NHS

Guidance for Mental Health and Wellbeing Hubs for Health and Social Care Staff

NHS England and NHS Improvement

1. Introduction

Through the NHS England and NHS Improvement People Plan a commitment was made to fund a wave of mental health and wellbeing hubs, in partnership with Occupational Health providers, to support the mental health of health and social care staff.

These pilots are to be funded for the remainder of the financial year 2020/21 and will generate data and learning to inform a wider roll-out in 2021/22, subject to further funding.

Funding has been allocated to support at least one mental health and wellbeing hub in each of the seven regions at ICS/STP level.

The Mental Health Directorate will work in partnership with the People Directorate and colleagues in regional teams to agree the allocated funding, to ensure the hubs are live ahead of winter 2020/21. Regional Mental Health Leads and Regional People / Wellbeing Leads should agree the allocations jointly, using the suggested criteria in Appendix 2 to support the decision making process.

This guidance is intended to support colleagues developing proposals for this funding, to establish a Wave 1 Mental Health and Wellbeing Hub for health and social care staff.

2. Context and evidence around mental health need

2.1. Population needs

The Covid-19 pandemic is a unique and unprecedented challenge for many health and social care staff, who are caring for people in unfamiliar and challenging clinical and support roles. In this section of the guidance we outline the evidence around mental health need which is driving the plan to develop mental health and wellbeing hubs for health and social care staff.

Evidence from China (Lai et al 2020[1], Zhang et al 2020[2]), previous pandemics (SARS, MERS) and emerging evidence in the UK and elsewhere from the Covid-19 pandemic, suggests an increasing need for psychosocial support and interventions for health and social care staff, as the acute phase of the pandemic moves into the recovery phase.

Recent studies[3,4,5] found rates of PTSD at 24.31% in NHS staff compared to 4.4% amongst the general population. Rates of depression were found to be 37.51% in NHS staff compared to 31% of the general population, and rates of anxiety at 38.32% in NHS staff compared to 25.20% of the general population. This highlights the increased level of mental health needs of health and social care staff compared to the general public.

2.2. At-risk staff groups

There is evidence[6] to suggest that particular staff groups may be disproportionately affected by Covid-19 and are particularly vulnerable to the effects of the pandemic.

The NHS is a diverse and inclusive employer and should ensure support for staff who have an underlying physical or mental health condition that may be made worse by the pandemic. One in five NHS staff come from BAME backgrounds, a population which has been particularly adversely affected by the Covid-19 pandemic and this will have placed additional stress on the workforce, with many having been exposed to the virus or experiencing bereavement as a result of the illness.

A literature review led by the People Directorate has concluded that the following staffing groups or factors may indicate a higher risk of mental health problems, and consequentially may be more likely to benefit from outreach, engagement and mental health support:

- Staff who have been bereaved personally or professionally by Covid-19
- Disadvantaged groups
- Black, Asian, and minority ethnic (BAME) communities
- Staff working in the most challenging environments and in high proximity to the delivery of care

- Those deployed into intensive roles outside of their usual training especially critical care nurses
- Agency staff, temporary staff and staff returning to practice
- Staff separated from their usual support network (family and friends)
- Parents of dependent children
- Less experienced staff working in complex or challenging environments
- Exposed to poor public behaviours or where team behaviours are problematic
- Those with existing mental or physical health conditions
- People who have shielded and not in regular contact with their line manager

There are obvious risks for staff that do not engage with mental health care when needed, leading to a deterioration in both physical and mental health, and impacting on the person's ability to work and on their relationships with families, friends and colleagues. It is in this context that NHSE/I is establishing a mental health support offer for health and social care staff, which consists of an initial wave of 7 staff mental health and wellbeing hubs.

3. Mental health and wellbeing hubs : Understanding the service model

There is evidence[7] around delayed presentations at mental health services, and low levels of help seeking behaviours amongst healthcare staff indicating a need for a proactive approach to delivering mental health care. The hubs should offer proactive outreach, by identifying at-risk groups and making contact with individuals to offer assessment and support should they need it. This will help to increase rates of access amongst health and social care staff, and crucially to encourage earlier access.

This principle is at the core of the design of the hub model which we are looking to test through a series of pilots.

In the main, the hubs themselves will not be delivering treatment and mental health interventions. Access to treatment for staff will be provided by local mental health services, who will work with the hub teams to offer rapid access based on clinical need. However, hubs may wish to commission local services where gaps are highlighted in provision and where a number of staff would benefit from a bespoke approach. Any locally commissioned services should be tailored to the needs of the local community and staff mix, and agreed with NHS England and NHS Improvement regional teams.

The hubs should provide a structured experience and consider staff's capacity to stay at work, or take time off and then return to work, which should be supported by occupational health and their local team/manager.

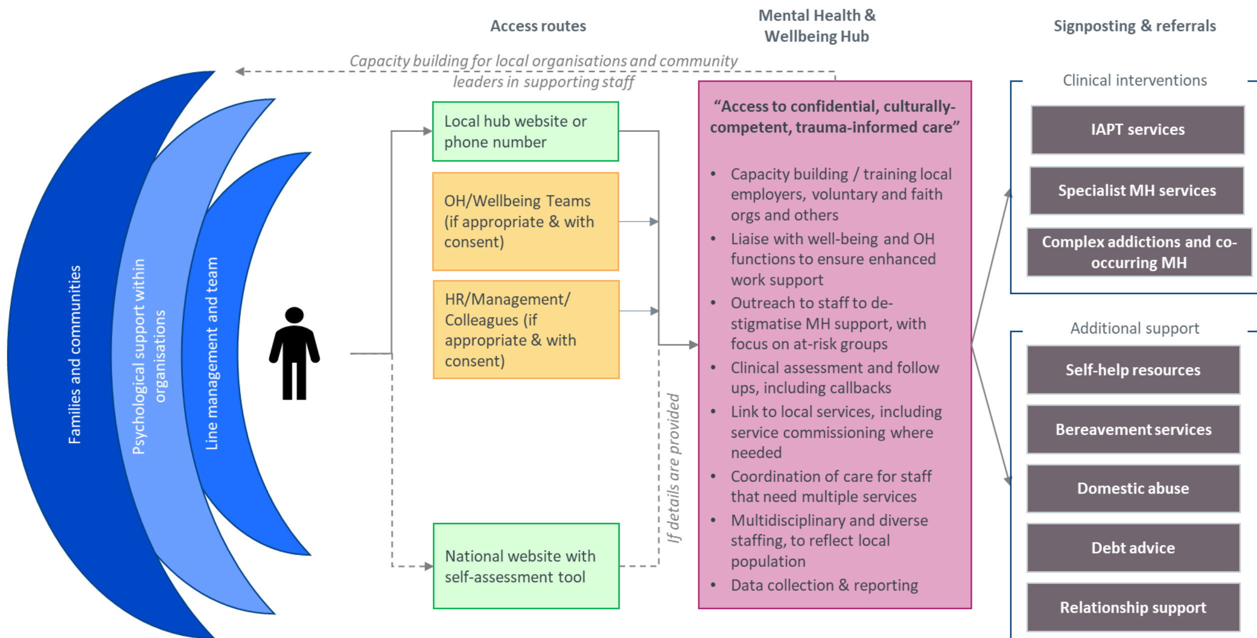
3.1. Key functions of the hub model

The key functions of the mental health and wellbeing hubs include:

1. **Deliver proactive outreach and engagement** – working in partnership with Occupational Health teams to deliver a positive health and wellbeing service to staff. Proactive outreach is key to highlight the value of mental health and wellbeing services to health and social care workforce and helping to overcome stigma and barriers to access. This includes establishing and promoting referral pathways with local key stakeholders.
2. **Build capacity in local employer organisations or teams via training** – support employers/managers/teams to improve and normalise help-seeking behaviours for professional groups. This will need to target culture and behaviours of the organisation, including line management capacity for supporting staff.
3. **Provide rapid clinical assessment** – for self-referrals, and referrals from other sources e.g. Occupational health, GPs etc, to identify where further support is required**.** This assessment should ideally be multidisciplinary.

4. **Provide onwards referral and care co-ordination to deliver rapid access to mental health services and support** - to ensure staff access relevant NICE recommended and evidence based psychosocial interventions and treatment. Hubs should also monitor the staff's progress through the system to ensure good outcomes.

Figure 1. Example Model of Care/Pathway



3.2. Supporting rapid access to mental health and psychosocial support services

Subsequent to clinical assessment, hubs should be able to provide rapid access for staff into IAPT, secondary care mental health services, and other services as clinically indicated. Proposals should set out how this rapid access will be achieved and what contingency will be in place where local services are not able to respond rapidly to provide the treatment indicated. Some ICS/STPs have established dedicated treatment resources to provide rapid access, whilst others have been able to ensure rapid access based on clinical need without establishing specific teams dedicated to the treatment of staff.

Hubs should also be able to signpost and refer staff to appropriate third sector organisations. This should include access to peer support services and signposting to local services providing help and advice specifically for marginalised groups including BAME communities, LGBT+ communities, people with disabilities, and people of different faiths and experiences. Examples of relevant third sector services include culturally competent bereavement support, domestic abuse services, relationship support, and debt advice, amongst others.

We recognise that there are a number of areas that do not have local pathways to support rapid access to treatment for people with complex addictions and co-occurring mental health problems. Therefore, NHSE/I is exploring the option to centrally commission a complex addictions treatment service which the hubs can refer onto for staff who have complex addictions alongside co-occurring mental health needs.

3.3. Geographical footprint

It is envisaged that the mental health and wellbeing hubs will be set up at an ICS/STP level, given that this is key in ensuring system partnership for health and social care services. Hubs should work collaboratively with NHS trusts and other providers in their ICS/STP area to ensure coordination of efforts.

It is also advised that the hub should have good links to NHS Trusts/Organisations in neighbouring ICS/STP areas or across the region. This will allow the hub to signpost or refer staff to alternative services outside their areas as required, for example to expediate waiting times or in case of confidentiality concerns. Hubs could also consider expanding their geographical footprint, if demand is lower than anticipated in their area but higher in neighbouring areas.

Where neighbouring ICS/STP organisations want to merge their provisions to create sub-regional hubs instead, care should be taken that staff outreach and engagement are not adversely affected. There should also be good links between neighbouring hubs, to allow for staff transfers, where required, along with information sharing and learning.

3.4. Population covered

It is envisaged that the wave 1 hubs can offer support to both health and social care staff. The proposal should include an assessment of what is feasible within the funding envelope available. The populations supported could include substantive staff, staff on fixed-term contracts, agency staff, seconded staff, staff on placements/training etc. This could also include healthcare staff employed by other organisations who are contracted to deliver NHS services e.g. Dentists and Pharmacists.

Whilst it is acknowledged that there is strain on family members of health and social care staff during the Covid-19 pandemic, it is not proposed that the hubs extend their scope to directly support families of staff; instead care could be expanded to more health and social care staff populations. However, hub staff will be encouraged to deliver their assessment and care co-ordination in a family orientated way, supporting staff to identify, understand, and address the impact of their pressures on family relationships.

3.5. Confidentiality

The promise of confidentiality is critical to staff engagement in mental health support, and concerns about a lack of confidentiality are a key barrier to access at present. Therefore, proposals should include a clear commitment to providing staff confidentiality and ensure pathways that protect the ability of services to confidently deliver on those commitments. This may include agreements between services within an ICS/STP to provide services to staff from neighboring areas. Clear guidelines are also needed on how the hubs will work with professional bodies where concerns about capability and practice are raised through the assessment process.

3.6. Integrated working with Occupational health

The importance of Occupational Health and other existing staff support systems is recognised as key in helping members of staff to take time off and returning back to work or putting in place modifications to support them to continue to work.

Therefore, where workplace support is required, it is important that the hubs link with Occupational Health to ensure these needs are being addressed. Work can have a big impact on an individual's mental health; therefore, it is important that this is considered as part of their assessment and support. For example, if someone is currently too unwell to work and needs time off or requires adjustments to improve their ability to work, then this can instrumental in their recovery. Please see appendix 1 for an example of how the hubs could work with Occupational Health.

Occupational Health Services and Health & Wellbeing teams should also be able to refer staff to mental health and wellbeing hubs (with the individual's consent), as part of their objective to keep employees physically and mentally healthy and to manage any work-related risks.

The hubs will play an important role in providing confidential specialist mental health advice to Occupational Health and Health & Wellbeing Teams, based on a clinical assessment by a qualified mental health practitioner. This can complement assessments and screening in Occupational Health services, to ensure that staff members with a range of needs are assessed and addressed

comprehensively. Therefore, hubs should develop good working relationships with these services in their local area to enable joined-up working and coordinated outreach and training approaches.

3.7. Governance

Mental health and wellbeing hubs may be hosted by an NHS provider e.g. a mental health trust, to fit in with existing governance and reporting structures but will be accountable to the ICS/STP awarded the funding. It should be noted that where hubs are hosted by trusts that the service should be treated confidentially and no personal information shared outside of the hub, to support staff privacy, unless there are any concerns around staff's fitness to practice. This should be in line with the Confidentiality: NHS Code of Practice.

All information shared with the hub will be subject to the General Data Protection Regulation 2016 and the Data Protection Act 2018.

4. Workforce requirements for delivering the hub model

The service should be delivered by a multi-disciplinary team with relevant skills and knowledge. This could include a Clinical Leadership post to provide clinical supervision for the team.

This staffing model could include psychology professionals, psychiatrists, nursing, social workers, as well as other relevant professionals to provide the outreach, assessment and care coordination functions, plus contract/performance and administrative support to help monitor data, record-keeping and diary-management etc.

To support the resourcing of the hubs, we would encourage sites to consider the following options:

- career development opportunities for existing local staff
- returners programme/retirement schemes
- secondments/fixed term contracts – to enable flexible staffing over the lifetime of the hubs.

Hub staff should be able to demonstrate cultural competence and an understanding of equality and diversity principles to support staff from ethnic minority backgrounds during Covid-19. Hub staff will also need to understand experiences of LGBT+ staff and the impact on their mental wellbeing during Covid-19, as well as the experiences of staff with disabilities, as this knowledge will be critical to successful outreach work.

The wellbeing of the hub staff is central to the service; therefore, hub staff could be supported through:

- Regular check ins with staff to update on workloads, manage any issues and discuss the themes, concerns and positives of the day.
- Clinical group, one to one and line management supervision should be in place for all staff, with explicit conversations regarding staff well-being and the impact of the work.

5. Addressing Inequalities

Hubs will also need to either establish or ensure appropriate local support is available for staff from marginalized groups, including BAME communities, LGBT+ communities, people with disabilities in their local area. This includes but not limited to:

- Culturally specific bereavement support
- Resources and support for faith leaders and community groups to understand and respond to trauma
- Increasing role of BAME, LGBT+, Disability networks to support staff
- Domestic abuse or relationship support services that are inclusive of LGBT+ communities
- Relevant and appropriate peer support services
- Signposting to relevant information/services regarding immigration status

It is also important that hub staff are culturally aware and competent, as well as the local mental health services/support that the hub refers onto. There is also a need to improve representation of BAME and LGBT+ communities within the delivery of mental health support services, therefore this should be considered when recruiting to the hubs.

6. Expectations of Wave 1 hubs – monitoring and evaluation

Services allocated the People Plan funding will form part of a national network responsible for generating learning about what works ahead of a potential roll out across the country next year.

Therefore, it will be expected that they contribute to regular network meetings and submit data on an agreed data set frequently, this will likely include the following data items:

- Number of staff contacting the hubs via self-referral
- Number of staff being referred to the hub from other sources e.g. OH/HR/Wellbeing teams, including source referral
- Number of staff assessed
- Time taken to contact staff after referral received
- Number of staff signposted/referred to services
- Number of staff monitored following assessment
- Number of staff accessing treatment/intervention through other services
- Number of supervision sessions provided to hub staff
- Number of training sessions provided along with training feedback
- Number of outreach / inreach events provided along with event feedback
- Monitoring of clinical outcomes in liaison with local services (collected via hub follow-up)
- Service user feedback/experience
- Hub staff feedback
- Number of staff sickness days lost due to mental health related reasons within ICS/STP area
- Number of staff waiting for treatment
- Demographics of staff referred, assessed and receiving intervention (e.g. ethnicity, sexual orientation, gender and trans status, age, job role etc)

7. Other forms of Mental Health support for health and social care staff in 20/21

We are conscious a number of ICS/STPs have already set up or are proposing alternative staff mental health support offers, outside of the hub model. Therefore, we suggest that as long as a region is funding at least one mental health and wellbeing hub with their allocation which is in keeping with the key principles within this guidance, we are content for remaining funds to be used to fund the continuation of or establishment of these other support offers. These support offers should be aligned with the key principles below:

1. **Rapid access to assessment and treatment for staff at high risk:** Ensuring that mental health services have agreed processes and protocols for ensuring rapid access to evidence based, NICE recommended treatment for staff at high risk, as agreed locally.
2. **Clarity on referral routes:** This should include options for staff to self-refer into mental health services and for Occupational Health staff to refer into mental health services where appropriate for them to do so.
3. **Confidentiality:** We expect services to be clear on how confidentiality will be maintained for any healthcare staff accessing mental health support, particularly in terms of addressing staff concerns around accessing support by their employer.

We are keen to ensure that all areas have at least an interim level of mental health support available to staff ahead of winter 2020/21. Therefore, we will be working with regions to map existing services so that we maximise support available.

Appendix 1

Example of a Healthcare Professional requiring mental health and Occupational Health support

A healthcare professional working in a specialist clinical area, who also has family caring responsibilities, had worked throughout the pandemic.

Their role involved maintenance of emergency services for a vulnerable patient group during a stressful period, exacerbated by staff absences related to sickness and shielding. During July 2020 the health professional felt the sense of pressure within their department for a return to 'normal' clinical services for a wider patient group, whilst working within stringent new infection control guidelines which would inevitably make some clinical processes lengthier and potentially more challenging.

In late July the staff member felt overwhelmed by events of recent months and was unable to continue at work. Advice was sought from Occupational Health (OH) resulting in signposts to urgent mental health support and advice and also, with the staff member's consent, liaison with their GP and line manager. Appropriate treatment and support is now in place, the need for a period of sick leave is understood and the manager is making longer term plans, in consultation with the staff member, informed by OH advice, for a supported return to work.

Appendix 2

Suggested criteria to support regional leads selection of wave 1 hub sites:

1. **Areas which have been highly impacted by covid-19 or showing signs of high mental health needs amongst staff affected .**
    - This may be assessed either via
        - data on COVID infection rates
        - data on COVID related mortality rates
        - staff sickness absence rates

2. **Ability to mobilise at pace** – due to the need to use funding this financial year to test the model ahead of wider roll out
    - Regional leads may wish to consider allocating the funding to models that are already live or in process of being mobilised.

3. **Ability to offer rapid access to mental health treatment for staff groups to test the end to end pathway**

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[1] Lai, J., Ma, S., Wang, Y., Cai, Z., Hu, J., Wei, N., … Hu, S. (2020). Factors Associated with Mental Health Outcomes Among Health Care Workers Exposed to Coronavirus Disease 2019. JAMA Network Open, 3(3), e203976.
[2] Zhang, C., Yang, L., Liu, S., Ma, S., Wang, Y., Cai, Z., … Zhang, B. (2020). Survey of Insomnia and Related Social Psychological Factors Among Medical Staff Involved in the 2019 Novel Coronavirus Disease Outbreak. Frontiers in Psychiatry, 11.
[3] House of Commons Library. (2020). Briefing Paper No. 6988. Mental Health Statistics for England: Prevalence, Services and Funding. London. UK
[4] Mental Health UK Study – N=3097(UK Public) – C19 UK Public Survey N=53,328 (UK Public)
5 NHS Check N = 10,281 (NHS Staff) – NHS Trauma Group -N = 1,211 (NHS & Social Care Staff)
[6] Kiseley, S., Warren, N., … (2020) Occurrence, prevention, and management of the psychological effects of emerging virus outbreaks on healthcare workers: rapid review and meta-analysis, BMJ 2020;369:m1642
[7] Lowell A, Suarez-Jimenez B, Helpman L, Zhu X, Durosky A, Hilburn A, Schneier F, Gross R, Neria Y. 9/11-related PTSD among highly exposed populations: a systematic review 15 years after the attack. Psychol Med. 2018; 48:537–553doi: 10.1017/S0033291717002033.