

The Royal College of Psychiatrists:

Response to the Health Committee's Inquiry into Workforce needs and planning for the health service

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and the Republic of Ireland and is the professional and educational organisation for doctors specialising in psychiatry.

1 General Overview of Workforce Planning for Medicine

- 1.1 Long term planning for the medical workforce has never been an easy task. Doctors take a long time to transform from aspiring medical school entrants into fully trained hospital specialists or general practitioners. Many become highly specialised early on in their careers so the possibilities of changing track to meet varying service demands are very limited. There are numerous points in the career pathway where even small changes can affect the final overall pool of appropriately qualified applicants for consultant posts. Matching supply to demand is a tricky business.
- 1.2 Allowing too many to train for too few eventual consultant vacancies leads to disappointment, discontent, and possibly a loss of doctors to the workforce whose training costs have been huge. A recent example of that occurred in obstetrics and gynaecology when too many doctors completed their higher training ahead of the anticipated consultant expansion.
- 1.3 There is strong central control at some points in the pathway. Medical school places are carefully regulated and the recent increase in student numbers has been planned to meet projected future requirements, and to reduce to a large extent the dependence on international medical graduates (IMGs) to fill both training scheme places and service posts.
- 1.4 At SHO level for many years there has been a virtual freeze on the creation of new posts, though during 2003 – 2004 there was some relaxation in order to try and relieve the bottleneck in some specialities between the SHO and SpR grades by altering the ratio of SHO to SpR posts.
- 1.5 It is at the specialist registrar level though that central control has existed in the most comprehensive way with the aim of ensuring that any new training opportunities (via additional National Training Numbers – NTN's) are given to the specialties with the greatest need to grow their particular consultant workforce.
- 1.6 The aim of all this control from the point of view of Health Departments is to ensure the correct balance between supply and demand is maintained, with the emphasis mainly on not training too many. However, on the demand side of the equation, more service work exists than can be covered by those in these regulated training grades. So the last decade has seen a huge growth in the numbers of non-consultant career grade doctors, recently renamed SAS doctors (Staff and Associate Specialist grades). This is a response to market forces and individual employers perceptions of service needs, developments and available funding. How many of these doctors will eventually find their way by one route or another into consultant posts is hard to predict.

2 Overview for Psychiatry

- 2.1 The problem for psychiatry with this model of control, aiming for supply and demand to stay in balance, is that as a specialty we have never managed to get anywhere near the training targets set, either by central government or as a profession, to generate sufficient fully trained psychiatrists to fill even existing established posts. Census data from both the Health Departments and independently from the Royal College of Psychiatrists over many years have shown a high level of consultant vacancies, currently overall in excess of 11%. These are much higher in some subspecialties and some geographical areas.
- 2.2 The reasons behind this failure to match supply to demand are complex. Psychiatry has never attracted enough UK graduates to fill existing training posts at SHO level. Medical schools vary in their ability to generate the next generation of psychiatric SHOs, but consistently the overall figure is stuck at around 4% to 5% of graduate doctors choosing psychiatry (2005 Goldacre). The slack, therefore, has to be taken up by overseas graduates whose career pathways may be more difficult to predict, and whose initial aptitude for the subject may be harder to gauge if their exposure to psychiatry before coming to the UK has been limited. We have also struggled to retain in the specialty those who have been recruited. Too many fail to make the expected transition along the career pathway, so all the factors that play a part in retaining staff need examining as part of the overall equation. In addition, many doctors aiming for a career in General Practice spend at least 6 months training in psychiatry, so psychiatric training posts can be used by doctors whose eventual career destination is not that of becoming consultants in the specialty and we have to recognise that in both our training and workforce planning.
- 2.3 Workforce planning not only for doctors but for all staff within the NHS has continued to receive a higher profile in recent years. This is partly because of the need to translate the aspirations of government initiatives such as in England the NHS Plan and the various National Service Frameworks for Mental Health, Children and Older People's Services, to drive up standards and modernise services for the 21st century, into care being delivered by the right staff with the right training, in the right place at the right time. In short, a workforce "fit for purpose".
- 2.4 Many questions remain to be answered about how to do this:
- What is the "right" number of doctors for a specialty?
 - Where will they come from?
 - How will changes to training and working practices affect this in the future?
 - How can we achieve the right balance between central control and the autonomy of local services to recruit as many (or as few) doctors as they feel necessary?

3 Historical Background to Manpower Planning

- 3.1 The history of what used to be called manpower planning, now workforce planning, has been marked by a number of landmark initiatives as successive governments have grappled with the problem of the imbalance in medical staffing. Four of the key ones deserve particular mention as they have shaped the way that central control has increasingly been taken over the medical workforce.
- 3.2 Achieving A Balance 1986: This set out the basic principle that far more care for hospital patients should come from consultants, and hence senior registrar numbers should be tailored to the expected consultant expansion needed to achieve this end.

This meant in the medium term planning for consultant growth at around 2% per year whilst progressively reducing career register numbers. A new staff grade was introduced in 1988 to plug the gap in service needs for employers and originally a ceiling was set so that numbers could not exceed 10% of the total number of consultants in that specialty.

- 3.3 Joint Planning Advisory Committee (JPAC): This was given the task of advising on the total number of training posts needed in each specialty and psychiatry was a beneficiary of this annual process which allowed for increasing numbers of what were then called senior registrar posts. Subspecialties were aided in their development by these JPAC allocations.
- 3.4 The Calman Report: The next significant impact on training and manpower came with the need to embrace the changes brought about by the freedom of movement within the European community. Because the length of specialist training was longer in the UK than the rest of Europe, there was a need to achieve a degree of harmonisation. The reforms came to be known as the Calman proposals because the committee's chair was Sir Roy Calman. They aimed to bring the UK in line with EU legislation on specialist medical training.
- 3.5 This report came out with 5 key principles which are still in force today.
- i Through structuring programmes, overall training times would be reduced.
 - ii At the end of training, doctors would obtain a UK Certificate of Completion of Specialist Training (CCST) on the advice of the relevant faculty or college.
 - iii CCST holders would then be eligible for consultant appointment.
 - iv A unified training grade combining registrar and senior registrar would be introduced so that training would comprise basic specialist training – SHO level and higher specialist training, at SpR level.
 - v A new system of National Training Numbers was to be introduced, with each specialty having a fixed, but annually negotiable quota of numbers which had to be completed for. Progress in higher training became subject to the RITA process (Record of In-Training Assessment) to ensure there were not significant delays in people progressing to CCST and thus blocking the release of a NTN for another doctor.
- 3.6 Medical Workforce Review Team: In England, this team took over responsibility for the annual review of NTNs for each specialty. It used computer modelling to predict the likely growth in consultant numbers if variables on the input side changed. Colleges, postgraduate deans and Health Departments all had the opportunity to influence this modelling process with any evidence they were able to muster as to the particular needs and circumstances of their specialty.
- 3.7 During 2004 the remit of this team was broadened to cover other grades and other professional groups as well and this has been reflected in a change of title to the Workforce Review Team.

4 Current Key Issues for Work Planning – The National Context

- 4.1 Medical School Numbers: The number of places at UK medical schools has increased dramatically over the last 5 years from 3749 in 1998 to a projected 5894 in

2005. The increase has come about by introducing new 4 year graduate entry programmes, establishing 4 new medical schools, and adding places to existing schools. It will take several years for these numbers to translate into extra doctors, but the aim is to reduce some of the excessive dependency on overseas doctors in the future to fill training grade posts.

- 4.2 The Feminisation Of Medicine: Over the past 40 years the number of women entering medicine has increased dramatically too. Over 50% of medical school places are occupied by women and in some schools the number exceeds 60%. Of the RCPsych's membership, 40% of UK and Irish graduates are now women. This raises interesting questions about the likely future career paths, demand for flexible training, and ultimately a higher degree of uncertainty about how many doctors will be needed to staff services if or when traditional full time working through most of a career ceases to be the norm. Funding of flexible training has always been subject to short-term decisions and the lack of adequately protected budgets for this growing group of doctors (which clearly includes men as well, but in far lower numbers) means delays to training programmes completion and so further unpredictability in CCST times and eligibility for consultant posts.
- 4.3 The Postgraduate Medical Education And Training Board – PMETB: In September 2005, PMETB took over responsibility for standards and quality assurance of all postgraduate education, training and assessment in medicine and dentistry. One of its responsibilities is to assess the eligibility for specialist registration under new EU legislation (articles 11 and 14). In brief, this means many doctors both outside and within the UK, previously unable to get onto the specialist register and hence be available for consultant appointments, may be able to do so by an alternative route. This is based on their experience and demonstrated competences, rather than having obtained MRCPsych and a CCST, the "current standard" route onto the register. This is likely to have a very significant short to medium term impact on the numbers of doctors able to be considered for consultant appointment. Psychiatry will be one of the main beneficiaries of this change, but the numbers involved are unknown as yet.
- 4.4 Modernising Medical Careers – MMC: MMC is an initiative developed from Professor Liam Donaldson's proposals to reform the SHO grade (Department of Health 2002). In February 2004 the 4 UK Health Departments endorsed the importance of care being based on effective interdisciplinary team work and flexible training pathways, tailored to meet service and personal development needs.
- 4.5 The first change came on-stream in August 2005 and that was the replacement of one year of pre-registration house officer training with a 2 year integrated foundation programme, focusing on generic competences and the management of acute illness. This will act as a bridge between undergraduate and specialist medical education, and full GMC registration will come after successful completion of the first year, F1. Psychiatry will figure in the second year, F2 programme, with likely 4 month slots and a very different training emphasis to current initial SHO posts. All the assessments in F2 will be workplace based.
- 4.6 Beyond foundation training, the plan is for selection for run-through training in one of 8 broad specialties, which include psychiatry. The College has already developed a competency based curriculum for SpR training and work is underway on a curriculum to precede it, the equivalent of what is now of basic specialist training. Work based assessments of performance and competences will be key. How selection for the programmes will take place, and the part formal examinations like the MRCPsych will have in this new world are questions still to be answered. In 5

years' time though, training will look very different with a curriculum running through from F2, basic and higher training and embracing lifetime CPD.

- 4.7 The unknowns for all this in workforce planning terms are how many F2 slots will be achieved for psychiatry and whether they will come from the existing SHO stock. An alternative may be to use some of the nearly 500 extra unfunded SHO posts released in England during 2003 – 2004 which had been intended as a means of improving the ratio of SHO to Specialist Registrar posts in psychiatry. There is agreement generally that getting psychiatry firmly established in F2 is crucial. Given the relative reduction of the time allocated to psychiatry in many undergraduate curricula, giving large numbers of young doctors a positive education and professional experience of the subject in F2 is vital if we are to improve the recruitment figures for UK graduates into the specialist run-through programmes. Overseas doctors will have the opportunity for competing for the schemes as well and may have access to some of the F2 posts.
- 4.8 European Working Time Directive – EWTD: This is a piece of health and safety legislation originally formulated in 1993 by the European Union. It came into force in 1998 for all doctors with the exception of trainees. From August 2004, trainees have been included with an initial reduction in weekly hours to 56, then down to 48 by 2009. Further restrictions around the definition of “working time” and “on call” and “compensatory rest” have been added. This means junior doctors are increasingly working shifts rather than on call rotas. They are less available for work during 9 am – 5 pm and when working at night their supervision and opportunity for educational activities is reduced. This in turn may lead to longer training times to achieve defined competences. Another uncertainty has been thrown into the equation by this.
- 4.9 New Consultant Contracts: A variety of new consultant contracts were introduced over the 4 UK jurisdictions. Doctors who have moved over have individually tailored contracts with agreed numbers of programmed activities, the whole exercise being underpinned by the job planning process, an annual event linked to, but separate from, appraisal arrangements. The distinction between full and part time posts is now much more blurred and talking of WTE consultant numbers very difficult to do. This means for census purposes it will become harder to establish the total available consultant workforce and hence more difficulty predicting future demand.

5 Current Key Issues for Workforce Planning – The Psychiatric Specialty Context

- 5.1 Influencing The Workforce Modelling Process: As mentioned earlier, the Department of Health in England has developed through its statistical section a sophisticated computer simulation model of workforce requirements. Psychiatrists have their turn as one of the 65 specialties considered annually by the Workforce Review Team at its meeting to look at the variances in the inputs and expected or required outputs of the model in terms of eventual consultant numbers.
- 5.2 Within psychiatry each of the 6 recognised subspecialties has the chance to present its individual case, General Adult, Old Age, Child & Adolescent, Learning Disability, Psychotherapy and Forensic, and until recently, Substance Misuse, Rehabilitation and Liaison Psychiatry have also been considered, but within the overall framework of General Adult psychiatry. The task is to make the case for increasing the share of the national cake of any additional NTN's made available centrally in order to grow more consultants.

- 5.3 All the issues listed above for the national context need to be addressed for each specialty as part of the review and psychiatrists like others, have to provide credible evidence for each area to show how the balance is likely to be affected by any changes, particularly on the supply side of the equation. Factors relevant for Psychiatry which feed into the model are as follows:
- Percentage of SHO posts filled by GP Registrars
 - Attrition rate of SHOs
 - Percentage of flexible trainees
 - Length of SpR training time to CCST
 - NTN unfilled
 - Retirement age of consultants
 - International recruiting
 - Post-retirement flexible returners
 - Consultant vacancy rates
- 5.4 Much of the evidence used to bolster psychiatry's case for additional NTNs has been derived from research studies carried out by the College Research Unit under the overall title of CIPTAC (Career Intentions of Psychiatric Trainees And Consultants) (Mears 2000). The annual College census of psychiatric staffing gives a detailed picture of geographical and speciality variations in consultant vacancies (2002 Royal College of Psychiatrists). Work on the use of locums in psychiatry by the Sainsbury Centre for Mental Health has helped to clarify both the cost and quality issues of having so many vacancies for established consultant posts (Sainsbury Centre for Mental Health 2005). Information gathered from College assessors on Advisory Appointments Committees for Consultants demonstrates how many or few applicants there are for each advertised vacancy. How many F2 posts are established in psychiatry and the plans for the transition to run-through training are likely in future to be added to the input side of the model.
- 5.5 What has become apparent in recent years is that action needs to be taking place at every point of the career pathway in order to improve recruitment and retention in psychiatry. Running the computer model makes it clear that improving consultant numbers in the short-term can only be achieved by either retaining existing consultants longer or importing fully trained doctors from elsewhere to fill vacancies and new posts.
- 5.6 All this work has led to 3 specific initiatives which although not only applicable to psychiatry, have been of particular relevance in looking at improving the overall workforce position:
- International recruitment.
 - Post-retirement options.
 - New Ways of Working for Psychiatrists.
- 5.7 International Recruitment: The Department of Health in England has been running an International Fellowship Programme since 2003, designed to recruit overseas doctors to fill vacant NHS consultant posts. The stated intention is to enable overseas doctors to take up appointments for 2 years to broaden their own experience. This programme has recruited more psychiatrists than all other specialties put together (124 out of 202 by the end of 2004) and in some areas it has been seen as a great success with both Fellows and local services deriving mutual benefit. There have been considerable anxieties expressed though at the ethics of taking fully trained staff from countries who can ill afford to lose them. Despite attempts to encourage

applicants from countries with an oversupply of doctors, most still come from the Indian subcontinent and widespread concerns exist about taking so many doctors away from the developing countries which have trained them. It is also impossible to predict how many will stay beyond 2 years and for how long. So another uncertainty in the supply of consultants for the permanent workforce has arisen (Goldberg 2004).

- 5.8 Post-Retirement Flexible Options: Research from the CIPTAC studies showed the mean planned retirement age for consultant psychiatrists was 60. As many psychiatrists now in their 50s have Mental Health Officer status, which can be an encouragement to retire early from 55 onwards, there is a potential pool of experienced consultants who could return or continue in the workforce post-retirement. The flexible careers scheme initiative of the Department of Health has made it much easier and more attractive for doctors to be retained, perhaps in less full time and also different roles. It is too early to say how attractive this is going to be, but persuading more to do so will have the quickest and most positive effect on the overall consultant numbers, as the computer model clearly demonstrates. Such doctors may take on new roles, for example, meeting the projected workforce demands of the introduction of the new Mental Health Act. Whether that happens or not is difficult to predict at this stage.
- 5.9 Because Psychiatry is a specialty which both attracts women doctors and has been in the forefront of promoting flexible working patterns, it is of particular concern that there have been significant difficulties in providing a steady stream of funding for doctors, both men and women wishing to work in this way, especially those returning to medicine, or choosing to switch specialty.
- 5.10 New Ways of Working for Psychiatrists: Consultant dissatisfaction with their jobs, workload pressures and changing expectations of mental health services for staffing new teams has led to a great deal of work on what have come to be known as “New Ways of Working for Psychiatrists”. The final report was published in November 2005 by the Department of Health. Moving to a more consultative style of working, for example, and challenging some of the traditional boundaries around what has been felt only consultants can do, may well free up existing psychiatrists to deploy their skills more appropriately. It is too early to say whether these moves will result in a more contented workforce. An optimistic view though is happier consultants will make better clinicians, better role models and mentors for their trainees and perhaps longer serving team members. That has to be the better way forward to producing a fully staffed consultant led service for the future working in conjunction with all other disciplines within the mental health workforce, who also are looking at new and different ways of working.

6 Conclusions

- 6.1 The basic workforce question, how many psychiatrists do we need in the UK to deliver appropriate services for the 21 century probably cannot be answered.
- 6.2 The current more pragmatic questions seem always to take precedence:
- How many can we afford?
 - How many posts can we fill?
 - What is the quality of the post holders?
 - How do we tackle the burdening cost and quality issue around locums?

- 6.3 The next few years will see huge changes in the way medical training from undergraduate through to CCST is delivered and assessed as a result of MMC. In the medium term, planning for the medical workforce may become even more problematic than in the past. Keeping pace with the changes and trying to take advantage of them to recruit and retain more psychiatrists will remain a major challenge for the profession. We continue though to work actively to tackle the many issues outlined in this submission.

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**Dr Sally Pidd, Deputy Registrar
The Royal College of Psychiatrists
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