including in social prescribing models / programmes.
	5	Ensure representation of the three Arts Therapies in the Regional AHP Group.
	6	Involve the three Arts Therapies as appropriate in the action of the HR strategy, with inclusion in HSC careers service information.
COMMUNICATIONS	7	For the three Arts Therapies professions to establish a regional group for communication and advocacy, interfacing with the professional bodies, and to function as a point of contact for the Department of Health, Public Health Agency and Health and Social Care Trusts. This is in order to facilitate the establishment of links as set out in this document and these recommendations.

TRAINING	8	In collaboration with Trust AHP Leads, to increase the development of placement support for Arts Therapists undertaking their pre-registration training on courses in the UK and ROI. This should also explore the possibility of implementing an apprenticeship programme for arts therapists as approved for delivery in England.
ART THERAPY EDUCATION & POSTGRADUATE TRAINING	9	Collaboration should be developed with Trust AHP Leads to explore the expansion of existing placements and the commissioning of new placement opportunities within Trusts for students on the MSc Art Therapy, Ulster University.
	10	Collaboration should be developed between the MSc Art Therapy, Ulster University, and wider AHP training to maximise the synergy of pre-registration and CPD education and develop training infrastructure and inter-professional learning.

5. Arts Therapists Workforce Review - Action/Implementation Plan 2019 -

	RECOMMENDATIONS	ACTIONS	LEAD RESPONSE	RECOMMENDATION TARGET DATE
POSTGRADUATE TRAINING				
RECRUITMENT & RETENTION				
POST QUALIFYING TRAINING				

WORKFORCE DEVELOPMENT & STABILITY				
WORKFORCE DEMOGRAPHY				
E-health				
WORKFORCE Review Cycle		.		