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The implementation of new roles in mental health trusts in England: a qualitative study of workforce leaders' perspectives

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Abstract

Background The workforce crisis in the English NHS is widely recognised and most acute in mental health (MH) services where demand has risen, impacting on other parts of the system. In response, new investment aims to expand the MH workforce through introducing new roles (skill-mix change). Outside MH, evidence suggests that skill-mix change disrupts systems, bringing significant organisational challenges as well as potential benefits. The study aimed to examine the perspectives of leaders involved in new roles change in English mental health trusts (MHTs) on the rationale for and process of introducing new roles, and key factors affecting implementation.

Methods A two-phase qualitative design examined purposively sampled leaders' perspectives on the implementation of new roles in MHTs. Phase 1 involved semi-structured online interviews with MHT leaders. Phase 2 comprised a series of online stakeholder reflection groups informed by Phase 1 findings, with leaders from provider, policy and professional bodies. Template Analysis assisted initial data coding followed by comparison of the template with the domains of the Consolidated Framework for Implementation Research (CFIR) to identify the most influential issues affecting implementation.

Results Leaders from 31 of 51 MHTs participated in Phase 1 (response rate 61%; 33 leads in total); 18 leaders participated in one of three reflection groups in Phase 2. Three cross-cutting themes were generated: (1) MHTs' motivation for implementation including drivers and concerns; (2) the challenging MHT implementation context and consequences arising (largely unintended); (3) the strategies that some leaders were employing in MHTs to support implementation despite challenges.

Conclusions The study provides valuable insights for implementers on the challenges and opportunities associated with introducing new roles in mental health services to help plan and conduct strategic, operational and relational implementation efforts. The policy/commissioning context (outer domain) was less controllable, however all remaining domains (the innovation, inner setting, attitudes of individuals, and process of implementation) were amenable to adaptation to some degree through the implementation work of leaders. Skill-mix change should be recognised as a process of adaptation and system change over time requiring multi-level implementation work tailored to local needs.

Keywords Mental health services · New roles · Skill mix · Implementation · CFIR · Qualitative research

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Abbreviations

AP	Advanced Practitioner
CFIR	Consolidated Framework for Implementation Research
CAP	Clinical Associate in Psychology
EMHP	Educational Mental Health Practitioner
HR	Human Resources
MH	Mental Health
MHT	Mental Health Trust
MHWP	Mental Health and Wellbeing Practitioner
MPAC	Multi-Professional Approved Clinician
NA	Nursing Associate
PA	Physician Associate
PSW	Peer Support Worker

Background

The workforce crisis in the English NHS is widely recognised [1, 2] and is most acute in mental health (MH) services, where higher staff turnover and more vacancies than the rest of the NHS challenge delivery [3, 4]. Additionally, demand for MH services has risen significantly in recent years [5], exacerbated in part by the impact of the COVID-19 pandemic [6]. This demand also creates pressures beyond MH services, as people with mental health problems are over-represented among users of primary care/urgent and emergency services [7]. In response, new investment was committed for English MH services to embrace new ways of working [8]. Consequently, MH services are drawing upon skill-mix changes introduced in primary care to address workforce shortages [9–12] and expanding the MH workforce by introducing new roles [13, 14]. While the dominant need for these roles is to fill workforce gaps, opportunities for more integrated working are also offered [13], aligned with concurrent developments in English Primary Care Networks [15] and Integrated Care Systems [16]. The NHS Workforce Plan [14] commits to a national expansion of particular new roles in MH services: Nursing Associates (NAs); Physician Associates (PAs); Advanced Practitioners (APs); Peer Support Workers (PSWs); Multi-Professional Approved Clinicians (MPACs); Educational Mental Health Practitioners (EMHPs) and Mental Health and Wellbeing Practitioners (MHWPs). Other new roles such as Clinical Associates in Psychology (CAPs) are also emerging [17]. The situation across English MH services is therefore variable, complex and rapidly changing, and to date little information has been available about new roles activity within individual trusts.

Evidence from other parts of the healthcare system suggests that changing skill-mix disrupts existing systems, bringing significant organisational challenges, such as additional work for existing staff, duplication/inappropriate deployment of roles, redesign of patient pathways and the renegotiation of professional boundaries [9–12, 18–21]. While there may be benefits to implementing new roles, such as greater collaboration between staff and increased continuity of care [22–24], change of this type is a complex, non-linear, multi-level process in a dynamic open system [25]. Consequently, workforce changes may benefit from examination informed by implementation approaches which recognise the diverse factors that potentially impact such initiatives [26].

More than a decade ago, Procter and colleagues [27] highlighted the need for conceptual multi-level models for the implementation of changes in the field of MH. However, only recently have studies informed by implementation frameworks been growing in this setting. For example, Normalisation Process Theory [28] underpinned research on the introduction of health promotion into MH services [29] and MH care into home-based nursing [30]; the Theoretical Domains Framework [31] underpinned work on implementing screening for MH in perinatal services [32] and a systematic review of task-sharing in MH [33]. The Consolidated Framework for Implementation Research (CFIR) is a meta-theoretical framework based on review of 19 other theories that is

internationally established and widely used [34]. It has informed a number of recent implementation studies in MH services including delivery of i-CBT [35], prisoner re-entry [36], teacher-led MH initiatives [37] MH professional/police co-responder programmes for people in crisis [38] and specialty MH probation [39]. While CFIR-informed MH workforce related literature is rare, two studies, both international reviews, used this framework to focus on the implementation of a single new role, PSWs in MH services [40, 41]. These studies, underpinned by implementation frameworks, highlight the influence of organisational culture, staff beliefs, time and resources on implementation of a range of innovations in MH services.

It is not known whether similar issues are being encountered in the context of English MH services where multiple new roles are being introduced and there is as yet little evidence to guide implementers (policymakers, clinicians, leaders and managers). Skill-mix is recognised as an important priority for UK workforce research [42] and McGinty and colleagues [43] have called for greater use of implementation science in MH research. Our aim in the current study was not to assess the clinical effectiveness/success of any individual role, but rather, using the meta-theoretical CFIR as a scaffold to understand the change process [44], to examine the perspectives of leaders with experience of workforce issues in English mental health trusts (MHTs) on the rationale for/process of introducing new roles and key factors most affecting implementation.

Methods

We used a sequential two-phase qualitative design to examine leaders' perspectives on the implementation of new roles in English MHTs (see Additional File 1 for COREQ checklist). Phase 1 comprised a round of semi-structured interviews; Phase 2 involved a series of stakeholder reflection groups. The study received institutional research ethics and Health Research Authority approvals.

Phase 1 qualitative interviews: sampling, recruitment, data collection and first stage analysis

In Phase 1 we invited senior leads with knowledge of the new roles implemented in their MHT in the last five years to participate. Leaders were purposively sampled to maximise variation according to their leadership role and were either workforce, HR, clinical or general leads. We contacted all 51 MHTs in England. MHT leads were identified by using information from organisational websites or requesting assistance from clinical/service leads, other suggested contacts, or research and development teams within each trust to locate the right person. Email invitations were sent.

Once a person was identified and had consented, we arranged a date and time for a semi-structured online interview via MS Teams (the preferred online platform in the English NHS). We shared with participants the key questions in advance of the interview in the form of a pre-interview prompt sheet (see Fig. 1), to aid reflection. This sheet underpinned the interview topic guide (see Fig. 2), informed by the skill-mix literature. Interviews sought to establish the number and types of new roles in each trust, where the new roles were sited (e.g. community, inpatient, specialist services), and their pay grade. These quantitative data are not the focus of this study and will be reported elsewhere. We also asked about the strategic or policy aim for the new role, how implementation decisions were made, and any specific barriers or facilitators to implementation. We did not ask for any personally identifiable information on individual staff members, only for aggregate descriptions of roles and their implementation.

All interviews were conducted by one or more authors, over a three-month period (October 2023-January 2024) and lasted between 24 and 60 min (mean 47 min). Where participants were unable to find time for an interview, we sent an online questionnaire covering the same topic areas (20 MHTs). Video recordings were converted to audio; they were not transcribed, but interviewers wrote detailed notes of each interview in line with rapid analysis techniques [45]. This enabled preliminary emergent messages to be rapidly summarised for use in

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1. How many of the following 'new roles' are employed in your Trust? How many of each, and has this changed in the last 5 years?

Advanced practitioners | Clinical Associate Psychologist | Physician Associate | Nursing Associate | Peer Support Workers

2. Do you employ any staff in the following "new roles", and if so, how many?

Specialist Nurse Practitioner	Lived Experience Worker	Employment Specialist
Assistant Practitioner	Experience & Engagement Liaison Officer	Employment Support Worker/Adviser
Wellbeing Practitioner (or similar)	Family Ambassador	Creative Practitioner
Mental Health Practitioner	Youth Intensive Psychological Practitioner	Art Therapist
Health & Wellbeing Triage Coach (or similar)	Children & Young People Senior Navigator	Drama Therapist
MH & Wellbeing Navigator (or similar)	Children & Young People Keyworker	Music Therapist
Community Connector	Education MH Practitioner	Telephone Triage Worker

3. Have any other new roles been introduced in your Trust? If any, can you indicate where possible: job titles, numbers, AfC banding?

Role (job title)	Number in role	AfC banding

To understand how and why these new roles were introduced, we would like to explore the following questions if you are able;

4. How long have the roles been established? Are they entirely new or a change to an existing role?
5. In which teams or services/settings have the roles been introduced?
6. What was the rationale for introducing the roles?
7. What was the intended impact of the roles? On staff, service users?
8. What approaches have been taken to embedding/supporting the roles? How were decisions made about implementing the roles?
9. What challenges/facilitating factors were associated with implementation? Has there been any evaluation?

Fig. 1 Phase 1 pre-interview prompt sheet

Fig. 2 Phase 1 interview topic guide

- Which new roles have been introduced into your Trust over the last 5 years?
  - List all known ones: names, number in role, Agenda for Change banding.
- Describe the nature of the roles e.g. entirely new role or change to existing role, how long have they been established, etc?
- In which teams or services/settings have these been introduced?
- What was the rationale for introducing these roles? Strategic/policy aim?
- What was the intended impact of the roles?
  - On staff, service users?
- What approaches have been taken to embedding and supporting these roles?
  - How were decisions made about implementation?
  - How effective have these approaches been?
  - Has any evaluation been undertaken?
- Do you think there may be other new roles that have been introduced that you are unaware of?
  - Is there anyone else you think we need to approach/ask for information?

the Phase 2 reflection groups. For questionnaire responses, qualitative data from the open-ended questions was extracted and added to the dataset.

Qualitative data from interviews and questionnaires were analysed in two stages (see Fig. 3). In the first stage, Template Analysis [46], enabled initial data coding: authors DH, PAN and SS independently read early interview notes to generate and agree preliminary categories; the first author subsequently read all remaining interview notes and created a template of 29 initial categories in discussion with the research team to capture broad ideas in the data; the template was applied to all interview notes to code and organise them in NVivo Version 14 [47] to rapidly produce key messages for the Phase 2 reflection groups.

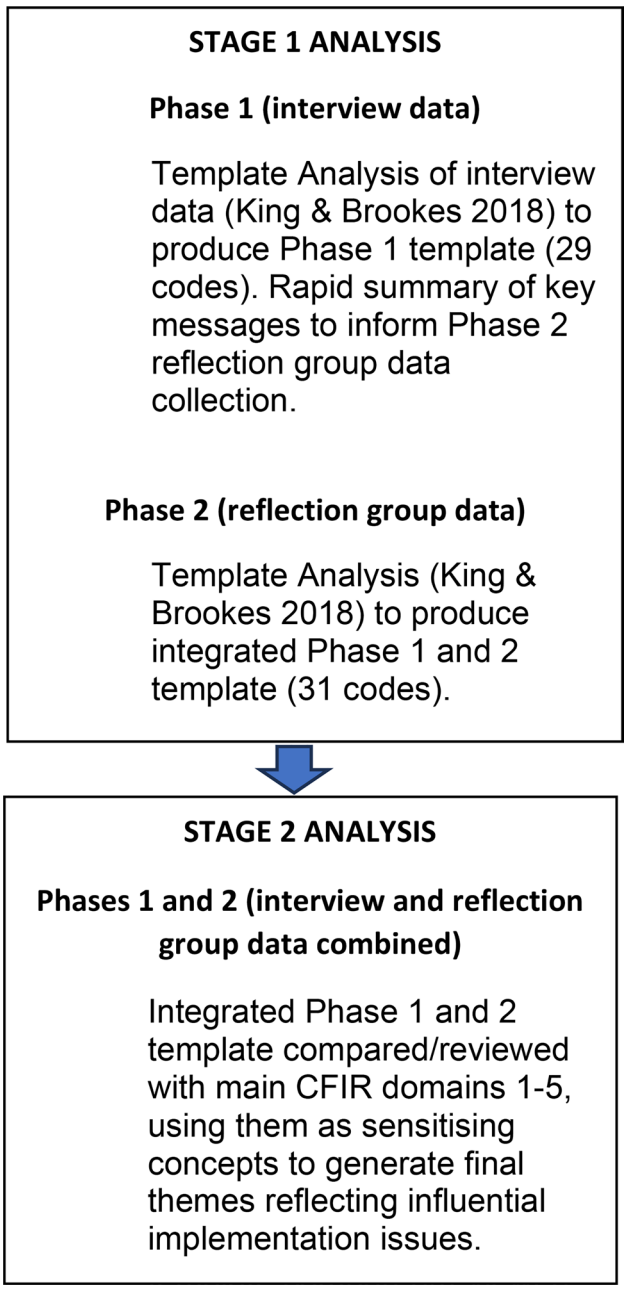


Fig. 3 Data analysis stages 1 and 2

Phase 2 qualitative stakeholder reflection groups: sampling, recruitment, data collection and first stage analysis

Senior leaders with expertise on new roles in MH services were purposively sampled for maximum variation according to leadership role, comprising leaders from policy, provider, professional and other relevant bodies. They were invited by email to participate, following consent, in one of three online reflection groups to consider Phase 1 findings and contribute perspectives. Some informants had been identified earlier during development of the research proposal, and some were purposively selected from participants interviewed in Phase 1.

Three reflection groups (mean length 1 h 25 min), took place via MS Teams over a one-month period (January-February 2024) and were jointly led by DH and EW with support from PAN and SS. During the sessions, preliminary, summarised findings from Phase 1 interviews were shared. The aim of reflection groups was to gather perspectives on the: availability of new roles data/national spread of roles reported; detail of particular roles and how they were reported to be working; drivers for new roles; and a potential preliminary categorisation (typology) of skill-mix change to make sense of the activity taking place in MH services (see Additional File 2 for reflection group topic guide). The Phase 2 perspectives were also intended to inform the selection of several new role case studies in a subsequent phase of the study (not reported here).

Video recordings were fully transcribed. During the sessions, participants also used the online chat function to add thoughts/queries; chat comments were captured and added to transcripts at the relevant place in the session. While quantitative data on the type, number and pay grade of roles, as well as a preliminary typology of skill-mix change, was described and visualised for use in reflection groups, these data are not the focus of this paper and will be reported elsewhere.

In line with analysis of Phase 1 interview data, as part of the first analytic step, the coding template was applied to the Phase 2 reflection group data [46]. Minor refinements were made to incorporate two further codes which accounted for new data, making an extended template of 31 codes (see Table 5 in Results for links between the coding template and the findings generated). All Phase 2 reflection group data were coded for organisation and management and integrated into a final template.

Second stage analysis: combined interview and reflection group data with the consolidated framework for implementation research

The second stage analysis focused specifically on the implementation of new roles. Two authors (PAN and JL) independently reviewed/compared the final template (comprising both interview and reflection group data) with the main CFIR framework domains [34], using them as sensitising concepts to consider the implementation-related data. The five domains, D1-5 (see Table 1), assisted in drawing out insights by focusing on different dimensions/aspects of implementing new roles change at multiple levels, i.e. the characteristics of: D1 - the innovation itself (in this case multiple new roles); D2 - the outer setting; D3 - the inner setting; D4 - the individuals involved; and D5 - the process of implementation [48]. We compared and contrasted leaders' perspectives on the change process to guide thematic analysis and generate three cross-cutting themes reflecting the most influential issues affecting the implementation of new roles.

Table 1 CFIR domains and constructs informing second stage analysis

CFIR DOMAINS AND CONSTRUCTS*				
1. Innovation Characteristics	**2. Outer Setting**	**3. Inner Setting**	**4. Characteristics of Individuals**	**5. Process**
A. Innovation source	A. Patient needs & resources	A. Structural characteristics	A. Knowledge & beliefs about innovation	A. Planning
B. Evidence strength & quality	B. Cosmopolitanism	B. Networks & communication	B. Self-efficacy	B. Engaging
C. Relative advantage	C. Peer pressure	C. Culture	C. Individual stage of change	B1. Opinion leaders
D. Adaptability	D. External policy & incentives	D. Implementation climate	D. Individual identification with organisation	B2. Formally appointed internal implementation leaders
E. Trialability		D1. Tension for change	E. Other personal attributes	B3. Champions
F. Complexity		D2. Compatibility		B4. External change agents
G. Design quality & packaging		D3. Relative priority		C. Executing
H. Cost		D4. Organisational incentives & rewards		D. Reflecting & evaluating
		D5. Goals & feedback		
		D6. Learning climate		
		E. Readiness for implementation		
		E1. Leadership engagement		
		E2. Available resources		
		E3. Access to knowledge & information		

*From Damschroder et al., 2009 (reference 34)

Table 2 Phase 1 MHT responses by region

Region	MHT response rate
North East and Yorkshire	7/8
North West	2/5
Midlands	8/11
East of England	1/4
London	5/10
South East	5/7
South West	3/6
TOTAL	**31/51**

Table 3 Phase 1 sample characteristics by leadership role category

Leadership role category	Number of participants
Workforce/HR leadership	14
Clinical leadership	12
General leadership	7
TOTAL	**33**

Results

Participants

Phase 1 data was gathered from 31 of 51 English MHTs (response rate 61%), and secured responses from all English regions (see Table 2). MHT participation did not appear to correspond with size, location or Care Quality Commission ratings.

The 31 Phase 1 responses were provided by 33 senior leads consisting of 28 interviewees and five individuals who returned questionnaires. In most cases a single participant represented each MHT. Participants were MHT staff in workforce/HR leadership roles (e.g. Head of People), and clinical or general leadership roles (e.g. Chief Nurse; Chief Operating Officer respectively). Although some held 'clinical' leadership titles the majority were no longer close to clinical practice but held responsibilities in the areas of provider-level workforce planning, development and/or transformation as well as staff recruitment and retention and were thus well-placed to comment on the implementation process for new roles. Table 3 presents the characteristics of the Phase 1 sample by leadership role category.

In Phase 2 a total of 18 senior leads with expertise on new roles in MH services from policy, provider, professional and other relevant bodies took part in the three reflection groups (six participants per group). Participants had similar provider-level workforce responsibilities as those outlined for the Phase 1 sample above or had a remit for national-level policymaking in the NHS or the professional associations/colleges/networks or were academic leaders. As such they were able to provide key perspectives on the implementation process. Seven of the reflection group participants had also taken part in Phase 1 interviews. Sample characteristics are presented in Table 4.

Cross-cutting themes: key issues influencing implementation of new roles

Informed by the use of CFIR [34], we generated three cross-cutting themes from the combined Phase 1 and 2 qualitative data. The themes reflected the most influential issues affecting the implementation of new roles in MH services: (1) motivation for implementation; (2) implementation context and unintended consequences; (3) strategies to support implementation. Table 5 presents details of the final cross-cutting themes generated and how they relate to the content of the coding template. The three themes are now presented with illustrative data extracts and with reference to particular CFIR domains (D1-5) informing the generation of each theme.

Theme 1: Motivation for implementation

All MHTs had implemented at least one new role, and most were more recent adopters. Motivation for implementation was strong among leaders with some commonly perceived advantages (CFIR D1, D3), however some caution was evident, where the value of/unknowns associated with implementation were questioned (CFIR D2, D3, D5).

Factors driving implementation of new roles

The principal driver for new roles was the need to address acute staff shortages to alleviate pressures on existing staff and fill gaps that would otherwise be vacant. Shortages varied between staff groups across MHTs and were being addressed by introducing different new roles in different contexts. For example, NAs were deployed to address registered nurse vacancies, CAPs and/or MHWPs to boost the psychology workforce, and APs, PAs, or MPACs to support psychiatrist shortages:

> *If we're honest, the reason we're using [APs] is because certainly in MH, we really struggle to get… psychiatry and geriatricians, they're both in short supply. So, the APs do provide a really valuable role for us within the organisation and supplement some of the skills that we need.* [Trust Y-1]

Workforce development was a second motivating factor. MHTs sought to diversify their workforce and broaden skill-mix by introducing roles with a particular emphasis, e.g., physical health, recovery/lived experience or trauma-informed approaches:

Table 4 Phase 2 sample characteristics by leadership role category

Leadership role category	Number of participants
Workforce/HR leadership	6
Clinical leadership	5
Professional body leadership	5
Academic leadership	1
Policy leadership	1
TOTAL	**18**

Table 5 Coding template and relationship to cross-cutting themes*

Code name	Code definition/content	Relationship to cross-cutting themes 1, 2 & 3	Code name	Codes definition/content	Relationship to cross-cutting themes 1, 2 & 3
Career pathway	New roles career structure, progression, consequences	1, 2, 3	**Pay differentials & banding**	Issues related to pay and banding of new roles	1, 2
Champions & leadership	Champions and leaders as enablers of new roles	2, 3	**Perception of roles**	Ways in which new roles are perceived by staff/patients	1, 2, 3
Change management	Challenges/enablers of change management and helping new roles to embed	1, 2, 3	**Recruitment & retention**	Issues related to new roles staff recruitment and retention	1, 2
Communication	Communication about new roles: funders/policymakers to trusts, trust leaders to implementers, implementers to staff	2, 3	**Reflections on skill-mix typologies**	Phase 2 participants' views of adapted Phase 1 skill-mix framework	Not applicable – reported elsewhere
Competition	Competition for new roles between geographies, trusts and secondary/primary care	1	**Reflections on uptake of roles nationally**	Phase 2 participants' views of Phase 1 workforce data summary	Not applicable – reported elsewhere
Consequences & impacts	Consequences and impacts of introducing new roles	1, 2, 3	**Regulation**	Issues related to the regulation of new roles	1, 2
Consistency	Differences in consistency in role implementation between areas/trusts/divisions	1, 3	**Role definition & ambiguity**	How new roles are defined and/or ambiguous	3
Drivers	Drivers for new roles	1	**Scepticism & protectionism**	Feelings of threat about new roles among existing staff	2, 3
Early adoption	Early adopter trusts' experiences of new roles	3	**Skill-mix typology 1**	Nancarrow & Borthwick (2005) skill-mix model	Not applicable – reported elsewhere
Enablers	Factors that facilitate the introduction of new roles	3	**Skill-mix typology 2**	Sibbald et al. (2004) skill-mix model	Not applicable – reported elsewhere
Evaluation	Activity to evaluate new roles	1	**Supervision & support**	Supervision for new roles staff	2
Funding	Funding context and issues	1, 2	**Training**	Training of new roles staff	1, 2
Governance	Governance issues	2, 3	**Work setting**	Where new roles work/train	2
Infrastructure	Infrastructure to support introduction of new roles	3	**Workforce data**	Quality of/access to workforce data on new roles	Not applicable – reported elsewhere
Integrated working	Cross-sector working involving new roles	3	**Workforce planning & development**	General workforce planning/development activities	2, 3
Learning	Shared knowledge about new roles implementation	2, 3			

The PSW is a fantastic role bringing a recovery focus - lived experience, empathy, but also they challenge staff around language and culture [in services]. [Trust D-1]

Trusts also utilised new roles to enhance career progression for staff internally with the aim of 'home-growing' their workforce along a pathway. For example, a Healthcare Assistant could progress to NA and potentially to registered nurse; a nurse or Allied Health Professional could progress to AP; a CAP to psychologist. This aspiration encouraged many MHTs to engage with new roles initiatives:

We know [CAP] is a bounce in-bounce away role because most people do… two years which then gives you your clinical experience to go and do your doctorate. If we can support CAPs in training to do the doctorate it's a way of recruiting clinical psychologists. [Trust E-1]

A final motivating factor for implementation was improving services for patients. New roles were considered to hold the potential to help service users *'wait well'* [Trust R-1], by providing triage/lower intensity interventions to listed patients, or enhancing patients' physical health. They were also a way to encourage patient engagement, improve medication adherence, or assist in reaching new/neglected patient groups:

[CAPs] have allowed increased engagement opportunities for historically hard-to-reach clients, including those with psychosis, bipolar or co-occurrences of issues. [Trust F-1]

Faced with workforce gaps, MHT leaders were largely receptive to new roles and viewed implementation as relatively advantageous.

Questioning the value of/unknowns associated with new roles

While the drive for new roles was strong in most MHTs, some leads questioned the underpinning logic for, and unknowns associated with the initiatives.

Evaluation of the process and/or impact of implementing new roles was rare and highlighted a significant gap in knowledge which evoked some concern. MHTs were often acting upon the *'stories that roles bring rather than the tangible'* [Trust B-1], meaning decisions about implementation could often be based on anecdotal rather than robust evidence.

The wider effects on existing staff, teams and systems of introducing new roles were identified as insufficiently known. Implementation could have profound implications for existing roles which would also need to change, with other knock-on effects:

If we don't change the [existing] roles, the new roles will just always seem like new roles and we will never get the best out of them. For example, we need to review what the doctor's role is in conjunction with new role changes - an existential question for the medical profession at the moment. [Trust M-1]

Tensions in the perception of new versus traditional roles surfaced on matters of training, expertise, registration/regulation, core profession and pay/banding. Some MHT leads questioned whether new roles were merely '*gap-filling*' or '*dumbing down*' service provision:

Are we diluting some of the traditional roles and substituting them with these associate-type, practitioner-type roles? Are we doing health on the cheap? [Trust W-1]

A main concern centred upon the introduction of roles which at the time of the study were unregistered/unregulated, such as PAs, MHWPs and PSWs. Some leads highlighted the potentially negative consequences of such roles serving a particularly complex and vulnerable population, and the possible weakening effects upon the MH workforce and specialist pathways:

What it all comes down to is a significant reduction in registered staff of any discipline compared to what are unregistered/unregulated, you could argue, less experienced, less educated… so we've become quite a diluted workforce as a whole in MH compared to our colleagues in physical health. [Reflection Group 2-F]

At variance with the intended outcome of strengthening the workforce, some warned that new roles could paradoxically contribute to '*disillusionment'* and *'destabilising the system*' [Trust A-1], due to pay/banding inconsistency. Some new roles involved shorter training yet equal (or higher) banding than traditional roles; this could cause resentment among existing staff, especially where they carried out a similar job to the new role while 'better' qualified and paid less. Pay parity was not only an issue between roles but potentially within a single role.

This arose where other trusts/organisations, such as primary care or the VCSE sector, competed for new roles staff by incentivising pay, or where a new role's core profession might result in different bandings:

> *I think it isn't helped that [MPACs] can come from one of four different professional backgrounds and that then causes some issues around parity when they start training and once they're qualified*. [Trust W-1]

Finally, there were fundamental questions about new roles being financially incentivised while support for traditional roles was seemingly de-prioritised:

> *It seems to be we're nudged towards these new roles where actually it may be more helpful if the traditional roles were just funded. If the government was really serious*, *why not fund properly and invest in those roles where we have had shortages for a long time?* [Trust W-1]

In brief, MHTs were motivated to implement new roles with some voices of caution. Focusing next on the context of implementation highlights some of the challenges MHTs encountered in introducing new roles.

Theme 2: Implementation context and unintended consequences

The organisationally pressured context of the MHT sector was a particularly demanding setting in which new roles were being implemented (CFIR D1, D3) leading to several unintended consequences (CFIR D2-5).

Tensions within and between external and internal settings

Within MHTs, severe workforce shortages and high staff turnover were compounded by a long-standing lack of workforce planning. There was low capacity for matching population needs with workforce composition. Organisations were often operating '*in adversity'* [Trust Q-1] with minimal planning and posts could be created without prior needs analysis:

> *I don't know how many NHS MH providers actually look at their demographics to really think about them - we need to have X*, *Y and Z - I don't think that really happens if I'm honest.* [Reflection Group 2-A]

Externally generated pressures in the policy/commissioning context could exacerbate rather than alleviate these internal difficulties. The rapid introduction of new roles schemes/funding was often misaligned with trusts' internal cycles, affecting the outset and sustainability of new roles:

> *MHWPs did not land well last year due to the tight turnaround [set by NHS England] - there was no time for planning or communication of the role.* [Trust H-2]

External information on new roles was often directed to MHT executive leads who could, *'see them and think - let's go for it… this is a great way to fill our vacancies!*' [Trust S-1]. Information was felt to '*not necessarily be going to the right people*' [Trust W-1], leaving gaps in internal communications and a lack of consultation that could result in clinicians and teams implementing roles to which they had not committed:

> *[Our senior leader] guaranteed [PSWs] a role in the organisation*, *which hadn't been agreed*, *so there was a big rush to find posts. Ward managers were just given PSWs. they arrived and people didn't really know what they were doing. There was no time to do proper engagement*, *it didn't work out – I'm not sure what happened to them*, *but they're not on the system now.* [Trust J-1]

National guidance and frameworks to steer new roles initiatives within MHTs were also largely absent. Leaders emphasised a desire for 'off-the-shelf' packages from policymakers/commissioners, such as job descriptions, competency frameworks, standard operating procedures and guidance on career pathways, pay/banding, governance and regulation. This guidance was said to hold the potential to accelerate implementation and avoid duplication of effort:

So that we could be really clear around what the workers were aiming to deliver - then we could build the support structures and supervision - get that in place before they started. [Trust S-1]

In addition to an absence of national guidance, networking with other Trusts to share learning about new roles was piecemeal, with implementers *'scrabbling around ringing each other'* [Trust C-1] or *'Googling and looking up'* information [Trust Z-1]. Thus, the absorptive capacity for new roles implementation in MHTs was challenged by several misaligned internal and external contextual factors.

Unintended consequences of implementation in a challenging setting

The misaligned internal/external contextual factors already highlighted drove reactive, limited thinking in MHTs and teams. Funding often covered training alone, falling away post-qualification to leave the costs of backfill, supervision, and ongoing support unfunded, in turn affecting sustainability:

What's relatively easy is for the taps to be turned on, on a stream of national funding… the difficult bit is at trust level. There isn't often any kind of direct operational leverage to say… you've got to reorganise your budgets to be able to make the posts for these people when they come out [and] here is a toolkit to help you think about all the implementation work you might need to do. [Trust X-1]

A rush to secure funding in the absence of planning could have negative implications both for new and traditional staff as well as services; the risk of unemployment post-training, or job dissatisfaction for trainees who did secure employment, sometimes compounded rather than alleviated high staff turnover:

The way we've planned the workforce historically has been financially led… so when opportunities come up, we've kind of reached for it and not thought about the implications of how we might use it… I'm sure it has caused [some trainees] harm because they've come into roles that haven't been widely understood and some of them have left as a result, which is absolutely what we don't want. [Trust S-1]

Paradoxically, existing staff shortages impinged on new role implementation where some MHTs did not have sufficient capacity to offer adequate supervision of new roles staff. An insufficient pipeline of nurses to supervise NAs, doctors to supervise MPACs/PAs and psychologists to supervise CAPs hampered implementation efforts in some:

Ensuring enough senior psychologists for supervision and support of CAPs can be a real challenge. We and other Trusts have not been equipped to provide the level of onboarding/supervision needed to expand the role… and recruitment into [clinical psychology] doctoral training places has been slow due to the time commitment needed for them to complete training and supervision. [Trust F-1]

Under these pressures, implementation was often rushed with little time to consider how changes could affect teams. Reflecting on team composition and the incoming roles' purpose and value was often lacking or done retrospectively, '*putting the cart before the horse'* [Trust A-1]. Without efforts to differentiate roles and their fit with the overall skill-mix of a team/organisation, supporting roles to embed and optimise their skills was challenging. MHTs had little space for reflection and could then struggle to effectively introduce, communicate the case for and socialise the new roles, meaning pockets of resistance (in the form of overt and covert protectionism) could thrive among traditional roles staff:

Until we [differentiate roles], we're just adding people fairly randomly to a mix. [Trust M-1]

[Medics] just didn't engage [with the MPAC role] and then you can't even have a conversation… at least when somebody's arguing with you, you can start to tap into that resistance a bit. [Trust O-1]

Some roles involved shifting work/responsibilities across professional boundaries. Where the internal structure of MHTs was such that disciplines were *'siloed'* [Trust J-1], this could have a significant negative impact on implementation because possibilities for communication across boundaries were hampered. Where staff lacked familiarity with/knowledge of a new role, misperceptions impinged on successful working:

> *If you've not got experience of it, how would you know exactly how an AP would function and work in your team?* [Trust T-1]

While some MHTs had expressly used new roles as a mechanism to grow a workforce along a pathway, in others, staff using new roles as a stepping-stone to higher roles was an unforeseen problem. Staff did not always stay long enough in a new role for the MHT to benefit from the investment in their training, which worked against the main intention of implementation, to extend and strengthen the workforce:

> *Nearly all of our NAs go on to become registered nurses, which is great, except… ideally we want them to practise a little bit as an NA in between. We're a bit held over a barrel on that because if we don't allow them to go onto the pathway, they leave and they get given it somewhere else, whereas we want them to work a year before they move on.* [Trust T-1]

Other negative impacts of new role changes included inappropriate work allocation, traditional roles relinquishing work they wished to retain, limitations on where new roles could be deployed due to lack of mental health training/skills, and duplication of work:

> *Not only is it inefficient but it's also not likely to result in a good experience for the patient when they're having lots of different people trying to do the same thing with them in slightly different ways.* [Reflection Group 1-A]

Finally, a lack of leadership to spearhead and support new role changes could result in their failure to embed:

> *[MPAC role] worked brilliantly in pockets, not so well when a psychiatrist was not on board – we learnt early on not to even try if they weren't up for it – it's too hard for the person training not to have a supportive mentor.* [Trust K-1]

Implementation of new roles in the challenging MHT setting could have unintended consequences for services and new/existing staff. Focusing next on strategies to support implementation will highlight how some MHTs were mitigating these challenges.

Theme 3: Strategies to support implementation

Some MHTs, largely earlier adopters, were engaging multi-level implementation efforts to address some of these challenges (CFIR D1-5).

Strategic and operational work to support implementation

MHT leaders who were earlier adopters of new roles had learned from '*experiencing the pitfalls*' [Trust L-1] (in the form of the challenges highlighted above), after a '*sticky start'* [Trust Y-1]. Some described a gradual move from reactive implementation led by the availability of finance alone, to harnessing organisational commitment to more strategic and longer-term internal workforce planning around new role changes. A few MHTs had been able to focus efforts on aligning, as far as possible, internal trust rhythms with external commissioning cycles:

> *Initially we went to new roles in a reactive way due to staffing shortages but now it is much more strategic. We work closely with the NHS England strategy and have a 5-year workforce plan of our own*. [Trust N-1]

Others had begun to focus, in the absence of national guidance, on developing a more strategic, coherent vision of the purpose and value of new roles and how they aligned with organisational goals. While a rare activity, connecting strategically with other MHTs via regional forums and collaboratives to share learning to support new role changes was emerging in pockets:

> *We're about to interview for someone to do some learning across the region about what is happening in new roles, where the obstacles have been and how we can facilitate coming together to learn from this.* [Trust X-1]

Alongside strategic efforts, some MHTs were making progress with operationally defining new roles and setting up internal infrastructure to enable changes. This was *'a lot of work in the background'* [Trust F-1], involving the creation of governance and/or advisory groups, and lead posts to head up support structures for new roles staff:

> *Part of our strategy has been to employ a member of staff to lead the PSWs. And a support post of two days a week was introduced to support teams and those in NA roles to understand what the new role was and how it fitted into the team.* [Trust AA-1]

This interlinked strategic and operational activity was a work in progress, involving a balance between 'top-down' planning, and enabling roles to grow organically if needed:

> *I think as we've moved, as we've become more mature in our approach to embedding things, we're taking a lot longer in planning, all it needs to look like and making sure our job description is as tight as it can be and we know where things are going to fit.* [Trust G-1]

> *The development of the [AP] has been incredibly organic, often driven by individual practitioners… so I've been trying to… make sure we've got the leadership, the reporting structures, a really clear career pathway, that the services understand the role and understand how they can develop and rejig their structures. For me, it's that balance between allowing things to organically develop and not stifling that creativity whilst getting some control and oversight.* [Trust T-1]

Thus, some MHTs had begun to overcome some of the contextual challenges of introducing new roles, by harnessing both strategic and operational implementation efforts within their organisations.

Relational work to support implementation

The introduction of new roles brought complex change into an already pressured system, and along with attention to strategy and operations, some MHTs recognised the high degree of relational work that was also required. The implementation process was described as '*fitty*', '*painful*', '*a journey*' involving '*teething troubles*', challenges often rooted in the protectionist attitudes among existing staff highlighted earlier:

> *So, then we're on a journey. One of our challenges with [PSWs] has been the culture of bringing lived experience into our mental health teams. Some teams have embraced it and have got on with it. Some have really struggled with it.* [Trust R-1]

Leads emphasised the need to be aware of the likelihood that re-configured teams would need to re-negotiate role boundaries, anticipating resistance to new roles and providing opportunities for *'candid concerns or questions'* to be voiced [Trust N-1]. Alongside this, encouraging an openness among staff to try out new roles over time was important, despite ensuing uncertainty and/or instability for teams, at least initially:

> *The teams where [NAs] are newer, probably have to go through their own journey of 'how's this gonna work and how we are gonna fit together?'. But I think overall the case has pretty much been made now".* [Trust X-1]

Communicating the purpose and value of changes within the organisation and encouraging understanding was said to be a key way of influencing staff knowledge, beliefs and attitudes to new roles. It was important to *'give [existing staff] headspace to try and get their heads around'* [Trust J-1], what a role can and cannot do, where it fits in teams and processes, and its benefit. Showcasing successful examples of new roles had helped some leaders to build organisational confidence in roles:

> *What we found is that showing the tangible clinical benefit is much more valuable than just providing a role summary.* [Trust-S1]

> *We are doing a cultural awareness programme with all MH teams around lived experience and getting the lived experience partners to talk to the teams and showcase how valuable the PSW role can be.* [Trust R-1]

Thus, the importance of '*going slow*' [Trust H-1] in efforts to familiarise teams with new roles and build trust was emphasised. For example, one MHT had temporarily paused the rollout of MHWPs to better address staff concerns about the role's value. This more relational approach was time-consuming, detailed and contrasted starkly with the rapid introduction of new roles schemes/funding and the reactive implementation responses it evoked:

> *You've got to get down to the real detail 'cause [existing staff] get wrapped up in - what systems are [roles] going to use? How're they going to record this? What about confidentiality? What about this? And you almost have to get right down to the detail and paint a picture of how it's going to look.* [Trust H-1]

Thus overcoming resistance through relational implementation work was described as a process over time, where the value and contribution of a new role was often revealed gradually:

> *It was an absolute battle with our medical colleagues to get [the MPAC role] over the line… they were very supportive for the training, but when it came to putting them into permanent posts… that was a challenge. But we're winning and we now have two on our acute adult MH wards… they will go on and we will… move over the doctors a bit.* [Trust B-1]

A key supporting factor at the relational level was the presence of a clinical leader to champion and communicate the value of new roles to '*push things along and get the rock up the hill'* [Reflection Group 3-C]. This was particularly the case at the outset of a new role where examples of successful working might be absent. Respected individuals with a vision, passion and belief in the benefits of new roles who could engage staff were particularly likely to be able to overcome resistant attitudes:

> *It sometimes just comes down to individuals who get it. They've got the kind of passion and insight to push it through. We've got a brilliant chief psychologist who is very engaged and understands the benefits [of CAPs]*. [Trust J-1]

In summary, despite the challenging implementation context, some MHT leaders had been able to support new role changes by engaging in relational work to build organisational trust and confidence in the initiatives as well as strategic and operational work to bring coherence and structure to implementation. This work had been key to mitigating some of the contextual challenges associated with implementation of new roles in MHTs.

Discussion

This study addresses a gap in knowledge by examining the perspectives of MH leaders with experience of implementing multiple new roles in the turbulent context of English MH services, a setting pressurised by high staff shortages and turnover. As a complex, disruptive change in MHTs [25], we analysed accounts using the five domains of CFIR as a scaffold to better understand key issues impacting the change process, how these might

be amenable to moderation [29, 44], and provide previously missing evidence to guide future implementation efforts [42].

In summary, new roles implementation was perceived as a relatively advantageous change for MHTs, with three potential benefits: addressing workforce shortages, enhancing skill-mix/ developing the workforce, and improving patient services. Two main concerns were also evident, centring upon the underpinning logic for skill-mix changes and the largely unknown associated system effects. Internal MHT pressures (workforce shortages, high staff turnover, and a lack of time/space for workforce planning), compounded by external policy/ commissioning pressures (rapid introduction of new roles schemes/funding, a lack of national guidance, and low opportunity to learn from other trusts), could induce MHTs to rapidly pursue funding without concomitant implementation plans, meaning new role initiatives could fail. Despite these challenges, some MHTs (particularly earlier adopters) drew on prior experience of pitfalls to support new role changes in better ways, through three interlinked types of implementation work. Strategic implementation work involved focusing efforts to: develop coherence in skill-mix changes by aligning roles to organisational goals; harness organisational commitment to building longer-term workforce planning activities including better matching of internal/external funding cycles; and create opportunities to learn from other trusts. Operational implementation work involved directing efforts to establish the requisite local infrastructure to better support changes. This could involve a careful balancing of consistency in systems and processes while allowing sufficient flexibility to develop roles around local needs. Underpinning these activities was relational implementation work, requiring efforts to support the re-negotiation of role boundaries by encouraging discussion among staff and a willingness to try out new ways of working, as well as harnessing the power of champions to support changes. Relational work was required in high degree to successfully socialise new roles and increase their chances of being sustained. In direct contrast to commonly reported experiences of rushed implementation, all these activities were considered a work in progress over time, requiring a slower pace of implementation to optimise success.

This work both supports and extends the prior literature on implementation of changes in healthcare settings, including new role changes.

In accordance with research on skill-mix change in wider health settings, our study found that implementing new roles in MHTs was a non-linear process with potentially disruptive effects [10, 12]. It brought some challenges in the form of additional work for existing staff such as supervision of new roles to bridge the training-practice gap [9, 12, 49, 50], duplication or inappropriate deployment of roles [11] and involved wider system effects such as organisational development [9] redesign of patient pathways [9, 18] and the renegotiation of professional boundaries [11, 20, 21]. When poorly managed, skill-mix change could destabilise established teams, cause problems with continuity and effectiveness of care, and undermine patient and service user experience [11, 20, 22, 23]. Also consistent with this literature, when new roles change was working well, it was perceived to bring some benefits such as increased access for patients and less fragmented care [22, 23], though these impacts had not been formally evidenced in MH services.

Our findings also support the prior implementation framework-informed literature on the introduction of a range of innovations in MH services more generally. This literature has been able to more specifically highlight the factors that may support or hinder the change process, emphasising the attention to context that is crucial in understanding implementation in different settings [29]. In common with our findings, these studies highlight the importance of strong leadership [40], a flexible organisational culture which is open/amenable to change [30, 33, 35–38, 40, 41] and the influence of staff beliefs and attitudes on changes [29, 30, 32, 36, 37, 39, 41]. Echoing our findings, Cooper and colleagues' [40] CFIR-informed review of the literature on the introduction of a single new role in MH services highlights the adverse effects that lack of time, resources and supervision/mentoring capacity can have on skill-mix implementation.

Our work extends both the existing skill-mix literature (largely focused on the introduction of single roles outside MH services), and the implementation literature within MH services (mainly focused on innovations other than skill-mix changes), to examine the broader effects of introducing multiple new roles on teams and/or whole systems in this setting.

In addition to the challenges already highlighted, our study suggests that skill-mix evaluation in MH (both process and outcome) is rare and warrants attention. Such evaluation could help address concerns among leaders that new role changes potentially dilute workforce knowledge/skills and seed disillusionment among staff. It could likewise help to examine aspirations that new roles improve MH services by encouraging more recovery- and trauma-informed delivery, a strengthened physical health offer and reaching new and/or neglected groups of patients. Recovery-oriented services can support users' mental health through the modelling of hope and coping strategies [40, 51] while integrating physical health into MH services is a priority since individuals with severe mental illness have a reduced life expectancy of up to 18 years due to physical health conditions [52].

Our study goes beyond the current literature by underlining the multi-level nature of the implementation process, drawing attention to the outer national policy/commissioning context and how this could work against the inner MHT context by provoking reactive, rushed implementation efforts, leaving little room for leaders to reflect and trial changes [53]. Further, it adds to the prior literature by demonstrating how some leaders, confronted with such paradoxical implementation problems, directed efforts to overcome contextual challenges by engaging in a high degree of multi-level implementation work. While new role changes were intended to stabilise the MHT workforce, ironically, the long-standing lack of workforce planning in MHTs, shortages of experienced supervisors/mentors, and risk of staff in new roles quickly moving could converge, with destabilising effects on the workforce. Walshe and colleagues [42], writing about the NHS in wider terms, proposed that health systems need better workforce policy/planning with improved modelling/forecasting of workforce needs. They also suggest that the NHS Workforce Plan [14] may have underestimated the need for highly skilled and experienced staff to mentor new roles. These concerns have certainly been borne out in our study of skill-mix implementation in MHTs. In response to these challenges, some MHT leaders had been able to focus on strategically aligning new roles with organisational goals and harnessing a commitment to reconcile internal workforce planning cycles with external funding rounds. Operationally, some had worked to establish the internal infrastructure and governance in their MHTs to support new role changes. Leaders needed to balance this 'top-down' development of roles with more 'organic' approaches to allow a degree of job crafting to meet local needs. Relationally, a high degree of effort was being employed by some leaders to successfully socialise new roles and increase the likelihood of sustaining them, including utilising the power of champions with the attributes and influence to engage staff, overcome institutional inflexibility and facilitate change efforts [54]. This multi-level implementation work required a high degree of effort to combat internal and external contextual challenges and a recognition that implementation was a process over time, requiring space for reflection and time to pilot changes to optimise success [53].

Our study suggests broadly that most CFIR domains (the nature of the new roles themselves, the inner setting of MH services, the attitudes/beliefs of individuals involved and the process of implementation), were amenable to adaptation to some degree while the outer policy/commissioning context was less controllable.

Strengths and limitations

Strengths of the study centre upon the sample, the approach and the findings. We recruited a varied sample of leaders from provider, policy and professional organisations with a good response rate and geographical spread of MHTs nationally enabling rich insights to be gathered. While interview transcription instead of rapid analysis techniques in Phase 1 may have led to other findings, previous comparative research has demonstrated similar results between the two approaches [45]. Rapid analysis techniques in this study enabled a rapid but robust sequential two-phase qualitative design in which Phase 1 findings informed Phase 2 data collection/analysis. The use of CFIR [34] as a second level of analysis enabled an attention to context and the most influential factors affecting implementation of new roles to be identified and how these might be amenable to change through the implementation work of MHTs. A limitation of the study is that in most cases a single individual represented each MHT, and we may not have captured information across the breadth of new roles in every trust. It is also possible that non-responding trusts had differing experiences of new role implementation. In addition, we did not

examine the perspectives of frontline leaders, staff in new and existing roles or the views of service users about their experiences, however these aspects are the focus of subsequent research.

Implications for practice, policy and research

Our study has implications for practice, policy and research. It provides valuable insights for policymakers, clinicians, leaders and managers on the challenges and opportunities associated with introducing new roles in mental health services to help plan and conduct strategic, operational and relational implementation efforts. However, providers need implementation know-how and a high degree of strategic, operational and relational implementation work across different domains (the new roles themselves, the inner setting of MH services, the individuals involved and the process of implementation), to overcome these challenges. Implementation of new roles needs to be understood as a process of adaptation and system change over time requiring an implementation plan with attention to different stakeholders and adequate organisational development, leadership, service redesign and supervision capacity. However, no one strategy fits all MHTs, and implementers must consider local needs, organisational context and the individuals involved in awareness that factors affecting implementation might change over time in different contexts.

Providers have little control over the outer policy/commissioning domain. Consequently, policymakers and commissioners could be more aware of MHT planning cycles and the high degree of implementation work MHTs need to engage in so that new initiatives can be communicated in a timely way to the right individuals to increase the likelihood that trusts can align their plans accordingly.

In terms of research, our study demonstrates that better evaluation of the process and the outcomes associated with the implementation of new roles in different contexts is needed. There may be a gap between the intended impacts of such changes and the ability to demonstrate them tangibly which research can help to address. In particular research on the working of new roles in practice is needed to increase understanding of implementation requirements. Better workforce planning, modelling, forecasting and their fit with service needs is needed and research may be able to assist MHTs in this challenge.

Conclusion

Informed by the domains of CFIR, our study underlines the multi-level nature of implementing new roles in English MHTs. It highlights that the outer national policy/commissioning and the inner organisational contexts were often misaligned, leading to rushed implementation efforts in MHTs where leaders had little opportunity for reflective/experimental approaches to skill-mix changes. It also demonstrates that some leaders, despite challenging circumstances and often paradoxical implementation problems, were able to direct efforts into a high degree of implementation work at different levels - strategic, operational and relational - harnessing organisational commitment to better support new role changes. Alongside these activities, leaders were also balancing ‘top-down’ development of roles with more ‘organic’ approaches to meet local needs.

Our study provides valuable insights for implementers on the challenges and opportunities associated with introducing new roles in mental health services to help plan and conduct implementation efforts. While one CFIR domain - the outer policy/commissioning context of implementation - was less controllable, our study suggests that remaining domains - the nature of the new roles, the inner setting of MH services, the attitudes/beliefs of individuals involved and the process of implementation - could all be amenable to adaptation in some degree through the implementation work of leaders. Skill-mix change in MHTs should be recognised as a process of adaptation and system change over time requiring multi-level implementation work tailored to local needs.

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Data availability The datasets generated and/or analysed during this study are in the form of anonymised interview notes and reflection group transcripts. Transcripts are not publicly available but are held on a University of Sheffield secure server, in line with study ethical approval. Transcripts are available from the corresponding author on reasonable request. Requests will require a protocol, research ethics committee approval, and will be pending a data sharing agreement.

Declarations

Ethics approval and consent to participate The study received approval from a University of Sheffield research ethics committee (Reference: 053435) and the Health Research Authority (Reference: 23/HRA/3186). Informed consent was obtained from all participants prior to data collection. This study adhered to the principles of the Declaration of Helsinki.

Consent for publication Not applicable.

Competing interests The authors declare no competing interests.

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