CLEAR
Empowering staff to innovate care

NHS
Health Education England

Themes for Workforce Redesign in Mental Health

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Overview

> "For far too long, people of all ages with mental health problems have been stigmatised and marginalised, all too often experiencing an NHS that treats their minds and bodies separately. Mental health services have been underfunded for decades, and too many people have received no help at all, leading to hundreds of thousands of lives put on hold or ruined, and thousands of tragic and unnecessary deaths."[1]

So begins the foreword to the 2016 report from the Independent Mental Health Taskforce to the NHS in refreshingly direct style. It's not a new theme: The British Government coined the phrase "There is no health without mental health" in a report in 2011[2] and outlined the need for Parity of Esteem – that mental health conditions be treated like physical health conditions.

In 2013, Bailey et al[3] broke down the term Parity of Esteem into 6 areas which include equal access to care, efforts to improve quality of care, access to resources, education, practice, measurement and aspiration for service users. By doing so makes it possible to prove that we are a long way from parity of esteem as they did in their 2018 editorial[4] by highlighting differences in treated prevalence, research funding and health funding in general.

In 2016 the Five Year Forward View was published highlighting responses to the challenge in the areas of data, access, incentives, regulation, leadership and innovation. Chapter four focused on actions to strengthen the workforce.

Since then, action has been taken, but measurement of progress by the British Medical Association[5], highlighting remaining gaps and stating *"Workforce shortages in mental health are affecting workload, wellbeing and morale. Shortages also affect the ability for clinicians to provide the quality of care they wish to."*

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[1] The Five Year Forward View, A report from the independent Mental Health Taskforce to the NHS in England February 2016
[2] HM Government, No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages, 2011
[3] Bailey, S., Thorpe, L. & Smith, G. (2013) Whole-Person Care: From Rhetoric to Reality. Achieving Parity Between Mental and Physical Health.
[4] Sue Bailey, Lucy Thorpe and Greg Smith (2018) Using the lever of parity of esteem between mental and physical health to close the mental health gap – a call for action
[5] Measuring Progress: Commitments to support and expand the workforce in England

The “workforce” is a group of people, and people do not operate in isolation – they are influenced by, and influence, the people they work with, the system, processes and tools (digital and otherwise) that they use. Because of this pivotal role, and with more than 194,000 people[6] working in the NHS in mental health provision in England, strengthening the workforce is an absolutely critical part of creating parity of esteem.

Stepping Forward to 2020/21: the mental health workforce plan for England sets out a range of plans to strengthen the workforce as part of the drive to identify and recruit more roles. At the heart of this strengthening is a need to grow Mental Health workforce by a third by 2024, but the growth of staff numbers is only a proxy measure for change and there is no assurance of multi-year funding for this growth within a packed set of priorities. Even if we are able to create new supply, it will take time, so we need to take some action now.

Specifically, we need to understand how to meet the Mental Health workforce challenge while we are growing the supply - we need informed regional and national plans that target high-impact changes and that bring in real innovation in whilst remaining consistent with safe staffing levels.

To help enable this, Health Education England has commissioned a programme of workforce redesign education and projects through the CLEAR (Clinically-Led workforcE and Activity Redesign) programme. This clinically led redesign approach that has already been used to great effect in the area of Urgent & Emergency Care.

As preparation for this work, we have undertaken interviews with nearly fifty people with experience of Mental Health workforce in England and reviewed more than sixty documents suggested by the interviewees.

With only a relatively short time since the 2017 report, and with a global pandemic still raging after nearly a year as we write this, it is unsurprising to hear that Interviewees report that Mental Health is still a “Cinderella Service”, where system barriers, insufficient funding, insufficient workforce and large-scale variation in models of care are significantly worse than similar issues in physical care provision.

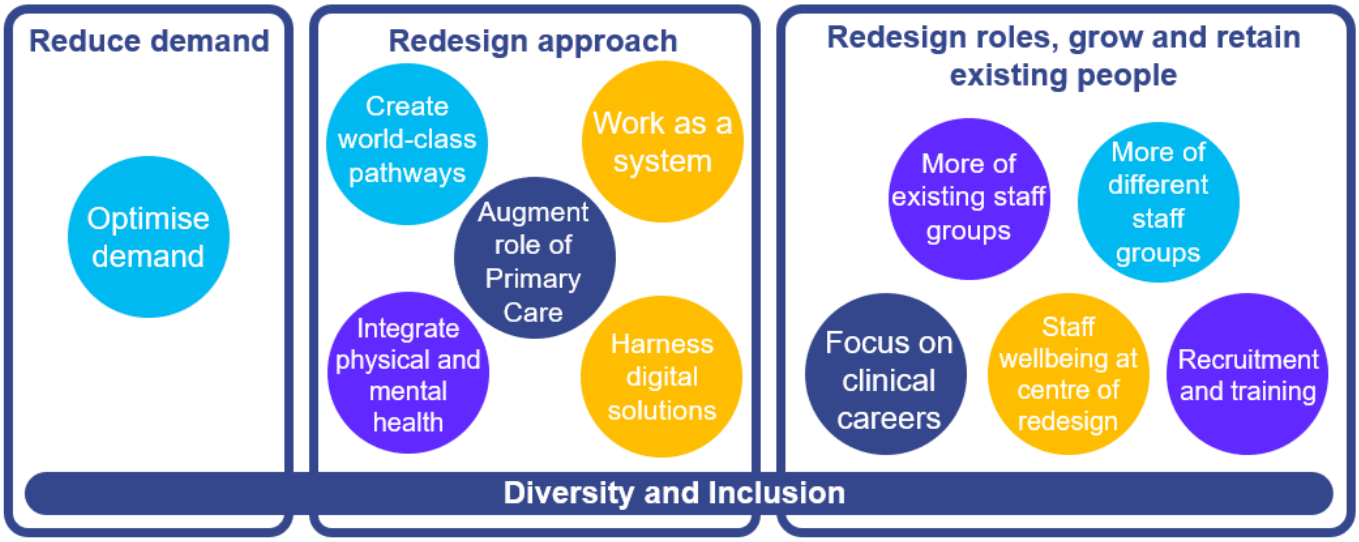
There is still a need for large numbers of people, and a doubt that we’ll be able to meet demand without significant redesign.

The interviews and research have highlighted twelve themes for workforce redesign. In presenting them, we are considering the future, not the past, and are focusing on

[6] Stepping Forward, The Mental Health Workforce Plan for England, July 2017

solutions rather than issues – as we see the redesign as a once in a lifetime opportunity to transform service and create parity of esteem.

Whilst considering the elements that need to be redesigned, we need to ensure co-production with patients and their families. This is considered critical to mental health redesign and is something that Mental health services have traditionally done well. In addition, we need to ensure that the staff in the service are fundamentally involved in the redesign – which is a given in this programme as CLEAR is clinically-led.



Workforce Redesign Themes

1. Optimise demand and reduce need for more serious interventions where possible

Pointing to the links between mental health and wider social determinants such as housing, employment and education, interviewees identified an opportunity to improve the mental health of the population and reduce the demand for workforce through public health interventions and through more voluntary and public sector support.

We will need to focus much more on prevention and the creation of opportunities for greater self-care. A fundamental focus on housing, education and all other determinants of mental health will be needed if we are to manage the steadily increasing demand. Case studies identify a range of examples of work being done locally to address this proactively (e.g. Cornwall Partnership Trust Early Intervention in Psychosis employment support[7]) and reactively in response to local crises (e.g. flooding in Somerset[8]).

> **"So many determinants of mental health are societal – housing, education etc. We are seeing much more activity into services from front-line emergency support workers like ambulance staff and the police"**

Other professionals, such as those in the police and ambulance services can be skilled and supported to assist people with mental health conditions. This should apply to all people in health and social care that may be able to identify or support such people – this will help ensure that people get access to the right services at the right time. Torbay Council's Vulnerability and Complex Needs Officer plays a key role in ensuring

[7] Cornwall Partnership Trust Early Intervention in Psychosis employment support scheme
[8] Addressing emotional wellbeing as part of flood recovery in Somerset – case study in "Better Mental Health for All"

that vulnerable patients get access to provision – and this role is co-located with police, fire immigration and probation services[9].

The Mental Health Foundation's document, "Better Mental Health for All" (16) provides some views on how to focus on prevention for those up to the age of 20, the wider population and yourself.

The impact of the COVID pandemic, and the impact of measures to contain it, must be assessed and built into the understanding of demand. This is likely to be substantial, and prolonged.

Finally, the physical health needs, especially long-term conditions, need to be better understood and addressed to improve both life expectancy and the quality of life for those with mental health conditions.

All of the above will help to improve and reduce the social determinants of mental ill health, promoting a community-based response to reduce the demand on primary and secondary care services (and thus the requirement for staff) whilst at the same time improving the mental health of the population.

2. Augment the role of Primary Care in supporting people's mental health

Where people do access services, the future will see primary care (and wider community/ locality models) being able to play a greater role in assisting far more people through different staff models and approaches. One of the documents reviewed from the British Psychological Society[10] references a view from Cumbria where the Primary Care team helps build on the strengths in the wider population, and then has a pivotal role in helping those that need assistance beyond that.

Primary Care will require investment in staffing to be able to provide quick access to support for patients with mental health needs. This staffing will involve more of the less-traditional roles (Peer Support Workers, Pharmacists, GP assistants and innovative new roles) operating in multi-disciplinary teams.

It may also involve bringing previously secondary care-based staff, such as Mental Health nurses and Nursing Associates, into primary care teams or in localities. Work done in Chorley in 2018[11] which drew on community resilience models in Fleetwood[12]

[9] QNI Case_Study_-_Torbay_Complex_Needs_Officer.pdf
[10] CLINPSYCH Implications & opportunities.pdf
[11] Innovation Agency 2018 Mental Health Workforce Redesign
[12] Healthier Fleetwood - https://www.healthierfleetwood.co.uk/

and social prescribing (amongst others) in Frome[13] has identified potential models for such teams, which can be built on. This needs to be supported with training for all primary care staff in managing mental health conditions.

3. Provide more of existing staff groups

As we move into more traditional mental health treatment in secondary care, part of the solution will be "more of the same" staff. The mental health workforce plan identifies an increase of 11,000 of these "traditional" roles by 2020.

Workforce redesign needs to consider how we get more medical staff. That will involve establishing how to recruit, retain and return people to practice as well as how to best redesign services to get the most out of valuable psychiatrist time, whilst simultaneously building interesting roles for medics.

Similarly, redesign needs to consider how to ensure that we have enough nurses to deliver the greater access to services that the demand levels require, without an over-reliance on Healthcare Support Workers. It will need to consider the roles and numbers of liaison nurses, advanced practice, and other mental health nurses.

More clinical psychologists and psychologists will be needed, and we have an opportunity to do more with Allied Health Professional credentialling and consider their role alongside nurses and medics to create a truly integrated workforce.

It will also need more of the support staff and other "non-qualified roles" as a core part of the delivery of services. We also need to consider expansion of roles/skills such as consultant nurse, non-medical prescribers, and non-medical responsible clinicians and approved clinicians.

We have a large occupational health workforce who have a critical role in supporting recovering and assessment of activities of daily living, but we will need to expand other roles such as physiotherapy and speech and language therapists.

Finally, the role and number of mental health Social Workers will need to be optimised, especially their role in MDTs.

Training and recruiting more of these same staff will be difficult. A core part of "more" staff has to be those staff working together in new ways – which we address as we go through this paper.

[13] Frome Community Connectors - https://healthconnectionsmendip.org/

> **"How can we move towards more standard practice, when the way we deliver care needs to take account of who you have available?"**

4. Provide more of different staff groups

As well as more of traditional roles, we need more (and more usage) of "new" roles – some of which are already defined, and others which may be even more innovative. A key opportunity is to get these roles more established in operations through:

- Evidencing the levels of new staff required and the impacts that they are having.
- We need to embed new roles and ensure that they meet the needs of patients and their families, actually fill a gap, do not make things more expensive/less efficient and that they meet the legal requirement for the role.
- The availability and skills of PAs, Peer Support Workers, Advanced Clinical Practitioners etc will need to be well articulated in new models. These are articulated in the Health Education England STAR tool[14]. A key element here will be the inspiring of teams to engage in new roles, ensuring that they are embedded into the skill mix. To fully establish and embed these roles, service users will also need to be educated and engaged to trust new roles and not default to expecting the more "traditional" roles every time.

Some of the solution will also be in enhancing the skills or focus of all staff – in the traditional as well as newer roles. This will include general identification of required skill areas, and upskilling people accordingly – but will also include upskilling in the ability to support people with multiple issues (mental (including learning disabilities & autism) and physical).

[14] HEE STAR tool - https://heestar.e-lfh.org.uk/

An increase in therapeutic skills may also be an opportunity for outcome improvement that should be tested. Skills in comorbid addiction is a large gap and will need addressing in new staffing models.

In order to develop enough new staff to meet rising staff demand we must consider the opportunities that the programme can have for system redesign, workforce redesign, recruitment, retention, wellness etc. Specific areas include the following:

5. Focus on diversity and inclusion

A focus on diversity and inclusion presents an opportunity for workforce redesign to grow staff numbers and create a positive work environment. The redesign must ensure that the offer to work in mental health is accessible to a diverse set of backgrounds, and that roles work for people from these backgrounds throughout their careers.

At the same time, it offers the chance to ensure that all people can access mental health services equitably and that these services take account of their needs – we must consider this at all stages from design to implementation and beyond.

> **"One thing COVID has taught us is that we need to focus on designing our service to meet the needs of diverse groups – in both patients and staff"**

All interventions and options should be culturally appropriate and offer the least restrictive options at all times. Case studies in NHS England's "No Assumptions document" [15] contain a wealth of examples from the UK, including The Somali Project in Lambeth and Mindout in Brighton.

[15] https://www.england.nhs.uk/wp-content/uploads/2014/08/no-assumps-mh.pdf

6. Focus on clinical careers

The redesign will need to focus on getting the most from people by building long and rewarding careers. It will need to create credible and attractive roles that allow people to remain clinical across their career.

We can consider how we train clinicians throughout careers, but as required – allowing people to enter the workforce earlier, but train throughout their careers, and develop greater access to portfolio careers.

The importance of varied careers is mentioned in many of the team focused documents including the BPS Briefing Paper on Psychology[16], and the Clinical Competency Framework for Mental Health Nurses from HEE[17].

7. Work as a system

For redesign to work, it will have to follow the direction set for the Health & Social care sector and ensure that it creates new models as a system, not as individual organisations. Health & Care systems will need to work together, producing the best model for patients, and find mechanisms to address impacts on organisations.

Interfaces between organisations need to be clear and defined to help patients clearly navigate and remain monitored throughout their care journey. To help create "comfort" in the movement to community settings, establishments and safe staffing in primary and community setting are needed to augment the work already done in secondary care.

Community working will require that estates be optimised to allow multi-organisation working in single locations. Finally, the redesign will need to consider the needs of private providers (which provide 25% of mental health services, and a lot of CAMHS tier 4 provision).

[16] Briefing Paper - Mental Health Support Teams.pdf
[17] Mental Health Nursing - Competence and Career Framework

The document Future in Mind from the DoH[18] talks about how the system can work around the patient, blurring the boundaries between tiers and the GIRFT rehab consultation[19] document also talks about the need to work as one system.

"How do we make sure that people not only don't drop through the cracks, but that organisations work together around the needs of the person?"

8. Create world-class pathways

There is a noted opportunity to reduce variation and improve efficiency in processes[20]. There should be variance in service only when warranted – which will be supported by having enough staff to deliver – and to create these the redesign will need to both go "back-to-basics" and build on the great work done by GIRFT[21], Trailblazers[22] and many systems (12) around the country. Services must be designed with the service-user at the centre – and this will require that the redesign be developed working with patients, their carers, and their families.

We will need to apply standard working like the acute physical health sector does and learn from acute models in areas like "home first" type models to support staff and patients. The patient journey needs simplifying to avoid too much jumping around and the gap between services (e.g., adult and children) needs bridging.

The Consultant Psychiatrist role needs agreed levels of intervention so that it is clearly agreed how much is led or delivered by this important role, and their expertise (as well as others) may need to be considered earlier in the process to better target interventions and support – including in the areas of addiction and eating disorders.

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[18] Childrens_Mental_Health.pdf
[19] GIRFT Psychiatric Rehabilitation Report_v1.9SK.docx
[20] Lord Carter's review into unwarranted variations in mental health and community health services 2018
[21] Get It Right First Time - https://www.gettingitrightfirsttime.co.uk/girft-review-of-mental-health-gets-under-way/
[22] Vanguards: New integrated care models in England associated with small reduction in hospital admissions in longer-term.

This approach would work well for nursing as well, working to ensure adherence to NICE guidance and evidence-based practice.

There are a whole host of areas for redesign to focus on the pathways. Examples include:

- Patients with long term severe and enduring mental health conditions that end up in secondary care need to be cared for and monitored in a way that reduces admissions (e.g., appropriate engagement of medics in care plan, care-co-ordinators in community).
- Re-assessment needs to be optimised.
- Information flow between outpatients, inpatients and crisis needs to be efficient.
- Risk assessment use needs to be optimised to avoid over-use.
- Need to address stranded patients in beds – patients that are in inpatient care are not able to be quickly discharged.
- Pathways through A&E will need to be clear to improve care and reduce demands on A&E staff.

With such a demand challenge facing a team that needs to grow rapidly to compensate, efficiency will be key. Workforce redesign will need to focus on minimising bureaucracy and optimising its impacts.

This will include minimising requests for information from the centre, addressing travel time and measuring and increasing overall productivity of the service (through all the support and improvements identified, not by expecting an already stressed group of staff to do more with the same).

9. Integrate physical and mental health

There is no health without mental health. The Five Year forward view clearly highlights where parity between physical and mental health needs to improve.

The redesign will need to consider how the integration of physical and mental health can be designed into the redesign, even though it is looked at from a mental health perspective. We need to integrate physical and mental health service, address

medically unexplained symptoms and specifically aid the physical health of patients with mental health issues to address the 15-20 years of lost life[23].

> **"People with complex mental health needs should have the same access to health care services and support as people with physical health needs."**

Clear links will need to be made with long term condition management, such as COPD and diabetes which are reported to be more prevalent in patients with mental health conditions. Specific case studies in this area, including those in Wales, Forth Valley and Kings[24] need to be built upon. Documents from the BPS[25] to the five year forward view (4) and many others highlight this as a fundamental requirement.

10. Harness digital solutions

The redesign needs to not only identify digital solutions that can be used now to optimise delivery, but it must provide people with the skills to be able to bring in new digital solutions and needs to consider how to be looking to the future for the next digital solution and make that happen – not just be reactive.

Redesign will need to consider the requirements of service users when assessing digital offers – but "back office" options to streamline care will be less contentious. Example uses of Population Health Analytics, Care co-ordination software and care package building platforms were highlighted in the Chorley case study.

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[23] Parity of Esteem: Delivering Physical Health Equality for those with Serious Mental Health Needs, Royal College of Nurses 2019
[24] Parity of Esteem: Delivering Physical Health Equality for those with Serious Mental Health Needs, Royal College of Nurses 2019
[25] BPS Response - Psychological Professions Vision for England 2019-24.pdf

11. Place staff wellbeing at the centre of redesign

Wellness will be at the heart of redesign, ensuring that people are working at the right level, have the right supervision and at safe staffing levels. Support for wellness is vital throughout.

> **"This can't just be about gym membership!"**

A range of opportunities in mentorship[26], better leadership, a focus on the needs of staff and their engagement in the redesign all point to opportunities for well-being - but increases in workload (general and now due to COVID) are likely to reduce wellbeing for many staff members.

A key consideration for the work is the need for clinical supervision in a staff-constrained environment – recognising that staff are exposed to high levels of violence, distress and trauma.

12. Focus on recruitment/retraining

Finally, recruitment and retraining needs to be optimised through the redesign. We need a mechanism for faster training of Clinical Psychiatrists, an expansion of the 2 year fast-track programme for Mental Health Nurses and co-ordination of training across mental health, especially in Talking Therapies.

We need to make mental health roles available to a wider set of people, and co-ordinate the effort around new roles as well as focusing on retention from recruitment, throughout people's careers. In addition, higher trainees are an important part of the workforce – we need to consider how others can provide service while training where it is appropriate.

[26] 22. CentreforMentalHealth_Future_mental_health_workforce.pdf

In conclusion

We are emerging from a pandemic that will increase demand and reduce the available supply of people able to help. We need to understand the long-term effects of the outbreak and the actions taken to mitigate its effects, and in each of these areas consider whether short and long-term actions are required.

By considering these areas, we will be able to appropriately transform the workforce and supporting processes, digital technology, organisation structures and estates to be able to improve parity of esteem for people with mental health issues.

The CLEAR Mental Health programme has been commissioned to develop workforce redesign skills in Mental Health clinicians of all types. It will deliver 14 projects, across seven themes:

- Adult Common Illness
- Adult Liaison MH, A&E, Ward Liaison Services
- Therapeutic Acute Mental Health Inpatient Care
- Children and Young People Mental Health
- Adult Severe Mental Illness Community Care
- Adult Crisis Alternative

This programme will start delivering projects in June and plans to operate across 25% of the Health & Care systems in England through two waves of projects. For more information see www.clear-uk.org.uk or email clear.team@hee.nhs.uk.

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Augment the role of Primary Care in supporting people's mental health

Provide more of existing staff groups

Provide more of different staff groups

Focus on diversity and inclusion

Focus on clinical careers

Work as a system

Create world-class pathways

Integrate physical and mental health

Harness digital solutions

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47. *First Response in Bradford*
48. *Leicester health screening*
49. *Mental Health Trust eliminates acute out of area placements for two years in Sheffield*
50. *Nottinghamshire street triage scheme*
51. *Psychological therapy helps people with long-term conditions to Live Well in Buckinghamshire*
52. *Talking Shop in Doncaster*
53. *Three dimensions of care for diabetes at King's College Hospital, London*
54. *Oxford trust delivers culture-change in care with integrated psychological medicine*
55. *Positive Step for carers in North Somerset*
56. *The Big Brew campaign created by Mersey Care*
57. *Dozens of children have smoother adoption thanks to unique Sheffield scheme*
58. *South West Zero Suicide Collaborative*
59. *Survivors Manchester tackles stigma and silence around sexual violence against men*
60. *Islington IAPT Service – An IAPT service with a strong focus on recovery rates*
61. *County Durham Crisis and Liaison – one year on*
62. *Mens Health - The Blues Boys*
63. *Mens Health - HEALTHY MAN: IMPROVING THE PHYSICAL HEALTH OF MEN DIAGNOSED WITH PSYCHOTIC ILLNESS*
64. *Mens health - The Light bulb Course*
65. *Health champions for the homeless*

66. *THE SOMALI PROJECT, CERTITUDE, LAMBETH, LONDON*
67. *QU'RAN AND EMOTIONAL HEALTH, SUFFOLK AND ROCHDALE MIND*
68. *MIND PEER SUPPORT FOR SOUTH ASIAN WOMEN, LEEDS*
69. *MINDOUT, BRIGHTON*
70. *MOTHERTONGUE, READING*
71. *TOGETHER YOUR WAY, LONDON*
72. *IDLE VALLEY ECOMINDS, NOTTINGHAMSHIRE*
73. *EMERGENCE PLUS ARTS AND SOCIAL NETWORK, LONDON*
74. *PSYPHER COMMUNITY TIMEBANK, HUMBER NHS FOUNDATION TRUST, HULL*
75. *HOURBANK, PECAN, PECKHAM, LONDON*
76. *SARAH'S HOUSING SUPPORT, AMBER TRUST, DERBYSHIRE*
77. *RETHINK DEVON COMMUNITY OPPORTUNITIES AND RECOVERY PATHWAYS, DEVON*
78. *LAUNCHPAD FREELANCERS, NEWCASTLE*
79. *COOLTAN ARTS, SOUTHWARK, LONDON*
80. *THE NATIONAL SURVIVOR USER NETWORK MENTAL HEALTHWATCH, NATIONAL*
81. *TELEHEALTH FOR INTEGRATED MENTAL AND PHYSICAL HEALTH, NATIONAL*
82. *SOLIDARITY IN A CRISIS, COMMUNITY CONNECTIONS AND TRAVEL BUDDIES, LAMBETH, LONDON*
83. *AIRDRINA'S INTEGRATED PERSONAL BUDGET, LAMBETH, LONDON*
84. *LINCOLNSHIRE COMMUNITY MENTAL HEALTH SUPPORT NETWORKS, LINCOLNSHIRE*
85. *ACTIVE MINDS, CROYDON*
86. *MIND AND BODY PROJECT, SHEFFIELD*
87. *VEE'S PLACE, ST HELEN'S, MERSEYSIDE*
88. *STAR WARDS, WARDIPEDIA, NATIONAL*
89. *LEEDS SURVIVOR LED CRISIS SERVICE, LEEDS*
90. *WISH – A VOICE FOR WOMEN'S MENTAL HEALTH, NATIONAL*
91. *GP WELLBEING PEER SUPPORTER, BRENT, LONDON*
92. *ALL TOGETHER POSITIVE PREVENTION AND PERSONALISATION SERVICE, STOCKPORT*
93. *ST DYMPHNA BEFRIENDING GROUP, NUNEATON*
94. *Outreach nursing model in High Wycombe*
95. *Torbay Complex Needs Officer*
96. *Bristol Wet clinic*
97. *Respite and intermediate care model - Bradford*
98. *Relationships in dementia - Bryn Hesketh*
99. *Patient Empowerment Project - Leeds*
100. *The COPD Manual*
101. *Addressing emotional wellbeing as part of flood recovery in Somerset*
102. *Five Ways to Wellbeing (5WtW) in Warwickshire*
103. *Dorset Mental Health First Aid Training*
104. *Mental health & wellbeing strategy and action plan Think Good Feel Good/TaMHS 'Broadening the Reach'*