Briefing
May 2017 Issue 297

Mental Health Network
NHS CONFEDERATION

The future of the mental health workforce

Key points

- Over the last few decades, mental health services have experienced great change in the way services are designed and delivered.
- National strategies emphasise the need for models of care that meet rising demand and better integrate care. At the same time the mental health sector is facing significant challenges – including in terms of resources available.
- Given that context, what should the future mental health workforce look like?
- This is the central question being explored in this ongoing piece of research, being led by the Centre for Mental Health on behalf of the Mental Health Network.
- The project is commissioned by NHS Employers and supported by Health Education England. A final report will be published by the Mental Health Network during the summer of 2017.
- This discussion paper sets out some findings from early analysis carried out, emerging themes, and sets out a series of questions for Mental Health Network members.
- We look forward to hearing your views – get in touch at **mentalhealthnetwork@nhsconfed.org**.

Introduction

Over the last few decades, mental health services have experienced great change in the way that they are designed and delivered. More recent national developments, including *The Five Year Forward View* and the report of the Mental Health Taskforce, emphasise the need to adopt new models of care, to meet rising demand, and to better integrate the way care is delivered to a population with complex physical and mental health needs. However, resources are limited and workforce development takes time to achieve.

This ongoing project explores, given this context, what the future mental health workforce should look like over the medium to long term (beyond the next five to ten years).

This first discussion paper presents data on the current picture of the workforce and emerging findings from the research to identify the challenges and opportunities that lie ahead for the mental health workforce.

It is important to note the scope of the project. Mental health is everyone's business, and there is not a part of the NHS which does not have a role in promoting positive attitudes to mental health and ensuring people with mental health problems can access appropriate health services. It is hoped that further work can be taken forward to examine how best to ensure the workforce across health and social care can best support improving mental health for all.

Given the time and resource available, this project focuses on the workforce working in secondary mental health services – whether they are employed by the statutory, commercial or not-for-profit sector. The scope of this report focusses on mental health services in England funded or provided by the NHS and where this provision links with social care. It does not include dementia, learning disability or substance misuse services, or general practice.

A final report later in 2017 will build on a series of focus groups and a review of relevant literature to identify shared priorities among people working in mental health services and those using them, including carers.

"Improving access to, and outcomes from, mental health services requires the right workforce."

The policy context

Improving access to, and outcomes from, mental health services requires the right workforce. This is a major theme in both the *Future in mind* report for children and young people's mental health and the *Five year forward view for mental health*.

The *Five year forward view for mental health* set out the priorities for NHS mental health care (and some wider recommendations for other government departments and agencies).[1] The strategy has major workforce implications including:

- A call for all NHS staff to have greater knowledge and awareness of mental health.
- The implementation of access and waiting time standards for adult Improving Access to Psychological Therapies services and for Early Intervention in Psychosis.
- Investment in new specialist perinatal mental health (community and inpatient) services.
- Investment in 'core-24' liaison psychiatry services in general hospitals.
- Expansion of the Improving Access to Psychological Therapies (IAPT) programme, with a particular focus on long-term physical conditions and medically unexplained symptoms.
- Improvements to community mental health care, including crisis resolution and home treatment and Individual Placement and Support employment service.

The *Five year forward view for mental health* was followed in July 2016 by an implementation plan which set out details of which of the report's recommendations for the NHS would be delivered at what times up to 2021.[2] The implications for workforce include:

- Children and young people (CYP): an extra 1,700 therapists and supervisors by 2020/21 and all services working within the CYP IAPT programme.

- Perinatal mental health: new multi-disciplinary teams providing evidence-based interventions and building relationships with other health services (for example, maternity and health visiting services).
- Common mental health problems: 3,000 additional psychological therapists working in primary care and focusing on the needs of people with long-term conditions and medically unexplained symptoms, and of older people.
- Community, acute and crisis care: developing a workforce to meet new standards for Early Intervention in Psychosis, to deliver Individual Placement and Support, to provide more physical health checks and psychological therapies to people with severe mental illnesses, and to extend access to liaison services in acute hospitals and to crisis resolution and home treatment services in the community.
- Secure care: developing a workforce capable of supporting people in the community for people who do not (or no longer) need to be in secure mental health care.
- Health and justice: expanding the liaison and diversion workforce, including a wide range of skills, backgrounds and competencies.

The implementation plan also notes the importance of supporting the mental health of the NHS workforce in order to improve quality and productivity, including through initiatives such as line manager training, providing rapid access to psychological therapies, mindfulness exercises and regular health checks.

NHS England subsequently published a one-year-on review of progress towards meeting these objectives. It noted that significant progress was already being made in many aspects of their process, including in both adult and children's IAPT, perinatal mental health and early intervention in psychosis. Other areas, such as crisis care, employment support and liaison psychiatry, are at an earlier stage of development in line with the implementation plan.[3]

Future in mind[4] was the result of a Department of Health taskforce investigating how to improve child and adolescent mental health support. It set out a range of recommendations for improvement and required local areas to produce Transformation Plans in order to receive a share of £1.25 billion investment over five years that was allocated as part of the 2015 Budget.

Key features of *Future in mind* with major workforce implications include:

- Creating "a [health, education and social care] workforce with the right mix of skills, competencies and experience" that can "promote mental health", "identify…problems early", "offer appropriate support", make referrals to targeted and specialist services and "work in a digital environment with young people who are using online channels to access help and support".
- Multi-professional training for all paediatric staff in physical and mental health "and the development of service models (such as paediatric liaison) which recognise the interaction and overlap between physical and mental health".
- Staff in targeted and specialist services "need a wide range of skills brought together in the CYP IAPT core curriculum". (This programme currently covers 68 per cent of the population and is a Mandate commitment to roll out further).
- A strategic approach to workforce planning: it proposes a "census and needs assessment" of the workforce "as the first stage in determining a comprehensive cross-sector workforce and training strategy".
- Accredited training in children's mental health "should be a requirement for all those working in commissioning of children and young people's services".

Developments impacting on workforce

In addition to the impact of mental health service changes, the future shape of the mental health workforce will be affected by a range of wider developments and policy changes. Alongside uncertainty relating to the outlook for the UK economy and funding for public services, the following issues are highlighted:

1 Apprenticeships

The Government has announced measures to increase the number of apprenticeships and included a target for public sector organisations and a levy of 0.5 per cent of the total pay bill from April 2017. This is likely to create opportunities for mental health services, for example to create nursing associate roles for apprentices, but will also create pressures on already limited funding for the existing workforce. It is unclear as yet how far mental health care providers are creating apprenticeship roles to ensure they recoup the cost of the levy.

2 Education funding reforms

The move from bursaries to loans to fund most health professional training from September 2017 may impact the numbers of people choosing to train in these fields. There are concerns from some quarters that this could disproportionately affect numbers of student nurses choosing mental health careers.

The Government has committed to increasing the number of health professional training places by 10,000. If this is successful, this will increase demand on services to provide placement opportunities and offer supervision to trainees.

3 New roles

The nursing associate role is being piloted in a number of mental health services. It is as yet unclear how far nurse associates will be additional to existing nurse roles or a substitute for some, and the implications of this development for mental health services. Physician associates are also likely to become a part of the future mental health workforce along with other new or expanding roles such as peer supporters, navigators and mentors.

4 Flexible working

The Government is seeking to increase opportunities for NHS staff to work flexibly, for example to have greater choice over shifts or to have term-time contracts. This could help to reduce the NHS's reliance on bank and agency staffing by enabling establishment staff to work flexibly.

5 Retention

NHS Employers is working with 100 NHS providers (including 12 mental health trusts) to support them to retain staff. The scheme includes examining why staff choose to leave or stay in their organisations and then helps them to develop, deliver and evaluate plans for improved retention. Learning from this initiative should help health care organisations to retain staff more effectively.

6 STPs, Vanguards and New Models of Care

Many Vanguard sites, including those focused on mental health, are developing new approaches with implications for the future workforce, for example increasing capacity in community services to reduce demand on inpatient care or developing alternative crisis pathways. This direction of travel is strongly supported in most STPs, some of which include specific pledges to develop improved mental health services (including prevention and earlier intervention) that will have a significant impact on the workforce.

An analysis by the Nuffield Trust concludes that the whole of the NHS faces a "huge organisational development challenge" in reshaping the workforce to implement new models of care. It notes that while training new staff will be crucial, "the biggest opportunity to reshape the workforce lies in developing the skills of the current workforce, particularly the non-medical workforce" for example in supporting people managing long-term conditions.[5]

7 The 'Brexit' effect

There are more than 161,000 people from the European Economic Area (EEA) working in social care and health care in England.[6] While these

are not disproportionately employed in mental health care, there are significant numbers of people working in NHS, local authority, voluntary sector and independent mental health providers from the rest of Europe.

It is as yet unclear what impact Britain's future relationship with Europe will have on this section of the workforce long-term, although in the short-term there is evidence of uncertainty about the future for those working in the UK and – one could speculate – the possibility amongst potential recruits to be reticent about coming to Britain who might otherwise have chosen to work here.

8 The Carter Review

NHS Improvement's review of efficiency and productivity in the NHS, led by Lord Carter of Coles, is currently investigating mental health and community trusts in England. The report, due to be published in late 2017, could have an impact on working patterns and financial management in mental health services.

9 Rising demand

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 – predominantly as a result of a growing population.[7] An estimated 1.8 million people were in contact with specialist NHS services in England during 2015/16,[8] and we expect the numbers of people coming forward for help to continue to grow. In turn this will have implications for the workforce within those services.

10 Tackling inequalities in access and outcomes

Of further relevance are known issues within current service provision, and the importance of ensuring the right workforce is in place to tackle inequalities in access and outcomes. Such inequalities are particularly marked for people from some Black and Minority Ethnic communities, who are less likely to access mental health treatment and more likely to be detained under the Mental Health Act. It is vital we see a much greater focus at a national level in tackling these inequalities and ensure everyone can access high quality, appropriate care and support. Meeting the needs of marginalised and vulnerable groups requires workforces to operate in different, flexible, and creative ways. There are interesting examples of partnerships between NHS providers and the third sector in this space.

11 Focus on access and waiting times

In recent times there has been a greater focus in national policy on the issue of improving access and waiting times for mental health services, with the introduction of a number of specific new waiting time targets.

For example, new national standards state that over 50 per cent of people with first episode psychosis are treated with a NICE-approved package of care within two weeks of referral. Provisional, experimental data from NHS Digital[9] shows that in a three-month period between the beginning of September and the end of November 2016, across English trusts there were 2,283 referrals on the Early Intervention Psychosis (EIP) pathway for treatment. Of these, 65.9 per cent (1,504) waited less than two weeks to begin treatment. There were, however, 12 trusts where over 50 per cent of referrals on the EIP pathway had to wait more than two weeks.

Should new waiting time standards be introduced across more mental health services then these will have implications for the workforce required to deliver them.

12 Reducing inappropriate out of area placements

The Government's national ambition of eliminating inappropriate OAPs for adults is being measured through a new dataset Out of Area Placements in Mental Health Services. Data from NHS Digital indicates that at the end of October 2016, there were 7,161 open ward stays in adult acute inpatient mental health care. Of these, where distance travelled could be calculated, 284 people (4 per cent) were receiving care 50 km+ away from their home postcode.[10] Ensuring more people have access to appropriate services closer to home has implications for future workforce planning.

The current clinical mental health workforce

The scope of the project will examine the mental health workforce – including clinical and management related roles. The below gives an overview of a selection of key available statistics relating to the current clinical mental health workforce. This draws largely on data from the World Health Organization and NHS Digital. It should be noted that NHS mental health services are delivered by a wide range of organisations from the statutory, commercial and third sectors. National workforce datasets, such as those outlined below, largely derive from employment statistics within statutory organisations, rather than those employed within commercial and third sector organisations providing NHS treatment and care, and therefore should be interpreted with care.

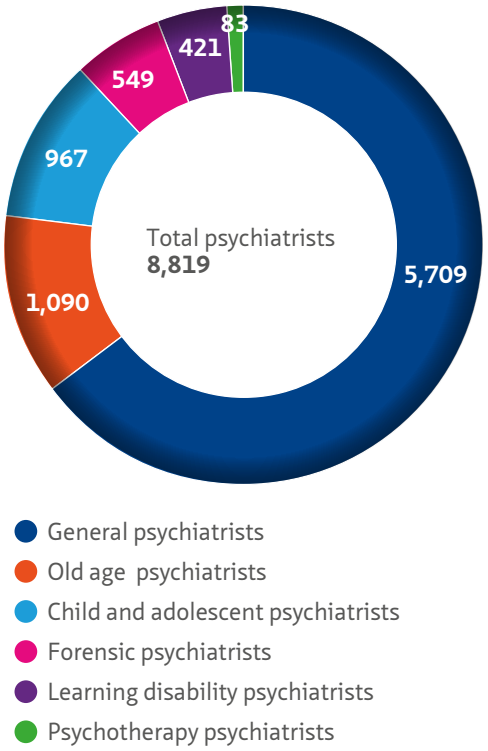
Psychiatry

The World Health Organization estimates that, across the whole of the United Kingdom, 14.63 psychiatrists were working in the mental health sector in 2014 per 100,000 people in the general population.[11] This compares to 14.1 in France, 20.1 in the Netherlands, 18.31 in Sweden, 13.42 in Canada, and 12.4 in the United States.[12]

According to NHS Digital provisional statistics covering English NHS Trusts and CCGs, in October 2016 there were 8,819 psychiatrists (full time equivalent, total number across all grades).[13]

Whilst the overall number of psychiatrists in England has increased in recent years, there are challenges facing the profession. Firstly, attrition rates amongst consultant psychiatrists aged 53 or less have been substantially higher than the attrition of NHS consultants as a group.[15] Secondly, there have been lower rates of trainees progressing with their training. Nearly one in five doctors in training failed to progress from core psychiatry training into higher speciality training.[16]

Figure 1: FTE Psychiatrists in England – NHS Trusts and CCGs (October 2016, provisional statistics)[14]



"Whilst the overall number of psychiatrists in England has increased in recent years, there are challenges facing the profession."

Mental health nursing

The World Health Organization estimates that, across the whole of the United Kingdom, 67.35 nurses were working in the mental health sector in 2014 per 100,000 people in the general population.[17] This compares to 90.86 in France, 52.9 in Sweden, 53.31 in Canada, and 70.91 in Australia.[18]

Provisional data from NHS Digital showed that there were a total of 35,943 mental health nurses in October 2016.[19] The number of nurses fell by over ten per cent between October 2009 and October 2016, when there were 40,862 mental health nurses in post.[20] Over the same period, there was an increase in the overall numbers of community psychiatry nurses, and reductions elsewhere.

Figure 2: FTE mental health nurses in English Trusts and CCGs (October 2016 provisional data)[21]

	October 2009	October 2016
	40,682	**35,943**
Community psychiatry	15,295	16,350
Nurse consultant	33	53
Modern Matron	48	44
Nurse Manager	647	945
Other 1st Level Nurse	14,450	15,172
Other 2nd Level Nurse	116	136
Other psychiatry	25,387	19,582
Nurse consultant	109	97
Modern Matron	550	395
Nurse Manager	1,060	1,095
Other 1st Level Nurse	23,230	17,901
Other 2nd Level Nurse	438	104

The Royal College of Nursing (RCN) have highlighted issues relating to the "debanding" in the mental health nurse workforce, where there has been a fall in higher bands of nurses.[22]

Additionally, RCN research reported in The Guardian in 2016 highlighted high numbers of vacancies amongst mental health nurses. Their research found that London hospitals had 10,000 nursing vacancies and NHS mental health trusts were among the worst affected by shortages of nurses.[23]

Potentially in response to such vacancies, there has been a reported greater reliance on temporary and agency staff. According to the King's Fund, by 2014 requests for temporary nursing in mental health services had increased by two-thirds.[24]

Nursing support staff

Provisional data from NHS Digital showed that there were a total of 1,611 nursing support staff (nursing assistants/auxiliaries, and nursing assistant practitioners) in the community psychiatry group in post at October 2016.[25] Again, these numbers have decreased since October 2009, when 1,979 staff were in post.[26]

Within the "other psychiatry" staff group, 19,149 nursing support staff were in post at October 2016. Within this group, overall numbers have remained largely stable since October 2009 when 19,337 staff were in post. However, within this staff group numbers are some interesting trends. Numbers of FTE nursing assistant/auxiliary staff have decreased from 13,727 in October 2009 to 8,296 in October 2016. Numbers of healthcare assistants have increased from 2,747 to 6,824 over the same period. Similarly, staff employed under the "support worker" label have increased from 2,841 to 3,739 FTE over the same period.[27]

Psychology and other therapies

The World Health Organization estimates that, across the whole of the United Kingdom, 12.8 psychologists were working in the mental health sector in 2014 per 100,000 people in the general population.[28] This compares to 10.77 in France, 47.42 in Canada, 12.78 in Denmark, and 16.68 in Australia.[29]

Provisional data from NHS Digital shows that in October 2016 a total of 7,057 FTE staff were in post within clinical psychology roles, a slight increase on October 2009 when 6,797 professionals were in post.[30]

From the same dataset, the number of psychotherapists has increased significantly over the same period. In October 2009 provisional data from NHS Digital indicates that 1,214 FTE staff were in post in psychotherapy roles, rising to 4,341 in October 2009.

Within clinical psychology support roles, there were 1,221 assistant practitioners in post in October 2009, rising to 1,825 in October 2016. Numbers of trainees and students however has reduced over the same period, from 1,832 in October 2009 to 1,305 in October 2016.[31]

In the psychotherapy support group, there were 133 assistant practitioners in post in October 2009, rising to 750 in October 2016. There were 201 trainees and students in post in October 2009, and 287 in October 2016.[32]

Further data on the workforce relating to talking therapies is provided by the 2015 IAPT workforce census, which achieved a 90 per cent return rate from services. Data from this report indicated that, as at April 2015, there were 6,897 FTE therapists and practitioners, 780 trainees and 127 employment support advisors.[33] The 2015 IAPT workforce comprised 36 per cent Low Intensity (Step 2) workers, 62 per cent High Intensity (Step 3) workers and 2 per cent Employment Support workers. The IAPT workforce is predominantly female (79 per cent), White British (83 per cent) and relatively young (66 per cent were reported as being under 46 years of age), meaning that the IAPT workforce is not always representative of local populations and service users. The census also highlighted that the majority of therapy capacity within IAPT services related to cognitive behavioural therapy and counselling, with an "underrepresentation" of brief dynamic interpersonal therapy, interpersonal psychotherapy for depression and couples therapy". The census report recommended that "increasing capacity for the full range of NICE approved therapies for depression will improve patient choice and may lead to increased treatment take-up and recovery rates".[34]

Social care

Social workers delivering statutory adult mental health services are currently most often employed or funded by local authorities. Skills for Care's national minimum dataset for social care estimates that there are 1.55 million jobs in the social care sector in England – across the independent and statutory sector, as well as direct payment recipients.[35] Across the statutory and independent sector, 82.73 per cent per cent of workers are estimated to be British, 6.76 per cent from the European Economic Area (EEA, non-British) and 10.52 per cent from non-EEA countries.[36]

Further data from the national minimum dataset for social care estimates that 28,500 jobs in the sector are concerned with exclusively providing care and support to people with "mental disorders or infirmities", 1,500 of which are within local authorities, 15,000 in the independent sector and 12,500 through direct payment recipients. Some 483,500 jobs provide care and support to people with "mental disorders or infirmities" combined with other care and support provision. Of those, 56,000 roles are through local authorities and 428,000 within the independent sector.[37]

Between 2009 and 2015 the total social care workforce increased by some 18 per cent.[38] The number of adult social care jobs increased between 2014 and 2015 for independent employers by around 2 per cent (20,000 new jobs). The number of adult social care jobs in the NHS increased by 6 per cent (5,000 jobs) and the number of local authority jobs decreased by 8 per cent (10,000 jobs) over the same period. Skills for Care report that commonly cited reasons by councils for reductions in staff were restructures, service closures and the outsourcing of services.[39]

Primary care

As at March 2016, there were 34,914 FTE General Practitioners, an increase of 0.9 per cent since September 2015.[40] There have been reported concerns around recruitment, with a 2013 survey finding average vacancy rates of 7.9 per cent.[41]

The Government has set an objective of an extra 5,000 doctors working in general practice by 2020. NHS England report that numbers entering GP training are up by 10 per cent since 2015 and that Health Education England will fill a further 230 places in 2017/18 to ensure they reach 3,250 trainees per year.[42]

Towards a vision for the future

Centre for Mental Health are collating and analysing the views and experiences of people who use and work in mental health services in order to develop a vision for the workforce for the future. This work is ongoing and a final report will be published later in 2017. Some of the main themes emerging from the Centre's work so far include:

1. The need to create more flexible career paths to enable people to progress their careers working in a range of roles for different organisations (including in the voluntary and independent sector as well as the statutory sector).
2. The importance of peer support and new roles such as navigators in offering practical as well as clinical help to individuals, carers and families.
3. A growing role for mental health professionals in providing advice and consultancy to other workers, for example through liaison roles in hospitals, primary care, schools and the justice system.
4. The need to train mental health professionals to work in different ways, for example with families and support networks as well as individuals, and in using digital technology to communicate and share information with service users.
5. The importance of ensuring that new and emerging roles such as nursing associates and physician associates are adapted successfully to mental health support.
6. The need to address attrition rates in mental health services, to ensure that people have a positive experience of training and working in mental health care.
7. The importance of developing local solutions to specific needs and challenges in different areas while maintaining consistency of standards nationwide.
8. The importance of providing opportunities for older workers to continue to practise and develop their careers as the age profile of the workforce rises.

Questions for Mental Health Network members

We are keen to hear the views of Mental Health Network members to inform the next stage of this project. We are particularly seeking views and experiences in relation to the following questions:

1. What opportunities are mental health care providers taking to make use of new roles, including apprenticeships, nursing and physician associates, and peer supporters? What issues have arisen from experience so far?
2. What measures are being taken to create more flexible ways of working for staff members wishing to pursue non-traditional career paths, and with what impact?
3. How are providers seeking to widen participation in the mental health workforce, particularly among the most excluded communities?
4. What impact have STPs had so far on local mental health workforce planning and development? What further impacts are envisaged longer term?
5. How far can local commissioners, providers and STPs innovate and develop alternative ways of working without creating unacceptable levels of variation?
6. How can we ensure that all of these developments reduce health inequalities and improve access, quality and outcomes for the most excluded and marginalised groups of people?

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