Shaping the Future

__________________ ...... Workforce

Interim Mental Health Care Area Workforce Report
At present the mental health programme for South Central is in the early stages of development, with an initial programme outline to be expected by January 2010. This interim report aims to complement this programme outline, by providing a contextual view of the current situation of the mental health care area workforce for NHS South Central.

1. Introduction

Nationally 1 in 4 adults experience some kind of mental health problem in the course of a year\(^1\). Mental health problems are typically a heavy financial burden, for both individuals and society. For instance according to the Sainsbury Centre for Mental Health the total costs to the nation of mental ill health is as high as £77 billion each year in lost earnings, productivity, and reduced quality of life\(^2\).

In 2007 an Association of Public Health Observatories report examined mental health indicators across England by Government Office Region (GOR)\(^3\). Within the South East a fairly mixed picture was found. Key factors such as employment, education and excessive alcohol consumption levels were good compared to the rest of the country; however, around 13% of the population were identified as having mental health problems.

The workforce that serve patients with mental health needs is wide ranging and includes the various psychological specialties (clinical psychology, community psychiatry, forensic psychiatry, general psychiatry, old age psychiatry, & psychotherapy), mental health nurses, various Allied Health Professions (AHP) (occupational therapists, speech and language therapists, pharmacists, art music and drama therapists, multi therapies, sports and exercise medicine & public health medicine), as well as community and social services and various support staff.

Within NHS South Central there are three principal providers of mental health services: Berkshire Healthcare Trust, Hampshire Partnership Trust, and Oxfordshire and Buckinghamshire Mental Health Trust. Organisations that are also known to have substantial mental health provider arms include Milton Keynes Primary Care Trust (PCT), Portsmouth City Teaching PCT and the Isle of Wight PCT.

This report excludes any information on learning disabilities and children’s and adolescent mental health, which are covered in alternative reports.

The main aims of this report are as follows:
- To identify the current workforce demand drivers and future forces for change
- To assess the current workforce supply, identifying the key opportunities or areas of concern within the workforce supply

To establish the key workforce priorities and next steps, whilst recognising the early developmental stage of the mental health programme.

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2. Workforce demand

There are a number of drivers that are anticipated to affect the shape of service provision in the future and drivers impacting on the workforce demand. Below is a summary of the main ‘forces for change’ currently facing the mental health workforce:

2.1 Prevalence of mental health conditions

_Debt, income and mental disorder in the general population_⁴ gives us some insight into the prevalence of mental health disorders and the associated economic costs. The annual service costs of depression in England in 2007 were £1.7 billion, whilst for anxiety the costs were £1.2 billion. Whilst the future of such disorders is less certain, the report argues that rates are likely to increase with increases in divorce, difficulties in home ownership, urbanisation, drug abuse and immigration.

2.2 Ageing population

Ageing population: The Office of National Statistics (ONS) forecasts that the fastest growing age group in England are the over-75s, who are some of the heaviest users of the health service. Within the South East (GOR), by the late 2020s, over 40 per cent of the region’s population is predicted to be over the age of 50, the number of people over the traditional retirement age of 65 is predicted to increase by nearly 50 per cent and those aged over 85 will more than double in number⁵. Consequently it is likely that health services will experience increasing demand for many services, in particular on services such as on old age psychiatry.

2.3 Prevalence of alcohol misuse

According to _Statistics on Alcohol England 2008_⁶, the prevalence of alcohol misuse is another factor that South Central needs to be aware of and ensure we have an appropriate workforce in place for:

- In England in 2007 24% of adults were classified as hazardous drinkers, with 6% of men and 2% of women estimated to be harmful drinkers (meaning damage to health is likely). Furthermore within the South East (GOR) 40% of men and 36% of women drink more than 4/3 units on at least one day of a given week.
- In England 222,600 of alcohol related admissions were for conditions wholly attributable to alcohol consumption of which mental and behaviour disorders were the most common alcohol related diagnosis, accounting for 144,700 admissions.
- It is estimated that the costs of alcohol related harm to the NHS in England is £2.7 billion in 2006/07 prices.

2.4 Prevalence of drug misuse

The prevalence of drug misuse also needs consideration. A report from the Information Centre (2009) shows the following statistics for drug use in England:

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• Overall drug use for adults has fallen in recent years, however is still prevalent enough to cause concern. In 2008/09 10.1% of adults aged 16-59 living in England and Wales had used one or more illicit drugs in the last year, with the most commonly used drugs being cannabis, followed by cocaine.

• Specifically to mental health, in 2008/09 there were 5,668 admissions to hospitals in England with a primary diagnosis of drug related mental health and behaviour disorders (15.1% less than in 2007/08). Among SHAs, the largest number of admissions with a primary or secondary diagnosis of drug-related mental health and behavioural disorders was 155 admissions per 100,000 population. South Central SHA had the lowest number of 40 admissions per 100,000 population.

2.5 The Bradley Report
Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system reviewed the experiences of people with mental health and/or learning disabilities in the criminal justice system. The report sets out a number of recommendations aimed at developing how these people are cared for. If government implements these recommendations many will have a significant effect on the workforce. Some of the key recommendations include:
  • The NHS taking commissioning and budgetary responsibility for healthcare services in police custody suites.
  • All police custody suites having access to liaison and diversion services
  • The probation service and the NHS to ensure mental health requirements for community treatment orders are available
  • The development of robust models of primary mental health services and appropriately skilled workforces to assess and treat those with mild to moderate conditions as oppose to inpatient treatment
  • The development of a new minimum 14 day targets to transfer prisoners with acute or severe mental illnesses to appropriate settings.

2.6 Improving Access to Psychological Therapies
Improving Access to Psychological Therapies (IAPT) began in 2006 with demonstration sites in Doncaster and Newham focusing on improving access to psychological therapies services for adults of working age. Theses pilot sites revealed benefits for individuals with mental illnesses such as better health and wellbeing, and helping people to stay employed. On world mental health day (2007), Health Secretary Alan Johnson announced substantial new funding to increase services over the next 3 years:
  • £33 million for 2008/09
  • A further £70 million to total £103 million in 2009/10
  • A further £70 million to total £173 million in 2010/11
With the intention of delivering 34 PCTs to implement IAPT services by 2008/09 and 3600 additional high and low intensity therapy workers by 2010/2011.

Some of the most recent data on the IAPT workforce shows it to be a largely female, white profession. The qualified high intensity IAPT workforce predominantly consists of CBT therapists, counsellors, nurses and psychologists. Trainees this year include substantial numbers of nurses, counsellors and graduate workers. Applied psychologists and psychotherapists are less well represented, which may cause a

barrier as to IAPT obtaining optimal clinical outcomes. The low intensity workforce consists of health care support workers, psychology assistants, and people working within administrative mental health roles.9

Within South Central there are currently 253 Full Time Equivalent (FTE) training places, of which 60% are high intensity and 40% are low intensity therapists. 43 started in November 2008 (26 high, 17 low), 111 started this year (66 high, 45 low) and 98 are due to start in April/May 2010 (59 high, 39 low).10

A current issue around the roll out of IAPT is that there may be a need to enhance/extend the current competencies of various staff. For instance, since monies have been targeted at existing services, many staff members within such services will already be qualified to deliver high intensity interventions. However staff trained in CBT several years ago are likely to require further training and updating to match the competencies of new IAPT trainees. Furthermore, existing services will also contain staff who wish to up-skill and extend their roles, or therapists who wish to offer therapy in an additional modality. As such continuing professional development is a vital aspect in the implementation of IAPT.

Another point is that in order to support IAPT there is a need for senior clinicians to become more involved with clinical leadership and service development issues, in addition to staff receiving expert supervision around clinical outcomes (1 competent staff member needs to be in place for every two trainees before a service will be given funding). In addition IAPT is likely to lead to an increase in referrals of more complex patients to psychotherapy services. Furthermore there is a concern that the focus on the delivery of psychological therapies may divert staff away from other areas of mental health provision.

Bearing the above points in mind it may well benefit NHS South Central to undertake a workforce capacity assessment to understand the impact of IAPT for the local workforce, and to consider IAPT in the light of the new economic climate.

2.7 Dementia

There are currently 700,000 people in the UK with dementia, costing the UK economy £17 billion a year, and in the next 30 years the number of people with dementia in the UK will double to 1.4 million, with the costs trebling to over £50 billion a year.11

Within primary care the National Audit Office’s report, Improving services and support for people with dementia12 tested GP’s knowledge of Dementia and asked them to rate their confidence in making a diagnosis. The average proportion of correct answers was 47%. Furthermore a recent report from the Alzheimer’s Society, entitled

10 South Central IAPT Programme, July 2009. Please note: 1 fte omitted in the revised funding and training schedule breakdown due to rounding issues
Counting the Cost\textsuperscript{13} found an unacceptable variation in the quality of dementia care. The report further highlighted that people with dementia tend to stay far longer in hospital than others who go in for the same procedure and this increases patients symptoms of dementia, damages their physical health, increasing discharge to care homes, increases the likelihood of antipsychotic drug use and places unnecessary financial pressure on the NHS. The report even states that supporting people with dementia to leave hospital a week sooner could result in savings of £80 million a year.

Counting the Cost also investigated what users and relevant staff saw as currently wrong with the system. Carer respondents identified various key areas of dissatisfaction including nurses not recognising or understanding dementia, a lack of person centred care, limited involvement in decision making, little assistance in eating and drinking and the person with dementia being treated with a lack of dignity and respect. Nursing staff also identified various areas of concern which included: managing difficult behaviour, communicating, not having enough time to provide one-to-one care, and difficulty in ensuring patient safety.

Clearly there is an issue around ensuring the necessary skills and knowledge are in place. Furthermore most people with dementia will at some point, exhibit challenging behaviour, personality changes and mood swings. Caring for such people requires a huge amount of skill and patience and without appropriate training carers and staff may not react appropriately to such behaviour.

Counting the cost (2009) also makes additional recommendations such as:

- Reducing the number of people being cared for in hospitals, by shifting services away from acute and more towards community care
- Commissioning liaison older people’s mental health teams to facilitate the management and care of people with dementia in hospital
- Hospitals identifying senior clinicians to take a lead on quality improvement in dementia and defining the care pathway
- Ensuring an informed an effective acute care workforce is in place to meet the needs of people with dementia. Within the current climates workforce development budgets for dementia need to be prioritised to ensure people with dementia are out of hospital as fast as possible.
- Reduce the use of antipsychotic drugs to treat people on general wards with dementia
- Involve patients, carers, family and friends in the care of people with dementia to improve person-centred care.
- Making sure patients with dementia’s nutritional needs are met
- Changing the approach of care to one of dignity and respect.

Living Well with Dementia: A national dementia strategy\textsuperscript{14}, aims to create significant improvements across three key areas of dementia services: improved awareness, earlier diagnosis and intervention and a higher quality of care. The strategy identifies 17 key objectives which should create improvements in the quality of dementia services provided and promote greater understanding of the causes and consequences of dementia. These objectives cover areas such as improvement in diagnostic services, post diagnostic counselling, intensive case management from

\textsuperscript{13} Alzheimer’s Society (2009) Counting the Cost, online: http://alzheimers.org.uk/countingthecost
diagnosis, and more co-ordinated person centred services for people developing dementia while of working age. South Central should review these objectives and where applicable implement them across the SHA.

South Central should review the objectives of the Living Well with Dementia and where applicable implement them across the SHA, in order to improve the care of dementia patients. The recommendations of Counting the Cost also need to be given consideration as a method for driving improvement in dementia care.

2.8 Postnatal depression
According to the Mental Health Foundation, between 8-15% of new mothers develop postnatal depression. Furthermore the Health Commissioner’s Maternity service review 2007 found only 55% of trusts conduct all mental health checks identified in NICE guidance for antenatal and postnatal health. Consequently South Central need to ensure a high quality workforce is in place to deal with this need.

2.9 New Horizons
New Horizons\(^\text{15}\) is a new Department of Health strategy that sets the vision for the mental health workforce for the next 10 years. It aims to build on the national service framework for mental health by taking a cross-organisational approach to mental health provision, incorporating the wider health service, local authorities, employers, education and criminal justice agencies in order to achieve the aims of improving the provision of mental health services and the mental health of the population.

The New Horizons report builds on many of the aims set out in its consultation document, such as taking a lifespan approach to mental health by setting the foundations for good mental health in childhood, recognising that a national and local cross-government approach is needed in order to reduce the burden of mental illness and unlock the benefits of wellbeing, and specifically that health services must work in partnership with local authorities and other organisations in order to deliver high quality, accessible, integrated and safe services. In terms of actions, New Horizons builds on the consultation documents aims, which were grouped into a number of key themes: prevention of mental ill health and promoting good mental health, early intervention, tackling stigma, strengthening transitions, personalised care, and innovation.

In terms of how New Horizons may impact on the mental health workforce, it is recognised within the strategy that a skilled workforce, working across all sectors are the main resource for delivering high quality care. It further comments that it is vital that staff are well led, well supported, supervised, and have access to continuing professional development. As such South Central should aim to ensure that appropriate leadership and senior support staff are in place, and that CDP opportunities are available. New Horizons identifies a wide range of initiatives that are occurring across different sectors, aiming to improve knowledge and skills of various staff groups that would lead to the delivery of New Horizons. South Central should review these and other opportunities.

New Horizons also advocates effective and resourced commissioning, and recommends the use of world class commissioning, and the payment by results framework to drive this forwards. Interestingly a further comment around the commissioning of services within the strategy is that the fact that mental health services are typically provided by a range of providers, is a major strength, and can

be used to drive innovation, quality and achieving value for money. On a more
general note, South Central should review the key aims of the New Horizons
strategy, and where appropriate implement them within their workforce, in order to
drive a high quality level of care.

Whilst considering New Horizons it is also worth considering *A future vision of mental
health*\(^\text{16}\). The coalition included groups such as the Royal College of psychiatrists,
Sainsbury centre, the Local Government Association and many other prominent
stakeholders. Their intention was to set out their vision for the future of mental health
and wellbeing in England, by listening to a number of people involved in mental
health in various ways, to contribute to the New Horizons consultation. The coalition
produced 4 main principals for mental health policy: that mental health and wellbeing
should be considered everybody’s business, that there is a need to promote good
mental health and intervene early when people become unwell, that people should
experience the same level of support to gain a good quality of life from mental health
services as they would from physical health services, and that service users, carers
and communities should be offered an active role in shaping the support available to
them.

Underpinning these values are a series of actions. To name a few more directly
related to workforce:

- To ensure that proactive physical health checks are provided by GPs to
  people with severe mental health problems, with the starting point being
  equality of access for all communities
- To pilot and build upon a community engagement approach to commissioning
  for mental health and well-being that involves service users and carers
- To pilot and evaluate the benefits and potential demand for personal health
  budgets for mental health support.
- To complete the roll out of IAPT (Improving Access to Psychological Therapy)
  to the whole of England, and extend and adapt coverage to meet those
  groups in need
- To offer mental health training to all frontline public service professionals

It would be worthwhile for South Central to review the recommendations of the vision
coalition and consider whether any of their actions would be beneficial if applied to
the mental health workforce.

2.10 Mental Health Act (2007)
An amended Mental Health Act came into effect in 2007, and introduced various
changes to the 1983 act including the removal of the ‘treatability test’ for patients with
personality disorders, a duty on trusts to provide advocacy support for patients
detained under the Act, and the introduction of Community Treatment Orders (CTOs)

A CTO is an order for patients to receive treatment of care and supervision in the
community, based on a community treatment plan, which outlines all aspects of care
believed necessary for people to live in the community rather than in hospital.
Naturally, this will place increased demand on the primary and community care
workforce.

2.11 Mental Capacity Act (2005)

\(^{16}\) Future Vision Coalition (2009) *A future vision of mental health*, online:
http://www.newvisionformentalhealth.org.uk/
The mental capacity act provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. It clarifies who can make decisions, in which situations, and how they should go about this. As a result more capacity assessments are likely to be sought, which would place additional pressure on all the psychiatric specialities, in particular learning disabilities and older people’s services such as old age psychology.

2.12 Working for a healthier tomorrow
In 2008 Dame Carol Black reviewed the health of Britain’s working age population in *Working for a healthier tomorrow* outlining 3 aims: the prevention of illness and promotion of health and well being, early intervention for those that develop a health condition, and an improvement in the health of those out of work.

Dame Carol Black highlights various areas for improvement, which may place increased demand on the mental health workforce. For example it is recommended that specialist mental health provision must be integrated into all employment support programmes for all those out of work, not just those on incapacity benefits. The report further argues that early intervention helps prevent short term sickness absence turn into long term sickness absence, and as such a new ‘Fit for Work’ service should be established. This service would be based on a case managed, multidisciplinary approach, and would provide, treatment and advice for people in the early stages of sickness absence. The case manager would have access to a wide range of services, to include non traditional services such as financial and housing support organisations, as well as traditional NHS services such as physiotherapies and talking therapies. Naturally, service developments such as these are likely to increase referrals to mental health services.

*Working for a healthier tomorrow* also recommends that the government should expand their provision of ‘Pathways to Work’, and pay particular attention to how to better tailor this service to people with mental health illnesses. This has the potential to lead to increased demand for the mental health workforce, and it is likely that particular demand would be placed on practitioners able to deliver CBT as part of the condition management programme. The condition management programme is a programme that sits within ‘Pathways to Work’ and aims to help individuals on sickness absence leave better understand and manage their conditions or disabilities through the use of cognitive behavioural therapy. The condition management programme is run for Jobcentre Plus by the NHS and the Department of Health.

2.13 New ways of working
New ways of working aims to establish a new way of thinking, which includes the development of new, enhanced and changed roles for mental health staff, and the redesign of systems and processes to support staff to deliver effective, person centred care in a way that is personally, financially and organisationally sustainable. It is aimed at any individual involved in mental health, regardless of care setting and the patients and carers they work with.

New ways of working aims to provide the tools, learning and communication necessary for service providers to analyse what skills are needed within their teams and what processes and infrastructure, in order to create more flexible person centred services. South Central needs to assess what work needs to take place within the SHA to fully embed NWW across health and social care organisations.

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2.14 Supply of Mental health nurses
Mental health nurses make up the largest group of the mental health workforce, with 48,000 registered nurses working in the NHS in England18. There are also 30,000 non professionally qualified staff working with nurses and making a vital contribution.

A poll of 600 mental health nurses by the RCN found that 42% thought that low staffing compromised care once a week, two thirds thought that that there were not enough members of staff to meet patient needs and over half the nurses surveyed believed they spent too much time on paperwork. The RCN general secretary, Dr Peter Carter said, “This survey shows that mental health nurses are facing serious obstacles to delivering the kind of care that their clients deserve” Within south central there is a known shortage of mental health nurses, with current supply modelling showing a decrease in supply forecast over the next few years. Coupled with the RCN findings there is arguably a need to develop the mental health nursing workforce.

In 2006 the Chief Nursing Officer carried out a review of mental health nursing in ‘From values to action’, and identified the following key ways of developing the workforce:

- Pre-registration training courses should be reviewed in order to ensure that essential competencies are gained by the point of registration
- Mental health nursing should incorporate the broad principles of the recovery approach into all aspects of their practice (e.g. working towards aims that are meaningful to service users, ensuring social inclusion, seeing change in a positive manner). These principles need to be reflected in both organisational polices and nurse training.
- A holistic approach should be taken, taking into account patients physical, psychological, social and spiritual needs. In order to achieve this mental health nurses will need training, initial supervision and managerial support.
- Support workers roles should be reviewed as a way of freeing up mental health nurses time for more direct clinical contact.
- Career structures for mental health nurses should be reviewed according to local need and a range of new nursing roles should be developed and supported by provider organisations.

South Central needs to consider the Chief Nursing Officer’s recommendations in conjunction with the current workforce supply and any issues faced in order to develop the mental health nursing workforce both in terms of capacity, and skills development.

3. Workforce supply

The following section aims to assess the current mental health workforce supply within South Central and outline any key areas of interest or potential opportunities for improvement.

In order to assess the current mental health workforce within South Central, organisations which provide a significant amount of mental health services within the patch were identified, and an aggregate profile was produced. This means that minor pockets of the learning disability workforce positioned in other organisations will have been excluded, however this analysis provides a strong indication of workforce

18 http://www.newwaysofworking.org.uk/content/view/49/460/
trends not only of those individuals directly involved in the care area, but all underpinning staff as well.

The organisations identified were as follows:
- Berkshire Healthcare Trust
- Hampshire Partnership Trust
- Isle of Wight PCT
- Milton Keynes PCT
- Oxfordshire and Buckinghamshire Mental Health Trust
- Portsmouth City teaching PCT

Any areas of particular interest or opportunity have then been commented on within this section. Due to variations in the data quality, some aspects of this analysis have not been commented on; however all the analysis included gives us a clear indication of the key trends within the workforce. (Robust headcount data was not obtained, and as such all analysis has been done around full time equivalent numbers. Consequently analysis of age, gender, ethnicity, and leavers must not be taken as absolute figures, but as strong indications of key trends within the mental health workforce. Where appropriate organisations are being contacted in relation to readily identifiable errors such as the miscoding of staff).

3.1 Staff profile
Based on this analysis the mental health workforce is approximately 8000fte, of which the most substantial staff groups include registered nursing staff, accounting for 30%, administrative and clerical, accounting for 24% and additional clinical services accounting for 21%.

![South Central mental health workforce profile](image)

Figure 1, South Central mental health workforce profile (data from organisations and ESR September 2009)

It is also interesting to analyse the workforce in terms of job roles. The highest job roles include staff nurse accounting for approximately 12.5% of the workforce, health care support workers, 11.4%, clerical workers, 5.8%, and healthcare assistants, accounting for approximately 5.6%.

3.2 Skills mix
Figure 2 show the current mental health workforce within South Central by AfC band. From the graph below we can see that a large number of staff are employed at bands 3 and 6, accounting for approximately 18% and 21% of the workforce.

![Graph of South Central mental health workforce by AfC band as at September 2009](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAJhAAAASCAIAAADbJ33GAAAABGdBTUEAALGPCW1hCgAAIfJwAAAgAElEQVR42u3QYAAAAABAAIAAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAAAAACAAAA
3.4 Gender
Based on FTE, approximately 71% of the workforce was reported as female and 29% were reported as male. Due to aspects such as maternity leave and the trend towards part time working South Central needs to consider how this might affect the workforce.

3.5 Ethnicity
The workforce profile shows that the majority of the workforce were white British, which accounts for approximately 75%. Other substantial ethnic groups included African accounting for approximately 6% and Indian accounting for approximately 2%. (Based on FTE)

3.6 Sickness absence
The average sickness absence rate across all the organisations analysed, between October 2008 and September 2009 was 4.3%, slightly above South Central's benchmark of 4%.

3.7 Turnover
The average turnover rate across all organisations analysed, between October 2008 and September 2009, was 12.2%, slightly below South Central's benchmark of 15%.

3.8 Leavers
The analysis of leavers from the mental health workforce between October 2008 and September 2009 shows that approximately 4% of the workforce left due to work/life balance issues, which may highlight a potential area of opportunity for South Central to better manage retention. Other reasons for leaving worth highlighting are, relocation and promotion which account for approximately 12% and 8%.

There is anecdotal evidence on a national level that nursing staff are moving into IAPT, which has the potential to have a negative effect on nursing supply. In conjunction with this, recent South Central modelling (figure 4) highlights that mental health nursing is expected to decline over the next 5 years, in spite of significant increases in commissioning.
This is partially attributable to higher levels of retirement, and high turnover rates, compared to other areas of nursing, currently standing at 8%. However demand for mental health nurses is also being affected by changes in skills mix, in particular the number of mental health practitioners and increases in the number of people in the workforce who can provide psychological therapies, through programmes such as IAPT.

The analysis of the leavers reported between October 2008 and September 2009 shows that 7% of registered nursing staff left due to receiving a promotion, which may be partially attributable to IAPT. Whilst this could not be considered a significant amount, it may be worth South Central investigating the impact IAPT may be having on other workforces.

4. Workforce Priorities

The following section aims to identify what the key workforce priorities are in terms of further developing the workforce to meet future demand.

4.1 Collaboration

Mental health and wellbeing is the responsibility of all NHS organisations. As such co-ordinated and assertive action is needed across all organisations involved in the provision of health.

The development of end to end, whole system integrated pathways should be considered, that bring in both traditional NHS services and non NHS organisations, with pathways starting in primary care. Such pathways should consider patients additional needs such as housing, employment, social and spiritual needs, to provide a holistic approach.
PCTs need to commission by pathway, as part of a wider partnership between health, social care and local communities. Furthermore working age adult mental health services need to identify flexible ways of bridging service transition points.

South Central should review the objectives of the National Dementia Strategy for England (2009) and where applicable implement them across the SHA. The recommendations of ‘Counting the cost’ (2009) also need to be given consideration as a method for driving improvement in dementia care. It needs to be ensured that appropriate staff, services and interagency working practices are in place to enable patients to build a meaningful life for themselves, around the principles of self determination and self care.

4.2. Wider workforce
Mental health care training needs to be embedded in training at all levels for all staff groups involved in all health provision, regardless of profession or work setting. Integrated working needs to be established between different care settings. Furthermore enhancing clinical knowledge and skills needs to be an ongoing process.

Promoting wider public health and mental wellbeing would lead to improved self management and earlier interventions. For instance if members of the public enjoy a balanced diet and regular exercise they are far less likely to suffer from depression. As such these values should be built into staff training at all levels and across all organisations.

Mental health care needs to be included in all physical health pathways and patients showing somatic symptoms need to be detected and treated appropriately.

It needs to be ensured that the strong inter-relationship between mental and physical health is recognised by staff. For instance if patients with a mental health condition develop a physical health condition then it is likely they will require an adapted pathway. Furthermore patients with a physical health condition can be considered more at risk of mental conditions such as anxiety and depression. Staff need to be appropriately trained to detect such symptoms.

4.3 Prevention and early intervention
There needs to be a focus on prevention and early intervention, particularly within primary care and the community. As such development opportunities and relevant training should be considered.

Services should be designed, with an appropriately skilled workforce, to target high risk groups for prevention and early intervention i.e. people from black and minority ethnic communities, refugees and asylum seekers, victims of abuse and violence, prisoners and members of the armed forces.

To improve access to psychological therapies a full clinical pathway should be developed which extends the stepped care model, and encompasses public health interventions, education in schools and the use of eclectic interventions involving CBT by individuals such as GPs, social workers and health visitors.

4.4 Specialist Workforce
South Central needs to assess what work needs to occur across all services involved in the provision of mental health, in order to fully embed ‘New Ways of Working’ across health and social care programs. This is particularly important in light of the
current economic climate, as through aspects such as the development of new roles; NWW has the potential to develop person centred care in a way that is personally, financially and organisationally sustainable.

South Central needs to consider the Chief Nursing Officer’s recommendations in ‘From values to actions’ (2006) in conjunction with how to mitigate any issues the mental health workforce is currently facing in order to develop the mental health nursing workforce both in terms of capacity, and skills development.

4.5 Stakeholder engagement
Service users, carers and communities should be offered an active role in shaping service models, and consequently how staff are trained. Furthermore service users should be given a genuine level of choice around which services they receive. As a consequence it needs to be ensured that the necessary services to support such people are available and appropriately staffed.

4.6 IAPT
IAPT should be extended where possible, and it should also be ensured that IAPT is targeted at relevant groups in order to reach those in need. Furthermore as cognitive behaviour therapy (CBT) is not the optimum treatment for everyone, in the long term the availability of a wider variety of therapies should be considered.

4.7 Clinical Pathway Development
Clinical pathways will also be developed around perinatal and parental mental health, dementia and personality disorders. Development of these pathways needs to take into account the associated workforce demand, supply and development requirements.

5. Workforce Strategy Alignment

The table below identifies the links between the themes and vision set out in the NHS South Central Shaping the Future Workforce Strategy 2010 to 2015 and the Mental Health Care Area workforce priorities.

<table>
<thead>
<tr>
<th>Strategic Theme</th>
<th>Vision</th>
<th>Alignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Share the journey: engage patients, carers and staff</td>
<td>Patients, carers, staff and the general public all need to be engaged and play their part in ensuring the NHS continues to provide excellent health care within a sustainable framework.</td>
<td>4.5 Stakeholder engagement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4.3 Prevention &amp; early intervention</td>
</tr>
<tr>
<td>2. Plan and Prepare: Manage the Change</td>
<td>To respond to the challenge and scale of both the forecast increase in demand for health care services, and the reduction in spending on public services we must actively plan the workforce and prepare intelligently to manage the change.</td>
<td>4.7 Clinical Pathway Development</td>
</tr>
</tbody>
</table>
3. Integrate and align: design a joint future
To maximise the effectiveness of our workforce planning we need to integrate and align our actions, taking a system wide perspective on the future workforce requirements to deliver the emerging service models.

4. Tighten up business: drive up quality and value
To drive up quality and value, and reduce waste and variation in the way we deploy the workforce in NHS South Central, we need to implement excellent human resource management across all health sector employers.

5. Step up flexibility: develop the workforce
To develop a more flexible workforce that can assimilate new skills rapidly and work in new and innovative ways, by targeting skills development and developing new employment models.

6. Be accountable: focus leadership
To enable the service changes that need to be delivered we need a culture of accountability at all levels, and leadership that is focussed on delivering the best health care system in the world.

4.1 Collaboration

4.2 Wider workforce
4.4 Specialist workforce
4.6 IAPT

6. Next Steps

- In order to improve access to education, CPD and clinical updating education should be provided in more accessible forms such as podcasts, CD’s and e-learning. In tandem with this commissioners need to buy in to the idea that they should insist that all staff are educated to a certain level.

- Mental illness should be identified and addressed in physical health pathways such as diabetes and musculoskeletal pathways, which should lead to improved outcomes for patients, reduced length of stay and reduced acute episodes.
Objective 8 of the dementia strategy should be implemented by increasing the diagnosis of dementia and implementing effective, tailored care, staffed by an appropriate workforce, for people with dementia. This in turn, should have the effect of reducing the length of inpatient stay, improving the quality of care, increasing the likelihood of discharge back home, and reduce the mortality rate of people with dementia in hospitals.

As a consequence of the development of clinical pathways, careful consideration needs to be given to what the workforce requirements will be.

South Central should investigate how many people in the workforce have mental health officer status, as this could significantly impact on retirement rates over the next 5 years.