Transcript of roundtable with practitioners for the Health and Social Care Committee Mental Health Expert Panel on Tuesday 12th October 2021

Group 1: Workforce

Participant A: Good afternoon everybody. I work as a consultant nurse and have done so for many years in older peoples' mental health and dementia. As well as my clinical role, I've been a lead for non-medical prescribing and done a lot of work locally in my trust and neighbouring trusts around advanced practice roles in mental health. I've got a strong interest in workforce, particularly the mental health nursing workforce, and obviously as well the reality of problems with having to utilise endless numbers of bank staff and deal with vacancies and all those issues we have in the real world on the front line of the NHS. So thank you very much; nice to meet everybody.

Participant B: I'm an associate director of nursing for a London based Trust. I'm a mental health nurse by background. Like Participant A I'm an independent nurse prescriber. I have many years of experience on an operational level within child and adolescent and in adult mental health. What I'm really interested in with workforce is the challenges we're facing on the front line. I'm particularly interested in nursing, being an associate director of nursing, but also thinking about those creative roles and how we embed them within our services going forward, because I think we need to consider those.

Participant C: Good afternoon everyone. I'm the director for mental health adult social care for a county council. I'm still a practising approved mental health professional, and I am involved with national mental health social care networks. So, I'm coming with different hats on: a policy and strategic hat, but equally with the grounded experience of continuing to undertake mental health assessments in the county.

Participant D: Good afternoon. I'm a jobbing old age psychiatrist in the North East. I do have other hats, like a clinical director and various things like that within the trust, as well as the Royal College. Coming back to the workforce – to use the terminology – you need the 'village' or 'town' for dementia care, so workforce in secondary care is not enough, you know, it needs to go into primary care, into social care, into the community. We do need a mental health workforce, especially for older people, so I would like to look at that and give my views.

Participant E: I'm a clinical psychologist in the City Community Learning Disability Team. I specialise in learning disabilities and autism, and I also have co-founded an activist movement for learning disabled and autistic people; that's another part of my job also. In terms of workforce, in the clinical psychologist role we often have a lot of work to do with other members of our wider team. We will act therapeutically with our patients, but also as part of our role within teams in mental health services we will often be tasked with a lot of work in counselling and supporting the staff around us, so I suppose that's another element as well in workforce that brings me here.

Jane Dacre: Just to orient us for our discussion, as a lot of you mentioned when talking about workforce, but the other commitments that we selected for our deep dive are children and young people, adult common mental illness, and adult serious mental illness. That's a hugely broad area, but our specialist advisors felt that we would be able to narrow it down to highlight specific issues within that. So our focus now for the next hour is on workforce, so if we could try not to overlap too much with the work of the other groups that would be really helpful – but we might. If we do say anything it can go into the transcript and come out of the hopper. What we say will be recorded. We will be looking at extracts and quotes to go into the report which goes to the committee and hopefully will have an impact in the report they make. I don't know if any of you saw the report

about the handling of COVID that came out this morning? What we hope to do is contribute to a similarly high impact piece of work. So the first question, and this is just a starter for ten to get you all talking, is that: the workforce commitment was pretty bland and pretty broad, and it was to grow the mental health workforce… What we're doing here is reviewing whether we think the government has met its pledges, and then we're going to be making judgements about our discussion on whether the government has met its pledges. Has the government succeeded in growing the mental health workforce to achieve the ambitions set out in the NHS Long Term Plan?

Participant D: I'll start by saying no; it is a big, massive no. I will give you my point of view as a jobbing psychiatrist: time and time again in my own particular service we are yet to recruit a psychiatrist to work with me. We have been advertising now probably for 3 years running. I am probably doing about one-and-a-half jobs with my clinical duties. We trained some of the trainees and we lost them. So recruitment is an issue and also retention is an issue coming back to medics. The second thing, on older people specifically, is the nursing workforce. Again, some of the ageless services came and went slightly – we have lost high quality trained older people as mental health nurses. As a community team, we are constantly short of allied health professionals. Occupational therapy is – again, post-COVID, we've got hundreds of OT assessments that are pending. There's always a lack in speech and language therapy, physiotherapy – physical health is another issue even though it's mental health – we do not have a significant amount of physical health practitioners or nurse practitioners within the acute wards, that's for us in the community. Clearly, in every aspect of older peoples' mental health we are short of workforce. Psychology – again, older peoples' mental health – it's almost like a bit of a pipe dream that patients will be given adequate psychological therapy. Clearly, from support worker up to the consultant psychiatrist or psychologist, every level is lacking in resource currently.

Jane Dacre: Can I just tease into that a little bit? Is that because the jobs aren't there, or is it because there aren't the people to fill the jobs? Because I'm a physician, we know there are several vacancies, so the trusts are saying they need the workforce, they need the jobs, they advertised the jobs and nobody applied. Is it that, or is it both?

Participant D: It is both, but more of the former: there is nobody there. If you think of even the training fill rate… we definitely are having more trainees being recruited but it's going to take a few years before they pass out. Currently in the nursing workforce there aren't many nurses coming out of nursing schools to take up the posts. There aren't many people there. Vacancies again is a smaller one, but not having the number of people is the biggest one.

Jane Dacre: So not having the pipeline coming through. Participant C, you had your hand up.

Participant C: I think we're reaping what we've been sowing really, I think the removal of nursing bursaries and all that kind of stuff, a chronic lack in investment over years, means that we haven't actually readied a workforce that's built on any sustainable platform. I think we are all constrained by a lack of long-term investment and proper planning. Going back to your question on whether we have grown the mental health workforce, coming at this from a social care perspective I would say no. You all know this, but the NHS plan draws down additional investment, particularly in relation to community mental health framework, into the NHS for locally planning, but the local authority is still financially constrained. What we are not really seeing is a well-developed, integrated workforce plan that recognises the importance of both clinical and non-clinical workforce in mental health, and speaks to the social determinants of mental health. There is so much evidence now of a kind-of overwhelming relationship between poverty, deprivation, and mental health. There's no excuse for us not to speak to social determinants in our workforce modelling now. I think that's one of the

points that I would like to make. I also think that whilst we have good intelligence about population demographics and population projections and good modelling around prevalence, what we haven't really done is switch that into a comprehensive workforce plan that speaks to a long-term integrated strategy. The final point is that models of care have changed, but I still think we've got a lot of work to do on the culture. I think where we are at the moment is that we really want to push the boundaries of supporting people in their local communities providing specialist care, but I think some of the cultures we are working in are very much constraining us from realising that ambition. I see that all the time. So, I think there's a structural aspect in terms of how we begin to blend and innovate around clinical and non-clinical roles in community provision, but I think there's a massive cultural piece as well that we see.

Jane Dacre: What do you mean about a massive cultural piece, is it people not wanting to change?

Participant C: Well I'll give you an example- in our local system we're working on the community mental health framework, and we're working on strengthening the primary care networks and having a more diverse workforce for that. What we've actually found is that we've encountered a lot of resistance from our GPs who believe that only psychiatric nurses can deliver mental health interventions to people in primary care. That's the kind of challenge that we're working with in terms of the cultural challenges, there is still a dominant view that mental health conditions need clinical interventions at every level rather than us being much more able to think about the function of interventions in terms of looking what we're trying to achieve, and to understand perhaps mental health problems from more of a social model than simply just a medical manifestation.

Jane Dacre: Thank you, that's very helpful. I notice now we have Participant F coming in – before I move on can I ask you to briefly introduce yourself?

Participant F: Good afternoon, thanks for accepting me late. I was in another [breakout] group and I asked to move. I'm Participant F, I'm a consultant psychiatrist working in London. I work with adults with intellectual disabilities, and I used to work in community services, but I now work in secure [inaudible] services, and I'm also involved with the Intellectual Disability Faculty at the Royal College of Psychiatry.

Jane Dacre: Thank you very much Participant F. If we could have a nursing perspective and then actually your timing is perfect, Participant F, because we'll then look at learning disability after that. Participant B?

Participant B: I just wanted to follow on from Participant C's point around changing the culture, and I will come back to the nursing workforce definitely. I don't think it's just about professionals, there's been a huge amount of work put into destigmatising mental health, which is fantastic, brilliant. However, as a result, I think the point that Participant C made is quite right, that families and young people do not feel they're getting a service unless they actually end up in a specialist service – I'm speaking from a CAHMS (Children and Adolescent Mental Health Services) perspective here – that ability to signpost and utilise primary care services and voluntary services that are able to provide some of that early intervention work – families become very angry saying, 'I need to go to a specialist CAHMS service' which then obviously has a huge impact on demand and capacity for those services. I don't think that's just in the South, I think that's a national picture. In terms of the workforce, in terms of nurses, I think Participant C is right, I think some of the changes in terms of nursing education has had a huge impact. I've been very involved in NHS England's Next Generation, going into schools and talking to young people about nursing and promoting nursing as a career, but I think it's not just about getting people in, it's about keeping people. That's something we need to

look at: how do we retain the workforce we've got because I think there's a lot of people leaving the NHS as a system, and even more so over the challenging 2 years that we've had during COVID. I think that's something we need to think about: how do we retain staff and what is it making staff want to leave? We may be training them but they're not staying, and it's not what they thought it was going to be. Just to add as well about career pathways- having career pathways, it's great to have Participant A here as a nurse consultant, in mental health thinking about those career pathways, advanced nurse practitioner pathways, really to keep those nurses. Because not all nurses are good managers. I'm going to put that out there now, they're not, and actually we lose that specialism and that clinical… you've got Participant A there as a nurse consultant who has years and years of experience of being able to deliver care at that level, and I think we've lost some of that.

Jane Dacre: Thank you, and I think you're reflecting on a lot of what Participant D was saying too, so it's good to have agreement. Participant A?

Participant A: There are a lot of statistics out there about the numbers of mental health nurses we've got registered with the NMC (Nursing and Midwifery Council), and I had a quick scan again looking at the Royal College of Psychiatry figures, RCN (Royal College of Nurses) and Nuffield at lunchtime today. The overall impression I get is that yes, there's been a level of investment in more places for nurse training, and a proportion of that has obviously been for mental health – on the good side there has been an increase in the number of applications for people to do undergraduate mental health nursing degrees, but it's still appears to be very much a drop in the ocean. Looking back over the last 10 years in terms of the total workforce, we've got this really significant, almost exponential increase in demand, and that was there pre-pandemic, we know that has been built on massively during the pandemic and we can confidently predict as we see the referral rates now that it's increasing, and the investment in the mental health nursing workforce being built up is nowhere near enough to meet that demand. I'm focusing purely on nursing for the sake of this. I entirely take account of earlier comments by previous speakers about what constitutes a mental health workforce in health and social care, in third sector provision; the need to be creative; the need to offer to service users and for service users to dictate more often than not what they want and what kind of service and provision they want and would find helpful for their mental health, and prevention of mental health problems. But, leaving all that aside – which is a massively important piece of work in itself – there will be and there is a massive need for more specialist mental health nurses, and we are very under-resourced. Just to add to that, as other people on the ground will know, I look at the numbers of bank shifts we're trying to cover, particularly for in patient mental health wards across the spectrum, and the pressure it puts on staff. They're under a lot of pressure to cover shifts, to cover hours, they're in stressful jobs, we've got many posts open really for recruitment – so the money is there, but the people aren't there to fill them, that's the same in most of the neighbouring trusts I am aware of in the North of England. So some small positives, but it's not been driven far or fast enough. I could come on to the whole advanced practices agenda but I might come back to that later.

Jane Dacre: Thank you, that's really helpful. Can we shift focus a little bit onto learning disability? Has the government succeeded in growing the workforce to achieve the ambitions set out in the long-term plan? Participant E, are you able to start?

Participant E: I think I'm mainly able to speak from a sort-of at the ground level than too much further up. What I feel like we're seeing within learning disability services more broadly is no influx of staffing, as has been needed. I think it's something that personally in my experience I would measure by the amount of work we're having to do as psychologists and as I said earlier with broader teams, with the multidisciplinary team in terms of providing reflective practice groups in

different ways to nurture and protect those staff numbers. The main reason behind that is because people are so overstretched, and we've seen no less need for any of that recently, if anything more so, and particularly with the struggles of COVID and having to work in such a different way, again there's been a bit more of that. I think in terms of… coming from a clinical psychologist perspective there's no shortage of people chomping at the bit to get on the training courses to train as clinical psychologists. There's a massive bottleneck getting people into that training – locally the training programme has been able to open up 2 or 3 more places this year, that's a result of some money that came in through expanding on equality and diversity. So that's good that we have a couple more, but we're not seeing any more job opportunities.

Jane Dacre: That sounds like a drop in the ocean.

Participant E: Oh sure. We're not seeing those posts open up for those extra people either so that would be my perspective on that one.

Jane Dacre: Ok thank you, that's great. Participant F?

Participant F: I'm just particularly interested in this issue of workforce because it's been a huge, huge challenge to us as psychiatrists. It's affecting all the professions, as has already been stated. My big concern through the college, and I've expressed it to RCN and other groups as well – particularly the Learning Disability Forum – is what's happened to nursing. It seems the challenges within training for acute nurses, but also mental health nurses, and especially so within learning disability, it seems as though it's the less popular of the three unfortunately, and it's always been a big challenge to recruit people. However, since I lost the bursary it was just really catastrophic in terms of recruitment. Services are advertising posts and they're lucky if they get maybe one or two who are interested, and this is even after efforts where services have actually brought students into them, because when you bring students in that's where you're likely to have your pool of people coming into vacant posts. But even then it's been a real challenge. Band 5 posts are not so difficult, but when you're getting to Band 6 and Band 7 posts, certainly the higher ones, it is a real, real problem just to get nursing staff in. Similarly with psychology, I think what it is when it comes to the training programme is that not all trainees have exposure to working in learning disability services, being exposed to developmental psychology work – that is really important. It's a pity really because it's restricting their perspective, if you like, and also restricting their opportunities to work with this group of people. They are challenging, but also an incredibly interesting group of people to work with, and it's not just the people it's the families as well. Just turning to psychiatry, it's been a real problem for us, what we call the fill rate – and what I mean by that is the number of trainees going into higher training, because in psychiatry you have 2 levels of training, core training and higher training. So for the posts that are available in the higher training, we've only been able to fill about 30% of them over the last 4 or 5 years, and this is even after the Choose Psychiatry campaign by the Royal College [of Psychiatrists] (you probably would be aware of that, other professions are aware of the campaign). The other specialties in psychiatry have managed to increase their fill rates for recruitment to nearly 100%, in some cases 80%, but we've kind-of kept going along the bottom at 30%. So we are doing a bit of work to actively remedy that. But again what we've actually found coming back to people being exposed to it in core training – and this is why it's so important people being exposed to learning disability services as medical students, as core trainees, so that they actually understand what's going on, particularly when you're talking about Oliver McGowen training where all health staff are meant to gain some basic competencies in supporting people with intellectual disabilities. Just going back to our low fill rate, it also has a knock-on effect when you're trying to fill consultant posts, and we have nearly 35% of consultant posts vacant in this country. Also quite a number of consultant posts in the independent sector; services have moved out to the

independent sector, so they actually draw people away from working in the NHS. All of this is occurring at a time when there's a big emphasis on providing support to people in the community, avoiding hospital admissions, so we actually need people in community teams supporting people, keeping them out of hospital, and we're talking about people with very complex challenges to services, people who in the past would have been directly admitted to hospital, but now we're saying that following transforming care that this isn't acceptable, that they should be supported in the community. I have been working in teams where people have been actively and positively supporting people in the community and keeping them out of hospital, but you need community support staff, you need professional staff there who can support them, families and also the paid carers to keep people in the community. It's really a big challenge what we're actually facing when you cannot fill these posts, and as a result of that what is happening in certain cases – I've seen it myself and heard it from colleagues – is that people are admittedly being admitted. We're doing what we don't want to do, and we're doing what is against policy, all because we really don't have the support of staffing in the community. The other small think I picked up as well from community service when you're talking about roles is the **delusion** of roles that's happening among health staff. What I mean by this is when people are working in more integrated health services where they're integrated with local authority service for example, and so quite a few health staff are being required to do what would be considered more social care, applying to funding panels for care packages. That's actually drawing them away from the whole health agenda, and we've got all of this around Oliver McGowen for example, nurses being expected to support physical health needs and mental health needs, but at the same time they're having to devote time to finding packages of care. Something has to give, and I can see it actually happening.

Jane Dacre: Participant F, can I just clarify the comments that you're making, more specifically, it sounds like things are worse in learning disability and pretty bad everywhere else… is that basically what you are saying?

Participant F: [nods]

Jane Dacre: Ok, thank you. Can we come back to Participant E and then Participant C on this? Then I might move us on with the conversation a bit.

Participant E: I just wanted to quickly jump off the back of Participant F there as well. I agree with the point on exposure, I think it's something we see an absolute dearth of in training throughout the healthcare training packages available. It's something that's very marked throughout and this is something we are trying to do something about up in our area. As I said before we're starting an activist movement for learning disabled and autistic people, we do some of the training now on some of the courses in universities up here in which we're facilitating alongside learning disabled and autistic activists in the form of informal, intimate and provocative conversations in which people are just being around each other. The feedback we get back is exactly what Participant F is pointing out, the idea that this population is one that has a stigma of being quite challenging and who people are quite worried about offending or not knowing how to talk to. But being given the opportunity to be exposed and have a decent conversation with, people are a lot more inspired to follow that career path, and we've got more people going in as a result of that up here. So I very much agree with Participant F's point there on the lack of exposure to learning disabilities and autism within the training, meaning we're not getting as many people coming this way.

Jane Dacre: Thank you. I think Participant D is pointing out [in the chat box] the disparity between the amount spent in hospital units as opposed to the community, so where there is support it's not necessarily getting to the right place. Participant C?

Participant C: I just wanted to come in on some of the points Participant F made. I think my observation of some of the reforms in the Mental Health White Paper was the Government's attempt to fix the transforming care issue, people with autism and learning disabilities going into hospital, as a kind-of back door means of trying to drive system change in local communities. I can see the exasperation because of the challenges that transforming care has presented, but I would go back to [the fact] that we need to develop joint community models that recognise the importance of clinical roles and non-clinical roles in providing specialist community provision as a local system through our populations. That will also involve a need to fund adequately and sufficiently the provision of social care as well in that space, particularly for learning disabilities where probably 80% of funding in community provision sits with that, with social care services. So, until we address that we will continue to be blighted by the challenges that we continue to have at the moment.

Jane Dacre: I think there is a big issue about the relationship between healthcare as social care – this is the Health and Social Care Committee that we're feeding into, so it's really helpful to have that perspective. Can I move on again to a sort of nuance, to a sort of subtlety about what we're talking about in relation to workforce and that is to talk more directly about money? Has the money been sufficient to make progress on this commitment or are there other ways – Participant C you've talked about changing the culture, accepting different patterns of working; we've talked about moving things from hospitals to the community – overall what do people think about the amount of money going into mental health services? Participant D?

Participant D: I think again the answer is no, but the explanation is, 1) there may be money coming in – like I think one of our colleagues mentioned – we get new models and then we get new money, but it's like robbing Peter to pay Paul, so we deplete the existing resources, so it's the same pot with probably only with 3 or 4 cups of rice, so you're just scraping and scraping and keeping on moving it into a different pot, but the pot is not full, I think that's where the catch comes, whatever money we give we haven't got people to… there are no bums on the seat.

Jane Dacre: I can see Participant B nodding her head vigorously. Do you know it's exactly the same in maternity, there's some new flashy, sparkly initiative that is funded, but what it does it suck people out of other areas. Very interesting. Participant C, how about you?

Participant C: The money that's come into the system through the community mental health framework is very much welcomed. I think the problem for us is we're not working as a system collaboratively in terms of how we're making joint decisions about what the system needs to look like, the local system design and the roles that health and social care play in making it a functional and good system. So I think there's a challenge there for me in respect of that issue, how we collaborate and how we're encouraged to collaborate, I think probably at a national level as well as a local level around that. I think there is also an issue with the fact – and I have mentioned this before but I will press the point – that the money is coming down the NHS England route, and therefore local CCGs (Clinical Commissioning Groups) are being driven to develop workforce plans that for me are very health and NHS focused at the moment, and don't speak to the wider integrated context of the mental health and social care provider network, so I think we're missing that aspect of things. Again, I think there needs to be some focus on how through policy we can tie some of that up into stronger local collaboration and working. Now with the mental health investment standard there was a point, particularly for learning disabilities and transforming care, an expectation that there would be some joint sign-off at a local level on investment, and I think we probably do need to move toward that position so that the money flow is through the system and the local systems to support clinical and non-clinical roles and design. We still continue to be… it's sometimes in this perpetual cycle of designing models of care that we cannot and would not be able to realistically resource. So,

what we end up doing is we inflate the costs, create specialist roles to recruit into those roles, and we just move the workers from core services into specialist services. We seem to be great at disappointing ourselves with great service designs that actually there's no hope at the beginning of the planning process for us to be able to sufficiently resource. I do think we need to challenge ourselves about that early on and think about how we can make that investment work best for local people and the systems in the context of where we are at the time, given that we might have planning and pipeline succession plans in train, but they're not going to realise for the next 5 or 10 years. So I do think we need to work in a more sophisticated way on that.

Jane Dacre: If we had all of the money that we asked for, would it be ok? I'm just going to leave that there and maybe people can answer that. Participant F?

Participant F: Thank you. I was just following up from Participant C was saying, and I think part of the problem in general with the workforce is, particularly when looking at community learning disability teams, is that they're expected to do everything, and really that's not going to work if that's what the expectation is. It really requires the more generic services, all services, to be able to support people with learning disabilities and their families, to a certain extent within their competencies but they're not acknowledging this and they're very reluctant to accept it. What I mean by this is that I do think that the specialist teams really do need to be concentrating on the high-cost packages of care, those who are at the greatest risk of going into hospital who need to be supported in the community, and whose packages of care range anywhere between £1,000 and £5,000 a week if no more in some cases. That is where the resource would be best spent and devoted to, compared with the other people who could benefit from support from mainstream services, but because that isn't so easily available the learning disability teams are pulled in to support them. This is where we need overall in health and social care people to be accepting that they will support people with learning disabilities, and it's most likely to be the majority of people who have a mild learning disability, we're not necessarily talking about those, it's the more severe and complex ones.

Jane Dacre: Thank you. Participant A?

Participant A: I think it's a very difficult question to answer in any simple way, isn't it: Is there enough money coming into the system? We know there are increasing waiting times and waiting lists across the spectrum of age in mental health and disability services wherever you look. At one level it seems self-evident in services as we struggle to try and meet this demand, and I think one of the risks from the workforce perspective is that we go down to risk management and core provision, and things become [about] passing the buck from one service to another, when 'where can we make this person meet the referral criteria for this other service', and all this shuffling around hides the problem. There is not enough resource. I think other people making comments as we go along are quite right about whole population mental health and all the other usual upstream interventions in society to try and make things better. But we do know there is a very heavy high demand for more experts, qualified interventions in mental health and the resources are not there at the minute. The short answer for me is that there isn't enough investment, and it doesn't all come down to models of provision, it does come down to resource levels and staffing.

Jane Dacre: Ok, thank you. Participant B?

Participant B: For me, if you're thinking about that national picture and we've got the NHS long-term plan, within that crucially for me is the NHS People Plan, because actually it doesn't matter how much money we throw into service… and I agree with all the points that we have these new models of care that come out and these new models of how we've going to deliver services, but actually we

need to keep the staff that we've got. That for me is one of the key issues. I mean, I don't have the figures unfortunately around staff that are leaving, but we do need to think about those priorities that were in the People Plan in terms of how do we retain the staff that we've got, because that for me is one of the biggest challenges across all professions I would say. We can have these new creative [things], we can have new nursing associates, we can think about peer support workers, we can have all these creative ways of developing the workforce, but if we can't keep them – because actually what they're facing day-to-day on the front line is hard going, and it is this tidal wave of demand – then that for me is integral to all of this. That is my impassioned viewpoint on all of that really, and I think for me that is the biggest challenge.

Jane Dacre: Do other people have a comment on that? It's all very well pouring money into a leaky bucket, but you've got to fix the bucket – that's the analogy. Participant D?

Participant D: I think rather than asking them to give me money, we should say give me people. There's no point in sending money – even if they say 'we will give you 6 nurse consultants, we'll give you 6 psychiatrists, we'll give you 6 psychologists,' rather than 'we'll give you £6,000,000 for you to recruit them. It's an issue, it's a benefit in kind because the cash comes – as soon as the cash comes it goes like a child with a flashy new toy and then the routine gets affected. So even the community transformation, which I'm all in favour for, but my memory clinic nurses are all being pulled in, so there is a memory clinic waiting list, new crisis intervention is affected because it's the same nurse who was probably headhunted. When it comes to talent management, we almost get the crème-de-la-crème to do these things – we talk about 'patient in the centre' but the patient in the centre just gets a sticky plaster.

Jane Dacre: Ok, yes, I see that. Participant C?

Participant C: I would come back to culture across the health and care system as being something that we really do need to tackle and work to move. I would come back to structural reform as well. This week one of the things I was asked to do was just to look at the number of referrals that are sent across to our local mental health provider trust, and a number of those referrals were assessed. For every 100, 60 of those referrals were pathway to improve that access to psychological therapies or other outcomes. About 40% were taken on. What that says to me, and this is quite consistent, is that there's a culture of referrers referring into specialist services with an expectation that specialist services will do it. Specialist services are limited, and they are struggling to be able to manage that demand. There is something for me about how we really drive system change in the primary care networks and enhance primary care – and shifting the culture as well. I think that the focus needs to be on skill-based activity in terms of supporting people with the right tools and supporting the confidence of the community health and social care workforce around mental health. I think what we've still got is quite an immature system with very, very different expectations around what parts of the system will do what for people with mental health [issues]. I think the consequence of that really is that our populations lose out because they do just get bounced around the system and in and out of things and they don't really get the care and support that they need at the right time. Going back to the leaky bucket and do we need to do something around it, I think it needs a good overhaul.

Jane Dacre: Thank you. Participant B?

Participant B: Participant C has put it much more eloquently than I was about to put it. That's basically exactly what I wanted to say, I think we need to look at it as a whole system, and [to ask] what do we want out of that system and what parts of the system should do what, rather than it all

going into specialist services. But within that I think there's something about educating the population as well. If you're going into an IAPT (Improving Access to Psychological Therapies) service to have a short-term brief intervention, that's not being fobbed off. Sorry, I use very basic language, but it isn't about being fobbed off, its actually about receiving the evidence based intervention you need at that time for how that person is. I think there's some education there. I think we've destigmatised mental health, which is fantastic, but not everybody needs specialist services. I think it's about that system and looking at that system as a whole.

Jane Dacre: It's demand management in a way, is that what you would call it?

Participant B: I don't know if I'd call it demand management. What I kind-of want to say is it's evidence-based interventions for the presenting issues. I'm trying to put it into a physical health analogy… I wouldn't go to A&E and be expected to be seen in acute care because I had – I'm trying to think of something, you know, low-level now – if you're having mild to moderate anxiety, I'm not saying that you shouldn't have a service, but it's about what service is the best to provide you and actually who delivers that, which is the point that Participant C is making, I'm not putting it as eloquently as Participant C, but for me it is about that whole system overview and educating the population.

Jane Dacre: Ok, about how their needs are most appropriately met?

Participant B: Yeah, and what their expectations are for that. If you're going to be seen in a GP surgery and offered some brief intervention, that that is an evidence-based approach that is meeting your needs at that time. I'm kind-of thinking about CAHMS more so, that actually when you're getting to that specialist level those other services have not failed, but it might be that your needs are more. We do need to stop this shuffling around, and I agree with Participant C on that because I think that does happen for our population.

Jane Dacre: Thank you. Participant D?

Participant D: I think coming on from what Participant B has mentioned, with chronic management like diabetes, not every diabetic needs to go on to a secondary diabetic care. I'll give you an example: a patient with dementia in a care home will be referred to a memory clinic because they say, 'I can't, I'm not allowed to diagnose dementia.' Clearly it is about empowering the primary care, the GPs and even a district nurse or the care home manager, anybody could be able to make that diagnosis but they'll say, 'let me get a memory clinic.' Two weeks ago there was a complaint I was going to deal with, so I was talking to the son, and I just ran through the notes and they said they are going to wait 3 months for a diagnostic appointment, so can I give that to you [the son] right now, as you are the nearest relative. Within 20 minutes of addressing the complaint I finished the diagnosis, started the medication and everything was done. We need to think about how to reduce the waits. We are more into process rather than people, and we don't use technology adequately.

Jane Dacre: So the shuffling around thing, that illustrates the shuffling around. We've got around 7 or 8 minutes left and there's just one other question that I want to get you to think about, which is how the problems related to lack of progress in this commitment have affected your working lives. What have people been doing about it? Participant B has been talking about attrition; there were people, I think Participant D, who were talking about having 8 nurses left. How has this affected your working environment and your practices? We talked about wellbeing, that's maybe another thing that might come up but I'm not allowed to put words into your mouth, I'm just trying to prompt you to think. Participant F?

Participant F: Just on the issue of workforce, how it has affected us is we've not been able to actually work with other professional staff to support people because they're not available, and therefore myself having to see people more frequently than they needed to really, and that will take me away from other people because of it. That is a big problem to us, just not having the time to see people and yet being expected to see people because we're not actually working with a psychologist or a nurse who could actually see people in between time.

Jane Dacre: So that must be building in inefficiencies then. Participant C?

Participant C: I think what I've seen is, because I think sometimes staff are so challenged by process and volume of activity, I think it is detracting from the interactions they're having with people. I see a lack of professional curiosity in staff and just taking a moment to reflect and really listen to what's going on and to think about the dynamic that's forming. I think we have a workforce sometimes that is so focused on activity, output and process that sometimes they're losing sight of the person in it. I think that's the direct result of being overwhelmed sometimes.

Jane Dacre: Yes, so absolutely focused on the patient. Participant B?

Participant B: Yeah you mentioned it – staff wellbeing. I think that's key for me in terms of the issues we've talked about. It's how we look after our people, and I think what I'm seeing on the frontline is staff that are burnt out. I'm going to be really blunt: staff that are really exhausted, burnt out. A lot of trusts have put a lot of work through COVID around staff wellbeing and opportunities, but actually for me staff wellbeing is about having a realistic workload and being able to get home on time.

Jane Dacre: Ok, yeah. You'd think that wasn't rocket science really, but there you go. Participant D?

Participant D: I'll say it because you said to be open – I would say CQC (Quality Care Commission) [is] the elephant in the room. Mental health services are scrutinised far more, 100% more, 3000% more than any of the acute hospitals. They used the same level of scrutiny – again I'm going to be blunt – most of the acute hospitals would be shut. Clearly, we are [beaten] with a stick of 'CQC – CQC – CQC' so we lose the patient, and I'm being very candid so forgive me, we are used to doing things because we have to tick the CQC box. We lose the patient. I really think staff are frightened, they are absolutely frightened of what their manager is going to say the next minute.

Jane Dacre: Great comment, thank you. Participant A?

Participant A: Very quickly, not dissimilar to other comments, but I think the quality of provision has clearly reduced, so I see that things we know are really helpful, psychosocial interventions for people with early stage dementia, one that's close to the heart for me, interventions for older people with moderate depression – staff are not able to do the depth and duration of intervention that we know is helpful and of a higher quality, and it comes back to minimum intervention, get them off the case load and see the next person.

Jane Dacre: Ok, so again it's the tick box, the lack of seeing both staff and patients as real people is what seems to be coming across to me. Participant E?

Participant E: I would say the biggest thing I would notice is the dwindling opportunities for multidisciplinary work in mental health services, in learning disabilities services in particular. That's absolutely paramount, I don't think you can do your job properly without having the wealth of experience from a wider multidisciplinary team because none of us can do it all. But with what's just been said there with people trying to churn through and get people off the case load, to manage their case loads. Sometimes you're missing windows to work with one another and just to have

those conversations, have those team formulations in which you can really get the number of what a person's needs are to be able to properly meet them. It turns into putting out little fires which never really gets the job done, and it's never really then properly focused on the person themselves, the patient. So lack of opportunities for multidisciplinary work.

Jane Dacre: Participant B?

Participant B: I guess the point I wanted to make following on from Participant E is, I think for a lot of front line mental health clinicians, they would be saying they're becoming firefighters and it's about risk management rather than actual therapy, and missed opportunities in terms of care. I don't think we're providing the high quality care that we want to provide, and that they would want to provide.

Jane Dacre: Very interesting insight. It can't possible be in the best interests of the patients that we serve. I've come to the end of my questions but is there something we should have discussed about workforce that hasn't come up, is there something that we've missed that needs to go into this thinking that we're doing about workforce in relation to mental health? Participant D?

Participant D: I think it's transparency across the system because sometimes there is a secret thing that we don't know what people one or two levels above are thinking. So grassroots level stuff is constantly put under pressure because they don't actually know how the service is changing. Usually they will say 'from tomorrow on you'll be doing this, there's a new…' There's a lack of transparency. People lose their trust and that's why retention is affected.

Jane Dacre: Ok, so a just and compassionate culture. So that's fantastic, you've given us huge food for thought, really, really engaged conversation and thank you all for contributing as much as you have