Workforce and staff wellbeing

Key points:

- Yet again, workforce retention and staffing shortages remain one of the greatest challenges for the mental health sector, with 1 in 5 mental health nursing posts vacant in the first 3 months of 2022/23.
- The shortage of doctors and nursing staff continues to have an impact on the quality and safety of care for people detained under the MHA. While steps are being taken to tackle issues around the mental health nursing workforce, we are concerned that this is not enough to address the current shortfall.
- To fill vacancies, many providers are turning to agency and bank staff. This increases the risk to people using services as it can be difficult for agency staff to build meaningful therapeutic relationships and provide personalised care to patients they are not familiar with.
- Rising demand, coupled with low staffing levels, increased use of agency staff and high turnover of management are taking a toll on the mental health and wellbeing of staff.

- Staffing challenges are not just affecting frontline workers. Uncertainty regarding long-term funding for the second opinion appointed doctor (SOAD) service is creating problems with resourcing the service and impeding its ability to provide vital safeguards for people in more vulnerable circumstances.

Workforce retention and staffing shortages continue to be one of the greatest challenges facing the mental health sector.

Figures from the British Medical Association show that, as at March 2023, around 1 in 7 full-time equivalent doctor roles in NHS mental health services in England were vacant. Figures for mental health nurses are worse, with data from NHS England showing that 1 in 5 mental health nursing posts were vacant in the first 3 months of 2022/23. NHS Confederation has described how this has left mental health services in "persistent crisis mode".

In its February 2023 report, the National Audit Office published the results of its survey of NHS mental health trusts, which highlighted trusts' concerns about shortages of medical and nursing staff, and psychologists. Reasons for these shortages included problems recruiting and retaining staff, a high turnover of staff between service areas, and competition from health and non-health sectors. As highlighted in our guidance, How CQC identifies and responds to closed cultures, these types of issues with staffing are inherent risk factors that could indicate a service might develop a 'closed culture'. See also the section on closed cultures.

Not having the right levels of suitably qualified staff can have a huge impact on the safety of people who are detained under the MHA and the quality of care they receive. Through our monitoring activity, we've seen how staffing shortages have affected patients' access to therapeutic activities, stopped them from taking planned leave, or even prevented them from accessing fresh air.

As we discuss in this section, our monitoring visits have enabled us to see the effects of low staffing on services' ability to maintain safe observation levels and care for patients in a person-centred way. We've also seen the effect of poor staffing levels on the workforce, with patients again reporting feeling concerned about the wellbeing and morale of staff members.

As part of our new powers, we will be assessing how well integrated care systems are resourcing planned activity, which will include workforce.

Staff skills and levels of staff

The MHA Code of Practice states, "patients should be offered treatment and care in environments that are safe for them, staff and any visitors, and are supportive and therapeutic." To do this, services need to have an adequate number of suitably skilled staff.

Through our monitoring activity, we have seen the impact of the recruitment and retention challenges on providers, with a lack of suitably qualified staff and permanent staff leading to some services operating with lower than recommended staffing levels. Despite these challenges, we have seen examples of staff providing support effectively and in a respectful and friendly way.

> "Senior staff were very open about the difficulties the unit was facing. We found staff nevertheless to be very committed, dedicated to caring for their patients, and optimistic about being able to pull through this period."

Mixed gender eating disorder unit, July 2022

> "The patients we spoke with told us the substantive staff team… were lovely. We were told they were friendly, approachable and kind. Both patients told us that staff were nicer on [this ward] than staff anywhere else. However, one patient told us they found the turnover of staff and large numbers of agency staff 'difficult'. We were told there had been 3 different consultants over the last 6 months…"

Mixed gender acute adult ward, September 2022

Patients have told us about their concerns around staffing levels and we have found services struggling to recruit suitably qualified staff.

> "All patients said there were not enough staff on the ward to provide patient care… On the day of the visit there were 3 qualified nurses and 5 healthcare assistants. Staff said registered nurses were moved to work on other wards to address staff shortages."

Acute admissions medium secure ward for men, October 2022

> "There were 7 Band 5 nursing vacancies with newly qualified staff expected to fill 5 of the vacancies in September. This reflected the situation reported by all London mental health hospital providers, that there are problems recruiting Band 5 nurses and with them all competing for the same pool of available candidates."

Medium secure ward for men, July 2022

Mental health nurses are essential in providing high-quality care to people detained under the MHA. Nurses are with the patients every day forming therapeutic relationships and they play a key role in enabling and empowering patients.

We are concerned that not having enough nursing staff is affecting the ability of services to provide safe care. This is a particular concern when patients need one-to-one observation, as a lack of qualified staff can leave the remainder of the ward being cared for by a small number of nurses:

> "On the day of our visit the ward did not meet the planned staffing levels of 6 staff. The actual staffing comprised 2 qualified staff and 3 healthcare assistants. One patient was on one-to-one observations and one member of staff was escorting a patient to the general hospital. This left 3 staff to care for 13 patients. The activity co-ordinator was also on the ward."

Assessment ward for men and women aged 65 and over, September 2022

In other services, we've seen how workforce challenges are affecting the quality of care people receive. Access to open spaces and fresh air, and a leave of absence, are vital in creating therapeutic environments and supporting people's recovery.

However, in multiple services, patients told us about times when they were not able to get any fresh air because there were not enough staff available to escort them, or that planned leave was cancelled.

> "...patients said reduced staffing levels affected their access to fresh air and escorted section 17 leave because staff must escort them off the ward. Patients raised further concerns regarding their access to the gym based within the hospital grounds. They said there was only 1 gym instructor who was not available when patients wanted to access the gym because he did not work full time. Patients' access to the gym was dependent on the availability of staff."

Medium secure rehabilitation ward for men, March 2023

We held a series of interviews with people with lived experience of being detained under the MHA. In one interview, we spoke with Alice who had previously been detained in an eating disorder clinic due to having anorexia. She was also later detained in a psychiatric ward for a mental health disorder. Alice told us about what impact the staffing issues had on her:

> "I love being outside but I couldn't go to the garden unless there was a member of staff available... Family and visitors weren't allowed on the ward and there wasn't a family visiting room."

Interview with person with lived experience

Article 8 of the Human Rights Act protects people's right to respect for their private and family life. We are concerned that cancelling patients' leave due to staffing issues could lead to a potential breach of their human rights.

Patients also continue to raise concerns about how staffing issues are leading to a lack of therapeutic activities and lack of one-to-one sessions with staff. Activities such as music, art or physical activity that are tailored to people's individual needs are important as they give people a sense of purpose, structure to the day and aid their recovery. Without these, patients tell us how this leads to boredom and could, in turn, lead to patient-on-staff violence, patient-on-patient aggression or self-harm.

> "Half of the patients told us how [the way] some patients treated staff was unacceptable. In some cases, patients told us they had felt they had to intervene, and one patient said this led to them hitting another patient. Patients told us they were bored. Except for occasional table tennis, jigsaws, and the gym they said nothing else was offered."

Acute admission for men, January 2023

> "One member of staff told us they rarely had time to complete one-to-one sessions with patients. They told us they would generally speak to patients when escorting them to the dining room as this was the only time they had. They attributed [this] to low staffing levels."

Assessment ward for men and women aged 65 and over, September 2022

Through our Give feedback on care service, one person told us how the lack of therapeutic activities available affected her son:

> "Section 17 leave was agreed at ward round… but [the] consultant was unable to sign [the] form for another 32 hours. Having been confined to the ward 24 hours a day for several days, without therapeutic benefit or anything to relieve boredom, my son was anxious."

Through our reviewer visits we have also heard that staffing problems can sometimes lead to concerns around the balance of gender between staff and patients on wards. For example, at one trust we were concerned that high levels of male staff were having a negative effect on some of the female patients who had experienced past trauma. At another trust, patients told us that this could lead to them feeling unsafe:

> "Some patients told us they felt unsafe on the ward due to the high turnover of staff and male staff observing them, especially at night. One patient told us they had not had a shower for a week as the appropriate staff had not been on duty."

10-bed medium-secure ward for women, December 2022

Issues around staffing levels, particularly the shortfall in mental health nurses and the impact on patient care and safety, have been acknowledged in the NHS Long Term Workforce plan. The plan sets out commitments to grow the number and proportion of NHS staff working in mental health, primary care and community care by 73% by 2036/37. It also aims to increase training places for mental health nursing by 93% to more than 11,000 places by 2031/32. To support this ambition, by 2028/29 the plan states it will increase training places by 38% for mental health nursing.

We are encouraged to see attempts to improve staffing at a trust level through our monitoring visits. This includes recruitment drives through event days, as well as an increased focus on international recruitment.

While it is encouraging to see steps to tackle the systemic issues around the mental health nursing workforce, we are concerned that this is not enough to address the current shortfall and the problems this creates both for patients and staff.

The workforce plan focuses on recruitment and training of new staff. Although it mentions the importance of staff retention, we are concerned that it doesn't acknowledge the issues around staff wellbeing and burn out following the pandemic.

Impact of the lack of permanent staff

As highlighted in our 2022/23 State of Care report, consistent staffing is fundamental to building therapeutic relationships with patients. Therapeutic relationships are “a partnership that promotes safe engagement and constructive, respectful, and non-judgmental intervention.” Based on acceptance and trust, therapeutic relationships have the capacity to transform and enrich a patient’s experiences. Without this kind of relationship, patients are less likely to engage with treatments and interventions, which can affect their recovery time.

Therapeutic relationships play an important role in helping to create a culture where people feel psychologically safe. Broadly, psychological safety can be defined as "a climate in which people are comfortable expressing themselves". It plays an important role in mental health in empowering staff, patients and families to voice their suggestions, concerns and anxieties.

We remain concerned that staffing pressures, and a lack of permanent staff, is preventing people from developing these therapeutic relationships and means that people do not feel psychologically safe. For example, people told us how a lack of staff left them feeling anxious and unsafe.

> "Patients told us the ward was often under-staffed. This impacted on getting off the ward and feeling safe. Some patients had some anxiety that staff were only just in control of the ward, with comments such as 'not lost control but very busy'."

Acute admission ward for male patients, January 2023

In some services, it was concerning to see staffing issues contributing to patients not being offered person-centred care. For example, this is an issue at the 3 high secure hospitals where significant shortages of staff, in particular, registered nurses, continue to restrict patients' access to therapies and activities.

Staffing difficulties at these hospitals are longstanding. In our letter to the Secretary of State as long ago as June 2017, we asked what more NHS England and others could do to encourage and create incentives for staff to work in these very demanding settings. Despite some efforts from the system and each of the hospitals working individually and together, we are concerned that there has not been more progress made.

Through our interviews with people with lived experience, we spoke to Andrew, who was detained after trying to take his own life. He explained that more staff could have helped his recovery:

> "If there had been more staff on the ward, I think I would have had more freedom and I think it would have helped my recovery. I wasn't allowed to be around other people without at least 2 people there who could restrain me."

Interview with person with lived experience

As staffing shortages persist, it's not surprising that many services are turning to agency and bank staff to fill vacancies. In mental health services, the use of agency staff, who can earn substantially more than permanent NHS staff, is higher than ever.

As we reported in our last MHA report, the use of agency staff can affect the morale of permanent staff. On our monitoring visits, permanent staff have continued to tell us how working alongside agency staff is putting them under increased pressure as they are required to carry out duties that agency staff were not trained to complete.

> "We were told that there were currently several bank and agency workers which staff described as having 'a knock-on effect on the substantive staff' as they felt they had to work twice as hard as they knew the ward and the patients."

Acute admission ward for men and women, September 2022

It can also be difficult for agency staff to provide personalised care to patients they are not familiar with. This impacts on recovery for these patients, as it creates barriers to building meaningful therapeutic relationships.

In our interview with Andrew, who has experience of being detained, he went on to describe noticing the difference between permanent and agency staff:

> "It wasn't necessarily an issue but I noticed a difference between permanent and agency staff. Some agency workers didn't have great English skills and it could be hard to communicate with them and they weren't very talkative. The permanent staff were

> better at holding conversations and building rapport with people, but they didn't have much time to spend with each patient."

Interview with person with lived experience

On one ward with a high number of agency staff, both patients and carers raised concerns about the lack of consistency and the knock-on effect on communication and the day-to-day running of the ward. At another service, patients told us they were concerned that agency staff did not always understand their needs and sometimes lacked the specialist training required to care for the people on the ward.

We have seen how a lack of training and support can prevent agency staff from providing the high-quality care they set out to deliver. Examples include a lack of basic support such as training on computer systems and access to all areas of the hospital. We raised issues around training for agency staff on some of our monitoring visits. As a consequence, a number of providers agreed to ward inductions for agency staff, including training on mutual expectations. This training enables staff and patients to understand what to expect from one another. This can clarify the relationship, reduce anxiety and uncertainty and improve communication between patients, staff and carers.

In our interviews with people with lived experience, we spoke with Julie who cares for her friend who has been detained several times. She told us about the impact of a lack of consistent staffing:

> "When he was on the ward he only had a couple of visits from the mental health team. There was always a change of staff and there were periods where he didn't have anyone allocated to him. My friend's symptoms already mean that he finds it hard to trust people and the constant staff turnover didn't help."

Interview with person with lived experience

Daniel, who cares for his father who has been detained multiple times, noted similar issues:

> "I felt there was a lot of churn of staff on the ward. They had day staff and night staff and there was inconsistency so I imagine they were agency staff. They didn't know the patients very well and didn't want to know the patients. They were there for numbers – not to forge any connection or relationship with patients on the ward. They were stand-offish and didn't engage with the patients at all, which is diabolical given it's the job they're paid to do. Small things like a cup of tea, my dad would have liked that, it would be an opening move for him to talk. He would use it well as a starting point and would ask or offer to make a cup of tea for something to do, but it wasn't received well 'you've already had lots of tea'. They didn't realise it was his way to engage. It's very basic what you can do and talk about in there with a bunch of strangers all unwell, trying to find something to talk about. A really difficult situation for everyone."

Interview with person with lived experience

Our monitoring activity has also alerted us to several concerns about the attitude of staff. This is supported by data from our complaints service, which shows that a large number of complaints (38%) received had an element that related to the attitude of staff (both agency and permanent).

This can be a particular concern in relation to agency staff. On one visit, some patients told us that agency staff could be "disrespectful" and "cold". On another visit, 2 patients described agency staff treating them in a way they perceived to be patronising.

We've also heard concerns about staff attitudes from advocacy professionals. For example, at one service an Independent Mental Health Advocate (IMHA) told us they were concerned about the way staff were addressing patients. In response, staff were given a significant amount of training in compassionate focused care. This training was also undertaken by agency staff, who make up a large percentage of staff at the service. In addition, the provider took a new approach to recruiting agency staff:

> "We have made the decision to utilise a different agency with more experience in working with complex individuals and high risk behaviours."

Rehabilitation unit for people with a personality disorder, May 2022

Staff wellbeing

As highlighted in our 2022/23 State of Care report, increasing demand and pressures on staff are taking a toll on their mental health and wellbeing.

We heard from our MHA reviewers that low staffing levels, work volumes, burnout, turnover of management and the use of agency staff was affecting patient care and the wellbeing of staff. One MHA reviewer said this is recognised by patients.

> "I think it's really quite sad when you hear patients talk about real, genuine concern for staff wellbeing. They're more concerned about the staff than they are about themselves and that's really quite sad, because it should be the other way around, really."

This is supported by a July 2023 report from the Public Accounts Committee (PAC), which warned that increased workload is leading to burnout for staff. This in turn contributes to a higher rate of staff turnover and is leading to a vicious cycle of more staff shortages. The report highlighted that 17,000 staff (12%) left the NHS mental health workforce in 2021/22, up from pre-pandemic levels of around 14,000 a year. Of those 17,000, 14% left due to work-life balance reasons in 2021/22, an increase from 4% in 2012/13. In addition, in its evidence submission, NHS England told the PAC that, in common with all NHS staff, mental health problems are one of the biggest drivers of sickness among staff.

In our State of Care report, we noted that without the appropriate support in place, stress and burnout can affect the care being delivered. This is supported by evidence provided at the PAC meeting in July, where witnesses described how it is much more challenging for staff to deliver compassionate care to patients when staff feel burned out. While we heard about initiatives to support the mental health and wellbeing of staff during the pandemic, we have since heard that support for staff has been decreasing.

Second opinion appointed doctors

The staffing issues raised in this section are not just affecting frontline workers, we are also concerned about the resourcing of the second opinion appointed doctor (SOAD) service. While we welcome the recent additional funding of £200k from the Department of Health and Social Care (DHSC), this only for 2 years. We are concerned that uncertainty regarding long-term funding for the SOAD service is threatening its sustainability.

We are experiencing challenges in retaining experienced SOADs. SOADs told us that despite a recent pay increase, other work is better rewarded, proportionately to the effort required, and this is a disincentive to choose SOAD work above it. This shortfall is creating a safeguarding issue for people whose rights are restricted under the MHA because there are not enough SOADs to meet the demand in a timely way.

In 2022/23, there were 15,370 requests for a SOAD. This is consistent with the previous year, when we received 15,832 requests for second opinions (see also the section on Our activity). However, resourcing issues created by the funding shortfall mean that the SOAD service is not keeping pace with demand and the length of time is increasing between receiving a request and the SOAD certification of the care and treatment. In 2022/23, waiting times increased by 22% from 2021/22 (28 days in 2022/23, compared with 23 days in 2021/22). This was higher for patients on a community treatment order (CTO), which saw a 49% increase in waiting times (58 days in 2022/23 compared with 39 days in 2021/22).

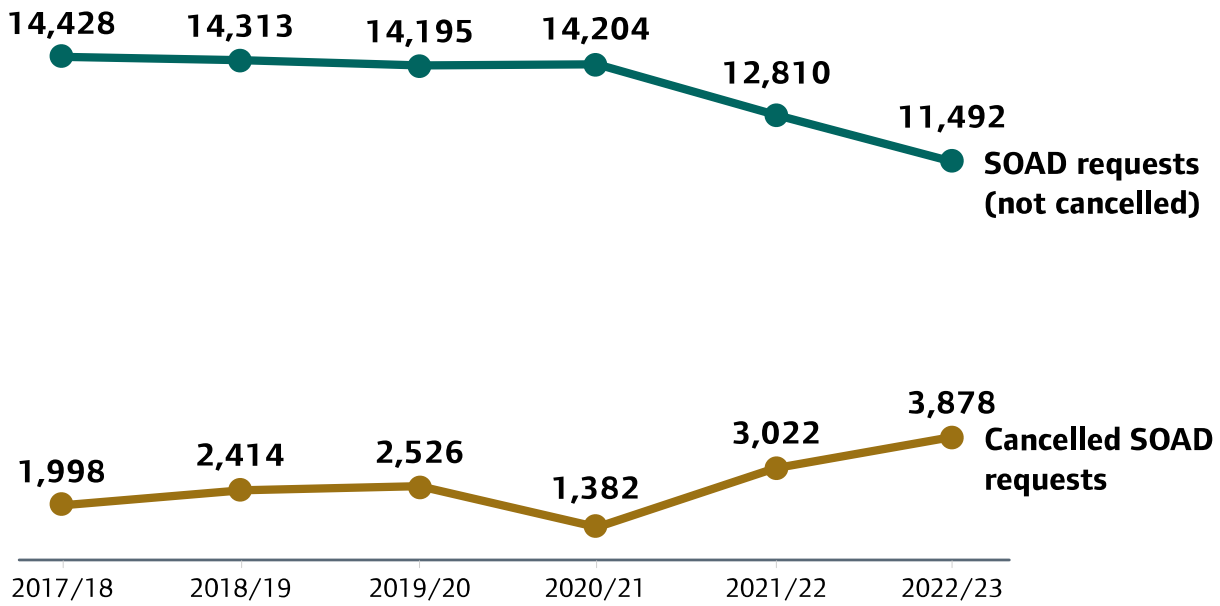
The higher waiting times for CTOs reflect the additional challenges that SOADs face in completing these requests. It can be difficult for the SOAD to speak with the right people concerned with the patient's care in the community, and there is a general lack of understanding of the SOAD role within community settings.

Increasing waiting times are especially concerning given the vital safeguards the service should deliver for people who are (or might be) made vulnerable. The SOAD service provides a safeguard for people who do not have capacity to consent to their treatment (last year this was 92% of SOAD requests). The service is also vital for people who disagree with their treatment (last year this was 8% of SOAD requests).

Of the SOAD visits made, 3 in 4 second opinions (76%) resulted in no change to treatment plans, 18% were slightly changed and 4% of plans changed significantly as a result of a SOAD visit. In the remaining 2% of cases, no certificate was issued. If a SOAD is not notified that a patient’s situation has changed, for example the patient might now agree to their treatment, the SOAD would not need to produce an additional certificate following their assessment.

SOADs have suggested that the length of time it is taking to respond to requests could also be a factor in the proportion of cancelled requests, which has been increasing year-on-year. Of the 15,370 requests received in 2022/23, 1 in 4 (3,878) were cancelled (figure 1).

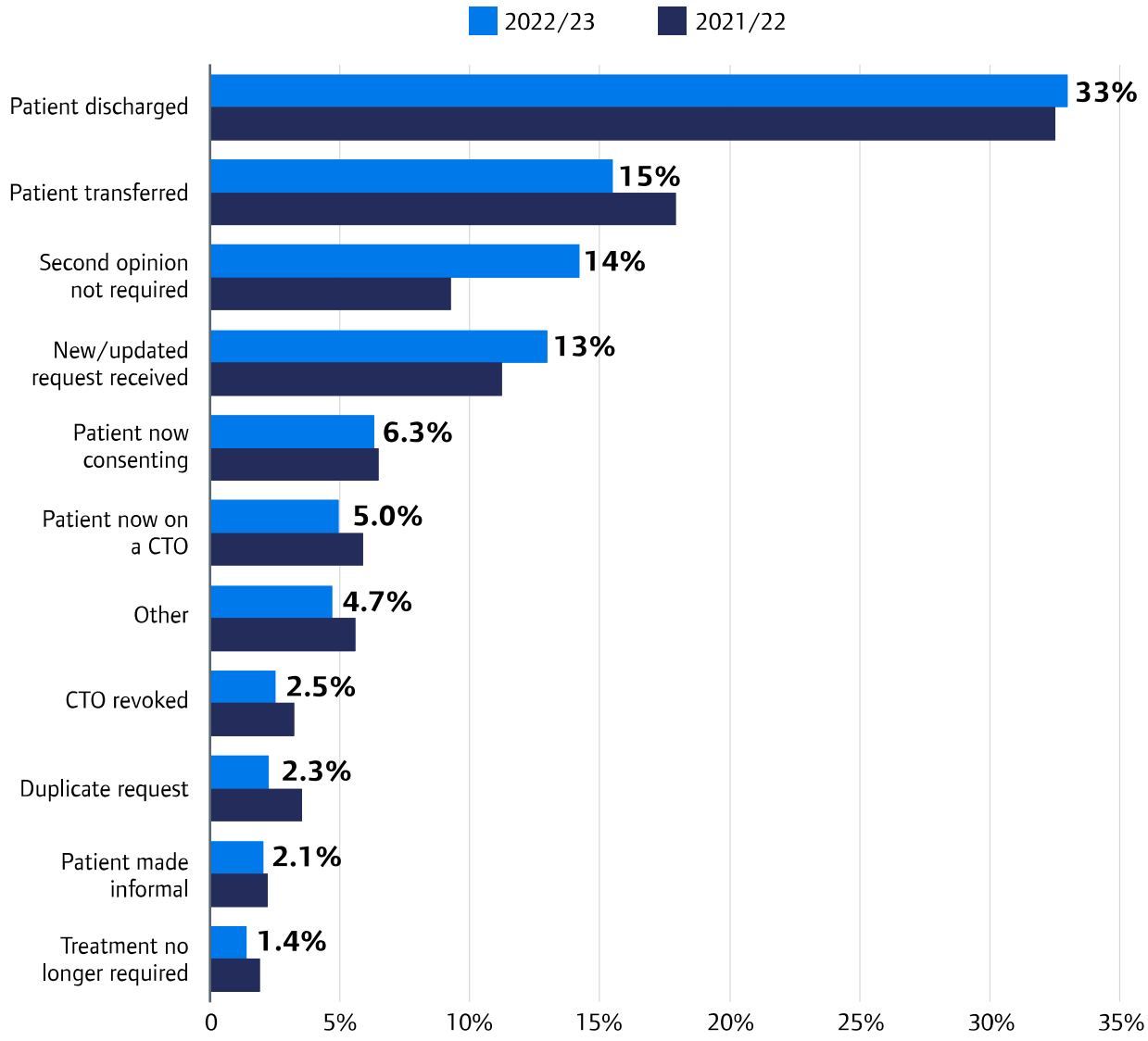
Figure 1: SOAD requests over time



Source: CQC

SOADs told us that cancelled requests may be because patients have been transferred or discharged. This is supported by our data, which shows that 48% of cancellations for 2022/23 are due to the patient being discharged (33%) or transferred (15%) (figure 2). When patients are transferred before a SOAD has responded to the request, this may lead to another request from a new service, in turn adding to the backlog. Not being able to respond to SOAD requests before people are discharged or transferred is a safeguarding issue and is putting people at risk.

Figure 2: Reason for cancellation of SOAD visit



Source: CQC

This year, we have seen that pressures on mental health services are adding to the SOAD workload when chasing requests. One SOAD told us that a shortage of beds means patients move between services and the increase in bank and agency staff can make it difficult to identify consultees.

We welcome the recent agreement with DHSC on funding for the SOAD service over the next 2 years to support with the challenges in delivering the SOAD service. To date, this funding has allowed us to increase the number of SOADs by 30%, with ongoing recruitment activity planned. Early data is also showing a decrease in wait times for second opinion appointments. However, we remain concerned that the one-off nature of this funding limits our ability to deliver the sustained improvements beyond 2024/25 that the service needs and address the significant risks to patient safety outlined in this section.