# Safe Staffing

## for

# Health and Social Care Professionals

A Fórsa Position Paper



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# List of Abbreviations

| | |
|---|---|
| AHP | Allied Health Professional |
| CDNT | Children's Disability Network Team |
| CPD | Continuing Professional Development |
| CSM | Common Staffing Method |
| DoH NI | Department of Health, Northern Ireland |
| ESRI | Economic and Social Research Institute |
| HIS | Healthcare Improvement Scotland |
| HSCP | Health and Social Care Professional |
| HSE | Health Service Executive |
| Ireland | Republic of Ireland |
| LPT | Leicestershire Partnership NHS Trust |
| MSLA | Medical Laboratory Scientists Association |
| NDA | National Disability Authority |
| NHS | National Health Service |
| NI | Northern Ireland |
| NICE | National Institute for Health and Care Excellence |
| NQB | National Quality Board |
| PSI | Pharmaceutical Society of Ireland |
| SCoR | Society and College of Radiographers |
| SDG | Sustainable Development Goal |
| SLT | Speech and Language Therapy/Speech and Language Therapist |
| TASC | Think-tank for Action on Social Change |
| UK | United Kingdom |
| WHO | World Health Organization |
| WHO Europe | World Health Organization Regional Office for Europe |
| WISN | Workload Indicators of Staffing Need |
| WTE | Whole-Time Equivalent |

# Section 1.
# Executive Summary

Safe staffing is a fundamental requirement for safe, effective and sustainable health and social care. Across Health and Social Care Professional services and disciplines in Ireland, there is currently no single national framework for determining whether staffing levels, skill mix and workload capacity are sufficient to meet population and service-user need. Existing approaches are fragmented across professions and services, and staffing decisions are not consistently linked to assessed demand, workload complexity, access pressures or service outcomes.

This gap has become increasingly important. Ireland's health and social care system is undergoing major structural reform while responding to population growth, ageing, chronic illness, long waiting lists and continuing workforce pressures. HSCPs are central to care closer to home, disability services, rehabilitation, mental health, primary care, diagnostics, social care and psychosocial services. The HSCP workforce has grown in recent years, but workforce growth alone does not establish that staffing is safe. Staffing adequacy must be assessed against the work required, the needs of the population, the available professional time, the mix and experience of staff, and the ability of services to provide timely and effective care.

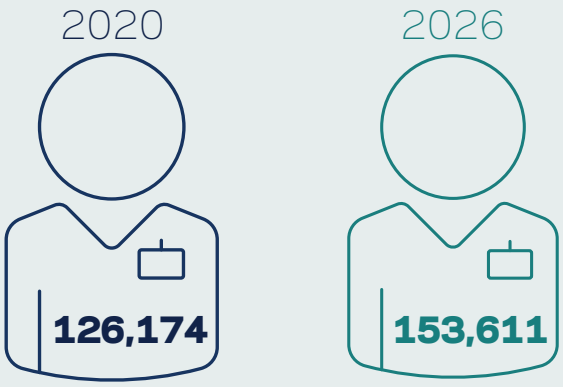
Current workforce intelligence remains incomplete. Published HSCP-wide vacancy rates are limited, while recent ESRI modelling covers selected primary and community services and does not establish whether baseline staffing levels were appropriate or safe. It also cannot fully incorporate waiting-list pressures or unmet demand. Evidence from services, staff surveys and Fórsa research indicates continuing pressures related to workload, recruitment, leave cover, staff wellbeing, retention, morale and access. High agency expenditure provides a further indicator of fragility where temporary staffing is used to sustain core services.

The evidence reviewed in this paper shows that safe staffing cannot be determined through workforce totals, funded posts or caseload numbers alone. Caseload measures are useful where professionals hold ongoing responsibility for service users, but they do not capture differences in complexity, risk, intervention intensity, travel, family circumstances or indirect work.

Workload is a broader concept that includes assessment, intervention, documentation, multidisciplinary working, safeguarding, supervision, administration, travel, continuing professional development, student education, governance and service development.

A service may also appear fully staffed on paper while having reduced operational capacity because of vacancies, absence, turnover, recruitment delays, staff experience or supervision demands.

## Total health service WTE staff




### This included

| | |
|---|---|
| 7,272 | therapy professionals |
| 5,595 | health science and diagnostics staff |
| 3,430 | social care staff |
| 1,561 | pharmacy staff |
| 1,367 | psychologists |
| 1,648 | social workers |

No single staffing methodology is sufficient for the full range of HSCP services. Ratios may provide minimum safeguards in some standardised or continuously staffed settings. Caseload models can support allocation and escalation in case-holding roles. Workload and time-use tools can capture direct and indirect activity. Demand-capacity models are useful for referral and waiting-list services. Acuity and complexity methods can distinguish between different levels of need. Skill-mix analysis can support the appropriate deployment of regulated professionals, advanced practitioners, assistants and support workers. Professional judgement and local service data are required across all of these methods.

The central conclusion is that Ireland requires a national principles-based framework supported by profession-specific and service-specific methods. The framework should create consistency in what must be considered without imposing one universal staffing ratio or formula across all HSCPs.

Fórsa's position is that safe staffing for HSCPs should be treated as a national workforce, service quality and industrial relations priority. Fórsa should advocate for a framework that is principles-based, evidence-informed and workload-sensitive, with transparent data, professional and trade union participation, clear governance and accountability, explicit attention to staff wellbeing and service-user outcomes, and a planned route from early learning pilot to phased implementation.

This paper proposes the following safer and effective staffing definition:

> *Safe staffing for HSCPs means having sufficient numbers of appropriately qualified, skilled and supported professionals, with the right skill mix and manageable workload, to deliver safe, timely, equitable and effective care in response to assessed population and service-user need. It requires staffing decisions to reflect local context, workload complexity, professional judgement, service quality, access, continuity and staff wellbeing.*

The proposed framework builds on the Department of Health, Northern Ireland, *Safer and effective staffing in social work: Guidance for Health and Social Care Trusts* social work and is organised around the 3Cs (McFadden et al., 2024 & 2025):

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**Capacity** means having sufficient staff, available working time, appropriate skill mix and organisational support to meet need safely.

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**Communication** means transparent and fair discussion of workload, risk, prioritisation and staffing pressure, supported by clear reporting and escalation routes.

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**Connection** means the leadership, supervision, team support, professional relationships and organisational belonging needed to sustain safe practice.

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These concepts are supported by ten HSCP safe staffing principles. They require:

1. Funded workforce capacity to be based on assessed need;
2. Workload to remain within safe capacity;
3. Skill mix to reflect professional standards and service-user need;
4. Compassionate and effective leadership;
5. Protection of staff wellbeing and psychological safety;
6. Team support and professional connection;
7. Governance that makes staffing risk visible and actionable;
8. Timely and effective intervention;
9. Regular workload review; and
10. Appropriate closure, discharge, transition and continuity.

The framework should apply across broad HSCP roles and service contexts rather than fixed organisational structures. Therapeutic and rehabilitation professions may require workload tools, clinical care ratios, demand-capacity analysis and waiting-list data. Social work, social care, psychology and other case-holding roles may require caseload review, complexity weighting, supervision and escalation processes. Diagnostic and specialist services may require methods that reflect equipment, throughput, technical complexity, operational hours and professional standards. Community and integrated services require attention to population need, travel, regional variation, multidisciplinary working and unmet demand. The framework should also recognise that management and governance arrangements vary across services, including settings where operational line management and discipline-specific clinical or professional governance sit separately. Skill-mix planning must also ensure that assistants and support roles strengthen services without substituting for the regulated professional capacity required for safe care.

In practical terms, the framework should require each HSCP service to be able to answer seven questions. These seven questions do not reproduce the ten principles one by one. Instead, they translate them into a practical service-level checklist. Some principles, particularly leadership, governance, wellbeing and professional connection, cut across more than one question because they shape how staffing risks are identified, discussed, escalated and addressed.

1. What population or service-user need is the service expected to meet? *(Principle 1 & 8)*
2. What workload is required to meet that need safely? *(Principle 2 & 9)*
3. What staffing numbers, skill mix and available working time are required? *(Principle 1, 2, & 3)*
4. What local data and professional judgement have been used? *(Principle 7 & 9)*
5. What risks arise when staffing or workload capacity is insufficient? *(Principle 2, 5, 6, 7, & 8)*
6. How are risks escalated, reviewed and acted upon? *(Principle 4, 7, & 9)*
7. How is the impact on access, quality, continuity, team functioning, and staff wellbeing monitored? *(Principle 5, 6, 7, 8, & 10)*

The policy and industrial relations implications are significant. Safe staffing should be embedded in national and regional workforce planning, service design and workload measurement. Workforce data should be transparent and routinely shared. Clear governance and escalation arrangements are required where workloads or staffing levels become unsafe. Recruitment, retention, planned and unplanned absence cover, direct employment and recurrent agency reliance should be addressed within the same planning process.

The framework should also support individuals, teams, managers and organisations to create a workplace wellbeing culture and climate in which workload, risk, support needs and professional concerns can be discussed openly. Recognised trade unions should participate in the development, implementation and review of staffing frameworks, workload tools and service redesign, with professional input sought where required. Implementation should be led by individual health sector employers in the first instance, supported by a Department of Health steering structure to enable oversight, shared learning and consistency across employers.

On this basis, Fórsa's position is that Ireland should:

1. Develop a national principles-based HSCP safe staffing framework.
2. Base funded workforce establishments on assessed population and service need.
3. Develop and validate profession-specific workload and staffing methods.
4. Establish consistent reporting on staffing, vacancies, workload and unmet need.
5. Create clear governance, supervision, escalation and accountability arrangements.
6. Support individuals, teams, managers and organisations to create a workplace wellbeing culture and climate.
7. Strengthen permanent workforce capacity, recruitment, retention and cover for planned and unplanned absence while reducing recurrent reliance on agency staffing.
8. Require safe skill-mix planning and protect profession-specific roles.
9. Embed trade union engagement at national, regional and local levels.
10. Implement the framework through an early learning pilot, followed by phased rollout, evaluation and regular review, with consideration of a legislative or statutory basis as a second step.

Safe staffing for HSCPs is now a necessary condition for safe care, equitable access, workforce wellbeing and sustainable services. A national, evidence-informed and workload-sensitive framework would provide a more transparent and accountable basis for workforce planning, service design and collective engagement. It would also ensure that Ireland's HSCP workforce has the capacity, communication and connection required to respond to changing health and social care needs.



# Section 2.

# Introduction: The Case for Safe Staffing in HSCPs

Safe staffing is a fundamental requirement for the delivery of safe, effective and sustainable health and social care services. Across Health and Social Care Professional (HSCP) disciplines in Ireland, there is no evidence of a single, system-wide framework that defines staffing levels based on population need, service demand, or complexity of care. Existing guidance is fragmented across professions and service areas, with strategic frameworks outlining roles and contributions, but without an integrated approach to determining safe staffing requirements (HSE, 2021). As a result, staffing decisions are not consistently based on assessed population need or service demand.

At a system level, workforce planning is recognised as complex and evolving, requiring alignment between workforce capacity, service delivery and population need (Department of Health, 2025a). This aligns with the global workforce monitoring priorities, including the United Nations' Sustainable Development Goals (SDG) Indicator 3.c.1, which measures health worker density and distribution by occupation and highlights the importance of comparable workforce data for planning, monitoring, and policy development (World Health Organisation [WHO], 2023). The HSE People Strategy 2025-2027 (Health Service Executive [HSE], 2025a) commits to strategic workforce planning and resourcing, including the use of population-based data, workforce projections and stronger regional planning. It also recognises the need to address current and future skills gaps, turnover, vacancy and difficult-to-fill posts. However, workforce planning continues to operate within finite resources, approved staffing limits and budgetary controls. This creates an ongoing challenge in ensuring that staffing levels reflect assessed need across services and settings.

Health and social care services are operating under sustained pressure in Ireland and elsewhere (Pierce, 2024). Demand continues to increase due to population growth, ageing, and rising levels of chronic illness (Department of Health, 2025a). These pressures are reflected in delays in access to care. National waiting list data indicate that over 640,000 people are awaiting outpatient appointments, alongside significant numbers awaiting inpatient and day case care (HSE, 2026a), while national service planning continues to prioritise improved access, reduced waiting times and care closer to home. (HSE, 2025b). Workforce sustainability is therefore a central concern, with policy emphasising the importance of attracting and retaining skilled staff to maintain service quality (HSE, 2025b).

Within specific service areas, structured approaches to workload management demonstrate that aligning staffing with demand is essential. For example, national social work policy identifies manageable caseloads as critical to staff wellbeing, retention and outcomes for service users (Tusla, 2018). However, such structured approaches are not consistently applied across HSCP disciplines.

Evidence from across health and social care systems shows that staffing levels are closely linked to both workforce outcomes and service quality. Safe staffing requires appropriate capacity, skills, and organisational support to ensure that services can be delivered safely and effectively (McFadden et al., 2024a). Taken together, the evidence points to a system characterised by increasing demand, workforce pressure, and fragmented approaches to staffing. There remains a clear gap in the development of a coherent, evidence-informed approach to safe staffing across HSCPs.

*Safe staffing is not optional. It is a foundational requirement for ensuring that health and social care services are safe, effective and sustainable.*

# Section 3.

## The Irish Context: Why This Matters Now

Ireland's health and social care system is undergoing major reform while facing sustained demand, workforce and access pressures. The HSE Corporate Plan 2025-2027 describes the creation of six Health Regions and 20 Integrated Health Areas as an organisational reset aligned with Sláintecare (Department of Health, 2025b) intended to support a modern, value-based health and social care system where people have equitable access to services based on need. The HSE National Service Plan 2026 similarly frames regional planning as central to improving coordination, access and responsiveness to local population need (HSE, 2025c).

This reform is taking place in a context of rising demand. The HSE Corporate Plan states that Ireland's growing and ageing population is increasing demand, changing expectations for care, and contributing to rising frailty and chronic disease. It also acknowledges that many people continue to face long delays in accessing care, particularly children, older adults, and those requiring disability and mental health services (HSE, 2025c). The HSE National Service Plan 2026 provides further demographic detail, reporting that the population aged 65 and over is projected to increase from 0.78 million from 2022 to more than 1.3 million by 2040, while the number of people with chronic disease could increase from approximately 778,000 in 2016 to 1.08 million by 2030 (HSE, 2026b). These trends increase the volume, complexity, and duration of need across community, acute, disability, older people's and mental health services.

Recent analysis of Irish health services shows that these pressures have been building over time. Pierce's review of health services in 2023 notes that the Irish health system was already grappling with increasing demand linked to population growth and ageing, alongside long waiting lists, health workforce shortages, budget overspend, and recruitment freezes. The article also highlights continuing barriers to access and challenges in workforce training, retention and capacity (Pierce, 2024).

Health and Social Care Professionals (HSCPs) are central to the delivery of the reform agenda. HSCP Deliver, the HSE Strategic Guidance Framework for Health and Social Care Professions 2021-2026 (HSE, 2021), identifies HSCPs as essential to Sláintecare, care closer to home and new models of care. It describes HSCPs as autonomous practitioners working across diagnostic, therapeutic, and social care domains, often providing sustained engagement with service users. The 2019 HSCP Catalogue of the Health and Social Care Professions (HSE, 2019) further demonstrates the breadth of HSCP roles, including audiology, dietetics, occupational therapy, physiotherapy, psychology, radiography, social care work, social work, speech and language therapy and other professions. This breadth matters because HSCP safe staffing cannot be reduced to a single profession, service model or ratio.

The HSCP workforce has grown substantially in recent years. The HSE Health Sector Employment Report for March 2026 records 153,611 WTE staff across the total health service, compared with 126,174 WTE in December 2020. Within this, Health and Social Care Professionals increased from 17,807 WTE in December 2020 to 23,019 WTE in March 2026. At the time of writing there are 7,272 WTE therapy professionals, 5,595 WTE health science and diagnostics staff, 3,430 WTE social care staff, 1,561 WTE pharmacy staff, 1,367 WTE psychologists and 1,648 WTE social workers (HSE, 2026c).

International policy now frames safe staffing as both a strategic and operational issue. WHO Europe defines safe staffing as the number and mix of staff required to deliver safe care in a specified workplace or environment. It distinguishes between strategic safe staffing, which includes governance, legislation, regulation, financing, workforce planning and monitoring, and operational safe staffing, which includes workload assessment, skill mix, shift allocation, deployment, and professional judgement (World Health Organization Regional Office for Europe [WHO Europe], 2026).

Ireland has already developed safe staffing policy in nursing. The Framework for Safe Nurse Staffing and Skill Mix provides an evidence-informed approach to determining nurse and healthcare assistant staffing requirements based on patient need, care setting, and skill mix (Department of Health, 2022). More recently, the Department of Health's Taskforce on Staffing and Skill Mix was established to develop and oversee the pilot testing of evidence-based safe staffing and skill mix models in non-acute settings, including long-term residential care for older people, community care, and step-down and rehabilitation care. The taskforce was also required to set out the assumptions underpinning staffing and skill mix ranges

## The HSE National Service Plan 2026

Population aged 65 years+

2022 → 2040

**0.78m** → **1.3m+**

People with chronic disease

2016 → 2030

**778,000** → **1.08m**

These trends increase the volume, complexity, and duration of need across community, acute, disability, older people's and mental health services.

and make recommendations for implementation, monitoring, investment, education, training and guidance (Department of Health, 2023). WHO Europe's 2026 technical brief also identifies Ireland as using national patient/acuity-based and benchmarking approaches within its safe nurse staffing frameworks (WHO Europe, 2026). However, there is no equivalent system-wide safe staffing framework for HSCPs, despite their central role in delivering community, disability, diagnostic, therapeutic, rehabilitation, mental health, and psychosocial services.

This matters because workforce growth alone does not establish safe staffing. Staffing levels need to be assessed against population need, service demand, workload, skill mix, vacancies, regional variation and the capacity required to deliver timely care (McFadden et al., 2024a). The HSE Corporate Plan commits to strategic resourcing to ensure the appropriate level of health and social care staff and the right balance between generalist and specialist skills. It also states that the HSE will establish and manage a Pay and Numbers Strategy to ensure optimum and affordable staff levels and teams (HSE, 2025c). The HSE People Strategy 2025-2027 similarly commits to strategic workforce planning and resourcing, including population-based data, workforce projections, regional planning, current and future skills gaps, turnover, vacancy and difficult-to-fill posts (HSE, 2025a).

Published HSCP-wide vacancy rates are limited. This absence of readily available vacancy data should be treated as part of the workforce planning problem. The HSE People Strategy 2025-2027 recognises the need to focus retention initiatives on areas with the highest rates of turnover and vacancy, and to reduce difficult-to-fill posts. It also commits to strengthening workforce planning through population-based data, workforce projections and improved reporting (HSE, 2025a).

Recent ESRI modelling provides an important step forward. Using the Hippocrates model, the ESRI projects substantial increases in workforce requirements for selected HSE primary and community care services by 2040, including audiology, dietetics, occupational therapy, physiotherapy, podiatry, speech and language therapy, associated health and social care assistants, public health and community nurses, and healthcare assistants. The report projects average annual growth requirements of between 1.0% and 3.2% for the HSCP groups included, with higher growth for services concentrated in older age cohorts. However, the projections should be interpreted carefully. The ESRI notes that the analysis does not forecast workforce supply, does not assess whether 2022 staffing levels represented appropriate or safe staffing levels, and could not formally incorporate unmet demand or waiting-list pressures into the projections. It also excludes several HSCP-relevant areas from the current analysis, including psychology, specialist disability, specialist mental health, and older people's care. For this reason, the projected figures should be treated as a useful medium-term planning guide but not be treated as safe staffing benchmarks or as an upper estimate of future need (Brick et al., 2026).

This is important for the present paper because it supports the case for more detailed HSCP workforce intelligence while also highlighting the limitations of current data. Future ESRI work is expected to expand projections into additional areas of the community-based healthcare workforce. This points to a continuing data gap for HSCP safe staffing policy, particularly where workforce requirements need to reflect unmet demand, waiting lists, service complexity, regional variation, vacancies, workload, and safe staffing standards (Brick et al., 2026).

Service-specific evidence indicates vacancy pressures in HSCP-heavy areas. In disability services, parliamentary responses have reported vacancy pressures in Children's Disability Network Teams (CDNT), where services rely heavily on therapy, psychology, social work and related HSCP roles (Houses of the Oireachtas, 2025). The HSE National Service Plan 2026 also commits to additional staffing in disability services and to reducing CDNT waiting lists, indicating that workforce capacity remains central to improving access (HSE, 2026b). This evidence should be framed carefully. It does not provide an HSCP-wide vacancy rate, but it does show that vacancy and staffing pressures are affecting services where HSCPs are central to delivery.

Workforce data should also be read alongside evidence from workers. The TASC/Fórsa mixed-methods study of members of Fórsa's Health and Welfare Division received 3,775 survey responses and included 24 focus group participants across HSCP, pharmacy, administrative, clerical and patient/client care roles. The report found that almost half of respondents often or always felt burnt out by work, 68% reported illness due to work-related stress, more than three quarters often thought about leaving their role, and 67% were considering leaving. Participants linked low morale and service strain to inadequate staffing, lack of cover for maternity and sick leave, workload pressure and the Pay and Numbers Strategy (TASC, 2025).

The findings from the TASC/Fórsa report are directly relevant to safe staffing because they connect workforce pressure to service capacity and staff retention. The report recommends staffing levels based on localised, assessed need, routine cover for maternity leave, streamlined recruitment, sustainable workloads and caseloads, and stronger worker voice in decision-making. These recommendations align closely with the case for an HSCP safe staffing framework that is needs-based, workload-sensitive and informed by frontline experience (TASC, 2025).

Agency staffing provides another indicator of workforce pressure and service fragility. In January 2026, the Minister for Health reported that expenditure on agency staff in Department of Health-funded services was €748 million for the eleven months to the end of November 2025. The response stated that the HSE National Service Plan 2026 includes a commitment to reduce agency costs by €80 million through measures such as converting agency workers to permanent HSE employment, improving rostering, increasing core capacity, developing internal staff banks and eliminating off-framework agency use (Houses of the Oireachtas, 2026). A later parliamentary response confirmed that the HSE Agency Control Framework seeks to reduce reliance on agency staffing while balancing direct, overtime and agency staffing, and that the 2026 National Service Plan includes an agency expenditure limit of €720 million (Houses of the Oireachtas, 2026).

These developments show that safe staffing must be understood as planned, permanent and needs-based workforce capacity. It cannot be treated as a reactive response to absence, vacancies, delayed recruitment or unmet demand. The Dáil debate on public health service staffing in October 2024 shows that recruitment controls, vacancies, agency expenditure and safe staffing had become live political and industrial relations issues (Houses of the Oireachtas, 2024a). The motion called for engagement with unions on a safe staffing framework for all departments and grades, while the Government response pointed to workforce growth and described the Pay and Numbers Strategy as a normal mechanism for managing funded staffing. This debate highlights the central issue for this position paper: safe staffing cannot be assessed through aggregate workforce growth alone, but must be considered in relation to assessed need, workload, service demand and the capacity required to deliver timely care.

The link between HSCP staffing and service access is visible in current service plans. The HSE Corporate Plan commits to reducing waiting times for primary care therapies by standardising the management of referrals, waiting lists and discharges. It also commits to improving access to disability services, reducing delays in Assessment of Need, and improving access to child, youth and adult mental health services (HSE, 2025c). The HSE National Service Plan 2026 further commits to removing 60,000 people from primary care therapy waiting lists, reducing waiting times for physiotherapy, occupational therapy and speech and language therapy, and recruiting permanent posts to sustain these improvements. In disability services, it commits to recruiting additional staff across therapy, case coordination and student placement roles, and to reducing Children's Disability Network Team waiting lists by 25% (HSE, 2026b). These commitments show that HSCP staffing is directly connected to access, waiting times and service quality.

The distinction between caseload and workload is especially important in this context. Caseload refers to the number of people, cases or children assigned to a practitioner over a period of time. Workload refers to the full range of activities required to manage that caseload safely and effectively, including direct work, indirect work, administration, meetings, travel, supervision, documentation, consultation, interagency work and professional development. Evidence from children's disability services highlights a clear shift away

from simple caseload counting towards workload approaches, because caseload numbers alone do not capture complexity, indirect work, interdisciplinary practice or the service model being delivered (National Disability Authority [NDA], 2024). This distinction matters for HSCP safe staffing because HSCP roles often involve complex, indirect, relational and interdisciplinary work that is not visible in simple activity counts. The children's disability workload review identifies factors influencing workload, including the complexity of children's needs, family circumstances, service model, vacancies, staff experience and interdisciplinary working (NDA, 2024). This has direct relevance for Fórsa's position. A safe staffing framework for HSCPs must account for workload, complexity and professional context, as well as workforce numbers.

## HSE Your Opinion Counts Staff Survey 2025

25,026 respondents (including 5,190 HSCPs)

**93%**
of all staff agreed that their role makes a difference to patients, service users or colleagues

**61%**
agreed that they had the necessary resources to do their job

**60%**
were satisfied with their workload

This suggests that staff commitment remains high, while workload and resourcing pressures continue to shape the conditions in which care is delivered (HSE, 2025d).

Staff experience evidence reinforces this point. The HSE Your Opinion Counts Staff Survey 2025 included 25,026 respondents, including 5,190 HSCPs. While 93% of all staff agreed that their role makes a difference to patients, service users or colleagues, only 61% agreed that they had the necessary resources to do their job, and only 60% were satisfied with their workload. This suggests that staff commitment remains high, while workload and resourcing pressures continue to shape the conditions in which care is delivered (HSE, 2025d).

The case for HSCP safe staffing also sits with Ireland's wider patient safety and governance agenda. The Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 places patient safety, notification, open disclosure, clinical audit, and learning on a statutory footing. Although it does not create safe staffing duties, it reinforces the expectation that risks to safe care should be visible, documented, escalated, and reviewed (Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023, 2023). For HSCP services, this is important because staffing deficits can contribute to delayed assessment, missed intervention, delayed discharge, reduced safeguarding capacity, incomplete communication and avoidable deterioration. Safe staffing should therefore be understood as part of quality and patient-safety governance, not only as a workforce or industrial relations concern.

Taken together, the Irish context points to a clear policy gap. Ireland has invested in workforce growth, regional reform, and safe nurse staffing, and international evidence now recognises Ireland's use of patient/acuity-based and benchmarking approaches in nurse safe staffing (WHO Europe, 2026). The Department of Health has also used taskforce structures to develop evidence-based staffing and skill mix models in non-acute care settings (Department of Health, 2023). However, there is no equivalent national framework for determining whether HSCP staffing levels, skill mix, and workload capacity are sufficient to deliver safe, timely, and effective care. A coherent HSCP safe staffing framework should therefore be evidence-informed, needs-based, workload-sensitive, and capable of linking population need, service demand, workforce supply, access delays, professional judgement, and service-user outcomes. Without such a framework, HSCP staffing decisions will continue to rely too heavily on historic patterns, available budgets and local workarounds, rather than assessed need.

# Section 4.
# Defining Safe Staffing for HSCPs

Safe staffing for Health and Social Care Professionals should be understood as the presence of sufficient staff, with the right skills, experience and support, to deliver safe, timely, effective and person-centred care in the context in which services are provided. It is therefore concerned with more than headcount. It requires sufficient workforce capacity, appropriate skill mix, manageable workload, protected professional time, safe access to services, staff wellbeing, and the ability to maintain quality and continuity of care.

This definition is consistent with international safe staffing evidence. WHO Europe defines safe staffing as the *"number and mix of staff required to deliver safe care in a specified workplace or environment"* and distinguishes between strategic safe staffing, including governance, workforce planning, financing and monitoring, and *operational* safe staffing, including workload assessment, skill mix, deployment and professional judgement (WHO Europe, 2026, p.3). This distinction is important for HSCPs because national workforce numbers alone do not show whether services have the capacity, skills or time required to meet local need safely.

It is also consistent with recent social work safe staffing research in Northern Ireland. McFadden et al developed a definition, conceptual framework and 10 principles for safer and effective staffing in social work, following regional data collection, focus groups, interviews and steering-group validation (McFadden, 2024a). The subsequent Department of Health NI guidance defines safer and effective staffing in social work as:

> *"Safer and effective staffing in social work requires having enough staff with the right knowledge, experience and skills, workload capacity, and flexibility, to respond to service user needs in an efficient, effective, and timely manner. Safer staffing requires regular supportive, reflective supervision and sufficient time to deliver the highest standards of care. This includes having effective and compassionate line management and a supportive team with adequate skill mix and knowledge to support the wellbeing of all team members, in particular, early career social workers,"* (Department of Health, Northern Ireland, 2026, p.7).

This social work definition is important for the present paper because it shows that safe staffing in an HSCP profession has already been framed as a combination of capacity, skill mix, workload, supervision, leadership, timeliness, quality and wellbeing. The Northern Ireland framework is organised around three linked concepts: *Capacity*, having the appropriate workforce to meet service demands, and individual staff having enough time to complete all aspects of the job within available working time; *Communication*, meaning open and transparent workload allocation grounded in equity, fairness and trust, plus communication from regulators and commissioners to the workforce; and *Connection*, meaning positive relationships with colleagues, managers and the wider organisation and professional partners. These concepts are highly transferable across HSCP services (Department of Health, Northern Ireland, 2026; McFadden et al., 2024a).

For HSCPs, safe staffing must be needs-based and workload-sensitive. Caseload or activity counts are insufficient because they do not capture the complexity, duration or intensity of work. HSCP workload often includes direct intervention, assessment, documentation, multidisciplinary working, travel, family and carer communication, supervision, safeguarding, discharge planning, student education, service development and governance. WHO's Workload Indicators of Staffing Need method is useful here because it calculates staffing requirements from actual workload, available working time, activity standards and allowance factors for support and additional activities (World Health Organization [WHO], 2023).

Safe staffing must also account for skill mix and professional competence. The UK's Society and College of Radiographers' safe staffing guidance rejects a single formula or patient-to-staff ratio and instead argues that staffing should reflect service complexity, patient pathways, equipment, operational hours, professional obligations, CPD, governance and local context (Society and College of Radiographers [SCoR], 2024). Similarly, the Pharmaceutical Society of Ireland's draft safe staffing guidance defines safe staffing in terms of sufficient, competent, empowered and supported staff, with attention to patient safety, legislation, continuous improvement and operational demand (Pharmaceutical Society of Ireland [PSI], 2026).

Safe staffing should therefore include the capacity to provide care without relying on unpaid overtime, missed breaks, reduced supervision, delayed documentation, cancelled appointments or routine workarounds. Evidence from adult social care guidance in the UK shows that inadequate staffing is reflected in high turnover, stress-related sickness, over-reliance on temporary staff, limited supervision, poor continuity, and staff having time only to complete tasks rather than provide person-centred care (Skills for Care, 2024). These are directly relevant to HSCP services where relational, therapeutic and preventative work is central to quality and safety.

The proposed HSCP definition builds on McFadden et al's (2024a) social work safe staffing definition developed in Northern Ireland but broadens it for a multidisciplinary workforce. The social work definition demonstrates how safe staffing in an HSCP profession can be framed around capacity, workload, skill mix, supervision, support, timeliness and wellbeing. The HSCP definition retains these core principles while allowing for profession-specific variation across diagnostic, therapeutic, psychosocial and social care services. A working definition for this position paper is therefore:

> *Safe staffing for HSCPs means having sufficient numbers of appropriately qualified, skilled and supported professionals, with the right skill mix and manageable workload, to deliver safe, timely, equitable and effective care in response to assessed population and service-user need. It requires staffing decisions to reflect local context, workload complexity, professional judgement, service quality, access, continuity, and staff wellbeing.*

This definition deliberately avoids a single universal ratio. The evidence reviewed across nursing, social care, mental health, radiography, pharmacy, social work and WHO workforce planning shows that safe staffing requires structured methods, but also professional judgement and local adaptation (Health Education West Midlands & NHS England, 2015; National Quality Board [NQB], 2016). For HSCPs, this means any national framework should establish clear principles, methods and accountability, while allowing profession-specific and setting-specific approaches to determine safe staffing in practice.

# Section 5.

# Workload, Caseload and Capacity: Why Numbers Alone Are Insufficient

Safe staffing cannot be determined through workforce numbers alone. Across health and social care systems, staffing levels are often discussed in terms of funded posts, whole-time equivalent staff, vacancy rates or caseload size. These measures are important, but they provide only a partial picture of staffing adequacy. They do not show whether professionals have sufficient time, capacity, skill mix and organisational support to deliver safe, timely and effective care. This distinction is especially important for Health and Social Care Professionals. Many HSCP roles involve complex, indirect, interdisciplinary and preventative work that is not visible within simple activity counts or workforce totals. Safe staffing for HSCPs therefore requires a broader understanding of workload, capacity and professional context.

## 5.1 Caseloads are useful, but limited

Caseload generally refers to the number of people, referrals, cases or service users allocated to an individual practitioner or team over a given period. Caseload measures are widely used because they provide a visible and comparatively simple way to monitor demand and allocation. However, caseload numbers alone are an insufficient basis for determining safe staffing. Two practitioners may hold the same numerical caseload while experiencing very different workload pressures. Complexity, intensity of intervention, safeguarding concerns, travel requirements, family circumstances, crisis work, case maturity, waiting list management and administrative demands can vary substantially between cases and services.

Research in Practice and the Department for Education in the UK distinguish clearly between caseload and workload in children and family social work. The reports define caseload as the number of children and families assigned to a social worker, while workload refers to the level of activity required by changing family circumstances and wider responsibilities beyond allocated cases. It also cautions that average caseload data can be misleading because it does not capture complexity, newly qualified workers with capped caseloads, practitioners holding few cases, or the wider work required to support children and families safely (Department for Education, 2025: Research in Practice, 2025).

For HSCPs, this limitation is highly significant. Many HSCP roles involve sustained therapeutic relationships, multidisciplinary coordination, family engagement, risk management, documentation, discharge planning, safeguarding, and preventative intervention. These activities may not appear in simple caseload statistics, but they are central to safe and effective care.

## 5.2 Workload provides a more accurate understanding of staffing pressure

Workload is a broader and more meaningful concept for safe staffing. It refers to the full range of activities and responsibilities required to deliver services safely and effectively, including direct and indirect work. Across HSCP services, workload commonly includes assessment and intervention, documentation, multidisciplinary meetings, communication with families and carers, safeguarding, discharge planning, supervision, student support, travel, administration, governance, service development, quality improvement, continuing professional development and mandatory training.

The WHO Workload Indicators of Staffing Need (WISN) methodology is useful because it calculates staffing requirements from workload rather than workforce numbers alone. WISN estimates staffing need using available working time, workload components, activity standards and allowance factors for support and additional activities. This is important because it provides a way to include work that is often omitted from staffing discussions, such as meetings, administration, supervision, teaching, reporting and other indirect tasks (WHO, 2023).

This distinction between direct and indirect work is particularly relevant to HSCPs because much professional activity occurs outside face-to-face contact. A speech and language therapist, physiotherapist, occupational therapist, psychologist, social worker or dietitian may spend substantial time on case formulation, family liaison, multidisciplinary planning, documentation, preparation, safeguarding discussions or professional consultation. These activities are essential to safe practice but are often invisible in simplistic staffing metrics.

The NHS Mental Health Staffing Framework makes a similar point in relation to therapeutic and relational work. It recognises that mental health staffing must account for therapeutic engagement, behavioural risk, supervision requirements, unplanned interventions and the time needed simply to engage with and talk to service users. This is highly transferable across HSCP services, particularly where communication, rehabilitation, psychosocial support and relationship-based practice are central to care (Health Education West Midlands & NHS England, 2015).

## 5.3 Capacity is not the same as funded establishment

Safe staffing also requires a distinction between funded establishment and actual workforce capacity. A service may appear adequately staffed on paper while lacking sufficient operational capacity in practice. Vacancies, sickness absence, maternity leave, recruitment delays, turnover, agency reliance, inexperienced staff, supervision demands, and induction requirements can all reduce the professional time available for direct service delivery.

This issue is reflected in Welsh statutory reporting on implementation of the Nurse Staffing Levels (Wales) Act 2016. The Welsh Government distinguishes between the required establishment and the planned roster, while also recognising that whether staffing is "appropriate" depends on more than whether a planned roster has been numerically met. A shift may meet the planned roster but still be inappropriate if acuity, complexity, or staff experience create additional pressures. Conversely, a shift may fall below planned numbers but still be judged appropriate in some circumstances (Welsh Government, 2025).

The Northern Ireland Social Work Safer Staffing Framework similarly defines capacity as having sufficient time to complete all aspects of the job within available working time. This is important for HSCPs because workforce capacity is shaped by more than the number of funded posts. It is also shaped by available time, skill mix, supervision needs, staff experience, leave, travel, administrative demands, and service change (McFadden et al., 2024a; Department of Health, Northern Ireland, 2026). Capacity must therefore include consideration of vacancies and turnover, annual leave, study leave, sickness absence, supervision and support needs, onboarding and preceptorship, skill mix, staff experience, travel time, geographical coverage, digital demands, administration, and service redesign. Without this broader understanding of capacity, safe staffing frameworks risk underestimating the resources required for safe practice.

## 5.4 Invisible and indirect HSCP work

One of the strongest arguments for a workload-sensitive approach to safe staffing is that much HSCP work is invisible within traditional staffing metrics. The UK's Society and College of Radiographers' safe staffing guidance explicitly rejects a single staffing formula or universal patient-to-staff ratio for radiographers. It argues that staffing should reflect local service context, including skill mix across the patient pathway, equipment complexity, patient condition, procedure type, students and trainees, operational hours, individual and collective capability, and the wider team needed to support safe care. It also states that staffing must include work such as administration, audit, quality assurance, governance, equipment responsibilities, regulatory compliance, safeguarding, CPD, student education, service development and research (SCoR, 2024).

Similar principles appear in the Pharmaceutical Society of Ireland's draft safe staffing guidance. Although pharmacy-specific, it defines safe staffing in terms of sufficient, competent, empowered, and supported staff who can maintain patient safety, comply with legislation, support continuous improvement and respond to the operational demands of the service (PSI, 2026). This is highly relevant across HSCP disciplines. Much HSCP work occurs outside visible treatment or appointment activity. Examples include multidisciplinary consultation, report writing, documentation, discharge coordination, safeguarding meetings, family communication, travel between sites, waiting-list management, student supervision, governance, audit, service planning, redesign and emotional or therapeutic labour.

Preventative and relational work is especially vulnerable to being overlooked. In many HSCP services, practitioners are expected to support early intervention, rehabilitation, education, prevention, and continuity of care. These activities are often difficult to quantify within simple productivity or throughput models. The UK's Skills for Care guide makes a similar point in adult social care. It warns that safe staffing is about more than numbers and that staffing must allow time for relationships, communication, handover, supervision, documentation, continuity, and person-centred care. It also highlights the need for contingency planning, capacity planning, safe rotas, and regular review of staffing levels in response to changing need (Skills for Care, 2024).

This issue is particularly important in integrated and community-based models of care. As services increasingly shift towards prevention, rehabilitation, and care closer to home, HSCPs are expected to work across organisational boundaries, coordinate care pathways and support increasingly complex service-user needs. These activities are time-intensive and cannot be captured adequately through simple caseload metrics.

## 5.5 Workload, wellbeing and service quality

Workload pressures affect both staff wellbeing and service quality. When staffing is insufficient, services may rely on unpaid overtime, missed breaks, compressed supervision, delayed documentation, cancelled appointments, or informal workarounds. These responses may keep services functioning in the short term, but they are not a sustainable basis for safe care. The Skills for Care guide warns that staff shortages can place services under extreme pressure, forcing staff to choose what care can or cannot be delivered. It also links routine working through breaks, poor work-life balance and repeated extra shifts with mental ill-health and reduced motivation (Skills for Care, 2024). This is relevant to HSCP services because professional practice often depends on continuity, communication, and therapeutic engagement. Excessive workload can reduce time available for direct intervention, increase delays, limit preventative work, weaken documentation, and undermine staff wellbeing (McFadden et al., 2015).

Safe staffing must therefore be understood as a quality and sustainability issue, not simply a workforce accounting exercise. It requires attention to how work is distributed, how demand is changing, whether staff have time to practise safely, and whether services have the right mix of professional skills and support to meet local need.

## 5.6 Position statement

Taken together, the evidence demonstrates that safe staffing for HSCPs cannot be determined through post numbers, workforce totals, or caseload size alone. Staffing adequacy depends on workload complexity, available professional time, skill mix, indirect work, supervision requirements, organisational context and service-user need. A safe staffing framework for HSCPs should therefore assess workload as well as caseload; account for indirect, relational, and preventative work; recognise differences in service context and professional roles; include allowance for supervision, governance, CPD and administration; consider vacancies, turnover and available working time; incorporate professional judgement alongside staffing tools; and link staffing decisions to service quality, access, continuity, and staff wellbeing. Without this broader approach, staffing models risk underestimating the true capacity required to deliver safe, timely and effective care across HSCP services.

# Section 6.

# Evidence and Methodologies for Safe Staffing: What Can Be Learned and What Must Be Adapted for HSCPs



The evidence base for safe staffing is uneven. It is most developed in nursing, where staffing frameworks, legislative duties, workforce planning tools, and outcome measures have been developed and evaluated over time. By contrast, evidence specific to HSCPs is more fragmented and often profession-specific, with examples emerging from social work, pharmacy, dietetics, occupational therapy, psychology, radiography, and wider allied health workforce planning. The central lesson from the evidence is that safe staffing cannot be reduced to a single number, ratio, or caseload limit. Existing approaches provide important learning, but they require adaptation for the diversity of HSCP roles, service settings, and workload demands.

The 2024 scoping review on safe staffing and workload management in social work provides an important foundation for this position paper. It found no clear international examples of social work-specific safe staffing definitions, legislation, or policy outside children's services, and concluded that social work safe staffing remained less developed than workload and caseload management. The review also identified the need for greater conceptual clarity, agreed outcomes, and evaluation of safe staffing approaches (McFadden et al., 2024). For HSCPs, the same challenge applies at a wider scale: the issue is whether current staffing tools are sufficiently sensitive to workload, professional judgement, service-user need, skill mix and local context.

## 6.1. Learning from nursing safe staffing

Nursing provides the strongest body of safe staffing evidence and the clearest policy precedent. In Ireland, the Framework for Safe Nurse Staffing and Skill Mix has been piloted, implemented, and evaluated across acute ward, emergency care, and older persons' residential settings. These evaluations are important because they show that safe staffing can be treated as an applied workforce planning process rather than an abstract aspiration. They use staffing measures such as nursing hours per patient day or nursing hours per patient presentation, alongside indicators such as skill mix, agency use, absenteeism, care left undone, delayed care, staff outcomes, patient outcomes and economic analysis (Drennan et al., 2018; Drennan et al., 2019; Drennan et al., 2020; Drennan et al., 2022).

The Irish nursing evidence is particularly useful because it demonstrates that safe staffing frameworks can be piloted, refined, and adapted across different settings. However, it also shows why simple transfer to HSCPs would be inappropriate. Nursing frameworks are often built around ward-based care, patient dependency, rostered shifts, and nursing-sensitive outcome indicators. Many HSCP services operate differently. They may be community-based, referral-led, appointment-based, interdisciplinary, consultative, diagnostic, therapeutic or statutory. Some HSCPs hold caseloads; others work through clinics, teams, waiting lists, equipment-dependent services, school or home visits, or specialist pathways. The transferable lesson is therefore methodological rather than numerical: HSCP safe staffing should be evidence-informed, piloted, evaluated, and adapted to service context.

Wales provides a further statutory comparator. The Nurse Staffing Levels (Wales) Act 2016 places duties on health bodies to have regard to the importance of providing sufficient nurses to allow time to care sensitively, and links staffing to workforce planning, recruitment, retention, education, and training (Nurse Staffing Levels (Wales) Act 2016, 2016). The 2025 statutory summary of nurse staffing level reports shows how this duty is operationalised through required establishments, planned rosters, reporting on whether staffing levels were maintained, assessment of impact on care and actions taken in response. It also shows the limits of simple compliance measures, because a roster may be filled numerically but still be inappropriate if acuity, skill mix, or staff experience do not match patient need (Welsh Government, 2025).

Scotland provides a broader health and care comparator. The Health and Care (Staffing) (Scotland) Act 2019 is not based on fixed ratios alone. It sets out guiding principles for staffing, including safe and high-quality services, improved outcomes, dignity and rights, staff and service-user views, staff wellbeing, openness about staffing decisions, efficient staff allocation, and multidisciplinary care (Health and Care

(Staffing) (Scotland) Act 2019, 2019). Early evidence from Scotland suggests both the promise and challenge of a principles-based legislative approach, with implementation depending on employer readiness, staff awareness, governance, and organisational capacity (Lake et al., 2025).

The Scottish Common Staffing Method (CSM) adds useful detail on how a principles-based legislative approach can be operationalised. The CSM is designed to support clinical leaders to understand and evidence staffing levels and quality of care, provide a consistent approach to staffing decisions, triangulate available data relevant to service delivery, and evidence governance processes for managing staffing risk. It includes preparation, data gathering, data analysis, quality assurance, reporting and decision-making, and requires attention to local context, including geography, service model, skill mix, waiting lists, delayed discharge, staff turnover, leadership responsibilities, multidisciplinary working and unmet need. Importantly, Scotland's statutory guidance makes clear that the Act does not prescribe fixed numbers, minimum ratios or predetermined skill mix, but seeks to support local decision-making, flexibility, professional judgement and service redesign across multidisciplinary settings (Health and Care (Staffing) (Scotland) Act 2019, 2019; Healthcare Improvement Scotland [HIS], 2024).

Together, these nursing and legislative examples show that safe staffing requires more than agreed numbers. It requires governance, workforce planning, professional judgement, monitoring, escalation, review, and accountability.

## 6.2. Learning from social work

Social work is the closest non-nursing comparator for HSCP safe staffing because it shares many of the features that make simple ratios difficult: relational work, statutory duties, complex risk, indirect activity, professional judgement, administrative demands, and workforce wellbeing concerns. The Northern Ireland Social Work Safe Staffing Framework is therefore highly relevant.

McFadden et al's Safer and Effective Staffing Research and Policy Development Older People's and Children's Social Work in Northern Ireland; Report 1 (2024), developed a definition, conceptual framework, and principles for safer and effective staffing in social work, grounded in regional evidence from team-level data, focus groups, interviews and steering group validation. It framed safe staffing around the 3Cs: Capacity, Communication and Connection. Capacity refers to having time to complete all aspects of the job within available working time; Communication refers to transparent workload allocation, fairness and trust; and Connection refers to supportive relationships with colleagues, managers and organisations (McFadden et al., 2024a). McFadden et al's Report 2 Social Work Caseload Capacity Analysis then moved from conceptual framing to capacity analysis, using an annual hours approach, professional task lists, complexity weighting, and case-type modelling to estimate caseload ranges across older people's, children's and mental health social work (McFadden et al., 2025). The subsequent Department of Health Northern Ireland guidance translated this work into employer-facing recommendations on workforce planning, workloads, caseloads, retention, training, development, supervision, and governance (DoH-NI, 2026). This evidence is directly relevant to HSCPs because it demonstrates how a non-nursing profession can move from a broad safe staffing concept to a practical workload and caseload methodology. It also shows that safe staffing must account for more than allocated cases. Unallocated work, duty intake, complexity, supervision, travel, records, statutory processes, and non-casework activity all affect capacity.

Other social work sources reinforce this point. The Research in Practice report on reducing unnecessary social worker workload distinguishes workload from caseload and highlights the importance of workload management, data limitations, and system-level responses (Research in Practice, 2025). The UK's Department for Education's guidance on caseload and workload approaches similarly notes that caseload approaches are simple and measurable, but do not capture complexity, sudden unpredictable work, or quality of practice, while workload approaches better reflect time, effort, resources and practitioner experience Department for Education, 2025). Tusla's National Policy and Toolkit for Social Work Caseload Management provide an Irish example of structured caseload management, escalation, and governance where caseloads become unmanageable (Tusla, 2018). Miller and Barrie's (2022) Setting the Bar for Social Work in Scotland report also shows the value and limits of indicative caseloads, recognising that manageability is shaped by complexity, geography, poverty, administration, support services, and staffing context (Miller and Barrie, 2022).

The transferable lesson is clear: caseload limits can create visibility and trigger escalation, but they are insufficient unless linked to workload, complexity, professional judgement, supervision, and capacity.

## 6.3. Learning from HSCP and profession-specific evidence

HSCPs are not a single profession, and a safe staffing framework must not treat them as though they are. The workforce includes social workers, social care workers, psychologists, physiotherapists, occupational therapists, speech and language therapists, dietitians, pharmacists, therapy assistants, and support roles, and other health science or diagnostic roles depending on the service context. Each profession has different workload drivers, professional standards, regulatory responsibilities, intervention models, and service settings.

Pharmacy provides a useful Irish example of a profession-specific safe staffing approach. The Pharmaceutical Society of Ireland's draft safe staffing guidance frames safe staffing as foundational to patient safety, service quality, and regulatory compliance. It emphasises adequate staff mix, appropriate rest periods, governance responsibility, workforce planning, and the need to review staffing as pharmacy services grow in complexity (PSI, 2026). This is relevant to HSCPs because it shows that safe staffing can be framed through professional accountability, legal duties, operational demand, and risk management, rather than through ratios alone.

Radiography evidence should be used only as a comparator, as radiographers are not within the Fórsa-represented HSCP group for this position paper. It remains useful because radiography safe staffing guidance demonstrates how profession-specific models must account for equipment, modality, operational hours, CPD, governance, indirect work, legal requirements, and professional judgement. The value of radiography evidence is therefore methodological: it shows why safe staffing frameworks must be adapted to the work of each profession rather than imposed uniformly (SCoR, 2024).

The wider international evidence also supports this direction. WHO's Workload Indicators of Staffing Need method provides a recognised workload-based approach to calculating staffing requirements from available working time, workload components, activity standards, support activities, and additional activities (WHO, 2023). WHO Europe's 2026 technical brief distinguishes between strategic safe staffing, including governance, regulation, financing, workforce planning and monitoring, and operational safe staffing, including workload assessment, skill mix, deployment and professional judgement. It also identifies a range of methods, including benchmarking, volume-based approaches, multifactorial indicators, timed-task approaches, acuity-based approaches, budget-based staffing, and team-based approaches (WHO Europe, 2026). These methods offer useful building blocks for HSCP safe staffing, but none is sufficient alone.

## 6.4. Methodological options and their limitations

The evidence points to several methodological options (see Table 1).

### Staffing ratios

Staffing ratios are clear, visible, and potentially enforceable. They can create minimum safeguards and support accountability. However, ratios are often too crude for HSCP services unless they are carefully adapted to context. A single ratio cannot capture the difference between a community dietetic service, an occupational therapy rehabilitation team, a psychology service, a child disability team, a social work safeguarding team, or a pharmacy service.

### Caseload models

Caseload models are useful because they make work visible and can support allocation, supervision, and escalation. They are especially relevant where practitioners hold ongoing cases. However, caseload models can underestimate workload where cases vary in complexity, intensity, risk, maturity, or indirect demands. They are less useful for services organised around clinics, diagnostics, consultation, waiting lists, or episodic intervention.

### Workload and time-use models

Workload and time-use models are more appropriate where the aim is to understand the full range of work required. WHO's Workload Indicators of Staffing Need is particularly useful here because it begins with available working time and then builds staffing requirements from workload components and activity standards. The limitation is that workload models require good data, agreed activity standards, professional engagement, and regular review (WHO, 2023).

### Demand-capacity models

Demand-capacity models are useful for services with waiting lists, access targets, and flow pressures. They can help link staffing to referrals, waiting times, throughput, missed care, and unmet need. However, they can become too productivity-focused if they do not include complexity, quality, prevention, relational work, and professional standards.

### Acuity and complexity models

Acuity and complexity models help distinguish between low, moderate, and high-intensity work. They are useful across social work, disability, mental health, rehabilitation, and older persons' services. Their limitation is that they require valid criteria, consistent use, and professional judgement.

### Skill-mix models

Skill-mix models are essential because HSCP services depend on the balance between registered professionals, advanced practitioners, assistants, support workers, administrative staff, students, and trainees. However, skill-mix models must not be used to substitute regulated professional capacity with lower-cost roles without evidence, governance, and supervision. Support roles can strengthen services, but they do not remove the need for sufficient registered professional capacity.

### Professional judgement

Professional judgement is essential across all methods. Welsh, Scottish, WHO and social work evidence all point to the need for professional judgement alongside tools and data (Health and Care (Staffing) (Scotland) Act 2019, 2019; Welsh Government, 2025; WHO Europe, 2026). However, professional judgement should be structured, documented, and open to review. It should not be left as informal local discretion without governance.

### Local service data

Local service data are also necessary. Safe staffing must reflect population need, referral demand, waiting lists, service model, geography, travel, staff experience, vacancy levels, absence, turnover, and outcomes. The limitation is that HSCP data are often incomplete, inconsistent, or not routinely linked to workload and outcomes.

## Table 1: HSCP or Comparator Services Methods for Staffing Requirements

| Method | Services where it may be useful | Why it fits | Key caution |
|---|---|---|---|
| Ratios | Ward-based nursing, long-term residential care, some highly standardised inpatient or residential settings | Ratios are clearer where activity is continuous, staffing is rostered, and service users are physically present in the setting. Irish nursing evaluations and Welsh legislation show how staffing levels can be linked to establishments, rosters and care outcomes. (Drennan et al 2018,19, 20 &22; Welsh Government, 2025) | Too crude for many HSCP services because they do not capture complexity, indirect work, travel, waiting lists or professional judgement |
| Caseload models | Social work, child protection, older people's social work, mental health social work, CDNT case coordination, some psychology or therapy case-holding roles | Caseload models help where practitioners hold ongoing responsibility for a defined group of service users. Tusla and the NI social work reports use caseload/ capacity approaches to make workload visible and support escalation. (Tusla, 2018; McFadden et al., 2025) | Caseload numbers alone can miss complexity, risk, case maturity, family circumstances, indirect work and duty work |
| Workload tools | Dietetics, occupational therapy, physiotherapy, speech and language therapy, social work, pharmacy, community services, disability services | Workload tools are useful where staffing need depends on the full range of work, not only contacts or cases. WHO WISN calculates staffing from available working time, workload components, activity standards and support activities. (WHO, 2023) | Requires good activity data, agreed standards, staff involvement and regular updating |
| Demand-capacity models | Primary care therapies, CDNTs, speech and language therapy, physiotherapy, occupational therapy, audiology, dietetics, podiatry, outpatient/community services with waiting lists | These models suit services where referrals, waiting lists, access targets and throughput are central. The ESRI modelling shows projected requirements for selected primary and community services and highlights waiting-list pressures, although these could not be formally incorporated into the projections. (Brick et al., 2026) | Can become too productivity-focused unless it includes complexity, quality, unmet need and safe staffing standard |
| Acuity/ complexity models | Older people's services, disability services, mental health, rehabilitation, social work, CDNTs, high-complexity therapy services | These models help where service-user need varies substantially. Irish nursing work in older persons' residential settings uses dependency/resource groups, while social work models account for complexity and case type. (Drennan et al 2022; McFadden et al., 2025) | Needs clear criteria, consistent scoring and professional judgement |
| Skill-mix models | Pharmacy, nursing, community care teams, therapy teams, CDNTs, rehabilitation teams, services using assistants/support workers | Skill mix is essential where safe care depends on the balance between registered professionals, assistants, advanced roles, administrative support and trainees. PSI guidance emphasises staff mix, governance, competence and rest periods in pharmacy; ESRI modelling also includes grade-mix and skill-mix scenarios. (PSI, 2026; Brick et al., 2026) | Risk of unsafe substitution if support roles replace regulated professional capacity without supervision and governance |

| Method | Services where it may be useful | Why it fits | Key caution |
|---|---|---|---|
| Professional judgement | All HSCP services, especially complex, multidisciplinary, community, disability, mental health and safeguarding services | Professional judgement is needed to interpret numbers, workload, risk, skill mix, service-user need and local context. WHO Europe, Wales, Scotland and NI social work evidence all support professional judgement alongside tools and data. (Welsh Government, 2025; WHO Europe, 2026; DoH NI, 2026) | Should be structured, documented and reviewable, not informal discretion |
| Local service data | All HSCP services, particularly regional services, primary/ community care, waiting-list services, CDNTs, therapy services, pharmacy, social work and disability services | Local data are needed to capture referral demand, waiting lists, geography, travel, vacancies, turnover, skill mix, absence, agency use and outcomes. The ESRI report shows the value of regional modelling but also the limits created by incomplete data. (Brick et al., 2026) | HSCP data are often incomplete, inconsistent or not linked to outcome |

## 6.5. Implications for HSCP safe staffing

The evidence points towards a blended approach. HSCP safe staffing should not begin with a universal ratio. It should begin with agreed principles, followed by profession-specific and setting-specific methods. A national framework should set out the required components of safe staffing, while allowing different HSCP professions and services to use appropriate tools. This means that a safe staffing framework for HSCPs should include:

- Assessed population and service-user need
- Workload as well as caseload
- Available working time
- Direct, indirect and non-clinical work
- Skill mix and professional competence
- Supervision, CPD, governance, and student education
- Local service data and waiting-list pressures
- Professional judgement
- Escalation when staffing becomes unsafe
- Monitoring of outcomes, access, continuity, staff wellbeing, and service quality

The main conclusion is therefore that no single method is sufficient. Ratios may have a role as minimum safeguards in some settings. Caseload limits may support visibility and escalation in others. Workload tools may provide greater accuracy, while acuity models, demand-capacity analysis, and professional judgement help interpret local need. For HSCPs, the safest approach is a principles-led national framework supported by workload evidence, professional judgement, and local service data. Such a framework would allow Ireland to build on existing safe staffing developments in nursing, learn from social work in Northern Ireland, draw on international workload methodologies, and adapt profession-specific evidence across HSCP services. It would also avoid the main risk identified across the literature: importing models developed for one profession or setting into another without adequate adaptation.

# Section 7.

# The Fórsa Position: A Principles-Based Framework for Safe Staffing

Fórsa's position is that Ireland needs a coherent, system-wide safe staffing framework for Health and Social Care Professionals. This framework should be principles-based, evidence-informed, and workload-sensitive. It should recognise the diversity of HSCP roles while establishing a common basis for determining whether staffing levels, skill mix, and workload capacity are sufficient to deliver safe, timely, effective and equitable care.

The evidence reviewed in this paper shows that no single method is sufficient for HSCP safe staffing. Ratios, caseload limits, workload tools, demand-capacity models, acuity measures, and professional judgement all have value, but none can provide a complete answer on their own. The appropriate approach is therefore a national principles-based framework that can be adapted across professions, services and local contexts. This does not mean that staffing should be left to informal judgement. It means that agreed measurement tools should be developed and validated for different HSCP professions and settings, rather than imposing one universal ratio across all services.

## 7.1. Principles-based safe staffing comparators

Fórsa's proposed HSCP framework is consistent with a wider body of principles-based safe staffing guidance. Across the literature reviewed, safe staffing is rarely presented as a single numerical exercise. It is usually framed as a structured process that combines workforce capacity, skill mix, professional judgement, local context, governance, escalation and review.

The UK's National Quality Board provides a useful comparator because its safe staffing framework was explicitly extended from nursing and midwifery to the wider multiprofessional workforce across different care settings. Its approach is organised around three expectations: the right staff, the right skills, and the right place and time. It also supports a triangulated approach to staffing decisions, drawing on evidence-based tools, professional judgement and comparison with peers, while cautioning against judging staffing adequacy solely through numbers or ratios (NQB, 2016). This is directly relevant to HSCPs because it supports a common framework that remains sensitive to different professions, settings and patterns of work.

Scotland's Common Staffing Method provides a further comparator because it shows how a principles-based legislative approach can be translated into a practical staffing process. The method is designed to support clinical leaders to evidence staffing levels and quality of care, ensure consistency in staffing decisions, triangulate available service data, and evidence governance around staffing risk. It includes preparation, data gathering, data analysis, quality assurance, reporting and decision-making, and can be used to support staffing establishment review, roster management, real-time staffing assessment, risk management, service redesign and skill-mix review. Importantly, the Scottish statutory guidance states that the Act does not prescribe fixed staffing numbers, minimum ratios or fixed skill mix, but supports local decision-making, flexibility and service redesign across multidisciplinary and multi-agency settings (Scottish Government, 2023; HIS, 2024).

NICE guidance on safe staffing in adult inpatient nursing also supports the need for professional judgement and local adaptation. Although it is nursing-specific, the guidance identifies organisational and managerial factors needed to support safe staffing and indicators for judging whether safe care is being delivered. It also states that safe staffing guidance should not override the need to use professional judgement in local circumstances (National Institute for Health and Care Excellence [NICE], 2014). This reinforces the argument that an HSCP framework should guide staffing decisions without reducing them to a rigid formula.

Adult social care guidance provides a further comparator. The UK's Skills for Care defines safe staffing as having enough staff with the right values and skills to deliver high-quality care and support. Its guidance links safe staffing to recruitment, competence, continuity, contingency planning and the ability to respond to staff sickness, turnover and other day-to-day disruptions (Skills for Care, 2024). For HSCP services, this is useful because many roles depend on continuity, relational work, safe handover, supervision, and flexibility across community and residential settings.

Irish pharmacy guidance is particularly relevant because it shows principles-based safe staffing emerging in an Irish professional regulatory context. The Pharmaceutical Society of Ireland's draft guidance frames safe staffing as foundational to patient safety, service quality and regulatory compliance. It emphasises adequate staff mix, appropriate rest breaks, clear roles and responsibilities, internal communication, regular staffing review and the ability of pharmacists to meet professional and legal obligations, including exercising professional judgement in the interests of patient safety (PSI, 2026). This supports the case for a framework that links staffing levels to governance, professional responsibility and safe service delivery.

Radiography guidance demonstrates why profession-specific safe staffing models are needed. The Society and College of Radiographers' guidance sets out principles of safe staffing for radiography leaders and includes consideration of legal requirements, operational matters, leadership, skill mix, workforce planning, equipment, CPD, education, service development and professional obligations (SCoR, 2024). This supports the argument that HSCP safe staffing must allow professional and service-specific adaptation within a common framework.

Mental health staffing guidance also supports a flexible and assurance-based model. The NHS Mental Health Staffing Framework was designed to help senior mental health professionals ensure the right people with the right skills are in the right inpatient mental health settings. It is explicitly described as support for workforce analysis and organisational assurance rather than a rigid or prescriptive model (Health Education West Midlands & NHS England, 2015). This is relevant to HSCPs because many services involve therapeutic engagement, risk, multidisciplinary working and local service complexity.

International workload guidance provides further support for this approach. WHO's WISN method calculates staffing requirements using available working time, workload components, activity standards, support activities and additional activities (WHO, 2023). This is useful for HSCPs because it demonstrates how staffing need can be linked to the actual work required, rather than to posts or headcount alone. A broader international comparator is provided by TruMerit's Safe Staffing Through New Models of Care framework (2026). It presents safe staffing as a dynamic system in which workforce inputs, service delivery and outcomes inform one another through continuous learning and improvement. The framework emphasises interprofessional teams, full-scope practice, delegation, supportive work environments, digital readiness, workforce capacity, regulatory context, and equitable access (TruMerit, 2026). This is useful because it reinforces the need for adaptable staffing frameworks that can respond to different service models and local conditions.

Taken together, these comparators support the case for a Fórsa HSCP safe staffing framework that is principles-based, workload-sensitive and adaptable across professions and settings. The key lesson is that safe staffing requires clear principles, but also practical mechanisms for workload assessment, skill-mix review, professional judgement, governance, escalation and outcome monitoring. Fórsa's proposed framework builds on this wider evidence while adapting it to the specific realities of HSCP services in Ireland.

## 7.2. The 3Cs Framework: Capacity, Communication and Connection

The proposed HSCP safe staffing framework builds on the 3Cs framework developed through the Northern Ireland social work safe staffing research: Capacity, Communication and Connection. McFadden et al's Report 1 identified these as the three inter-related concepts underpinning safer and effective staffing in social work, and the Department of Health Northern Ireland guidance has since used them to structure safer staffing policy for social work services (McFadden et al., 2024a; DOH-NI, 2026).

For HSCPs, the 3Cs provide a practical and transferable framework.

### Capacity

Capacity means having sufficient staffing resources, available working time, appropriate skill mix, and organisational support to meet service-user need safely. In the social work framework, capacity means time to complete all aspects of the job within the working time available (McFadden et al., 2024a). For HSCPs, this includes direct care, indirect care, documentation, multidisciplinary working, travel, supervision, CPD, governance, waiting-list management, and service development.

### Communication

Communication means transparent, fair, and multi-directional communication about workload, risk, prioritisation, and staffing pressures. The Department of Health Northern Ireland guidance links communication to open discussion between frontline staff, managers, and the wider organisation about workload allocation, equity, fairness, and trust (DOH-NI, 2026). For HSCPs, this requires clear escalation routes when workloads become unsafe, visible reporting of staffing gaps, and shared decision-making about service priorities.

### Connection

Connection means the relationships, team support, leadership, and organisational belonging needed to sustain safe practice. The social work framework conceptualises connection as positive relationships with colleagues, managers, the wider organisation, and the profession (DOH-NI, 2026). For HSCPs, this is especially important because many services depend on interdisciplinary working, continuity, clinical supervision, peer support, and collaborative decision-making.

These three concepts are not separate from one another. Capacity without communication can hide unsafe work. Communication without capacity can identify problems without resolving them. Connection without capacity can leave staff relying on goodwill and informal support to manage unsustainable demand. A safe staffing framework for HSCPs must therefore address all three.

## 7.3. Principles for HSCP Safe Staffing

The following principles adapt the ten Northern Ireland social work safe staffing principles for the wider HSCP workforce. The original principles covered workforce capacity, workload within capacity, skill mix, compassionate leadership, wellbeing, camaraderie, governance, timely interventions, regular review, and timely case closure (McFadden et al., 2024a). The HSCP principles below retain the core logic of that framework while broadening it across diagnostic, therapeutic, psychosocial, rehabilitation, social care, and community-based roles. They are also consistent with wider principles-based safe staffing comparators, including nursing, adult social care, pharmacy, radiography, mental health, workforce planning and international safe staffing guidance.

### Principle 1: Funded workforce capacity should be based on assessed need.

HSCP staffing should be planned against population need, service demand, workload, complexity, and access requirements. Workforce growth alone is not sufficient if staffing levels do not match the volume and nature of need. This requires funded establishments that reflect service requirements rather than historic staffing patterns or short-term budget constraints. This principle is consistent with wider safe staffing guidance that links staffing requirements to patient or service-user need, acuity, local demand and workforce planning, rather than relying on staffing totals alone (NICE, 2014; NQB, 2016; WHO, 2023; WHO Europe, 2026).

### Principle 2: Workload must be kept within safe capacity.

Safe staffing requires the workload of teams and individual practitioners to remain within manageable limits. Caseloads, referrals, waiting lists, duty demands, indirect work, administration, travel, and supervision responsibilities should be considered together. The Northern Ireland framework emphasises that workload allocation should be based on trust, integrity, transparency, fairness and equity (DOH-NI, 2026). This is also supported by workload-based approaches such as WISN, which calculate staffing need from available working time, workload components, activity standards and allowance factors, and by adult social care guidance which recognises that safe staffing must include indirect work, continuity, handover and person-centred support (WHO, 2023; Skills for Care, 2024).

### Principle 3: Skill mix must reflect professional standards and service-user need.

Safe staffing is about whether teams have the right blend of regulated professionals, advanced practitioners, assistants, support workers, administrative staff, students and trainees. Support roles can strengthen services, but they must be deployed with clear role boundaries, supervision and governance. They should not be used as a substitute for the professional capacity required to deliver safe care. This principle aligns with the National Quality Board's emphasis on the right staff, with the right skills, in the right place and time, and with pharmacy guidance that links safe staffing to adequate staff mix, competence, role clarity and regulatory accountability (NQB, 2016; PSI, 2026). Radiography guidance also demonstrates, as a comparator, that safe staffing requires attention to team composition, professional competence, trainees, support roles and operational context (SCoR, 2024).

### Principle 4: HSCP services require compassionate and effective leadership.

Leadership is central to safe staffing because managers and professional leads make decisions about workload allocation, prioritisation, supervision, escalation, service development, and risk. In services where operational line management and discipline-specific clinical or professional governance are separated, safe staffing arrangements should clarify how these responsibilities interact and how staffing or workload risks are escalated. The Northern Ireland social work evidence emphasises compassionate leadership, line management support and organisational oversight as key components of safer staffing (McFadden et al., 2024a). For HSCPs, leaders also need the authority and data required to act when staffing is unsafe. This is consistent with wider safe staffing guidance that places responsibility on organisations and senior leaders to review staffing, monitor quality indicators, respond to staffing risks and maintain governance from frontline services to board level (NICE, 2014; NQB, 2016; Welsh Government, 2025).

### Principle 5: Staff wellbeing and psychological safety are safety issues.

Safe staffing should protect staff wellbeing as well as service-user safety. Persistent workload pressure, lack of cover, insufficient supervision, inability to take breaks, and repeated exposure to unmet need can contribute to burnout, distress, and intention to leave (McFadden et al., 2024b). The social work safe staffing research links safer staffing to workforce wellbeing, retention, and support (McFadden et al., 2024a). This principle is supported by wider comparators that link inadequate staffing to staff stress, sickness, poor work-life balance, burnout and reduced motivation, and by international frameworks that treat workforce wellbeing as a core outcome of safe staffing (Skills for Care, 2024; TruMerit, 2026). HSCP safe staffing should therefore treat wellbeing as part of service quality and workforce sustainability.

### Principle 6: Team support and professional connection should be built into staffing models.

Safe practice depends on more than individual productivity. HSCPs need time and structures for team discussion, peer support, interdisciplinary planning, supervision, and shared learning. This is especially important in services managing complex need, safeguarding concerns, rehabilitation, mental health, disability, older persons' care, and community-based work. Mental health staffing guidance is useful here because it highlights the need for the right people with the right skills in settings where therapeutic engagement, risk, multidisciplinary working and local context shape staffing requirements (Health Education West Midlands & NHS England, 2015). TruMerit's international framework similarly emphasises interprofessional teams, supportive work environments and full-scope practice as part of safe staffing through new models of care (TruMerit, 2026).

### Principle 7: Governance should make staffing risks visible and actionable.

A safe staffing framework should include clear governance arrangements for monitoring staffing levels, workload, waiting lists, vacancy pressures, unallocated work, delayed interventions, and service risk. The Department of Health Northern Ireland guidance includes governance, supervision, and waiting-list management as part of safer staffing (DOH-NI, 2026). For HSCPs, governance should include escalation routes, review processes, and accountability for action. Where responsibility for service delivery, professional supervision and clinical or professional assurance sits across different roles or structures, governance arrangements should specify how concerns are shared, reviewed and acted upon. This principle is also consistent with Welsh statutory reporting, which requires reporting on whether staffing levels have been maintained, the impact of staffing shortfalls on care, and actions taken in response, and with NHS safe staffing policies that include escalation processes, red flags, thresholds and board assurance (Leicestershire Partnership NHS Trust [LPT], 2022; Welsh Government, 2025).

### Principle 8: Service users should receive timely, flexible, and effective HSCP intervention.

Safe staffing should be judged by whether services can provide timely access to the right professional input. Delayed assessment, cancelled appointments, long waits, missed therapy, delayed discharge planning, or reduced safeguarding capacity are indicators that staffing may be insufficient. The original social work principle emphasises timely, flexible, efficient and effective interventions in line with professional codes of conduct (DOH-NI, 2026). This principle is supported by wider safe staffing guidance that links staffing to quality, safety, outcomes, access and the ability to meet service-user need, rather than treating staffing as a workforce metric alone (NICE, 2014; NQB, 2016; Skills for Care, 2024).

### Principle 9: Workloads should be reviewed regularly through supervision and service-level monitoring.

Workload review should not rely on crisis escalation. It should be built into supervision, team meetings, professional governance, and workforce planning. For some HSCPs this may include caseload review; for others it may include waiting-list review, demand-capacity review, clinic capacity, referral trends, complexity, acuity, missed care, delayed care, or service-user outcomes. This principle is consistent with guidance that emphasises regular establishment reviews, staffing reviews, professional judgement, local data, peer comparison and monitoring of indicators such as quality, safety, workforce outcomes and patient or service-user experience (NQB, 2016; WHO, 2023; Welsh Government, 2025; PSI, 2026).

Principle 10: Safe staffing should support appropriate closure, discharge, transition, and continuity.

The original social work principle refers to timely case closure (DOH-NI, 2026). For the wider HSCP workforce, this should be broadened to include timely closure, discharge, transition, onward referral, and continuity of care. Staffing models should allow professionals to complete episodes of care safely, communicate decisions clearly, document appropriately, and avoid unsafe drift, premature discharge, or unnecessary delays. Adult social care guidance is especially relevant here because it links safe staffing to continuity, handover, communication and person-centred care, while wider safe staffing frameworks emphasise that staffing decisions should be judged against quality, outcomes and service-user experience (NQB, 2016; Skills for Care, 2024).

Taken together, these principles provide the practical basis for a Fórsa HSCP safe staffing framework. They build from the Northern Ireland social work safe staffing model but are also supported by wider principles-based comparators across health and social care. The purpose is not to impose a single staffing ratio across all HSCP services, but to establish a common framework through which staffing can be planned, reviewed, escalated and governed in relation to assessed need, workload, skill mix, local context, professional judgement, service quality and staff wellbeing.

## 7.4. From Definition to Framework

The definition of HSCP safe staffing has already been set out in Section 4. That definition establishes that safe staffing is concerned with sufficient numbers of appropriately qualified, skilled and supported professionals, appropriate skill mix, manageable workload, safe and timely access, local context, professional judgement, service quality, continuity and staff wellbeing. The purpose of this section is to translate that definition into a practical framework for policy and workforce planning. The 3Cs provide the organising structure, while the ten principles set out the conditions that should be present if HSCP staffing is to be considered safe.

This approach builds on the Northern Ireland social work definition, which refers to having enough staff with the right knowledge, experience, skills, workload capacity and flexibility to respond to service-user need in an efficient, effective and timely manner. It also draws on the wider social work framework's emphasis on reflective supervision, sufficient time to deliver high standards of care, compassionate line management, team support, skill mix and staff wellbeing (DOH-NI, 2026).

For HSCPs, the framework must apply across a broader range of professions and service models, including social work, social care, psychology, physiotherapy, occupational therapy, speech and language therapy, dietetics, pharmacy, therapy assistant roles and other HSCP services. It must also be applicable across acute, community, disability, mental health, older persons, rehabilitation, primary care, and specialist services.

The framework deliberately avoids a single universal ratio. It recognises that HSCP safe staffing must be determined through a combination of workload evidence, service-user need, available working time, local service data, professional judgement, and skill-mix analysis. This is consistent with WHO Europe's distinction between strategic safe staffing, which includes governance, regulation, financing, workforce planning and monitoring, and operational safe staffing, which includes workload assessment, skill mix, deployment and professional judgement (WHO Europe, 2026).

Fórsa's position is therefore that Ireland should develop a national HSCP safe staffing framework based on the 3Cs and the ten principles above. Such a framework should establish a common standard for safe staffing while allowing profession-specific and service-specific methods to determine staffing requirements in practice. It should not be a rigid formula. It should be a transparent, accountable, and evidence-informed framework for ensuring that HSCP services have the capacity, communication, and connection required to deliver safe, timely and effective care.

# Section 8.

# Applying the Framework across HSCP Roles and Service Contexts

Given the current restructuring of the HSE into Health Regions, Integrated Healthcare Areas and new models of integrated service delivery, this section does not attempt to map the framework onto a fixed list of services. Instead, it applies the framework across broad HSCP roles and service contexts. This avoids tying the framework to structures that may change, while still showing how safe staffing principles can be adapted across therapeutic, diagnostic, psychosocial, social care, community, acute and specialist roles.

## 8.1. A common framework, adapted locally

A national safe staffing framework for HSCPs should provide a common structure without imposing a single staffing formula across all professions and services. HSCPs work across therapeutic, diagnostic, psychosocial, social care, rehabilitation, community, acute and specialist contexts. Their work varies by population need, service model, intervention intensity, professional risk, geography, waiting-list pressure, skill mix and the level of direct and indirect work required. A safe staffing framework must therefore be consistent in its principles, but flexible in how those principles are applied.

The wider workforce planning literature supports this approach. Needs-based workforce planning seeks to align workforce capacity with population health need, service demand and the care required to meet that need, rather than relying on historic staffing patterns or supply-driven projections (Asamani et al., 2021). Strategic workforce planning literature similarly argues for whole-system approaches that can account for integrated health and social care, skill mix, changing models of care and population need (Sutton et al., 2023). Fraher and Brandt (2019) make a related argument that workforce planning should be organised around patients and populations, rather than professional silos alone. This is directly relevant to HSCPs because many services depend on overlapping professional contributions, interdisciplinary working and shared responsibility for outcomes.

At the same time, local adaptation is essential. Evidence from multi-professional needs-based workforce planning in Nova Scotia shows that implementation depends on robust workforce data, collaborative relationships and clear service planning. It also highlights recurring barriers, including limited workload data, inconsistent service-level planning and weak outcome data (MacKenzie, 2025). These are highly relevant to Ireland. A national HSCP framework should therefore set the principles and governance expectations, while allowing each profession and service area to develop appropriate workload measures, caseload approaches, demand-capacity tools, acuity or complexity indicators, and skill-mix models.

This approach also fits with allied health evidence. Clinical care ratio research shows that allied health professionals spend substantial time on activity beyond direct client contact, and that ratios vary by profession, seniority, setting and service model (Brown et al., 2024; Hearn et al., 2024). These findings support the need for profession-specific application. For example, a speech and language therapy service may need to account for direct therapy, indirect client work, report writing, family liaison, school or home visits, dysphagia risk, multidisciplinary meetings and waiting-list management. A social work service may need to account for caseload intensity, statutory duties, duty intake, court work, safeguarding, supervision, travel and unallocated work. A dietetic, physiotherapy or occupational therapy service may need to account for intervention intensity, rehabilitation goals, discharge planning, assistants, specialist equipment, group work, indirect care and service development.

The application of the framework should also recognise variation in management and governance arrangements across HSCP services. In some settings, particularly integrated community services, operational line management may sit separately from discipline-specific clinical or professional governance. In other settings, these functions may be more closely aligned within a profession-specific management structure. The framework should not prescribe one management model across all services. Instead, it should require each service to make clear who is responsible for workload review, professional supervision, clinical or professional assurance, escalation of staffing risk, and decisions about service priorities. This is important because safe staffing depends not only on workforce numbers, but also on clear accountability for professional standards, workload capacity and service-user safety.

The purpose of a national framework is therefore to create consistency in what must be considered, rather than uniformity in the staffing method used. In practice, the framework should require each HSCP service to demonstrate how staffing levels and skill mix have been assessed against local need, workload and service risk. It should also require clear arrangements for review and escalation when staffing becomes unsafe or workloads become unsustainable. This would allow the framework to remain stable through HSE restructuring, while giving professions and local services the flexibility to apply it in ways that reflect their work.

## 8.2. Applying the framework across broad HSCP analytical groupings

The HSCP workforce is diverse, but the same safe staffing framework can be applied across broad professional groupings. The purpose is to ensure that each profession and service can show how staffing levels, skill mix and workload capacity have been assessed against need, complexity, access, quality, and staff wellbeing. A practical way to apply the framework is to group HSCP work by the nature of the service being delivered (see Table 2). These groupings are not intended to be fixed or exhaustive. They provide a way of showing how the same principles can be adapted across different forms of HSCP practice.

### Table 2: Applying the Framework Across Broad Professional Groupings

| HSCP group | Examples | Main workload drivers | Useful staffing methods | What the framework should test |
|---|---|---|---|---|
| Therapeutic and rehabilitation professions | Speech and language therapy, occupational therapy, physiotherapy, dietetics, podiatry, orthoptics | Referral demand, waiting lists, therapy intensity, direct and indirect care, travel, rehabilitation goals, family work, documentation, supervision, CPD, discharge planning, delegation to assistants and support roles | Workload tools, clinical care ratios, demand-capacity models, acuity or complexity measures, skill-mix analysis, local service data | Whether staffing allows timely access, safe assessment, appropriate intervention, review, discharge, prevention, rehabilitation and professional development |
| Psychosocial, social work and social care roles | Social work, social care, psychology and related psychosocial roles | Caseload size, case intensity, safeguarding, relational work, statutory duties, risk, supervision, duty work, records, court or legal processes, emotional labour, continuity | Caseload models, workload tools, complexity weighting, professional judgement, supervision review, escalation processes, local service data | Whether workloads are manageable, risks are visible, supervision is meaningful, unallocated or delayed work is monitored, and staff can sustain safe relational practice |
| Diagnostic, technical and specialist services | Diagnostic-facing HSCP roles, specialist clinical services, radiography as comparator only | Equipment, procedure type, throughput, operational hours, technical skill, regulatory duties, CPD, quality assurance, reporting, indirect work, service development | Demand-capacity models, workload tools, skill-mix analysis, professional judgement, local throughput and waiting-list data | Whether staffing reflects procedure complexity, equipment use, operational demand, governance requirements, safe throughput and professional standards |

| HSCP group | Examples | Main workload drivers | Useful staffing methods | What the framework should test |
|---|---|---|---|---|
| Community and integrated care roles | Primary care, disability, older people's services, mental health, community rehabilitation and integrated care teams | Population need, regional variation, waiting lists, travel, interdisciplinary working, home or school visits, care coordination, unmet demand, family or carer work, changing service models | Needs-based planning, workload tools, demand-capacity models, acuity or complexity measures, skill-mix analysis, local service data | Whether staffing reflects population need, local demand, complexity, access pressures, geography, continuity and multidisciplinary working |
| Skill mix, support roles and advanced practice | Therapy assistants, health and social care assistants, support workers, advanced practitioners, clinical specialists, practice educators | Delegation, supervision, role clarity, scope of practice, career pathways, governance, staff experience, student education, professional leadership, advanced practice responsibilities | Skill-mix analysis, supervision models, role and scope review, workload allocation, governance, competency frameworks, and professional judgement | Whether skill mix strengthens services, whether delegated work is safe and supervised, whether advanced roles add service development, and whether support or advanced roles are used appropriately rather than as substitutes for necessary registered professional capacity |

For therapeutic and rehabilitation professions (see Table 2), the framework should focus on the full workload required to deliver safe intervention. This includes direct appointments, indirect client care, reports, preparation, review, family liaison, equipment, group work, travel, supervision and service development. Allied health evidence shows that clinical care ratios vary across professions, grades and settings, and should be refined by profession, model of care, workforce structure, governance and training requirements (Brown et al., 2024; Hearn et al., 2024). This supports the use of workload tools and clinical care ratios as aids to planning, but not as rigid targets.

Speech and language therapy provides a useful Irish example of this approach. The National SLT Managers Group's draft framework for safe and sustainable workloads distinguishes between client-focused activity and wider workload activity, including supervision, CPD, student education, service development, audit, administration, travel and operational delays. It also applies the approach across primary care, disability, CDNTs, acute and rehabilitation services, with indicative ranges presented as guidance rather than prescriptive limits (National SLT Managers Group, 2026). This illustrates how the national HSCP framework could enable profession-specific workload tools while retaining shared principles.

For psychosocial, social work and social care roles, the framework should account for caseload, workload, risk, and relational practice. In social work, Irish and Northern Ireland evidence shows the value of structured caseload and workload approaches, including attention to complexity, intensity, duty work, travel, supervision, unmanageable caseloads, and escalation processes (Tusla, 2018; MacLochlainn et al., 2025; McFadden et al., 2025b). These methods may also be relevant to other case-holding HSCP roles, including some psychology, social care and disability roles, where the number of allocated people does not capture complexity, indirect work, risk, or duration of involvement.

For diagnostic, technical and specialist services, the framework should allow for different workload drivers. These may include equipment, procedure type, operational hours, throughput, reporting, professional regulation, quality assurance, trainees, and service development. Radiography is used here only as a comparator, but its safe staffing guidance is useful because it demonstrates why profession-specific models need to account for technical, regulatory, and operational context, as well as staff numbers (SCoR, 2024). The wider lesson for HSCPs is that diagnostic or specialist services should not be assessed only through appointment numbers or throughput. Staffing must also reflect complexity, governance, professional standards, and indirect work.

For community and integrated care roles, the framework should be linked to population need, local demand, and access pressures. The ESRI's Hippocrates modelling for selected primary and community care services shows projected growth in workforce requirements for several HSCP services, while also noting important limitations, including the inability to assess whether baseline staffing was appropriate or safe and the inability to formally incorporate unmet demand or waiting-list pressures (Brick et al., 2026). This supports the need for local service data and demand-capacity approaches, particularly in primary care, disability, older people's services, mental health, and community rehabilitation.

For skill mix, support roles and advanced practice, the framework should test whether different roles are being used safely, appropriately and sustainably. Assistant and support roles can strengthen HSCP services by improving capacity, continuity and access, but they require clear scope, supervision, governance and career pathways (McFadden et al., 2024a). Evidence on the allied health support workforce suggests that support workers and assistant practitioners are often underused because of inconsistent deployment, unclear scope of practice and limited career structures (Etty et al., 2024). Advanced practice roles can also strengthen services, but they bring different considerations, including specialist expertise, professional leadership, education, supervision, service development and governance. Evidence from occupational therapy in acute mental health cautions that specialist HSCP roles should not be absorbed into generic staffing models where this reduces profession-specific intervention and weakens care quality, retention and student experience (Phoenix and Taylor, 2023). A safe staffing framework should therefore assess skill mix without allowing assistant, support or advanced roles to substitute for the registered professional capacity required to meet service need.

Across all groupings, the framework should require services to make the basis for staffing decisions visible. This means showing how staffing has been assessed against need, workload, skill mix, complexity, local context, and professional judgement. The methods may differ across HSCP roles, but the accountability should be consistent. Each service should be able to explain how staffing levels are determined, how workload is reviewed, how risk is escalated, how skill mix is governed, and how service-user access, quality, and staff wellbeing are monitored.

## 8.3. What the framework should require in every setting

Although HSCP services differ in their professional roles, service models, and workload demands, a national safe staffing framework should require every setting to address a common set of core questions. These requirements should create consistency in how staffing is planned, reviewed and escalated, while allowing local services and professions to use the methods most appropriate to their work. Drawing on the 3Cs and the ten HSCP safe staffing principles, the framework should require each HSCP service to be able to answer seven practical questions:

1st

Every HSCP service should be required to assess staffing against population and service-user need. This means moving beyond historic staffing patterns, funded establishment, or current workforce availability. Staffing should be tested against referral demand, waiting-list pressure, demographic change, complexity, geography, service model, and the level of intervention required. Needs-based workforce planning literature supports this shift because it links workforce requirements to the needs of the population and the services required to meet those needs, rather than supply alone (Fraher and Brandt, 2018; Asamani et al., 2021; Sutton et al., 2023).

2nd

Every service should assess workload as well as caseload or activity volume. A caseload figure, appointment count, or referral number does not show the full professional work required to deliver safe care. HSCP workload may include assessment, intervention, indirect client work, documentation, family liaison, multidisciplinary meetings, safeguarding, equipment, travel, supervision, student education, CPD, audit, service development, and waiting-list management. Allied health evidence shows that direct clinical time varies by profession, seniority and setting, and that significant time is spent on work beyond direct contact (Brown et al., 2024; Hearn et al., 2024). The SLT Managers Group draft framework provides a profession-specific Irish example of this approach by distinguishing between client-focused activity and wider workload activity, and by treating indicative ranges as guidance rather than prescriptive limits (National SLT Managers Group, 2026).

3rd

The framework should require skill-mix review in every setting. This should include the balance between registered professionals, advanced practitioners, clinical specialists, assistants, support workers, administrative staff, practice educators, students and trainees. Skill mix should be used to strengthen safe care, not to replace professional capacity without evidence, supervision and governance. Evidence on the allied health support workforce shows that assistant and support roles can contribute to workforce redesign, but that their impact is limited where scope, deployment, and career pathways are unclear (Etty et al., 2024). Evidence from occupational therapy in acute mental health also cautions that specialist professional roles can be weakened when they are absorbed into generic staffing models (Phoenix and Taylor, 2023).

4th

Professional judgement should be built into staffing decisions. Tools, ratios, caseload ranges, and workload calculators can support planning, but they cannot determine safe staffing on their own. Professional judgement is needed to interpret complexity, risk, staff experience, local context, service model, and the quality of care being delivered. This judgement should be structured, documented, and subject to governance. It should not depend on informal local discretion or individual goodwill. The Scottish Common Staffing Method provides a useful comparator for this kind of structured decision-making. It requires staffing decisions to be informed by multiple sources of evidence, including professional judgement, local context, quality measures, service demand, staff experience, skill mix, specialist expertise, measures of quality, and patient or service-user outcomes. It is therefore useful for HSCPs because it shows how a common staffing process can support local application without imposing a single staffing ratio or fixed method across all settings (Scottish Government, 2023; HIS, 2024).

5th

Every setting should use local service data. This should include, where available, referral demand, waiting lists, waiting times, unallocated work, vacancies, turnover, sickness absence, maternity leave, agency use, skill mix, staff experience, travel time, caseload intensity, delayed care, missed care, complaints, incidents, outcomes, and service-user feedback. Local data are essential because national workforce figures cannot show whether staffing is safe in a particular team, region, or service. The ESRI workforce projections are useful for medium-term planning, but they also show the limits of available modelling where unmet demand, waiting-list pressures, and safe staffing baselines cannot be fully incorporated (Brick et al., 2026).

6th

The framework should require clear governance and escalation processes. Where workloads become unsafe, there should be a transparent route for recording concern, assessing risk, agreeing mitigations and escalating unresolved issues. This should apply to individual practitioners, teams, services and senior management. Irish social work caseload policy provides one example of structured escalation for unmanageable caseloads. The policy makes caseload pressure visible by requiring workload concerns to be discussed in supervision, reviewed against case complexity and practitioner capacity, and escalated through management structures where risks cannot be safely managed (Tusla, 2018). Welsh statutory reporting also shows the importance of requiring organisations to report whether staffing levels have been maintained, the impact of shortfalls on care, and the actions taken in response (Welsh Government, 2025).

7th

Safe staffing should be linked to staff wellbeing and workforce sustainability. A framework that ignores wellbeing will fail to address retention, burnout, and the loss of professional expertise. Workload pressure, inadequate supervision, unsafe caseloads, poor skill mix, lack of development opportunities, and repeated exposure to unmet need all affect the sustainability of HSCP services. Evidence on physiotherapy and wider AHP retention highlights the importance of reducing workplace stressors, including workload, rostering, and physical demands, while supporting professional development and measuring retention during service change (Watson et al., 2025).

Finally, every setting should monitor whether staffing is supporting safe, timely and effective care. This means linking staffing decisions to access, quality, continuity, outcomes and service-user experience. For some services, this may involve waiting times, therapy intensity, discharge delays or missed appointments. For others, it may involve unallocated cases, safeguarding risk, delayed assessment, unmet need, continuity, case closure, avoidable deterioration, or service-user feedback. The indicators will vary, but the expectation should be consistent: safe staffing must be judged by whether the service has the capacity, communication, and connection required to deliver safe and effective care.

In practical terms, the framework should require each HSCP service to be able to answer seven questions. These seven questions do not reproduce the ten principles one by one. Instead, they translate them into a practical service-level checklist. Some principles, particularly leadership, governance, wellbeing and professional connection, cut across more than one question because they shape how staffing risks are identified, discussed, escalated and addressed.

1. What population or service-user need is the service expected to meet? *(Principle 1 & 8)*
2. What workload is required to meet that need safely? *(Principle 2 & 9)*
3. What staffing numbers, skill mix and available working time are required? *(Principle 1, 2, & 3)*
4. What local data and professional judgement have been used? *(Principle 7 & 9)*
5. What risks arise when staffing or workload capacity is insufficient? *(Principle 2, 5, 6, 7, & 8)*
6. How are risks escalated, reviewed and acted upon? *(Principle 4, 7, & 9)*
7. How is the impact on access, quality, continuity, team functioning, and staff wellbeing monitored? *(Principle 5, 6, 7, 8, & 10)*

These requirements would allow the framework to be applied consistently without imposing a single ratio or staffing tool across all HSCP services. The national framework should set the standard for what must be considered. Professional groups and local services should then determine the most appropriate way to evidence safe staffing in their own context.



# Section 9.

# Implications for Policy, Planning, and Industrial Relations

The proposed HSCP safe staffing framework has implications for workforce policy, regional planning, service design and industrial relations. Its value will depend on whether it is embedded in staffing decisions, supported by transparent data and developed through meaningful engagement with professionals and trade unions. Fórsa has argued that workforce planning should reflect population growth, service demand and safe staffing requirements, and that major staffing decisions should be negotiated rather than introduced through unilateral controls or opaque employment ceilings (Houses of the Oireachtas, 2024). The framework should therefore operate as both a service-planning mechanism and a basis for collective engagement.

## 9.1. Workforce and regional planning

A safe staffing framework for HSCPs should be embedded within national and regional workforce planning. Staffing requirements should be assessed against population need, service demand, workload, skill mix, access pressures and projected changes in care, rather than current establishments or historic staffing patterns alone. Needs-based workforce planning literature supports this approach because it connects workforce supply to the services required to meet population health and social care need (Asamani et al., 2021; Sutton et al., 2023).

This is particularly relevant during the restructuring of the HSE. National policy should establish common safe staffing expectations, while Health Regions and Integrated Healthcare Areas should apply the framework using local population, workforce and service data. Regional flexibility is necessary because geography, demand, workforce availability, waiting lists and service models vary. However, flexibility should operate within a national framework so that local differences do not produce unequal standards or staffing decisions driven mainly by available budgets. Any proposed regional or local variation in staffing models, establishments, skill mix or service configuration should be evidence-based, transparent and subject to consultation and agreement through appropriate professional and industrial relations structures. Regional application should therefore support responsiveness to local need without enabling unilateral decision-making or dilution of safe staffing standards.

Current workforce projections provide useful planning evidence but should not be treated as safe staffing benchmarks. Recent ESRI modelling projects increased workforce requirements across selected primary and community services but does not establish whether baseline staffing levels were appropriate or safe and cannot fully account for unmet demand or waiting-list pressures (Brick et al., 2026). Regional workforce plans should therefore combine national projections with local workload evidence, professional judgement and service-level data.

Fórsa has called for a negotiated workforce plan linked to population growth, service demand and safe service provision. It has also raised concerns about limited access to vacancy data and the absence of meaningful engagement before the Pay and Numbers Strategy was introduced (Houses of the Oireachtas, 2024). A national framework should require each region to report how HSCP workforce requirements have been assessed, where staffing risks remain and what action is planned. This would support consistency, accountability and collective engagement and ultimately better service provision.

## 9.2. Service design and workload measurement

Safe staffing should be considered whenever services are designed or reorganised. Integrated care pathways, extended hours, digital delivery, new team structures and care closer to home can redistribute work across professions and settings. Such changes may improve access, but they can also increase travel, coordination, documentation, supervision, indirect care and responsibility for complex cases. Service redesign should therefore include an assessment of its impact on workload, skill mix, professional roles and staffing capacity.

Workload measurement should reflect the full range of work required to deliver safe care. Appointment numbers, caseload totals or direct contact time are insufficient on their own. Allied health evidence shows that clinical care ratios vary by profession, grade and setting, and that substantial time is spent on indirect care, supervision, administration, and service development (Brown et al., 2024; Hearn et al., 2024). The National SLT Managers Group's draft framework provides an Irish example by distinguishing between client-focused activity and wider workload activity, and by requiring professional judgement and local context when interpreting indicative workload ranges (National SLT Managers Group, 2026).

Different services will require different measures. Caseload and complexity tools may be appropriate for social work and other case-holding roles. Demand-capacity approaches may be more suitable for referral and waiting-list services. Workload, acuity and skill-mix measures may be needed where intervention intensity, indirect work or professional risk vary. Tusla's caseload management policy demonstrates how supervision, case intensity, duty work, travel and escalation can be incorporated into structured workload review (Tusla, 2018).

The Scottish Common Staffing Method also provides a useful comparator. It links staffing review to local context, professional judgement, service data, quality assurance, risk management and service redesign, rather than relying on one numerical measure (Scottish Government, 2023; HIS, 2024). For HSCPs, workload tools should support consistent and transparent decisions while remaining adaptable to profession and setting. Importantly, workload measures should be developed and reviewed with the professionals and trade unions affected. They should not become narrow productivity targets or be used to increase throughput without regard to quality, complexity, professional standards and staff wellbeing. The staffing consequences of service redesign should be discussed before implementation and reviewed afterwards.

## 9.3. Recruitment, retention, and agency reliance

Safe staffing depends on the recruitment and retention of a sufficient permanent staff. Workforce planning will remain unstable where vacancies are left unfilled, predictable absences are not covered and experienced staff leave because workloads are unsustainable. Recruitment and retention should therefore form part of safe staffing policy.

Fórsa has reported that recruitment controls and the Pay and Numbers Strategy affected core service delivery through longer waiting times, reduced service capacity and increased pressure on existing staff. It also raised concerns about the non-replacement of turnover, limited maternity leave cover and the absence of transparent vacancy data (Houses of the Oireachtas, 2024). These issues affect access, continuity and workload.

Evidence relating to physiotherapists and other allied health professionals shows that workload, rostering pressures, physical demands, professional development and organisational change can influence retention (Watson et al., 2025). Safe staffing policy should therefore include manageable workloads, effective supervision, career development and planned cover for maternity leave, sickness absence and other predictable gaps.

Agency staff may provide necessary short-term contingency, but recurrent use can indicate insufficient permanent capacity. Fórsa has argued that agency workers have been used to provide core services where permanent posts were not filled, while agency expenditure continued to rise. Agency use should therefore be monitored alongside vacancies, turnover, overtime, absence and unmet demand. Where agency use is sustained, services should assess whether the underlying requirement should be converted into permanent capacity. This would support continuity, team stability, supervision and workforce development.

Agency staffing should not obscure persistent deficits or substitute for posts required for routine service delivery.

Recruitment controls, employment ceilings and decisions not to replace vacant posts should also be supported by evidence and subject to consultation. Staff should not be expected to absorb the work of vacancies indefinitely. Fórsa's industrial action instructions reflected this concern by directing members not to undertake duties associated with unfilled posts or posts left uncovered during maternity leave.

## 9.4. Professional voice and data transparency

Safe staffing decisions should include the professionals who understand the work, risks and service context. HSCP staff and their representatives should contribute to workload measures, staffing assumptions, skill-mix decisions and the assessment of service redesign. Professional voice should form part of routine planning and governance rather than sought after problems emerge. This requires reliable data on funded establishments, vacancies, turnover, absence, maternity leave cover, agency use, waiting lists, unallocated work, workload, skill mix and service outcomes. Without shared data, it is difficult to assess whether staffing reflects need, understand regional variation or evaluate the effects of workforce controls.

Fórsa has reported difficulty obtaining a complete national picture of vacant and decommissioned posts and has argued that sound workforce decisions cannot be made where validated data are unavailable or withheld (Houses of the Oireachtas, 2024). Fórsa, the INMO, MLSA, Connect and Unite subsequently established joint organising committees across the six Health Regions to collect information on vacancies, unfilled maternity leave positions and third-party contractors. However, trade unions should not have to create parallel systems to establish the scale of staffing gaps. A national framework should require consistent data collection and routine disclosure to recognised staff representatives. It should also allow staff and unions to challenge incomplete information and raise concerns where reported staffing levels do not reflect actual capacity. Additionally, professional judgement should be documented and considered alongside workload measures, local data and service-user outcomes. Staff must be able to raise concerns about unsafe staffing without fear of adverse consequences. Scottish statutory guidance provides a useful comparator by emphasising staff involvement, transparency and a culture in which staffing concerns can be raised safely (Scottish Government, 2023).

## 9.5. Negotiation and collective engagement

Safe staffing should become a standing matter for engagement between health sector employers and recognised trade unions, with input from the Department of Health and relevant professional bodies where appropriate. Staffing decisions affect workload, role boundaries, access, professional standards and working conditions. They should therefore be addressed through established industrial relations structures.

National-level engagement will be required to agree the principles, governance, reporting requirements and minimum expectations of the HSCP safe staffing framework. Regional and local structures should then apply these expectations to service demand, workforce availability, workload and skill mix. The framework should also establish a clear process for resolving disagreement. Where staff or representatives consider workloads unsafe, services should review the evidence, record the risk, identify interim protections and agree a timescale for action. Unresolved concerns should be capable of escalation through regional and national industrial relations mechanisms.

Furthermore, changes to establishments, skill mix, professional roles, working patterns or service models should be discussed before implementation. This is especially important where proposals transfer work between grades or professions, increase reliance on assistants or agency staff, or require staff to absorb vacant posts. Engagement should be supported by staffing data, workload analysis and risk assessment.

Safe staffing cannot depend on goodwill, informal cover or repeated crisis intervention. It requires negotiated standards, shared evidence, escalation mechanisms and regular review. Collective engagement should therefore form part of the framework itself.

## 9.6. Closing position

Safe staffing should be treated as a shared responsibility across government, health sector employers, regional structures, managers, staff and recognised trade unions, with input from professional bodies where appropriate. National policy should set clear expectations, while regional and local services should apply them using transparent data, professional judgement and evidence of workload, skill mix and service need.

Staffing decisions must be open to scrutiny and collective engagement. Changes to establishments, recruitment controls, skill mix, service models or working arrangements should be supported by evidence and discussed with the staff and representatives affected. Where staffing risks arise, there should be clear routes for review, mitigation and escalation.

A credible HSCP safe staffing framework should combine national standards, local application, shared workforce intelligence, professional voice and agreed oversight. This would support a more transparent, sustainable and needs-based approach to staffing.

# **Section 10.**
# Recommendations

The evidence reviewed in this position paper supports the development of a national safe staffing framework for Health and Social Care Professionals in Ireland. The framework should establish common principles and governance expectations while allowing profession-specific and service-specific methods to reflect differences in workload, complexity, skill mix and service context. Its development should be led through engagement between health sector employers and recognised trade unions, supported by Department of Health policy direction and input from relevant professional bodies, professional representatives and other stakeholders where appropriate.

The ten recommendations that follow should be understood as the practical application of the 3Cs framework. *Capacity* is addressed through needs-based establishments, workload methods, skill-mix planning, recruitment, retention and permanent workforce capacity. *Communication* is addressed through transparent staffing data, professional judgement, reporting, escalation, governance and shared review. *Connection* is addressed through staff wellbeing, professional voice, trade union participation, supervision, team support, continuity and sustainable service design. Together, the recommendations translate the 3Cs into the policy, planning and industrial relations actions required to support safe staffing for HSCPs.

## Recommendation 1: Develop a national principles-based HSCP safe staffing framework

The Department of Health, the HSE and other health sector employers should develop a national safe staffing framework for HSCPs based on the definition, 3Cs and ten principles set out in this paper. The framework should apply across HSCP professions and service contexts without imposing one universal ratio or staffing formula. It should require staffing decisions to consider assessed need, workload, available working time, skill mix, professional judgement, local service data, access, quality, continuity and staff wellbeing. Profession-specific methods should sit within this shared national structure.

This recommendation gives practical effect to *Capacity* by establishing a shared basis for assessing whether services have sufficient staffing, skill mix and workload capacity to meet need. It supports *Communication* by creating a common language for staffing decisions, escalation and review. It supports *Connection* by linking safe staffing to leadership, staff wellbeing, professional support and continuity of care.

## Recommendation 2: Base funded workforce establishments on assessed population and service need

Funded HSCP establishments should be determined through needs-based workforce planning rather than historic staffing patterns, current workforce availability or budget ceilings alone. Planning should account for population and demographic change; deprivation and regional variation; referral demand, waiting lists and unmet need; workload intensity and complexity; workforce turnover and predictable absence; changing service models and projected future demand.

National workforce projections should inform this process but should not be treated as safe staffing benchmarks. Regional and local workforce plans should combine national modelling with service-level evidence and professional judgement (Asamani et al., 2021; Sutton et al., 2023; Brick et al., 2026).

This recommendation gives practical effect to *Capacity* by requiring staffing levels to reflect population need, service demand, workload complexity and available working time rather than historic staffing patterns or current workforce availability. It supports *Communication* by making the assumptions behind workforce establishments more visible and open to review.

## Recommendation 3:
## Develop and validate profession-specific workload and staffing methods

Each HSCP profession or professional grouping should develop and validate methods suited to its work. These may include workload tools, caseload models, demand-capacity approaches, clinical care ratios, acuity or complexity measures, skill-mix models and structured professional judgement. These methods should capture direct and indirect care, administration, documentation, travel, multidisciplinary working, supervision, education, CPD, governance and service development. They should support transparent staffing decisions without becoming rigid productivity targets. Agreed measurement tools should therefore be developed and validated for different HSCP professions and settings, rather than relying on informal judgement or imposing one universal ratio across all services.

Existing Irish and international examples, including social work caseload management, the National SLT Managers Group's draft workload framework, WISN and the Scottish Common Staffing Method, can inform development (Tusla, 2018; National SLT Managers Group, 2026, unpublished final draft; WHO, 2023; Healthcare Improvement Scotland, 2024).

This recommendation gives practical effect to *Capacity* by ensuring that staffing requirements are based on the actual work required across different HSCP professions and settings. It supports *Communication* by providing structured methods through which workload, complexity, professional judgement and local context can be discussed, documented and reviewed.

## Recommendation 4:
## Establish consistent reporting on staffing, vacancies, workload and unmet need

The HSE and other health sector employers should establish consistent national and regional reporting across HSCP services. Reporting should include, where relevant: funded, filled and vacant posts; turnover and absence; maternity and other planned leave cover; agency and overtime use; waiting lists and waiting times; unallocated, deferred or unmet demand; workload and caseload intensity; service restrictions, delayed care and missed intervention; staff wellbeing, retention and service-user outcomes.

Data should be available at profession, grade, service and regional levels. It should be shared routinely with recognised trade unions. Staff representatives should be able to question incomplete information and challenge reported staffing levels that do not reflect actual service capacity.

This recommendation gives practical effect to *Communication* by requiring transparent and consistent data on staffing, vacancies, workload, waiting lists, unmet need and service pressure. It supports *Capacity* by making visible where services lack the staffing, time or skill mix required to meet assessed need safely.

## Recommendation 5:
## Create clear governance, supervision, escalation and accountability arrangements

The framework should establish a documented process for identifying and responding to unsafe staffing or workload. This should include regular workload and staffing review; agreed indicators or thresholds of concern; documentation of staffing and service risks; interim risk-control measures; escalation from team to regional and national levels; defined responsibility and timescales for action; review of whether agreed action has resolved the risk.

Staff should be able to raise concerns without fear of adverse consequences. Where concerns remain unresolved, there should be timely access to established professional, governance and industrial relations mechanisms. Where operational line management and discipline-specific clinical or professional governance sit separately, the framework should make clear how workload concerns, staffing risks and professional standards are shared, reviewed and escalated.

This recommendation gives practical effect to *Communication* by ensuring that staffing risks are recorded, discussed, escalated and acted upon through clear processes. It supports *Capacity* by requiring organisations to respond when workload or staffing levels become unsafe, and it supports *Connection* by giving staff confidence that concerns can be raised and addressed.

## Recommendation 6:
## Support individuals, teams, managers and organisations to create a workplace wellbeing culture and climate

The HSE and other health sector employers should support HSCP individuals, teams, managers and organisations to create a workplace culture and climate that protects wellbeing, psychological safety, professional connection and retention. Safe staffing is affected by the everyday conditions in which staff practise, including workload, supervision, team support, leadership, professional development, role clarity and the ability to raise concerns. Evidence from the TASC/Fórsa study found high levels of burnout, work-related stress and intention to leave among health and welfare workers, with participants linking low morale and service strain to inadequate staffing, lack of cover for maternity and sick leave, workload pressure and the Pay and Numbers Strategy (TASC, 2025).

The HSCP framework should therefore require employers to treat wellbeing as a core safe staffing outcome rather than an individual responsibility. This should include protected supervision, team time, mentoring, peer support, professional development, induction, leadership support, and clear routes for discussing workload and staffing risks. Northern Ireland social work guidance similarly emphasises the importance of team culture, professional identity, peer support, mentoring, learning and development, and wellbeing initiatives for retention and workforce sustainability (DoH NI, 2026).

Supporting workplace wellbeing culture and climate gives practical effect to *Communication* by enabling open discussion of workload, risk and support needs, and to *Connection* by strengthening team cohesion, professional identity, psychological safety and staff retention.

## Recommendation 7:
## Strengthen permanent workforce capacity, recruitment, retention and cover for planned and unplanned absence while reducing recurrent reliance on agency staffing

Safe staffing policy should prioritise the recruitment and retention of sufficient permanent staff. Services should plan and fund cover for turnover, maternity leave, parental leave, sickness absence, study leave and other predictable gaps, rather than relying on existing staff to absorb additional work.

Retention strategies should include manageable workloads, effective supervision, professional development, career progression, mentoring, leadership support and protected capacity for specialist, educational and governance responsibilities. Workforce plans should monitor the effect of workload, service change and working conditions on turnover and intention to leave (Watson et al., 2025).

Direct employment should be the default model for meeting ongoing HSCP service need. Agency staffing should be used only as a short-term, time-limited contingency where direct recruitment or temporary direct cover is not immediately available. Where agency use is recurrent or long term, health sector employers should assess whether the underlying service requirement should be converted into funded permanent posts.

This recommendation gives practical effect to *Capacity* by focusing on the stable, permanent workforce required to deliver safe and sustainable services. It supports *Connection* by recognising that retention, planned leave cover, manageable workload and reduced reliance on agency staffing are essential to staff wellbeing, team stability and continuity of care.

## Recommendation 8:
## Require safe skill-mix planning and protect professional roles

HSCP staffing reviews should assess the balance of regulated professionals, advanced practitioners, clinical specialists, assistants, support workers, administrative staff, educators, students and trainees. New service developments should include the full HSCP, assistant, administrative and support staffing required to deliver the service safely from the outset.

Assistants and support roles can increase capacity and strengthen services, but their use should be supported by clear scope, competency requirements, supervision and governance. They should not replace the regulated professional capacity required to meet service-user need safely.

Service redesign should also protect profession-specific intervention. Specialist HSCP roles should not be absorbed into generic staffing arrangements where this reduces access to the professional assessment or intervention those roles are intended to provide.

This recommendation gives practical effect to *Capacity* by ensuring that services have the right balance of regulated professionals, advanced practitioners, assistants, support workers and administrative support. It supports *Connection* by protecting professional identity, specialist expertise, supervision and team functioning, and by ensuring that support roles strengthen rather than dilute safe professional practice.

## Recommendation 9:
## Embed trade union engagement at national, regional and local levels

Recognised trade unions should participate in the development, implementation and review of the framework. Engagement should include defining workload measures; reviewing staffing assumptions and local data; assessing changes to establishments and skill mix; evaluating service redesign; agreeing escalation and reporting processes; monitoring implementation and outcomes; and reviewing unresolved staffing concerns. Professional bodies and professional representatives should provide input where this is required to support professional standards, scope of practice, governance or profession-specific workload methods.

National-level engagement should agree the common framework and minimum expectations. Regional and local structures should apply these expectations to local need and service context through consultation with recognised trade unions. Collective engagement should form part of safe staffing governance rather than beginning only after staffing problems develop into disputes.

This recommendation gives practical effect to *Communication* by ensuring that recognised trade unions are involved in decisions about staffing, workload, service redesign and risk, with professional input sought where required. It supports *Connection* by strengthening staff voice, collective engagement, trust and shared ownership of safe staffing decisions.

## Recommendation 10:
## Implement the framework through an early learning pilot, followed by phased rollout, evaluation and regular review, with consideration of a legislative or statutory basis as a second step

The framework should be introduced through an early learning pilot followed by phased rollout. The early learning pilot should test how the framework can be applied in selected HSCP services, including how services assess need, workload, skill mix, local data, professional judgement, governance and escalation. Learning from the pilot should inform refinement of the framework before wider implementation across professions, services and regions.

One practical option would be to test the framework in selected services where HSCP staffing, workload, access and skill-mix pressures are already visible. Children's Disability Network Teams may provide one such setting, given their integrated service model, reliance on multiple HSCP disciplines, waiting-list pressures and current workforce-planning challenges. Any pilot or phased implementation should be agreed with Fórsa, relevant trade unions, and should include clear arrangements for data collection, workload review, governance, escalation and evaluation.

In the first instance, implementation should be led by individual health sector employers, with each employer responsible for applying the framework to its own HSCP services, staffing structures and local service context. A Department of Health steering group should support oversight, shared learning and consistency across employers. This group should provide a mechanism through which health sector employers, Fórsa, other recognised trade unions, and relevant stakeholders can review learning, identify implementation issues and support wider rollout.

Implementation should be evaluated against access and waiting times; workload and caseload manageability; delayed or missed care; service quality and continuity; service-user outcomes and experience; staff wellbeing, sickness absence and retention; vacancies and agency reliance; regional equity; feasibility and consistency of application.

The framework, profession-specific methods and reporting requirements should be reviewed regularly as services, workforce roles and population needs change.

Subject to learning from implementation, consideration should be given to placing the HSCP safe staffing framework on a legislative or statutory footing as a second step, similar to the North of Ireland and Scotland. This would support consistency, accountability and sustainability over time, while allowing the initial phase to test the framework, refine profession-specific methods and identify the governance arrangements required for wider implementation.

This recommendation gives practical effect to *Communication* by requiring ongoing monitoring, evaluation and review of how the framework operates in practice. It supports *Capacity* by ensuring that staffing methods remain responsive to changing population need, workload and service demand, and it supports *Connection* by including staff experience, service-user outcomes and workforce sustainability in the review process.

## Closing statement

A national HSCP safe staffing framework should provide a consistent basis for deciding whether services have sufficient capacity, appropriate skill mix and manageable workloads to meet assessed need. It should be supported by transparent data, profession-specific methods, clear governance and meaningful collective engagement. This would provide Ireland with a more sustainable and accountable approach to HSCP workforce wellbeing, workforce planning and service quality.

# **Section 11.**
# Conclusion

Ireland's health and social care system is facing sustained pressure from population change, rising demand, waiting lists, workforce shortages and uneven access to services. HSCPs are central to responding to these pressures across therapeutic, psychosocial, social care, community, acute and specialist services. However, there is currently no coherent national framework for determining whether HSCP staffing levels, skill mix and workload capacity are sufficient to meet assessed need safely.

The evidence reviewed in this paper shows that workforce growth alone does not establish safe staffing. Staffing must be considered in relation to service demand, workload complexity, available working time, professional responsibilities, regional variation, unmet need and the quality and timeliness of care. Existing approaches remain fragmented across professions and services, while gaps in vacancy, workload and unmet-need data limit effective workforce planning.

HSCP work is too diverse for one universal staffing ratio or method. Caseload models, workload tools, demand-capacity approaches, acuity measures, clinical care ratios, skill-mix analysis and professional judgement can all contribute to staffing decisions. Their usefulness depends on the profession, service model and local context. A national framework should therefore establish common principles and governance expectations while allowing profession-specific methods to determine staffing requirements in practice.

The proposed framework offers a practical basis for this work. The 3Cs of *Capacity, Communication* and *Connection* provide an organising structure, supported by ten principles covering assessed need, manageable workload, skill mix, leadership, wellbeing, professional connection, governance, timely intervention, regular review and continuity. Together, these provide a shared standard through which HSCP staffing can be planned, reviewed, escalated and evaluated.

Implementation will require transparent workforce data, profession-specific workload methods, clear accountability and meaningful engagement with staff and recognised trade unions. Staffing decisions should be open to scrutiny and should reflect population and service-user need rather than historic establishments, short-term controls or local workarounds. Recruitment, retention, planned and unplanned leave cover, direct employment and recurrent agency reliance must also be addressed as part of the same workforce planning process. The framework should also support workplace cultures in which workload, risk, professional concerns and support needs can be discussed openly.

Fórsa has an important role in advancing this agenda through policy advocacy, professional engagement and industrial relations. An early learning pilot, followed by phased rollout, would provide a practical route for testing and refining the framework across HSCP services. Employer-led implementation, supported by Department of Health oversight and shared learning, would help ensure that the framework is applied consistently while remaining responsive to local service context. Over time, consideration should be given to placing the framework on a legislative or statutory footing to support consistency, accountability and sustainability.

*Safe staffing for HSCPs is now a necessary condition for safe care, equitable access, workforce wellbeing and sustainable services. Ireland requires an appropriately resourced, principles-based, evidence-informed and workload-sensitive framework capable of supporting its HSCP workforce and meeting changing health and social care needs.*



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