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NHS

Workforce guidance for mental health, learning disabilities and autism, and specialised commissioning services during the coronavirus pandemic

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This document provides mental health, learning disabilities and autism, and specialised commissioning workforce guidance and considerations for systems, providers, NHS commissioned services and staff, to ensure safety in the workplace is maintained during the COVID-19 outbreak.

1. Introduction

This guidance is intended to support the local contingency planning already underway for a range of resource-constrained scenarios. It is provided in response to the specific queries raised by colleagues across the system.

It covers:

- general principles
- ways in which staff work
- releasing time to care
- training and CPD
- safer staffing models.

It will be updated as required should additional issues need to be covered or the government's guidance on infection control change.

This guidance is one of a suite of resources which should be consulted in parallel. The other resources cover:

- managing capacity and demand within inpatient and community mental health and learning disability and autism services
- patient and carer/family engagement and communication
- maximising use of digital and online channels
- Legal guidance for mental health, learning disability and autism, and specialised commissioning services supporting people of all ages during the coronavirus pandemic.

2. General principles

COVID-19 and the national measures being announced to delay the spread of the pandemic will inevitably have significant impact on both demand for and capacity to deliver support for people with mental health needs, a learning disability or autism. The impact on people's mental health will endure beyond the pandemic.

The principles that should inform our response as a mental health/learning disability and autism system include:

1. People with mental health needs, a learning disability or autism should receive the same degree of protection and support with managing COVID-19 as other members of the population. This may mean providing additional support including by making reasonable adjustments.
2. In preparing for and responding to COVID-19, staff within mental health/learning disability and autism providers may need to make difficult decisions in the context of reduced capacity and increasing demand. These decisions will need to balance clinical need (both mental and physical), patient safety and risk. Due to the need for rapid decision-making, providers may choose to use an existing patient panel or an ethics committee to advise on decisions.
3. When considering plans, providers should consider not just patients' vulnerability to the physical infection but also their vulnerability stemming from mental health needs, a learning disability or autism. People will be at risk of mortality through suicide, injury through self-harm and of self-neglect, and therefore concern for patient safety needs to be paramount in any changes to services.
4. Partnership working is crucial and responses will need to be co-produced where possible. To maximise the use of community assets and to draw on the insight and expertise of partners, response plans will need to be developed alongside patients, families, carers, voluntary community sector (VCS) organisations as well as neighbouring mental health/learning disability and autism providers. This will include planning within an NHS-led provider collaborative, with social care partners, the Criminal Justice System, commissioners, and education providers

for children and young people (CYP).

5. Providers will need to maximise delivery through digital technologies to ensure continuity of care for patients who are asked to isolate and in response to reduced staff numbers or mobility. Digital technology can also be used to support continuity of social contact for patients, families and carers.
6. Providers should bear in mind the longer term impact of the pandemic and associated impacts on the mental health needs of the population, and seek to minimise changes that impact on the capacity and capability of the system in the longer term.

3. Staff ways of working

It is essential that the ways in which staff and teams work can adapt in the context of COVID-19. To support local planning and decision-making, some of the ways of working that may need to change are listed below, along with suggested considerations, advice and ideas.

3.1 Personal protective equipment (PPE)

- All clinical mental health, learning disability and/or autism staff should follow the guidance here.
  - Staff supporting clients and service users with suspected or confirmed COVID 19 must be bare below the elbow, have their hair tied back, and wear no false nails, nail varnish or jewellery. Stoned rings on the hands should not be worn.
  - When working in close contact (within 2 metres) of a patient with suspected or confirmed COVID-19 symptoms: fluid resistant surgical mask (FRSM) and apron and gloves must be worn.
- Spitting and NG feeding are not aerosol-generating procedures so PPE should be as above with additional eye protection if felt necessary.
- It is recognised that in some circumstances use of plastic aprons for service users with suspected or confirmed COVID-19 may pose other risks when restraining the client, whilst recognising that the need for restraint will be changed by the nature of the disease itself. It is recommended that an individual risk assessment is made and reviewed on a daily basis to ensure that all risks are managed by the organisation.
- All providers have access to their own infection prevention and control (IPC) specialists who can advise on local implementation.

3.2 Staff safety and wellbeing

All of us will feel the impact of COVID-19 and it is likely to be a distressing and potentially traumatising time for many. Supporting staff wellbeing will be vital, both in our responsibilities

as an employer and as providers of compassionate, safe, quality healthcare. More detailed guidance regarding the psychological support for our workforce will follow shortly.

It is also important to consider the safety of staff both with regard to protection from COVID-19 (please see PPE advice above) and to managing risk with a reduced workforce.

- A risk assessment is required for health and social care staff who are more vulnerable to COVID-19 as per guidance (COVID-19: infection prevention and control). Employees who are assessed as being more vulnerable will need to be deployed away from areas used for the care of those who have or are clinically suspected of having COVID-19.
- With a reduced workforce, lone working and environmental risks will need further consideration and further advice is being developed with regard to this. Local teams should ensure the risk of lone-working, eg with new home visits, is fully assessed and effective safety measures are put in place.
- It is recognised that during this time service user and staff safety is paramount, but changes in practice and skill mix may be required to maintain this. Local review and risk assessment should be carried out to support safety.

3.3 Remote working

- If it is decided that a staff member should work from home they should still expect to receive support and guidance from their line manager.
- Attempts should be made to increase online/telephone contact with colleagues working from home.
- Consideration should also be given to the vital tasks staff who are working from home working can do to free up clinical capacity on site.
- Staff who are well but need to self-isolate may be able to undertake certain clinical activities remotely, including providing clinical advice by telephone/online or undertaking telephone/video consultations. Such activities should be discussed and agreed with the service manager.

4. Releasing time to care

4.1 Releasing clinical capacity for direct patient care

- Clinical leadership will be required to support the redeployment of staff as appropriate. Guidance on this is given in managing capacity and demand within inpatient and community mental health (MH), learning disabilities and autism services for all ages.

- As per contingency plans, organisations will be required to reorganise tasks to ensure clinical time is released to focus on delivering direct patient care. This may mean that staff who are vulnerable to COVID-19 or non-clinical staff are asked to fulfil non-direct patient contact tasks to free up direct clinical capacity. Suggestions for local consideration are:
  - Undertaking investigations (serious incidents, complaints, workforce)
  - undertaking necessary clinical audit
  - monitoring impact of COVID-19 (confirmed cases, self-isolation, staff and patients, etc)
  - monitoring impact of decisions made in light of COVID-19 (such as blanket restrictions, rationalising care, etc)
  - screening new referrals
  - continuing to contribute to patient care through non face to face contacts.
- With a reduced mental health, learning disability and/or autism workforce, it is likely staff will focus on delivering priority regulated activities and capacity for other tasks important to patients may be reduced, such as one-to-one time, ward activities, access to gym, groups, etc. It may be helpful to think about how activities workers, peer support workers, recovery college staff and experts by experience may support such important activities on wards and in community teams/crisis teams. It will be important to explain changes to activities to patients in an accessible manner, to mitigate against a negative response.
- Clinical staff in non-direct patient care roles, such as research, training, practice development nurses, quality roles, management posts, etc should be considered to provide direct patient care.
- Services will need to review how best to allocate time for clinical care to manage competing clinical priorities. Senior clinicians and managers will need to review new and existing cases with clinical staff members to support this process and decision-making.
- Services will need to review different ways of working to support patient clinical reviews in an effective and safe manner, eg telephone reviews and online consultations. Digital technology can be used in a number of ways to support patient reviews and reduce the need for face-to-face contact.

4.2 Reporting requirements

- Further information will be provided when available regarding relaxing reporting requirements. However, in the interim, local systems should discuss with commissioning colleagues reduced contract monitoring, reduced reporting and reducing any other tasks that require clinical input.

4.3 Multidisciplinary teams and multi-agency care

- Consideration should be given to the role of the whole MDT in supporting the delivery of prioritised direct patient care. The whole MDT should, where appropriate, be trained in responding to incidents, eg in the likely event of a reduced workforce trained in the appropriate physical interventions for the services.
- Psychology staff could prioritise group work on wards and direct clinical support in crisis teams and community teams, as well as providing psychological therapy via teleconferencing. They could also support staff through daily debriefs, 121 support and reflective practice.

4.4 Increasing capacity outside the current mental health, learning disability and/or autism workforce

Collaborative working with local partners

- All mental health, learning disability and/or autism organisations must have a local protocol in place to determine with health and social care partners who is best placed to visit a service user. Services are advised to ensure the following guidance is in place for all individuals supported in the community: COVID-19: guidance on home care provision.

Extension of approved clinicians' licences

- The Department of Health and Social Care will be extending the licences of approved clinicians and will formally communicate this shortly. Licences will be extended for 12 months, either from the expiry date or from the date of application for licence renewal from doctors whose approvals have lapsed within the previous 12 months.

Health Education England (HEE) measures

- HEE are putting in place measures to support an increase in capacity from outside the current workforce. This includes;
  - agreement that final year medical students can be registered without further legislation. Working with medical schools, this will allow 2,200 between April and June to join the register and support FY1 posts
  - working with the Royal College of Psychiatrists to identify novel ways to enable trainees to progress through training despite the cancellation of exams and face-to-face recruitment events
  - The Nursing and Midwifery Council (NMC) has agreed to register third year nurses in their last six months of training and place them for their last six months to support the service, this will be paid and uptake voluntary.

- HEE has written to all academic trainees to urge them to return to their base specialty and support direct clinical care.

4.5 Wider capacity options

Wider options considered by HEE

Wider options are being considered to release further staff to support mental health providers, and will be communicated. They include:

- Once government has passed the legislation to enable the NMC to establish a temporary COVID-19 emergency register, our first focus will be to invite those people who have left the register within the last three years to opt in, should they wish to do so.
- Encourage those who are skilled and on the register but not working in clinical care to consider coming into clinical practice during this time.
- Change the nature of the programme for undergraduate nursing students in the last six months of their programme so that they may be clinically placed.
- The next stage of the COVID-19 temporary register will be to establish a specific student section in the emergency register. This will include specific conditions of practice to ensure appropriate safeguards are in place.

Voluntary community sector organisations

- It will also be helpful to contact voluntary sector partners, such as the Red Cross or St John Ambulance, that may be able to help meet the needs of services users, as well as local mental health charities and mental health supported living organisations.
- VCS colleagues may be able to provide peer support, active listening, being with patients to free up clinical time, run activities and provide practical support to learn Activities of Daily Living, etc.
- VCS colleagues could also work in crisis and community teams to offer telephone support, befriending and practical advice on budgeting, benefits, paying rent, etc.
- It will also be helpful to consider students from psychology courses, health and social care NVQs and hospitality NVQs as potential bank healthcare support workers.

5. Training and CPD

5.1 Training

- As per the letter from Simon Stevens and Amanda Pritchard to system leaders, refresher physical healthcare training should be provided to all mental health,

learning disability and/or autism staff delivering patient care. This should cover physical health care, vital signs and the deteriorating patient.

- It is proposed that training departments focus on delivering on-site training in these areas to support learning while on shift.
- The national team are exploring opportunities to extend non mental health-specific mandatory training, to avoid the need for refresher training in things such as information guidance for staff who have previously received such training, so as to free up clinical capacity.

5.2 Clinical placements and rotations

- HEE and health education institutions have agreed to stop all clinical placements, to release the time of supervisors.
- To reduce disruption, maintain continuity of care and reduce supervisory burdens, rotations will be suspended, and trainees will remain where they currently are.
- HEE is advising that all non-essential education and training activities be suspended.

5.3 Continual professional development (CPD)

- CPD may need to be delayed to support contingency plans and/or redeployment requirements.

5.4 Revalidation

- Revalidation periods for nurses are currently under review.

5.5 Training to increase workforce capacity

- However, some mental health-specific training will need to be prioritised and, in some cases, increased to ensure any increase in staffing is supported to mitigate staff absence. Suggested priority areas are:
  - physical health, vital signs and deteriorating patient
  - AMHP training
  - approved clinician and section 12 refreshers/training
  - the prevention and management of violence and aggression or equivalent (although this may be delivered in an alternative format to reduce human-to-human contact)
  - learning disability and/or autism-specific training, such as diagnostic overshadowing, reasonable adjustment training, communication training for people with learning disabilities and/or autism, and specific interventions that can have an impact on the respiratory system

- specialised commissioned services should consider what specific training/induction will be required. New staff will require bespoke but condensed training in many of these areas, to ensure safety of staff and patients.
- updated guidance on the Mental Health Act; more guidance to follow when available.

6. Safer staffing models

- Further work will be undertaken to review the principle of relaxing safer staffing requirements to ensure the availability of the core workforce.