Stepping forward to 2020/21:
The mental health workforce plan for England
July 2017

A report from Health Education England to support the delivery of the Five Year Forward View for Mental Health in England.

There has never been a more important time to work in mental health. There is a genuine consensus that mental health matters as much as physical health and it is one of only four priority areas that will benefit from additional resource needed to deliver real improvements for those who access services.

The *Five Year Forward View for Mental Health* set out the improvements we can expect in mental health services by 2021. Now we need to make sure we have the workforce to deliver them. Nurses, Occupational Therapists, Psychiatrists and peer support workers – to name but a few – will turn our ambitions into a lived reality for patients and their carers.

Stepping Forward to 2020/21: the mental health workforce plan for England sets out a high level road map and reflects the additional staff required to deliver the transformation set out in the *Five Year Forward View for Mental Health* based on best evidence to date. We are working with NHS England, other arms length bodies (ALBs), and local service providers to trial essential components of this programme (including, for example, integrated IAPT services, perinatal care and an expansion of liaison services) to identify the best skill mix to deliver evidence-based care in the optimal way and test innovations (e.g. increasing use of digital services) designed to improve productivity. Findings from these workstreams will be used to refine this model.

This plan makes clear that no one organisation holds all of the levers necessary to produce the required workforce. Delivery will require providers, commissioners, ALBs, local authorities and the third sector to work together to ensure we recruit, retrain and retain the staff that we need. Success requires not just good data, but patient-focussed thinking, pro-active, system level leadership and behaviours that reflect the values of the NHS Constitution.

But we know change is already happening as staff in mental health services develop new and better services: the integration of physical and mental health, the range of settings and partnerships, self-care and user-led models. This document provides a basis for local conversations and plans to enable local systems to continue to deliver improved services.

Our primary focus has been to identify key actions to deliver the 2021 commitments, from a starting position where mental health services are not meeting current need. HEE will continue to work with our partners to develop a longer-term strategy to ensure we have enough people with the right skills in the right place to meet the forecast needs of patients.

But right now we need to seize the challenge we have been set and with our brightest and best people start the journey to deliver world-class mental health care.

Professor Ian Cumming OBE
Chief Executive
Health Education England

The *Five Year Forward View for Mental Health* is committed to an ambitious and exciting set of service developments which are part of a significant forward step towards world leading, compassionate and modern mental health services by 2021.

Stepping forward to 2020/21: the mental health workforce plan for England focuses on the health workforce to 2021 whilst acknowledging that social care, housing, community and the third sector all provide invaluable services which need to be thought about in the context of the cross-government plans for better mental health. It is also acknowledged that a longer term integrated health and care workforce strategy would be invaluable and that many health posts, such as medical consultants, takes 14-15 years to plan and deliver, if we count from the time the person enters medical school.

This document sets out the high level road map for regions, STPs and local areas from which to build their regional workforce plans to 2021 that reflect local needs and strengths. Iterating service designs and workforce solutions locally will change the aggregate picture of how many professionals are needed as local solutions are created to address local shortages e.g. expanding the use of new roles to support existing teams, or investing in Advanced Clinical Practitioners to lead them.

Mental health services offer a comprehensive range of roles, providing scope to touch and change people's lives and access to primary and specialist services from cradle to grave. Whilst new services and innovations are being introduced as part of the Five Year Forward View for Mental Health, vital core services such secondary care in-patient wards and CRHTTs have more scope to refine their expert offer and modernise essential care.

Working alongside service users, co-producing care, growing more peer support worker roles in all settings, introducing apprenticeships at every level, Nursing Associates, support worker roles across all settings and professions, mean that entry into the mental health workforce has never offered so much choice, flexibility and opportunity for such a wide range of skills and abilities.

For professionally clinically qualified staff across the wide range of disciplines which contribute to comprehensive, multidisciplinary care, the choice of settings within which to work, the diversity of team membership and skills and the freedoms to innovate, have never been greater. Working more closely with general practice, hospitals, specialist inpatient and community teams and in partnership with service users of all ages and needs, affords opportunities for professional advancement and fulfilment; the like of which is unprecedented.

We understand that this plan is only a first vital step on an important and challenging journey for mental health. But the opportunities to challenge stigma, change and enhance lives and to create local workforce plans, meeting the needs of diverse and rewarding communities and individuals are available here. *Stepping Forward* gives us an imperative to think about how we recruit, train, develop and support our most valuable resource. Our people.

Claire Murdoch
National Director of Mental Health
NHS England

1. Purpose

Mental health has never had such a strong focus and support. Following the publication of The *Five Year Forward View for Mental Health,* the Government has committed to a more proactive and preventative approach to mental health by investing £1bn[1] in:

- **Improved access to services at an earlier stage:** an extra one million people will be able to access mental health services by 2020/21 including 70,000 more children and young people gaining access to evidence based interventions and with a greater focus on prevention and mental wellbeing.
- **Services accessible at the right time:** 7 days a week, 24 hours a day when needed. There will be full coverage across England with evidence based Crisis Resolution and Home Treatment Teams and Community Perinatal teams providing care in local communities and improved access to Liaison Mental Health care in secondary physical care services; this will ensure no one experiencing a mental health crisis is turned away.
- **Services delivered in a more integrated way:** for example, through integrated primary care based clinics serving long-term conditions and depression and anxiety; by expanding perinatal services, so 30,000 more women have access to services; providing more mental health services in physical healthcare settings, expanding access to places of safety and improved crisis services.
- **Embedding mental health services into the NHS:** with better data, the right workforce, more investment in research, and local leadership to deliver the best possible outcomes. Those who access mental health services will be able to check how well local areas are doing through published mental health dashboards.

This programme of investment and reform provides a rare opportunity to improve the way we provide care across all settings (including primary, community and secondary care services including urgent/emergency care), across all age groups (for example, with old age specialists), and across all health and care professions, with more care delivered in the community. The additional investment will deliver real improvements for those who access mental health services and will increase the rewards, skills and opportunities available to the whole workforce, both formal (e.g. nurses, doctors and therapists) and informal (e.g. peer support workers and volunteers).

To deliver this growth and transformation agenda we will need motivated and multi-professional teams focused on delivering person-centred care: expert clinicians, doctors, nurses, psychologists, allied health professionals, and social workers, combined with new and enhanced roles such as peer support workers, nursing associates, assistant practitioners and assistant psychologists.

The NHS will establish 21,000 posts and employ 19,000 additional members of staff by 2020. 11,000 of these will be drawn from the 'traditional' pools of professionally regulated staff, e.g. nurses, occupational therapists, or doctors. In addition, there will be 8,000 people moving into new roles e.g. peer support workers, personal wellbeing practitioners, call handlers, or nursing associates. The growing proportion of support staff represents both a broadening of the talent pool as we develop new roles, but also the emergence of new service models, e.g. the 'Sunderland' model for CRHTT teams, which relies on a wide range of roles to work alongside qualified staff and help ensure they are making the most productive use of their time.

[1]To deliver the new commitments set out in 5YFV for Mental Health published in 2016. It builds on the £280 million investment each already committed to drive improvements on children and young people's mental health, and perinatal care. See Annex 2, p34 for a breakdown of additional investment

All our staff need to be: highly skilled in partnership working, integrating care and co-production with those who access mental health services and their carers; technologically-adept; values-driven; and able to provide physical as well as mental health care. They will need the space to innovate and to work to their full scope of practice, as well as practical help to develop their skills, knowledge and competence so as to reflect the changing mental and physical care outcomes required by people with a mental health need, learning disability and/or autism. This may involve investing in staff training to increase skills, knowledge and competences in order to help them deliver care differently or to a higher standard, especially for marginalised groups, including black, Asian and minority ethnic (BAME) people, lesbian, gay, bisexual and transgender people, disabled people, and people who have had contact with the criminal justice system, among others.

This will only happen if we act now, in concert, to deliver it. Delivering the mental health plan will require providers to establish employ an 19,000 new members of staff, whilst maintaining and improving existing services. The sheer scale and complexity of the service-wide growth and transformation needed will demand aligned actions from providers, commissioners, local government and third sector partners, supported by Health Education England (HEE) and the other national ALBs. This document offers a workforce plan to help local systems deliver the *Five Year Forward View for Mental Health* to 2021.

It sets out:

- **Where we are now:** the overall numbers, skills and location of our current workforce in mental health.
- **Where we need to be:** our underpinning assumptions and modelling about the overall number and types of skills required to provide mental health services in the growth areas, whilst ensuring the service as a whole is maintained and improved.
- **What we need to do to get there:** who needs to do what and when to achieve the net growth in staff – with clear actions for local and national partners.

There are many different services, labour markets, and multi-professional teams across England. Some of these are delivering innovative models of care which we need to build on. HEE has developed a national workforce model as a framework to support local workforce plans. This will deliver the service models and growth set out in the *Five Year Forward View for Mental Health*. We will continue to work with our partners and stakeholders to develop a longer-term strategy, so we can plan sustainable improvements beyond 2021, which are aligned with emerging strategies in related areas such as primary care and maternity.

2. Our existing workforce – where are we now?

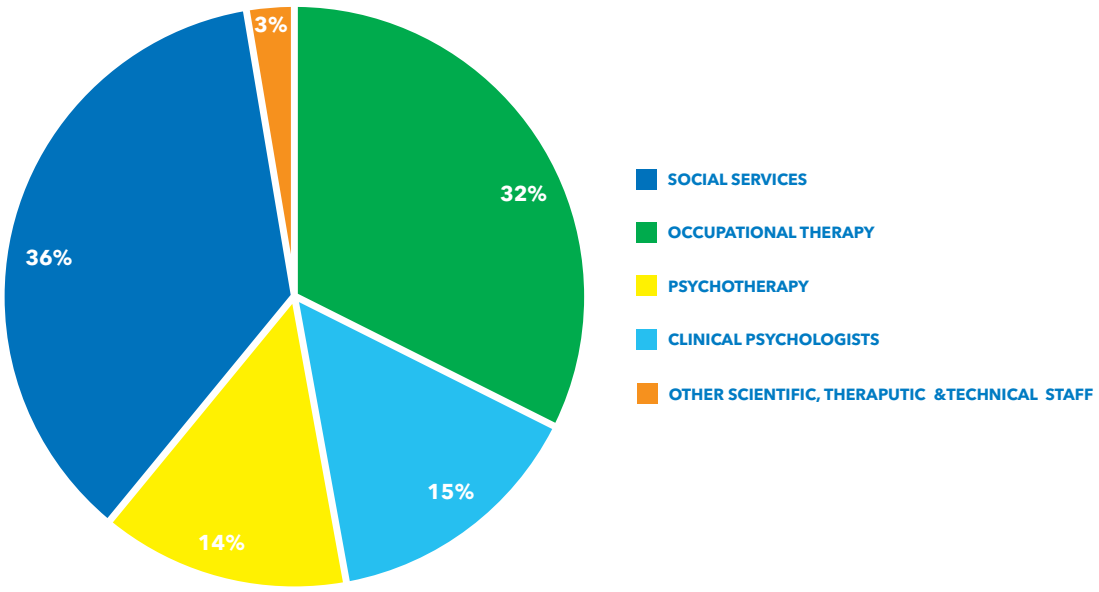
Many health and social care workers working in multi-disciplinary teams already contribute to the mental wellbeing of those who access mental health services as part of their clinical practice. There is also a powerful army of users, carers and volunteers who make a positive difference every day. This plan, however, is primarily concerned with the formal, specialist mental health workforce employed by Mental Health Trusts and other NHS-funded providers. It focuses on the changes we will need to bring about by 2021 to grow and transform services. The NHS currently funds over 214000 posts to provide specialist mental health services in England. Just over 20,000 of these are vacancies; largely filled by bank and agency staff, although this aggregate data masks geographical and service specific variations.

So approximately 194,000 people are substantively employed by the NHS to care for people who need mental health services (Table 1).

Figure 1. Distribution of qualified staff groups in Mental Health Trusts in whole time equivalent (WTE) (excluding Improving Access to Psychological Therapies (IAPT) services) identified in clinical area audits as in Table 1.[2]

Posts (of which vacancies)	Medical *	Nursing and Midwifery	AHPs and Scientific, Therapeutic and Technical Staff	Total Professionally Qualified Clinical Staff	Support to Clinical Staff	Administrative and Infrastructure Staff	Total
Children and Young People's	800 (100)	3000 (400)	4000 (500)	7900 (900)	1800 (0)	1700 (100)	11400 (1100)
Adult Improving Access to Psychological Therapies	0 (0)	0 (0)	5200 (600)	5200 (600)	2600 (300)	2000 (0)	9700 (900)
Perinatal	100 (0)	200 (100)	100 (0)	300 (100)	100 (100)	100 (0)	500 (200)
Crisis - Adult Improving Access to Psychological Therapies	400 (0)	3300 (400)	500 (100)	4200 (500)	1000 (100)	0 (0)	5200 (500)
Liaison Mental Health	400 (0)	1600 (0)	100 (0)	2100 (0)	100 (0)	300 (0)	2500 (0)
Early Intervention in Psychosis	100 (0)	800 (0)	400 (0)	1300 (0)	300 (0)	300 (0)	1900 (0)
Liaison & diversion	0 (0)	200 (0)	100 (0)	300 (0)	0 (0)	0 (0)	400 (100)
Total Transformation Areas	**1900 (100)**	**9200 (800)**	**10400 (1300)**	**21400 (2200)**	**5800 (400)**	**4400 (200)**	**31600 (2800)**
Core Acute	5200 (700)	31900 (3700)	14000 (900)	51100 (5300)	32800 (2600)	15400 (1500)	99300 (9400)
Core Community	4300 (600)	26700 (3100)	11800 (800)	42800 (4400)	27500 (2200)	12900 (1200)	83300 (7900)
Total Core	9500 (1200)	58600 (6800)	25800 (1700)	93900 (9700)	60300 (4800)	28400 (2700)	182500 (17300)
TOTAL	**11400 (1400)**	**67800 (7600)**	**36200 (3000)**	**115300 (11900)**	**66100 (5300)**	**32700 (2900)**	**214100 (20100)**

Table 1. Number of posts (in FTE) and vacancies (in FTE) in Mental Health Trusts as of 2016[1]



[1] This includes data drawn from audits, censuses and other workforce collections carried out in 2016/2017 which focused on individual services such as Children and Young People's services of Liaison Mental Health. Mental Health Trust data is drawn from NHS Digital publications and has been rounded up. Note, it is difficult to draw broad conclusions about mental health services or the staff delivering them because mental health services can be delivered in a variety of settings by a wide variety of staff, including non-health staff such as social workers, Youth Offending Teams and voluntary and community organisations. * 'Medical' is the NHS Digital categorisation of this staff group, and includes all grades, including consultants who work in either a MH service or in a MH Trust.

[2] Source: NHS Digital, March 2017

This table shows only the mental health workforce employed by NHS statutory organisations (for which good data is available), not the workforce in social care or the private, independent or voluntary sector organisations. As part of implementing this workforce plan HEE will seek to improve the available data on the non-NHS workforce.

If looking through the eyes of those that use mental health services, their families and carers, there is a very different picture with significant care being provided on behalf of the NHS in other care sectors (for example inpatient children and young people's services). Additionally, mental wellbeing and prevention activity can take place in schools, community centres and prisons.

More importantly, looking at the workforce in terms of current and forecast changes in our population, it is not just the volume of demand for mental health services which is likely to change, but the range and breadth of different needs. For example, there are 10 million older people in England, and the number is growing rapidly.

The assessment and management of mental health problems in this age group requires bespoke competencies not always available in general adult psychiatric services. This results from the presence in individuals of comorbid physical illness, frailty and cognitive impairments coupled with unique social factors (e.g. post retirement life changes and inevitable deaths of peers).

In addition, attrition rates for all mental health staff are rising, the number of people leaving Mental Health Trusts has risen from 10.5% in 2012/13 to 13.6% in 2015/16 (compared to 8.6% in secondary physical care services). This means that the NHS loses more than 10,000 mental health staff each year.

This high level table (table 1) cannot bring out the comprehensive diversity of teams (in terms of professions), including Allied Health Professionals (AHPs) such as psychologists, occupational therapists and social workers, but gives an indication of the varied nature of those teams as demonstrated by the pie chart on page 6:

Given the complexity of the workforce and the current gaps in data, it has not been possible to cover in this plan every profession or aspect of mental health services.

We have therefore focused on the following workforces:

1. Mental Health nursing workforce
2. Medical workforce
3. Wider workforce (psychology and psychological therapies – including adult IAPT, Occupational Therapy and other Allied Health Professions, and new roles)

The Mental Health nursing workforce

With 67,800 posts in 2016, the mental health nursing workforce has the highest number of qualified staff. It forms the backbone of current and future services. Whilst training courses are oversubscribed and the attrition rate for psychiatric nursing undergraduate education is comparable to other nursing branches (at 12.1%) compared to 10.6% in adult nursing and 15.5% in learning disability nursing[1]), the number of posts for qualified nurses available has fallen in recent years. In 2016 it was nearly 12% below the 2009 level, in contrast to nursing as a whole which has grown over the same period (Figure 2).

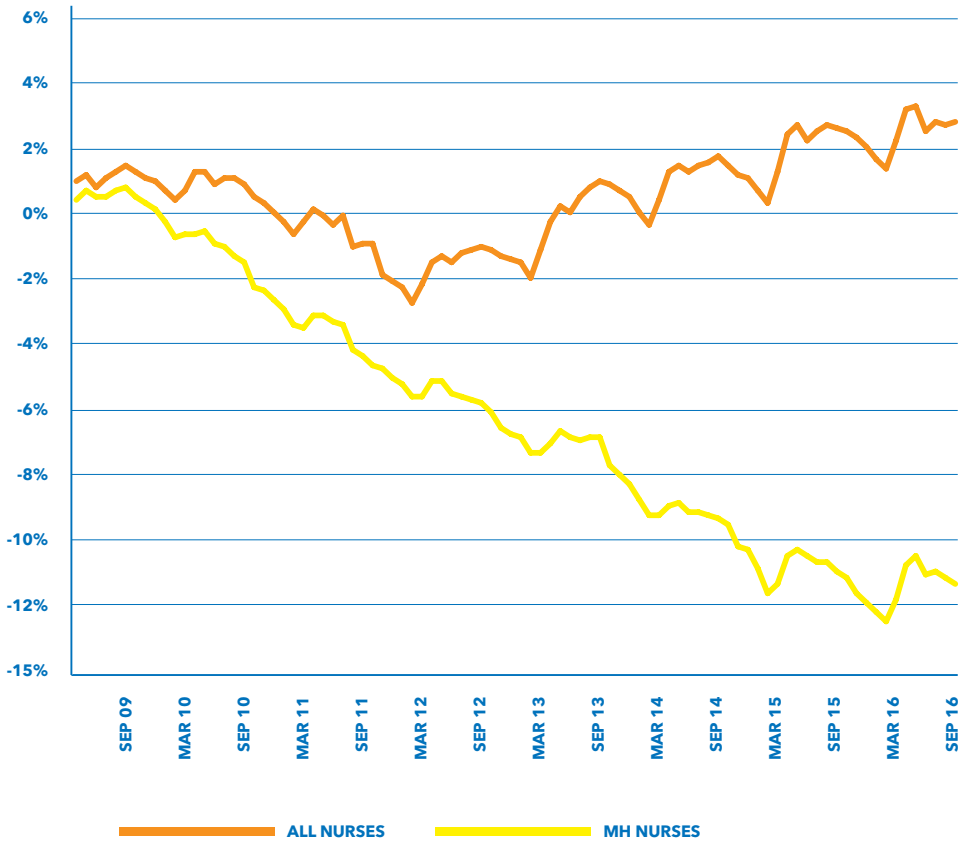


Figure 2. Comparative growth of mental health nursing and all nursing fields[3]

[1] HEE analysis of Higher Education Funding Council for England data on confirmed course dropouts

[3] Source: NHS Digital, March 2017

Mental health nursing has also lagged behind the growth seen in other mental health professions.

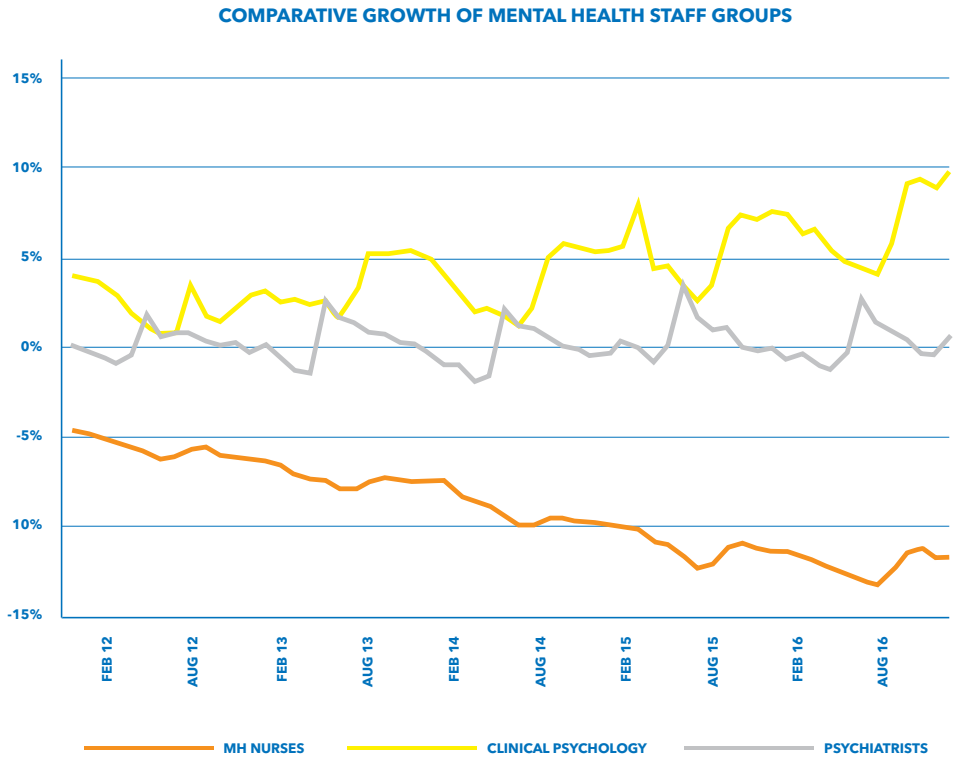


Figure 3. Comparative growth of staff groups in mental health[4]

In order to qualify as a registered nurse, typically, all nursing students need to complete a three-year degree which involves on the job training and working in a variety of health and care settings (Figure 3).

Figure 4. Training pathway for Mental Health Nursing

Student nurses register with the Nursing and Midwifery Council after completing their undergraduate degree and immediately commence work as a registered nurse. Registered nurses who wish to advance their practice can undertake post graduate studies in specialist areas up to Masters level and beyond e.g. Child and Adolescent Mental Health Services (CAMHS) or non-medical prescribing. Such ongoing continuing professional development and specialisation is the responsibility of the employer and the individual registered nurse.

Experienced nurses may also choose to move into clinical leadership and teaching roles. These arrangements have the advantage of being flexible, but supply risks being reactive and unplanned.

[4] Source: NHS Digital, March 2017

In 2015, a range of reforms to clinical education were announced, moving nursing students onto the Student Loans Company support transitioning to the open market. The Government and the Council of Deans anticipates this will remove the de facto 'cap' on training places created by the bursary funded system. However, mental health nursing students are typically older (27% of applicants in 2015/16), and it will be important to ensure that the changes do not adversely affect recruitment. Post-graduate students bring maturity and adaptable skills to the system and we should seek to retain this depth of experience where possible.

A more flexible option has recently been introduced by HEE in the form of the current national pilots for 2000 Nursing Associates. A two year Foundation degree will allow these staff to achieve clinical competence to support a registered nurse. Nursing associates could then, if they wish and with their employer's support, undertake further training to become a registered nurse.

While the percentage of non-UK nurses[5] working in mental health tends to be lower than in other branches, their contribution to the NHS is highly valued and it is essential that we retain their skills while also ensuring we have a sustainable future workforce.

Given the existing vacancy rate and the wider factors that may influence nursing supply, it is imperative that we do all we can to understand the causes of attrition and turnover and take urgent steps (nationally and locally) to address them.

So what does this mean for the mental health nursing workforce?

Although training courses for mental health nursing are oversubscribed and the attrition rate is comparable to other branches of nursing, the growth of nursing posts in mental health has not kept pace with other professions to date and 11% of these are vacant.

More worryingly, the net effect of staff turnover in mental health nursing is currently negative which means there are fewer mental health nurses employed each year (-4% each year compared to +2% for Adult Nursing). Whilst mental health nursing currently relies less on non-UK staff than other branches, close attention will need to be paid to the impact of Brexit and bursaries, with a shift away from planning for this key workforce.

It is clear that as services expand, more mental health nurses will be needed to fill the new posts. Given the lead time to train a nurse, it will be essential to explore opportunities for reskilling and developing existing staff, as well as attracting qualified nurses back to the NHS.

[5] Comparison of nationality of mental health and adult nurses in the Electronic Staff Record. Source: NHS Digital, March 2017

Almost a third of all qualified mental health nurses do not currently work substantively in the NHS – there are approximately 96,000 mental health nurses on the register across the UK compared to 68,000 employed in English Mental Health Trusts and other specialist mental health providers. Section 4 sets out some clear actions to address these issues.

Current status of the Mental Health medical workforce

There are currently 11,400 medical posts in mental health services of which 5,400 are consultants). Of these 1,400 (12%) are vacant including 700 (13%) consultants. Although the medical workforce in mental health has grown in recent years, there has been lower growth in the numbers of psychiatrists employed relative to the wider medical workforce (Figure 5).

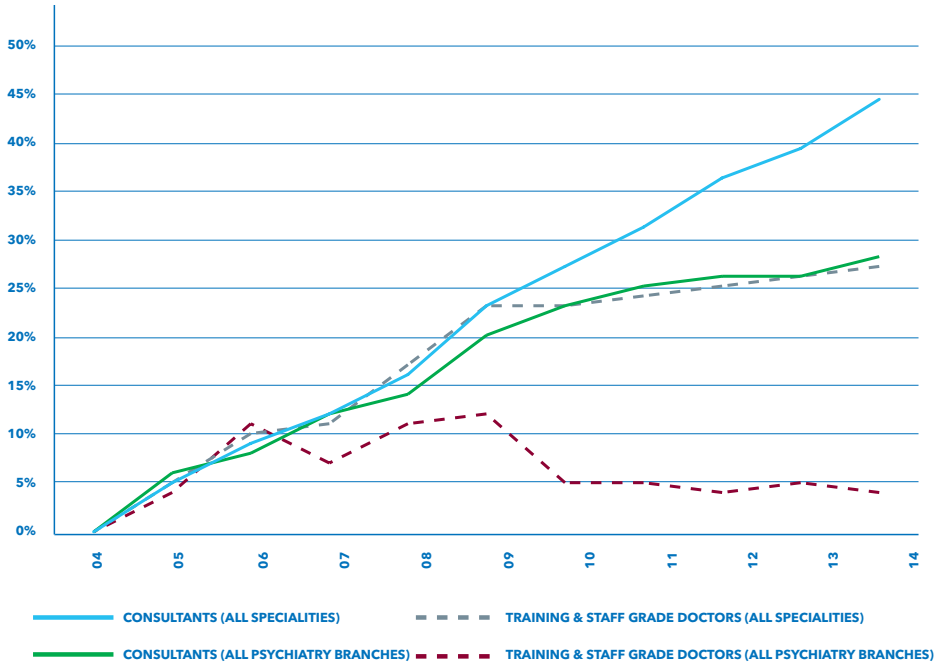


Figure 5. Comparative wte growth of psychiatry and total medical workforce, indexed to 2014[6]

To consider how best to increase the supply of medical staff in general and psychiatric consultants in particular, it is helpful to understand the training 'pipeline' which eventually produces a doctor eligible to be a Consultant Psychiatrist, including the points when individuals can step in or out of training. It is often said it takes six years to train as a Psychiatrist but, including time at Medical School, it is more like 14-15 years (Figure 6).

Figure 6. Psychiatry training pathway.

[6] Source: NHS Digital, March 2017

Following graduation from undergraduate medical school, there are a number of points along the 'pipeline' for psychiatrists where potential supply can be lost:

- **Not enough newly qualified doctors choosing/able to train in psychiatry.** In 2016, only 349 of the advertised 417 Core Psychiatry Training places were filled by a trainee (83%). The percentage of unfilled training posts in psychiatry is consistently higher than any other specialty. Doctors in postgraduate training programmes contribute significantly to the service by delivering care, as well as getting trained. The impact of poorly filled training programmes therefore directly affects care today as well as risking care tomorrow if too few consultants are produced.
- **Low direct transition rates from Core to Higher Specialty Training.** Historically, for every 100 psychiatrists recruited into core psychiatry, 60 will complete core training and then proceed directly to complete higher psychiatry training. For UK medical graduates, the figure is significantly higher than overseas medical graduates. Trainees may temporarily or permanently step out of training at this transition point to work as locum or non-consultant, non-training grade doctors.
- **Recruitment into higher psychiatry is therefore reliant on non-UK doctors in training** and augmentation from beyond the pool of former core trainees. As many as 48% of higher specialty trainees in psychiatry have non-UK Primary Medical Qualifications. 67% of our medical staff in mental health services are British (10% EU, 17% non-EU) compared to 75% of all medical staff (9% EU, 16% non-EU). The contribution of overseas doctors to the NHS is highly valued and it is essential that we retain their skills whilst also ensuring we have a sustainable 'homegrown' future workforce.
- **A quarter of recently qualified consultant psychiatrists do not go on to be employed substantively by the NHS** (although they may be providing NHS-funded services in other settings or working as a locum for the NHS). This figure rises to a third within five years of registering. The GMC annual report[2] shows over 8000 psychiatrists on the Specialist Register (across the whole of the UK), but the NHS in England employs fewer than 5000.
- **The psychiatric workforce also relies heavily on non-consultant, non-training grade (SASG) doctors** (24% of the psychiatric workforce). This staff group is unplanned and therefore does not have a secure supply pipeline, but are a vital and valued part of specialist medical care.

The *Five Year Forward View for Mental Health* and this Workforce Plan identify the need for significant additional psychiatrists to be employed, if these services are delivered using current service models. This is in addition to filling the high levels of vacancies in current services.

The current levels of medical attrition may, in parts of the senior and experienced workforce, be attributed to the Mental Health Officer (MHO) scheme. The MHO scheme was introduced in 1976 to address recruitment issues and offered members the opportunity to retire at 50 after 20 years of MHO membership. While the scheme made working in associated professions, including psychiatry very attractive, it created a large early retirement bulge. The remaining members of the scheme will exit the workforce over the coming years.

This means that psychiatry is under pressure from the need to rapidly expand services, a high attrition rate and the early retirement effect from the MHO scheme. The projected supply of newly qualified consultant psychiatrists will allow only limited workforce growth to 2021.

Consultant Workforce

	Staff in Post	Vacancies*	Current Establish-ment	Expan-sion	2020/21 Funded Posts	% Expan-sion	% Current Vacancies	% Future Vacancies
CYP - Community	450	70	520	0	560	0%	-13%	-13%
CYP - Crisis	20	0	20	50	70	350%	0%	-66%
CYP - CEDS	40	0	40	30	0	67%	0%	-11%
CYP - Tier 4	70	0	70	20	90	30%	0%	-18%
CYP Total	570	70	640	100	740	15%	-11%	-18%
Adult IAPT	0	0	0	0	0	0%	–	–
Perinatal (MBUs and Community)	30	10	40	40	80	126%	-15%	-56%
Liaison and Diversion	0	0	0	0	0	0%	–	–
Crisis - CRHTTs+	240	10	250	220	470	87%	-5%	-51%
Liaison Mental Health	200	0	200	150	350	74%	0%	-40%
Early Intervention in Psychosis	90	0	90	60	150	66%	0%	-40%
Total Expansion Areas	**1,130**	**90**	**1,220**	**570**	**1,790**	**47%**	**-7%**	**-35%**
Other Community	1,950	290	2,240	0	2,240	0%	-13%	-12%
Other Acute	2,320	340	2,670	0	2,670	0%	-13%	-12%
Total Other/ Core Services	**4,270**	**630**	**4,900**	**0**	**4,900**	**0%**	**-13%**	**-12%**
Total MH Services	**5,400**	**720**	**6,120**	**570**	**6,690**	**9%**	**-12%**	**-18%**

* vacancies are not identifiable in all service areas - where vacancies exist but are not observed then fewer expansion posts would be required (as there are more currently funded posts than currently identified)

+ It was agreed to reflect the pure 'Sunderland model' (which is consultant only), to establish the level of senior medical coverage but local implementation may vary this to include appropriate use of other senior clinicians (including those already in the system).

What does this mean for the medical workforce?

Mental health is an exciting area of growth and innovation, but some areas are failing to attract and retain doctors in psychiatric training. In 2017, by HEE region, the South West fills almost 100% of Higher Specialty Training posts in General Psychiatry, and in London and the South East 78% of all higher training posts are filled, but in other parts of the country such as the North, the 'fill rate' can be as low as 38%. This can lead to little or no competition for places and a higher rate of non-UK recruitment into these posts.

Whilst non-UK trainees make a valuable contribution to the service, some may have less incentive to remain in the UK and work substantively for the NHS at the end of their training programme.

Attracting more UK medical school graduates into both core and higher psychiatry training is therefore essential, since any policy that tightens control on overseas recruitment could constrain the supply of new psychiatry trainees and consultants to fill existing vacancies, resulting in inequity of access for those who access mental health services.

Any workforce delivery plan for mental health therefore needs to address the current shortages in the medical workforce as well as ensuring the NHS has a workforce of the right numbers, with the right skills, in the right place to deliver the *Five Year Forward View for Mental Health* strategy. Medical bank, agency, and locum usage cover a significant proportion of the 13% of consultant posts currently vacant, but this national figure masks geographic and service specific variations. And even after the workforce interventions modelled in the following section, the vacancy rate for consultant posts is expected to rise from 13% to 18%, with significantly higher vacancy rates possible in rapidly expanding areas such as perinatal services or liaison mental health.

This highlights the need to take urgent action to increase current medical supply such as international recruitment, as set out in section 5.

Wider workforce (psychology and psychological therapies – including Adult IAPT, Occupational Therapy and other Allied Health Professions wand new roles)

Psychologists and psychological therapists fill a range of roles in mental health services. They deliver evidence-based psychological therapies, including through IAPT services. They also use psychological theory and evidence to help teams understand and respond to people with mental health challenges, through formulation, supervision, consultation, training, and research.

There are 10,000 clinical psychologists registered with the Health and Care Professions Council (HCPC), most of whom primarily undertake NHS work, and alongside them smaller numbers of counselling psychologists (1,900) and forensic psychologists (800)[8].

There are approximately 29,000 psychological therapists working across the health and wellbeing system (all sectors) as evidenced by membership of relevant professional bodies. Retention of the psychological professions is traditionally very high relative to other registered professions.

[8] Source: HCPC 2017

The *Five Year Forward View for Mental Health* requires significant expansion of the psychology and psychological therapies workforce to deliver greater access to psychological healthcare. This includes all work streams, but a particular focus on Children and Young Peoples' Mental Health, Adult Mental health: Common Mental Health problems and Adult Mental Health (including older people): Community, Secondary and Crisis Care.

Improving Access to Psychological Therapies for adults – Current Workforce

The Improving Access to Psychological Therapies (IAPT) service follows the principles of 'stepped care'; i.e. the treatment offered should be the least intensive treatment that is appropriate. It employs two groups of clinicians, Psychological Wellbeing Practitioners (PWPs) and High Intensity Therapists (HITs). The most recent annual HEE commissioned IAPT Census Report[2], covering the entire IAPT workforce, identified nearly 7,000 WTE staff in post providing psychological therapies.

This workforce consists predominantly of High Intensity Therapists, Cognitive Behavioural Therapists (CBTs) qualified in other modalities and PWPs. There are also a small number of employment advisers in IAPT teams, although many services refer their clients out to external organisations.

The census identified high levels of movement of staff, although the rate of movement between services was not known. The 2016 census will provide more detail about the reasons for this movement and the destinations of staff.

The census also revealed that the IAPT workforce, in common with many psychological workforces, is, predominantly female, white, British, and aged 26-45. This means that the workforce is not always representative of local populations and the communities they serve.

What does this mean for the IAPT Workforce

The *Five Year Forward View for Mental Health* sets the objective that IAPT services should see 1.5m people a year by 2020, with 75% of people accessing care within six weeks and 95% within 18 weeks, with particular improvements in access people from black and minority ethnic groups, people with a learning disability, older people, and women in the perinatal period. This will require the training of an additional 4,500 therapists between 2016 and 2020. A substantial part of this expansion will rely on a move to further integrate mental and physical health services through the development of Integrated IAPT Services. This is reflected in the General Practice Forward View with the objective that there will be 3000 therapists co-located in primary care by 2020.

A successful transition from central funding by HEE to localised funding by Clinical Commissioning Groups (CCGs) will be key to achieving the 2020 ambition. Opportunities for productivity gains through online delivery of therapies could enhance the capacity of available trained therapists. During 2016/17 and 2017/18 a targeted group of geographies will work to develop the evidence base for implementing co-located integrated services for people with co-morbid Long Term physical Conditions (LTC) and/or Medically Unexplained Symptoms (MUS). These will deliver holistic care to improve outcomes for those who access mental health services by addressing anxiety and depression leading to improved quality

[2] https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/09/adult-iapt-workforce-census-report-15.pdf

of life. These changes are expected to lead to significant cost savings due to reduced healthcare demand in other areas, such as unplanned/urgent care, short stay admissions, and prescribing medication. If implementation is successful, this will enable savings to be reinvested by commissioners so that these services become sustainable in the future.

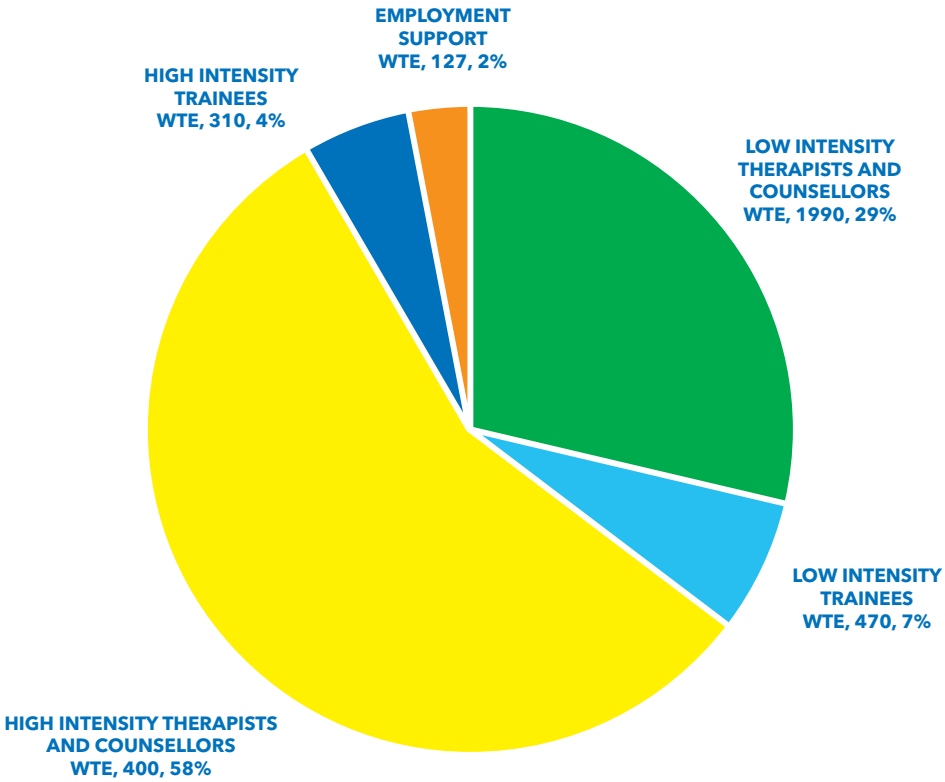


Figure 7: Composition of the IAPT workforce (WTE) .

The number of staff needing to be trained to supply this workforce will vary by area and may exceed these numbers taking into account the current trend of a high proportion of psychological wellbeing practitioners to transition to high intensity roles. Traditionally training positions received salary support; this will transition from central to local funding in all areas from April 2018. After this point a new offer will be needed to incentivise providers to recruit trainees in order to meet the national expansion targets, rather than tending to favour the recruitment of qualified staff from other services.

Occupational Therapy

There are currently 38,000 Occupational Therapists registered with the Health and Care Professions Council. Whilst it is not possible to know how many of these are working within mental health services, it represents a significant part of the total, and it is a key and expanding workforce which is growing. Occupational Therapists operate in a range of roles in mental health services, both generic and specific to their core training.

[3] https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/09/adult-iapt-workforce-census-report-15.pdf

They have a fundamental role to play in the delivery of the *Five Year Forward View for Mental Health*, particularly in the following areas:

- Occupational therapists are particularly concerned with the individual and the environment. They consider this within the framework of the wider determinants of health such as housing, employment, education, and family and friends.

- Occupational therapists are crucial in delivering the roll out of Individual Placement with Support (IPS), to increase the numbers of people with a range of mental health conditions supported to obtain and retain suitable work. As well as working to break down stigma around mental health conditions in the workplace.

- Occupational therapists are skilled in assessing and modifying the home environment (including assistive technologies) to ensure that people can live in the community or in a suitable residential environment as independently as possible. They also provide support and consultation to third sector providers in managing people with complex needs in residential settings.

- Occupational Therapists are trained in both physical and mental health, so are confident in raising physical health issues with people. They are therefore well placed to contribute to the improving physical health agenda as required by the *Five Year Forward View for Mental Health*.

New Roles

Whilst we need urgent improvements in how we recruit and retain staff to existing and new posts, this needs to go hand in hand with skilling up our staff to provide new models of care in new settings and teams in a way that supports culturally sensitive services. This is a transformation and skills agenda as much as a growth agenda.

In recent years, trusts have developed a number of innovative models where staff from non-professional backgrounds have been deployed to deliver the competences required in a team. New roles including peer workers, graduate mental health practitioners, nursing associates, assistant practitioners and physician associates complement staff from traditional professions. A key innovation of IAPT services was the development of a new workforce - (psychological wellbeing practitioners), trained and highly skilled but not through traditional professional routes.

These developments demonstrate the opportunity to explore innovative workforce models. This may mean staff working to deliver specific care and treatment, including brief psychological interventions, case management and peer support, as an integral part of the multi-disciplinary team working alongside colleagues from more tradition professions. The quality of training, supervision, leadership and career progression would be key to the success of this development.

Section 3. Our future workforce – where do we need to be?

The *Five Year Forward View for Mental Health* set out a vision for more integrated services offered in community settings. A number of areas are already leading the way in this. For instance, services in Sunderland, North East London, and Sheffield have invested heavily in multi-disciplinary home treatment teams, community mental health, social care and housing services, while managing significant reductions in their inpatient bed base so that people who can more appropriately receive care in community settings are able to do so, and ensuring that inpatient care is reserved only for people who need it. Each of these areas have chosen different models to undertake this system transformation, but all have required staff and services to shift models of care that have been traditionally been delivered in inpatient beds enabling recovery in people's homes and communities, while continuing to ensure that the quality of care improves.

We expect local systems to learn from each other and consider how best to deliver the required improvements. For example, in Crisis Resolution and Home Treatment Teams, a good service would deliver the following outcomes:

- 24/7 crisis assessment of new referrals at home.
- Rapid response to people with urgent and emergency needs.
- 24/7 intensive home treatment visits as an alternative to secondary care admissions.
- Appropriate staffing levels vs caseloads.
- Home treatment that offers therapeutic value.

Whilst the exact details will vary from area to area, in order to deliver increased access to more integrated care at the right time and in the right place, the NHS will need to:

- Provide more person-centred care.
- Focus more on retaining our existing staff.
- Invest in the skills and development of existing staff.
- Expand the number of staff in mental health services.
- Support staff to work flexibly across boundaries and in increasingly integrated settings.

Implementing the *Five Year Forward View for Mental Health* set out the specific areas that require additional investment in order to deliver the agreed strategy within the allocated spend in areas such as health and justice to follow as they are developed. This investment will only turn into improved services if we have the staff and infrastructure to deliver them.

Whilst the national ALBs have necessarily used one care model in each area to create a high-level workforce planning model to inform the development of the Workforce Plan for Mental Health, we are clear that there is no one right way to deliver the outcomes set out in the *Five Year Forward View for Mental Health*. Different areas will have different communities and different starting points. Nevertheless, given the scale of the challenges and opportunities, a starting point is required.

In the next section, we set out the detailed work that has been carried out by HEE to scope what would be needed to deliver the workforce required to deliver the *Five Year Forward View for Mental Health* across the country. We are setting this out as the basis for local conversations and to support and inform local planning processes.

Agreed areas of growth to deliver the *Five Year Forward View for Mental Health*

Current Posts + Expansion Posts	Medical *	Nursing and Midwifery	Allied Health Professional and Scientific, Therapeutic and Technical Staff	Total Professionally Qualified Clinical Staff	Support to Clinical Staff	Administrative and Infrastructure Staff	Total
CYP	800 (200)	3000 (1200)	4000 (700)	7900 (2000)	1800 (2200)	1700 (200)	11400 (4400)
Adult IAPT	0 (0)	0 (0)	5200 (2900)	5200 (2900)	2600 (1600)	2000 (0)	9700 (4500)
Perinatal	100 (100)	200 (500)	100 (200)	300 (700)	100 (400)	100 (0)	500 (1100)
Crisis[9]	400 (0)	3300 (4600)	500 (200)	4200 (4800)	1000 (2300)	300 (200)	5200 (7100)
Liaison MH	400 (300)	1600 (400)	100 (-100)	2100 (600)	100 (-100)	300 (300)	2500 (600)
EIP	100 (100)	800 (1200)	400 (200)	1300 (1600)	300 (700)	0 (0)	1900 (2600)
Liaison & diversion	0 (0)	200 (300)	100 (0)	300 (400)	0 (0)	0 (0)	400 (400)
Total T.A.s	**1900 (700)**	**9200 (8100)**	**10400 (4200)**	**21400 (13000)**	**5800 (7100)**	**4400 (700)**	**31600 (20900)**

Table 4: Current posts plus expansion posts by 2021

It is clear from section one that simply increasing the number of funded posts by 21,000 in the growth areas will not deliver the improvements which those who access mental health services need. Unless we have enough skilled staff to fill the newly created posts and are able to retain them, we will fail. Workforce levels are dynamic as people enter and leave the service, so local providers and commissioners will need to understand the different variables at play, and take targeted action to ensure they have enough staff with the right skills in the right place when those who access mental health services need them.

It is also clear that the sheer scale of growth – in some cases doubling or trebling the workforce – cannot be met via the traditional training routes within this timescale. We will need to seriously invest in the development and reskilling of our existing staff, and/or recruit from the global market.

To support local conversations and delivery, the national ALBs have worked together to develop a high-level workforce planning model to deliver the vision set out in the *Five Year Forward View for Mental Health*. We have set out the assumptions as a waterfall (Figure 8), to make explicit the key variables that will affect the supply of posts and people and to highlight the dynamic and interdependent nature of the model.

[9] As noted earlier in this document, the modelling reflects the pure 'Sunderland model' (which is consultant only) – the required expansion of consultant workforce is modelled to be 220 (please refer to 'Consultant workforce table above), with an expected equivalent reduction in the number of more junior medical staff. The overall expansion of medical staff group for CRHTTs is thus rounded to zero, reflecting the shift from more junior medical staff to senior medical staff.

While our modelling suggests only a small net increase in CRHTT medical staffing is required, we foresee a shift in skill mix with a significant increase in more senior medical staff within these teams.

Growth and transformation for mental health services to 2021

Figure 8: The 'waterfall': Workforce requirements and interventions 2016-2021

The waterfall diagram sets out the endpoint we are trying to reach: a net growth of 11,000 qualified staff by 2021 (19,000 in total) to support over a million more patients accessing treatment with improved quality of care. We are currently planning for a net gain of 11,000 professionally qualified staff to ensure we meet the Government's commitment to delivering a net growth of at least 10,000 professionally qualified staff, recognising that forecasting is not an exact science and the dynamic nature of any model with so many variables.

The key value of this graph is that it clearly identifies the variables and levers that we will need to influence and the fact that no one organisation has control of all of them. It shows that in order to achieve not just a growth in funded posts but people to fill them, will require active and coordinated system management. As an aggregate view of the workforce, it masks geographical and specialty-specific issues and is subject to ongoing refinement at a local level. Below we set out our current planning assumptions so that local systems can begin the conversations and develop plans that are relevant to their specific labour markets and needs.

Existing posts and vacancy assumptions: data from NHS Improvement suggests that the vacancy rate in mental health services broadly correlates with bank, agency and locum spend, suggesting that service is largely covered albeit not in the most efficient way possible. However, this aggregate data may mask regional and service specific variations (such as psychiatry) which we will continue to explore. Our model assumes that although it may not be possible to fill all the vacancies by 2021, the 'vacancy rate' (20,000, 10% of the mental health workforce) will reduce as we shift people onto substantive contracts in line with national policy.

New posts and growth assumptions: the modelling suggests that in order to deliver the vision set out in the *Five Year Forward View for Mental Health*, we will need employers to create an additional 21,000 posts in the initial seven growth areas (Figure 7).

Growth and transformation assumptions: at the heart of the *Five Year Forward View for Mental Health* was an ambition to provide more integrated and early interventions, thus reducing the demand for secondary care and shifting activity to the community. This requires not just an increase in posts, but a transformation in the service offer. To support this transformation, we will need fewer staff in those areas where we anticipate reduced demand and more staff in the growth areas where we expect more patients to be seen as new service models are implemented. At an aggregate level, we have modelled a reduction of 5,000 posts in services facing reduced demand by 2021. Local employers will need to think about what posts they need where, how they can encourage other professions such as AHPs, social workers and pharmacists to work differently, and when to support the growth and transformation of new and existing mental health services, so that the service as a whole continues to improve.

People to fill the posts:

Staff leaving assumptions: based on observed workforce trends, 18,000 support staff and 21,000 clinically-qualified staff are forecast to leave statutory mental health services if we do nothing. We know that there is variation in staff retention rates between services, Trusts and geographies. It is not always a bad thing when a member of staff leaves an organisation – they may be going to provide service to those who access mental health services in the community or in another setting. However, it is expensive and disruptive for both staff and those who access mental health services for there to be high rates of turnover in a service or an organisation. Leavers must be replaced by suitably trained and skilled individuals. This model reflects the NHS Improvement national programme of mental health retention, which is part of a comprehensive program of work with providers. This should provide an increase of 6,000 WTE to the system when measured against current trends, as skilled staff are retained in their roles, services and organisations or attracted in to substantive employment in mental health organisations.

Supply of non-clinical staff assumptions: it is estimated that employers will source 18,000 non-clinical support staff through local labour markets to replace staff who leave and support the new clinical posts and services.

Supply of HEE commissioned clinical staff assumptions: additional clinical staff are currently being trained by HEE (which began as early as 2010 for medics and 2014 for nurses for the cohort coming out of training in 2017) and 29,000 newly qualified clinicians will be available for employment by 2020. This includes psychiatric, nursing, and IAPT staff, as well as a proportion of other clinical staff including occupational therapists, speech and language therapists and others. Although this is 'fixed', there is a lot we can do to increase fill rate and reduce attrition throughout the training pathway.

Supply of other new staff: In addition, it is anticipated that employers will source 5,000 clinical staff (Physician Associates, Nursing Associates and telephone triage staff in crisis teams etc.). from outside the training pipelines described above. This may also involve attracting social workers or paediatric nurses into mental health teams.

The waterfall shown in Figure 8 represents a fluid and dynamic model. Worse performance on one aspect will require greater effort on another. But overall, if the identified actions are achieved then our assessment is that by 2021 the NHS will benefit from as many as 19,000 net additional WTE staff (11,000 qualified) working in NHS funded mental health services. Although we have made aggregate numeric forecasts, the workforce consists of people, with different levels of skills and knowledge, so we can expect this model to be dynamic, subject to constant change, review and adaptation. Success needs to be driven and judged through the eyes of services users, who will expect to see improvements in their whole experience, not just the growth of one particular service at the expense of another. Large scale growth and transformation programmes require senior time and investment, with explicit plans developed in collaboration with staff and service users and drawing on appropriate change management experience and expertise to help mitigate risks.

In the next section, we highlight the risks to delivery, before considering actions and recommendations to increase our chance of success.

Section 4: How we will get there: agreed actions

No single part of the system holds all the levers necessary to implement this workforce plan. The Department of Health determines the number of undergraduate medical student places available and universities educate students to the standard required by the professional regulators (i.e. the General Medical Council, the Health and Care Professions Council and the Nursing and Midwifery Council). HEE funds the clinical placements for undergraduates and is responsible for commissioning postgraduate education and training for doctors. From September this year, the market will decide how many nurses, midwives and AHPs will be trained.

Decisions on the pay, pensions and contractual terms and conditions for NHS staff are principally taken by the Government, working with NHS employers. Individual NHS employers are responsible for the recruitment, retention and skills development of their staff. Finally, as with any labour market, individuals are then free to make decisions about which profession they wish to join and in which organisation, geography and sector they wish to work and for how long.

Given these complexities and the scale of the challenge we face, the system must work together to ensure we have enough staff with the right skills in the right place at the right time to meet the needs of those who access mental health services.

The key actions different organisations will take to increase workforce supply and support the delivery of the *Five Year Forward View for Mental Health* are set out below.

1. Producing good mental health

The vision set out in the 5YFV was not just about managing demand better – the ambition is to reduce demand by preventing the forecast rise in mental health problems. It has been suggested that by 2030 there could be as many as two million more people in the UK with a mental health problem than there are today. We will take steps to reduce this:

- HEE will work with Public Health England, using the emerging findings of their Prevention Concordat to support implementation and improve the mental health promotion and prevention training of the public health workforce.

- The NHS employs over 1.3m people and should be an exemplar in creating a mentally healthy workplace: reducing stress and improving wellbeing, supporting staff who develop mental health problems and welcoming them back to work when they are ready. The imminent employer review should form the basis for honest board-to-ward discussions about how NHS organisations can better support their own staff, as well as those who access mental health services, drawing on the success of the dementia awareness campaign.
- If we are committed to improving the mental health of our staff, then we must recognise and tackle the stigma that still exists about mental illness within the NHS in general and mental health services in particular. We need to make it easier for mental health staff to ask for and receive help, and every employer should sign up to Time to Change[5] or similar.
- In addition, HEE will support mental health professionals to have the skills and confidence to raise physical health issues with their service users, through Make Every Contact Count (MECC).

2. Identifying and responding as soon as possible to mental and physical health issues

- Drawing on the experience of the dementia awareness programme, HEE will raise the awareness of mental health amongst NHS staff, and work with the Royal College of General Practitioners to encourage GPs to enhance primary care mental health skills by doing a year post-qualification in psychiatry.
- All mental health staff, particularly those based in the community, need skills in prevention and improving physical health. HEE will work with employers to expand the use of MECC in mental health services.

3. Retaining and supporting our existing staff

NHS organisations currently loses 10,000 staff each year from mental health services. As well as being an inefficient use of public money, driving up agency and bank costs, as well as appointment processes, a high turnover rate is often associated with poorer quality of care, and may be symptomatic of deeper problems within an organisation. NHS Improvement is implementing a national programme of mental health staff retention, which is part of a comprehensive program of work with providers. This should provide an increase of 6000 WTE staff in the system when measured against current trends, as skilled staff are retained in their roles, services and organisations or attracted in to substantive employment in mental health organisations.

These programmes offer:

- Targeted support to those with the highest clinical leaving rates. From July 2017, 20 mental health trusts will be identified as outliers for high leaver clinical staff rates, with further cohorts to follow later in the year.
- A series of retention masterclasses for Directors of Nursing and HR Directors
- A joint support national retention programme run by NHS Employers to provide direct retention support to all trusts.
- Encouragement to employers to intelligently rethink the skill mix within teams.

[5] https://www.time-to-change.org.uk/

In addition to this:

- HEE will support improved retention by exploring the creation of a dedicated workforce development budget to help employers retain and develop and reskill their existing staff in mental health services and other *Five Year Forward View for Mental Health* priority areas.
- DH will explore the opportunities from the Naylor Review and the potential to improve access to NHS accommodation for mental health staff.
- NHS Employers will work with NHS Improvement to better understand sickness rates in particular and work with mental health charities to improve the mental health of our own workforce. Linked to this, we will consider the roles of carers and how the NHS might better support staff with caring responsibilities.
- NHS Employers will work with providers to encourage and support more flexible approaches to retirement, offering more flexible arrangements so that the NHS can retain most of its skilled and experience staff.
- The National Mental Health Nurse Directors Forum is working with the Royal College of Psychiatrists (RCPsych) and the Royal College of Nursing (RCN) to examine the impact of the of the end of Mental Health Officer status. They will make recommendations on how to draw on the skills of the recent retirees to enable them to form a considerable 'transition bridge' of expertise.

4. Employers supporting clinical staff to release more time for those who access mental health services.

It takes many years to train a Consultant Psychiatrist, but too much of their skilled time can be taken up with administration and other tasks. In order to improve productivity and release more time for consultants to provide skilled care for patients at most risk, NHS England, NHS Improvement, and HEE will work with Royal College of Psychiatrists (RCPsych) and NHS Employers to develop and spread solutions, such as:

- Personal Assistants, so that Consultants are enabled to spend more time with those who access mental health services.
- Pharmacists working alongside Consultants, to offer advice, support and services with regard to prescriptions.
- Physician Associates, supporting teams and enabling Consultants to use their specialist knowledge more effectively.
- Supporting senior nurses to work at the 'top of their licence' and use the full range of their skills.

5. Encouraging qualified staff to return to practice in the NHS

Currently 4,000 psychiatrists and 30,000 mental health nurses are not employed substantively by the NHS in England (although many of these will be working in Scotland, Wales or Northern Ireland). It is not known how many are providing services for NHS patients in other sectors, but there may be opportunities to draw on the learning from HEE's Nursing Return to Practice programme, where they have succeeded in attracting 3,200 nurses back to the profession at an average cost of £2,000 per returning nurse.

- Working with NHS Improvement, NHS Employers, RCPsych and mental health charities, HEE will lead and co-ordinate a major Return to Practice campaign for psychiatrists and mental health nurses to support local employers.
- As well as seeking to attract these groups back into the NHS, HEE and NHS Improvement will explore support for other qualified staff who may wish to develop a career in mental health.

6. International recruitment to help fill short-term gaps

The above recommendations will help ensure we expand existing supply in both the nursing and medical sector. However, it is clear that in the short term, we will need to source some key skilled workers from the global market to ensure we have sufficient staff to meet the rapid growth in posts.

- HEE is looking to take forward a number of international workforce initiatives including recruitment from overseas, focusing initially on the four key priority areas, mental health, primary care, urgent care and cancer, building on recent successes such as with nurses and urgent care.
- RCPsych and HEE will work to ensure that psychiatry has a significant share of the Medical Training Initiative (MTI)* allocation which helps skill up overseas doctors wanting to improve their knowledge and skills as well as supporting domestic programmes.
- Consideration should be given to developing academic postgraduate degrees, i.e. Masters in Psychiatry for senior doctors from overseas.

7. New skills, roles and ways of working

Developing new care models means building flexible teams across traditional boundaries and ensuring they have the full range of skills and expertise to respond to service user needs in different settings.

- NHS England's commissioned pathways and guidance work, with the support of HEE, will reflect more modern diverse and highly multi-disciplinary teams. All other organisations producing similar guidance should seek to adopt this approach. All guidelines will both ensure highly skilled specialists (particularly those in short supply) have the greatest impact on patient outcomes and experience and ensure all staff are adequately supported by a diverse and skilled team in their day-to-day work.
- HEE will work with partners to continue the expansion of recently created roles in mental health services including: advanced practitioners, apprenticeships, nursing associates, consultant allied health professionals and consultant nurses, peer support workers, physician associates and clinical academics.
- HEE will work with partners to consider the creation of new roles such as: Early intervention workers (building on the IAPT training model but ensuring they are fully integrated with existing teams and are not stand alone) focussed on child wellbeing as part of a psychiatrist-led team. More non-clinical roles in areas of lower risk and as part of an integrated consultant-led team, allowing more qualified staff to use their skills in higher risk areas and Consultant Personal Assistants to free up consultants to make the most of their valuable skills.
- The Leadership Academy will develop and deliver leadership training courses for Consultant Psychiatrists, Nurse and AHP Consultants, Consultant Clinical Psychologists and others to enhance and support their skills as team leaders.

*The Medical Training Initiative (MTI) is a national scheme designed to allow a small number of doctors to enter the UK from overseas for a maximum of 24 months, so that they can benefit from training and development in NHS services before returning to their home countries. http://www.aomrc.org.uk/medical-training-initiative/

8. Expanding the talent pool of future staff

At present, potential medical students are required to have a set of 'A' levels dominated by the 'pure' sciences. Psychology is popular and rigorous, but is not recognised by medical schools, thus reducing the pool of potential applicants for psychiatry.

- HEE will explore with the Medical Schools Council changing entry requirements so that Psychology 'A' level is considered of equal merit to increase the pool of applicants likely to go on to become Psychiatrists.
- HEE will work with the GMC to ensure the priority of mental health is reflected in the UK Medical Licensing Assessment.
- HEE to explore the development needs of SASG doctors working in Mental Health, to ensure they are equipped to deal with current and future patients.

9. Attracting people to work in mental health

Working with the Royal Colleges, trainees and mental health charities, HEE will build on the success and learning from the 'Ten Point Plan for GPs' to:

- Develop an urgent action plan to attract and retain more clinicians to work in mental health services and psychiatry.
- Commission focus groups and polls of potential and existing trainees so we can better understand the obstacles, increase the support offered to them and increase the profile and attractiveness of careers in mental health.
- Develop a major campaign in advance of the 2018 recruitment round to help attract newly qualified people to training courses, as well as recruiting qualified staff from other sectors.
- Develop and publish a clear career pathway that supports and attracts individuals from wide ranging backgrounds (with a broad range of skills, clinical, research, management etc.).
- Widen participation through local recruitment drives to support the attraction of a representative workforce but crucially, service providers have to ensure that there are mechanisms and training in place to enable individuals/practitioners provide non-discriminatory care.

10. Increasing the number of applicants for clinical training courses

With the expansion of medical student places by 1,500 in England, HEE, the RCPysch, and partners will:

- Work to ensure that the allocation of these places is to universities with a proven track record in producing psychiatrists.
- Increase the exposure to psychiatry during training (which can help increase applications for the specialty). HEE has already increased the number of doctors in the Foundation Programme doing a four month psychiatry post to 50%. The RCPysch will complete the review of this expansion with a view to HEE commissioning a further expansion from 2019.
- Ensure all doctors in the Foundation Programme will be required to undertake a 'taster' 2 week attachment in Psychiatry unless they are doing a four month post from 2019.
- Explore bursaries (learning from the GP Target Enhanced Recruitment Scheme (TERs) scheme, funded by NHS England), and opportunities in academic training to increase the popularity of the speciality.

11. Supporting and retaining our trainees

We know that significant numbers of training places at both core and higher psychiatry training schemes go unfilled. A proportion of trainees do not transition directly from core to higher training, but may take up higher specialty training some years after completing core. To help address this:

- HEE and RCPsych will work together with trainees to understand what makes them leave/stay throughout the course and attract more trainees for mental health during key transition points, such as from core to higher points.
- HEE will continue its work to develop 'run through' training for Child and Adolescent Psychiatry, and explore how best to scale this up.
- HEE will work with RCPsych and employers to reduce attrition rates from training programmes, including ensuring that all trainees get the agreed one hour direct supervision per week. Building on the *Enhancing Junior Doctors' Working Lives* report, HEE will explore flexibility within training and work with the RCPysch to examine different training options including run-through.
- The RCPysch will be a pathfinder college working with HEE on the Accelerated Return to Training programme.
- The RCPysch will work with HEE to develop alternative training support for those doctors not in training programmes and who are not consultants.
- Employers will be asked to consider board level leadership and support for all trainees and existing staff, so that through CPD and innovation, NHS employers become learning organisations with opportunities for staff to develop their skills and progress into leadership roles.
- Employers will be asked to review rotas so that doctors in training get access to training episodes and are supported by the appropriate clinical team out of hours.

12. Better intelligence about the mental health workforce

HEE currently only has access to workforce data from NHS organisations, which means we cannot get a complete picture of how many staff are employed, and where, across the entire system, including social care, private and third sectors.

- HEE will work with NHS Digital and other ALBs to secure we have access to workforce data from non-NHS sectors as soon as possible to aid more effective workforce planning.

13. A Compendium of Best Practice

- HEE will support the Royal Colleges and providers to establish a Compendium of Best Workforce Practices, to support employers and teams to achieve workforce transformation and growth.

14. Robust local workforce plans to grow and transform the Mental Health workforce, aligned with finance and service plans

By April 2021, employers are expected to create, fund and fill 21,000 new posts in the priority growth areas, but this must not be at the expense of the wider service that those who access mental health services rely on, nor in isolation of ongoing efforts to improve quality and achieve financial balance. To this end, we recommend:

- Each STP will appoint a senior leader (Chief Executive or Executive Director) to lead the development and delivery of a delivery plan for mental health, that ensures ongoing alignment between the funding, policy commitments and workforce availability and actions.
- HEE's Local Workforce Action Boards (LWABs) will lead on the workforce element of the plan, supporting each STP lead with data, analysis. Help them understand their current labour market and develop robust plans for developing new services within the funding envelope available.
- STPs should include workforce plans as part of their finance and service submissions. STPs will need to be assured not just that the figures add up, but that implementation is carefully planned, and risk identified and managed so that transition and growth aligns with when the workforce and funding becomes available and that the quality of care is not affected during transition.
- STP plans should include how they intend to re-skill the existing workforce to help transform services. Ensuring equal opportunities for career progression and set out how local providers will use this opportunity to ensure our workforce is more representative of the communities they serve.
- National ALBs will review regional and local governance, resources, and data collections, to support alignment of finance, policy and workforce in mental health, whilst reducing duplication and maintaining their statutory accountabilities.

Section 5. The Delivery Architecture

This document sets out our initial assumptions about the skills and numbers we will need to deliver the Five Year Forward View for Mental Health and the high-level model that underpins it.

Our aim is to provide a framework and a workforce model that enables STPs to develop local plans and actions. HEE will provide local workforce data and forecasts to help underpin those local plans.

Delivering a national programme of growth and transformation in a place-based way across over 80 different statutory providers, supported by three ALBs, presents challenges and opportunities. It will require clarity of purpose and a flexible approach to governance arrangements, with regular review and refinement. In this first phase, we propose:

- Each STP should appoint a senior leader (CEO or Exec Director) to lead the development and implementation of a Mental Health Delivery Plan that includes workforce. This plan should be designed to ensure ongoing alignment between funding, policy commitments and workforce availability and to maintain quality of mental health services during transition.
- HEE Regional Directors will be responsible for coordinating the support given to STPs by ALBs and other national bodies in developing and implementing the workforce element of the Mental Health Delivery Plan. The regional offices of HEE, via LWABs, will support each STP with dedicated resource, data, analysis and expertise to help them understand their current labour market and develop robust plans for developing new posts and skills within the funding available. HEE Regional Directors will attend their Regional Mental Health Programme Board to help ensure that workforce activity is integrated with wider delivery objectives at regional level, and will report progress to the HEE SRO.
- The Mental Health Delivery Programme Board, will continue to provide oversight of, and advice on, overall delivery of the Five Year Forward View for Mental Health. Regional Mental Health Programme Boards will report on overall local progress to the Mental Health Performance and Delivery Group.
- A workforce operational sub-group, chaired by HEE SRO, will review regional progress in developing and implementing workforce plans. The Mental Health Advisory and Oversight Group, chaired by Paul Farmer and made up of key stakeholders, will help ensure that together the system achieves the ambition set out in the Five Year Forward View for Mental Health.
- The ALBs will review their national and regional resources/processes to prevent duplication, and ensure clear accountability for oversight and support.

Planning for the longer term

Our primary focus has been to identify key actions to deliver the 2021 commitments, from a starting position where mental health services are not meeting current need. We recognise the need to build a longer-term strategy that identifies both the fundamental shifts in demand we are seeing within our population, as well as the length of time it takes to train and redesign a skilled workforce. HEE will work with our partners and the wider system to set out in more detail the longer-term strategy for the mental health workforce, including a coherent academic strategy to achieve the *Five Year Forward View for Mental Health* ambition to make the UK a world leader in the development and application of new mental health research.

Annex 1 – *Five Year Forward View for Mental Health* Deliverables

1. CYP

ACCESS:

The table below sets out an indicative NHS England trajectory for increased access. This is based on existing data on prevalence of mental health problems in children and young people. It will be reviewed in 2018 following publication of a new national prevalence study, and may be revised.

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
At least 35% of CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH service.	28%	30%	32%	34%	35%
Number of additional CYP treated over 2014/15 baseline	21,000	35,000	49,000	63,000	70,000

EATING DISORDERS:

By 2020/21, evidence-based community eating disorder services for children and young people will be in place in all areas, ensuring that 95% of children in need receive treatment within one week for urgent cases, and four weeks for routine cases.

OUT OF AREA PLACEMENTS:

By 2020/21, inappropriate placements to inpatient beds for children and young people will be eliminated: including both placements to inappropriate settings and to inappropriate locations far from the family home (out of area treatments).

Inpatient stays for children and young people will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements.

C&YP WORKFORCE:

By 2020/21, at least 1,700 more therapists and supervisors will need to be employed to meet the additional demand.

By 2018, all services should be working within the CYP IAPT programme, leading to at least 3,400 current staff being trained by 2020/21 in addition to the additional therapists above.

The table below sets out an illustrative trajectory for the necessary growth in therapists, which reflects the growth in additional funding in CCG baselines. This does not include consequent growth in other staff such as psychiatrists and mental health nurses.

Workforce type	2016/17	2017/18	2018/19	2019/20	2020/21
Therapists	200	428	428	228	52
Supervisors	50	107	107	57	13

2. PERINATAL

By 2020/21, specialist perinatal mental health services must be available to meet the needs of women in all areas.

The table below outlines an indicative trajectory towards the 2020/21 objective. This shows the total number of additional women to be treated each year at a national level, above the baseline.

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
To support at least 30,000 additional women each year to access evidence-based specialist perinatal mental health treatment..	500	2,000	8,000	20,000	30,000

To build perinatal mental health capability, HEE is leading work to develop a skills competence framework by October 2017. This framework will set out the competences in relation to three levels across ten domains, covering generic knowledge and understanding required by all staff, more advanced knowledge required in certain situations, and specialist skills and understanding.

By 2020/21, all teams should be sufficiently staffed to meet the recommended levels – for both inpatient mother and baby units and in perinatal mental health community teams.

3. ADULTS

By 2020/21, there will be increased access to psychological therapies, so that at least 25% of people (or 1.5 million) with common mental health conditions access services each year. The majority of new services will be integrated with physical healthcare of particular importance to older people and frailty. As part of this expansion, 3,000 new mental health therapists will be co-located in primary care, as set out in the General Practice Forward View.

In parallel, we will maintain and develop quality in services; including meeting existing access and recovery standards so that 75% of people access treatment within six weeks, 95% within 18 weeks; and at least 50% achieve recovery across the adult age group.

During 2016/17 and 2017/18, a targeted group of geographies will work to develop the evidence base for implementing these new services at scale, supported by wider investment in training and infrastructure. From 2018/19 integrated services will be rolled out across all CCGs, in line with the indicative trajectory set out below:

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
At least 25% of people with common MH conditions access psychological therapies each year.	15.8%	16.8%	19%	22%	25%
Total number of people accessing treatment	0.96m	1.02m	1.16m	1.37m	1.5m

The table below outlines the indicative trajectory of additional staff needed to deliver the objective, year-on-year:

Workforce type	2016/17	2017/18	2018/19	2019/20	2020/21
Psychological wellbeing practitioners	210	350	338	408	408
High intensity therapists	390	650	630	760	760

1. ADULT MENTAL HEALTH: COMMUNITY, ACUTE AND CRISIS CARE

By 2020/21, adult community mental health services will provide timely access to evidence-based, person-centred care, which is focused on recovery and integrated with primary and social care and other sectors. This will deliver:

- At least 60% of people with first episode psychosis starting treatment with a NICE-recommended package of care with a specialist early intervention in psychosis (EIP) service within two weeks of referral.
- A reduction in premature mortality of people living with severe mental illness (SMI); and 280,000 more people having their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year.
- A doubling in access to individual placement and support (IPS), enabling people with severe mental illness to find and retain employment.
- Increased access to psychological therapies for people of all ages with psychosis, bipolar disorder and personality disorder.
- **By 2020/21, NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission.'**

- Out of area placements will essentially be eliminated for acute mental health care for adults.

The table below outlines an indicative trajectory for delivery of these objectives:

Objective		2016/17	2017/18	2018/19	2019/20	2020/21
Early intervention in psychosis	% of people receiving treatment in 2 weeks	50%	50%	53%	56%	60%
	Specialist EIP provision in line with NICE recommenda-tion Xi	All services complete baseline self assess-ment	All services graded at level 2 by year end	25% of services graded at least level 3 by year end	50% of services graded at least level 3 by year end	60% of services graded at least level 3 by year end
People with a severe mental illness receiving a full annual physical health check			140,000	280,000	280,000	280,000
Doubling the number of people accessing individual placement and support		Baseline audit of IPS provision under-taken	STP areas selected for targeted funding	25% increase in access to IPS	60% increase in access to IPS	100% increase in access to IPS

By 2020/21, all acute hospitals will have all-age mental health liaison teams in place, and at least 50% of these will meet the 'Core 24' service standard as a minimum.

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
% acute hospitals with an all-age MH liaison service achieving Core 24 service standard	7% (current)	13%	20%	40%	50%

2. ADULT MENTAL HEALTH: SECURE CARE PATHWAY

By 2020/21, NHS England should lead a comprehensive programme of work to increase access to high quality care that prevents avoidable admissions and supports recovery for people who have severe mental health problems and significant risk or safety issues in the least restrictive setting as close to home as possible.

This should seek to address existing fragmented pathways in secure care, increase provision of community-based services and trial new co-commissioning funding and service models.

3. HEALTH AND JUSTICE

By 2020/21, there will be evidenced improvement in mental health care pathways across the secure and detained settings. Access to liaison and diversion services will be increased to reach 100% of the population, whilst continuing to ensure close alignment with police custody healthcare services.

The table below sets out the indicative trajectory for expansion of liaison and diversion services over this period:

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
% of population with access to liaison and diversion	60%	75%	83%	98%	100%

4. SUICIDE PREVENTION

By 2020/21, the *Five Year Forward View for Mental Health* set the ambition that the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels. To support this, by 2017 all CCGs will fully contribute to the development and delivery of local multi-agency suicide prevention plans, together with their local partners.

Annex 2 – Financial investment 2016-2021

	2016/17	2017/18	2018/19	2019/20	2020/21
Investment (£m)					
CCG Baseline Allocations	149	265	550	779.5	1007
STF Monies for Allocation (indicative)	5	30	70	95.5	142
National Programmes (indicative)	152.7	212.7	126.7	165	132
Total investment (£m)	**306.7**	**507.7**	**746.7**	**1040**	**1281**
Savings (£m)					
Mental Health	0	-4	-72	-147	-188
Acute	0	-53	-218	-374	-556
Total savings (reinvested in expansion)	**0**	**-57**	**-290**	**-521**	**-744**
Net additional investment	**306.7**	**450.7**	**456.7**	**519**	**537**