Workforce

Key points

- Problems with workforce retention and staffing shortages continued in 2023/24. While the mental health workforce has grown by nearly 35% since 2019, we are still seeing a shortage in both medical and support roles, which is negatively affecting patient care.
- We have ongoing concerns around training and support for staff, with evidence of staff not having the specialist training required, particularly in caring for autistic people and people with a learning disability.
- We continue to face challenges in the delivery of our Second Opinion Appointed Doctor (SOAD) service due to the shortage of doctors able to take on the role. The long-term sustainability of the service is a key concern, with proposals in the Mental Health Bill due to increase the numbers of second opinions required while at the same time reducing the timeframes for delivering some second opinions.

In last year's Mental Health Act annual report, we reiterated our concerns around workforce retention and staffing shortages being one of the greatest challenges for the mental health sector. While we continue to see problems with the levels of staffing, patients and carers are generally positive about staff themselves. Patients we spoke with have described feeling safe on the ward and feeling that staff treated them with "dignity and respect". They also spoke of staff as being "reassuring", "considerate", "caring", and "supportive". In addition, patients recognised that existing staff worked hard to try to mitigate any impacts on the patients, even when there were some issues they could not address. For example, at one location carers "spoke highly of the staff, describing them as 'wonderful'".

Recruitment, retention and skill mix

Recruitment to mental health roles has continued over the last year. However, we still hear that not all vacancies are being filled. As a result, we are seeing a shortage in both medical and support roles, which is negatively affecting patient care.

Between March 2019 and March 2024, the mental health workforce grew by nearly 40,000 full time equivalent (FTE) members of staff (35%). While this is a positive improvement, difficulties in recruiting staff to specific, skilled roles remain. Results from the 2023 NHS staff survey showed that on average 58% of staff working in mental health and learning disability trusts (including those providing other types of community services) reported working unpaid hours on a weekly basis – higher than the national average of 53%.

Problems with staffing and skill mix were key concerns identified through our special review of services at Nottinghamshire Healthcare NHS Foundation Trust (NHFT). Evidence from our monitoring activity shows that services across the country are currently facing many of the same challenges in recruiting staff, including nurses, psychologists, occupational therapists and consultant psychiatrists.

Issues included:

- Wards without a permanent Responsible Clinician. As a result, in one instance, doctors from another hospital over 40 miles away were covering the ward, and there was not always a doctor available on-site within normal working hours.
- Multiple wards with no occupational therapists available for their patients.
- Instances where services were without a physiotherapist or reported difficulties recruiting tutors for young people of compulsory school age.

A recent report by the King's Fund has also raised concerns around challenges with staffing and skill mix. In its report Mental health 360, the King's Fund described how the recent increases in overall staffing levels has led to a higher proportion of newly qualified staff. This, it highlighted, has changed the level of staff experience and skill mix of services.

As we reported in last year's report, not having the right levels of suitably qualified staff can have a huge impact on the safety of people who use services and the quality of care they receive. This includes affecting patients' access to therapeutic activities, stopping them from taking planned leave, or even preventing them from accessing fresh air.

This year, we continued to see how staff shortages led to activities, such as group excursions, day trips and access to gyms being delayed or cancelled. We heard how not having enough staff can lead to limits being placed on entertainment activities available on the ward or, where patients need to be escorted, stopping them from being able to go outside to get fresh air because there are not enough staff to escort them. For example, one MHA reviewer described how patients at the service they visited, "had a weekly timetable of activities, but sessions were sometimes cancelled because there were not enough staff".

Shortages of staff are also preventing patients from taking leave authorised under section 17 of the MHA. This can delay people's recovery or create unnecessary distress. At one ward, patients told the MHA reviewer that the shortage of staff on the ward "sometimes meant that section 17 leave was postponed. [The patient] said they were usually given another day or time, but occasionally leave was cancelled altogether."

We also continue to hear about the impact of problems with workforce retention and staffing shortages on the quality of care for patients detained in the 3 high secure hospitals. Examples include concerns around inappropriate use of confinement of patients during the daytime at Rampton high secure hospital, as raised in our Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust. In that report, we highlighted issues with confinement being planned several weeks in advance of known staff shortages, rather than considering less restrictive measures.

Challenges in addressing staffing issues

To manage gaps in staffing, we heard examples from several hospitals of staff in wards that were already short staffed being moved to provide cover for worse shortages in other wards. For example, on one ward we heard how, "activities were often cancelled or postponed as activities staff were pulled into numbers to cover shortfalls in staffing across the hospital". In hospitals with a range of wards, this can often mean that staff are pulled from rehabilitation wards, or other wards where patients are less unwell, to support the management of acutely ill patients on admission wards. As a result, this can lead to activities being limited. This is particularly damaging to the effectiveness of rehabilitation wards, where this can be a major part of the ward's therapeutic purpose.

This supports the findings from our inspection of acute wards for adults of working age and psychiatric intensive care units in October 2023, and our inspection of wards for older people with mental health problems in November 2023. In both these inspections, we found that the services did not have enough staff to keep people safe. It was also an issue we raised in our Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust, where we highlighted how moving staff around to cover gaps elsewhere increases the risk of harm and compromises the quality of patient care.

To fill vacancies, many services are continuing to use agency and bank staff. As highlighted in our previous reports on Monitoring the Mental Health Act and our 2022/23 State of Care report, the use of bank and agency staff can prevent meaningful therapeutic relationships from developing between staff and patients. This was supported by feedback from MHA reviewers who described the barriers patients face in building therapeutic relationships. As a result, patients are less likely to engage with treatments and interventions, which can affect their recovery time.

Our analysis of monitoring reports found examples of poor interactions between staff and patients at multiple locations. Some patients stated that there were sometimes problems with "bank or agency staff not knowing the patient's needs very well." At other services, some patients described agency staff as 'not friendly' and 'less caring' towards patients, with one patient telling us they saw agency staff speaking to patients in "an abrupt and harsh tone". In this instance, we recommended that the provider take action to ensure agency staff treat patients with respect and dignity. Poor interactions can also lead to communication issues, with a patient on one ward describing how they found it "difficult to talk to others because they did not know them."

Relying on non-permanent staff can also affect the quality of care people receive. For example, in some wards we found that staff shortages and turnover were leading to issues such as patients not having a named nurse. A named nurse should promote patients' wellbeing, safety and satisfaction, developing therapeutic relationships with patients, families, and carers. At one clinic, we heard that a patient's "named nurse had left and not been replaced". At a different hospital, patients also claimed that they "did not know who their named nurses were" and this was supported by staff who stated, "they no longer received named nurse days because of staffing issues", which "had a direct and adverse impact on care planning".

Feedback from our MHA reviewers suggests that agency staff are often less familiar with the ward and as a result need to be supervised more. This reflects previous concerns we raised in our 2021/22 Monitoring the Mental Health Act report around issues with inductions for agency staff, and agency staff not always receiving the level of support and supervision they need. This can add to the pressure created by staffing shortages and in turn affect the morale of permanent staff.

Working under this sustained pressure poses a challenge to the safe, effective care of people using mental health services. This is reflected in results of the NHS staff survey which show that, when asked if they would want their friends and relatives to be treated in their organisation, many staff working in mental health and learning disability trusts (including those providing community services) still do not feel the standard of care is high enough (64% in 2023, compared with a high of 70% in 2020).

Training for staff

We have ongoing concerns around training and support for staff. As highlighted in previous Monitoring the Mental Health Act reports, this can be a particular issue for bank and agency staff where, for example, they may not have received even basic induction on the computer systems or have access to all areas of the hospital. Analysis of our monitoring reports has also highlighted how a lack of training may mean that agency staff do not know or follow ward practices.

Broader issues included staff missing required training, such as risk assessment training, and a lack of knowledge and training around record keeping. MHA reviewers often found that clinical records, such as patient care plans, did not record information about patient engagement, or show evidence that the patient's views or wishes had been taken into account. Furthermore, paperwork relating to reviews of medicines, treatment plans, or seclusion were sometimes missing. These findings reflect concerns around risk assessment and inconsistent record keeping that we raised in our Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust.

As we highlight in the inequalities section, we continue to find evidence of staff not having the specialist training required to care for the people, particularly autistic people and people with a learning disability. In more than one location, we found that staff were not trained to support autistic patients and people with protected characteristics. As highlighted in last year's Monitoring the Mental Health Act report, we are concerned that this lack of training can lead to people not receiving the care they need. In addition, poor staff training and supervision, high turnover of staff and consistent staff shortages are all inherent risk factors that lead to services developing a closed culture. We define a closed culture as 'a poor culture that can lead to harm, including human rights breaches such as abuse'. In these services, people are more likely to be at risk of deliberate or unintentional harm.

We also continue to see different interpretations of the interface between the Mental Health Act and the Mental Capacity Act, which the Deprivation of Liberty Safeguards (DoLS) are part of. In recent State of Care reports, we have raised concerns that providers' understanding of DoLS remains varied. This affects how the safeguards are applied and, in some cases, means people may not have a DoLS authorisation in place when they need one.

In the 2018/19 Monitoring the Mental Health Act report we raised our concerns that neither patients nor professionals were likely to be clear on when the MHA or DoLS should be used. This could lead to the safeguards and rights relating to deprivation of liberty being applied inconsistently. We suggested that the government should update the respective codes of practice to reflect evolving case law needs, but this has not happened.

In 2019, the government passed the Mental Capacity (Amendment) Act, which planned to replace the DoLS system with the Liberty Protection Safeguards (LPS). While this has been delayed, the introduction of LPS will not resolve the questions of interface between these systems and the MHA.

We remain concerned that clinicians may not always be considering where the MHA can be used when the DoLS framework is not appropriate and where the patient is objecting to their placement. This concern is heightened by widespread delays in DoLS assessments, which can mean that some patients never receive an independent assessment of their clinician's decision to initiate an urgent deprivation of liberty. When such urgent applications expire, delays in the system mean that patients and clinicians are left in legal limbo, without any effective safeguard or procedure.

In 2024, the High Court decided that such legal limbo excludes patients in independent health providers from the reach of state obligations to its detainees under the Human Rights Act. In other words, the High Court found that, since a DoLS authorisation was not in place, it could not be argued that the functions carried out by the independent health provider were of a public nature. As such, the significant procedural failures in DoLS implementation have the effect of pushing some detained people beyond the reach of the Human Rights Act.

The court also found that neither the joint-funding arrangement under section 117 of the MHA nor CQC regulation could be used as evidence to conclude that the provider in question was delivering functions of a public nature. As a member of the National Preventive Mechanism, we are concerned that failure to close this gap may also have implications for ensuring that people have protections against inhuman or degrading treatment. We note that this issue has been raised in parliament over the passage of the Mental Health Bill and hope that government will want to close this gap in the protection of patients.

Second Opinion Appointed Doctor service

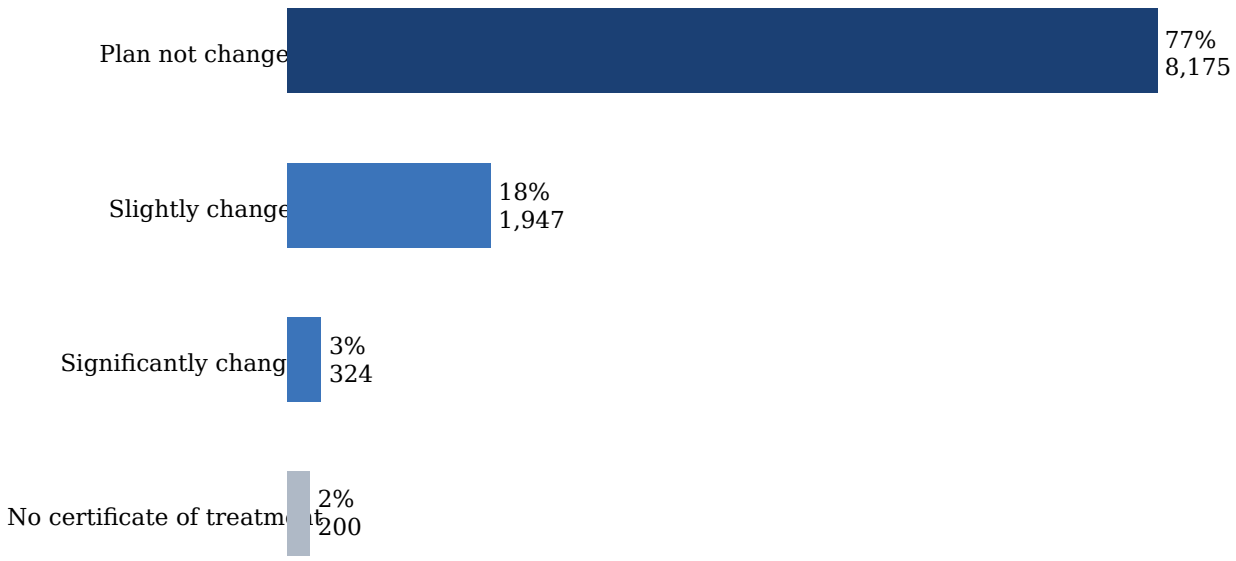
Second Opinion Appointed Doctors (SOADs) are consultant psychiatrists appointed by CQC to deliver the statutory second opinions required to authorise treatment under the MHA in specific circumstances. The SOAD service provides a safeguard for people who do not have capacity to consent to their treatment or who do not consent to their treatment.

Currently, a statutory second opinion to authorise treatment plans that include medication can be requested after a detained person has had 3 months of treatment with medication. For treatment with electroconvulsive therapy (ECT) a second opinion can be requested as soon as a person is detained as there is no 3-month period within which the treatment can be given without consent or a second opinion.

CQC is responsible for administering the SOAD service, but SOADs make independent decisions, reaching their own conclusions by using their clinical judgement. Depending on their assessment, SOADs will issue a certificate to approve treatment plans in whole, in part, or not at all for a person's treatment plans. A SOAD can decide not to certify the proposed treatment if, in their view, this is not appropriate.

In 2023/24, we received 15,698 requests for a second opinion. For most patients (77%), treatment plans were not changed following review by a SOAD (figure 1).

Figure 1: Outcome of SOAD review, 2023/24



Source: CQC

Where treatment plans were changed, it was most likely to be changed for detained patients receiving ECT and medication, and for detained patients receiving medication only.

In our last Monitoring the Mental Health Act report, we highlighted our concerns about the long-term sustainability of the Second Opinion Appointed Doctor (SOAD) service. We highlighted how, despite additional short-term funding from the Department of Health and Social Care, we had difficulties in providing the number of second opinions that were requested, within a reasonable timeframe.

Over the last 2 years we have increased the fee paid to SOADs and carried out targeted recruitment to increase the number of SOADs. However, we are still struggling to recruit enough SOADs and have significant shortfalls in the numbers of SOADs needed to deliver our current second opinion duties.

As noted in last year's report, the shortfall affects how quickly SOADs are able to respond to requests for second opinions. We highlighted how we were not keeping pace with demand and, as a result, the length of time between receiving a request for a second opinion and the SOAD certification of the treatment was increasing. Over the last year, we have worked to reduce the backlog of requests. However, there are still significant delays in delivering second opinions and we are continuing to work on improving our processes and recruitment.

Of the second opinion requests received in 2023/24, over a quarter (28%) were cancelled by providers before we could provide the second opinion. The proportion of total requests cancelled has increased year-on-year since 2017/2018. The most common reason for requests being cancelled was because the patient had been discharged.

To be able to carry out their duties, SOADs need access to the relevant patient medical information and consultees (people involved in the patient's care, including the responsible clinician, nurse and another professional involved in the person's care). Good communication and information sharing is important to enable the SOADs to work effectively. In many cases, MHA administrators are good at supporting this process. However, where this does not work well it can lead to additional delays in people receiving a second opinion.

The future of the SOAD service

There are many positive proposals in the Mental Health Bill. The reforms will increase safeguards for people who are detained under the MHA and aim to address many of the issues we have raised in successive Monitoring the Mental Health Act reports.

The Bill puts forward changes that will affect the SOAD service. There are very important changes to reduce the length of time that people who are detained can be treated without their consent before a statutory second opinion is required to authorise the treatment. This will mean there are additional expectations of the SOAD service.

These proposals will increase the numbers of second opinions required and will reduce the timeframes for delivering some second opinions. Our duties under the MHA are funded by grant in aid, and additional funding is needed to deliver the future second opinion service. This has been accepted by the Department of Health and Social Care (DHSC) in its impact assessment for the Mental Health Bill. However, as we highlight above, ongoing challenges with workforce availability means that additional funding alone will not be enough to address the issues facing the service.

- **Urgent SOAD certification** – we support increasing protections for patients under urgent electroconvulsive therapy (ECT) procedures. We will need to revise and review our SOAD service processes to establish how we can deliver this reform.
- **Remote technology** – the Bill allows the use of remote technology for urgent ECT second opinions. We think this should also be extended for use in other routine second opinions, where appropriate, to avoid unmanageable cost pressures in an expanded SOAD service and we are in discussions with DHSC about this.