RCPSYCH CHILD AND ADOLESCENT FACULTY RETENTION AND RECRUITMENT STRATEGY

Introduction:

All of us who work as child and adolescent psychiatrists do so because we want to be able to make a positive difference to infants', children and young people's lives. Historical under-funding, increases in the prevalence of mental health disorders and referrals to specialist mental health services have exposed the insufficient numbers of trained psychiatrists working in specialist CAMHS and the urgent need to recruit more SAS doctors, trainees and consultants. However, this needs to be matched by making best use of psychiatrists' expertise, by supporting those working in demanding services on a long-term and sustainable basis and ensuring that all are treated with compassion, respect and fairness regardless of their backgrounds. This paper seeks to address how we can work together within the Child and Adolescent Faculty, within the Royal College of Psychiatrists and with external stakeholders to ensure that we recruit the brightest and best doctors to work in specialist CAMHS and that we retain them in this important work. A summary of the actions required is listed in the Appendix.

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Background:

The importance of child psychiatrists

Psychiatrists are a crucial part of child mental health services. Consultant child and adolescent psychiatrists (henceforth referred to as child psychiatrists for brevity) are usually the most highly trained clinicians in a mental health team, requiring basic medical school and postgraduate training; with 3 years in core psychiatry and 3 years in higher specialty training to qualify. Many consultant child psychiatrists have trained in general practice, paediatrics or other mental health specialities or undertaken research qualifications. Child psychiatrists are crucially trained in both psychological and pharmacological interventions and have experience with both child and adult mental health, with extensive experience in decision making with respect to risk and the legal framework. This makes them best placed to view a child holistically, within the context of the family, which itself may have parental mental health burden, and be able to consider the full range of intervention costs and benefits. Specialty Grade doctors are an invaluable workforce resource, holding many of the qualifications and experience of consultant child psychiatrists. Trainee doctors are a core member of CAMHS teams, providing valuable support to the multidisciplinary team and aspire to become the next generation of CAMHS psychiatrists and clinical leaders.

Child psychiatrists are an essential part of the multidisciplinary workforce and have unique statutory and specialist roles in the following:

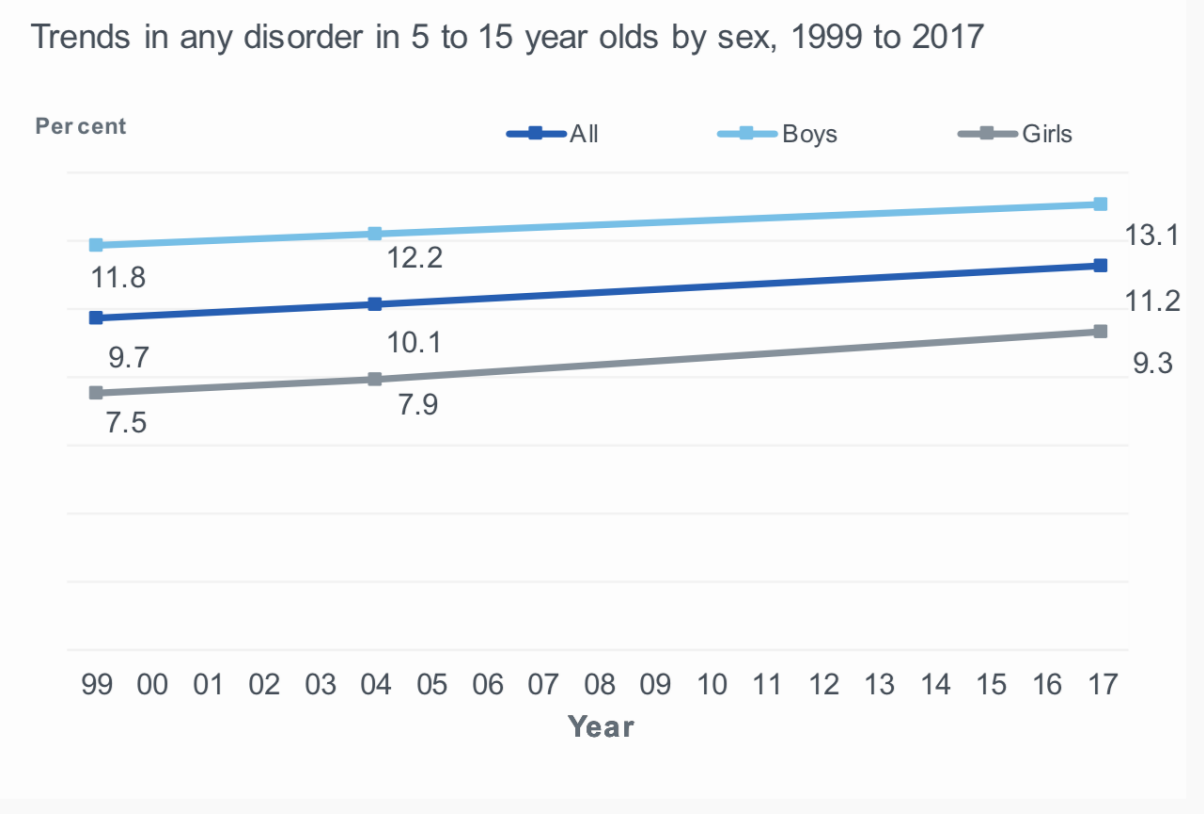
- diagnosis and biopsychosocial formulation,
- providing clinical leadership to the CAMHS team and networks around a case in safely managing uncertainty and differences of opinion'
- overseeing care-planning and delivery of treatment for the most complex and risky patients,
- risk assessment and management,
- supervision of licensed and unlicensed medicines,
- overall responsibility for detention under mental health legislation and other compulsory measures,
- senior clinical decision-makers in and out of hours,

- supervision of other clinicians
- provide clinical and strategic leadership within CAMHS and with partners across health, local authorities and the third sector,
- teaching and training,
- research and audit.

The impact of vacancies in CAP Consultant psychiatrists jobs within teams results therefore in not just the loss of clinical capacity and expertise at a time when teams need it most (often the most immediate concern amongst many for service managers), but also of other essential functions of the consultant role i.e. in clinical and strategic leadership, teaching-training-developing the future workforce, and also on research and innovation.

Increased mental health demand

There has been a sustained increase in prevalence of mental health disorders in CYP.



Data from the Mental Health of Children and Young People surveys (Ford et al. 2018)

As well as documented survey data on rising levels of childhood mental health disorders (MHCYP, Ford et al 2018), statistics show increased referrals to specialist CAMHS (almost 100% increase in June – Sep '21 versus same period '19 and a 39% increase April 2021-22. The demand is particularly biting as historically the specialty is underfunded and neglected, with many years of poor recruitment to training, which was been recently reversed by Royal College campaigning. Mental health of CYP is complex and is subject to cumulative disadvantage in relation to poverty, social

exclusion, attainment gap – all problems which have increased over the last decade and are likely to continue. Covid-19 lock-downs and the consequent impact on education has affected CYP as well as the medical workforce, leading to dual stress on the system of increased demand, reduced staffing and low morale within the medical workforce.

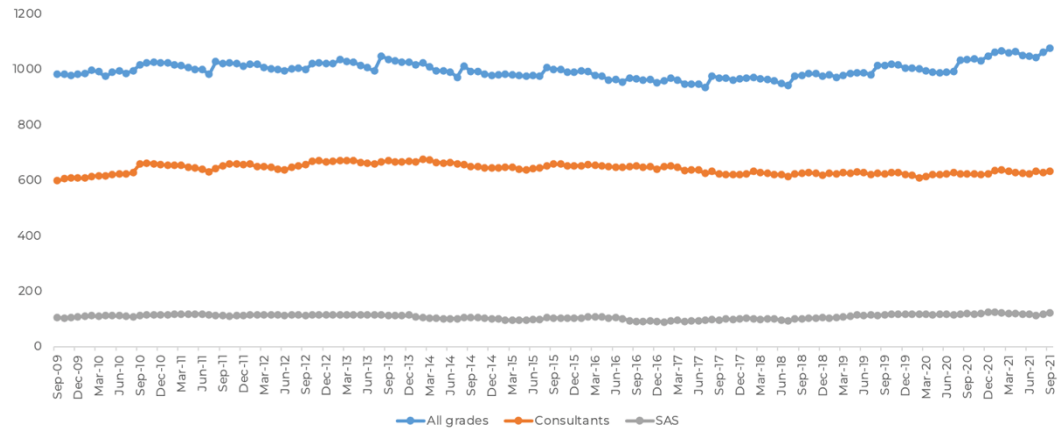
Workforce data

Between 2010 and 2020, FTE psychiatrists at all grades working increased by 7.5% compared to all other doctors which rose by 28.9%. For FTE consultants only, the increases were 5.7% for psychiatry and 34.4% for all other medical specialties (2012 – 2020). Between 2010-2020 the FTE number of psychiatrists has increased by: general (14.4%), forensic (3.1%) and child and adolescent psychiatrists (0.9%).

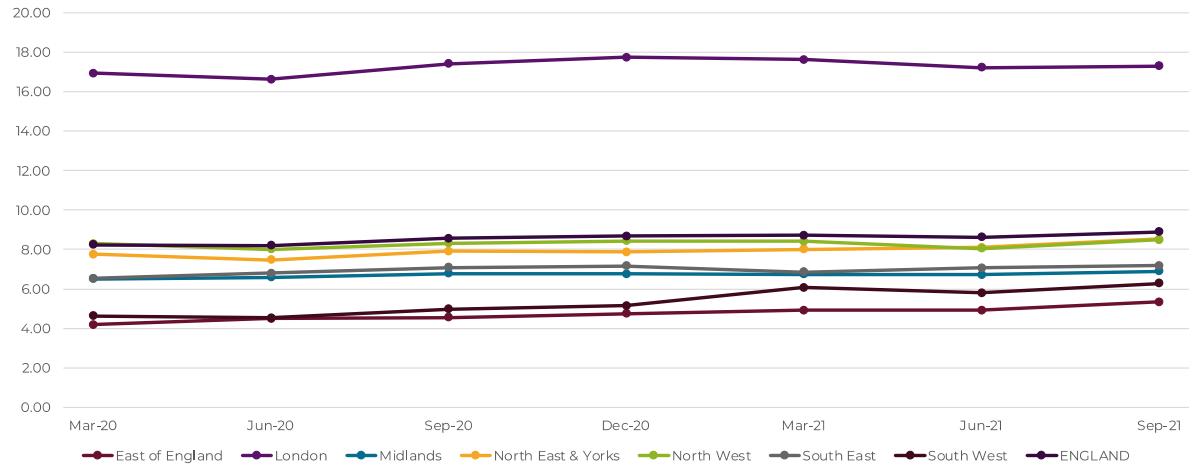
HEE Stepping Forward strategy supported delivery of the Five Year Forward View for Mental Health and committed to increase the number of CAP consultants by 100. NHS Digital data however confirms that the number has declined. The 2021 Census data shows 14.8% Consultant vacancy rate and 11.7% SAS vacancy rate across English Trusts, with similar figures across the UK.

Latest GMC data (Data Explorer, 2021), shows currently 1,486 doctors registered with specialty of child and adolescent psychiatry. Of these 539 or 36.3% are aged 55 and over, 316 or 21.3% are aged 60 and over, these percentages are roughly equivalent to psychiatry overall, but compares with 17% and 10% respectively for all UK doctors. The respective percentages for each of the UK nations is as follows: England – 36.6% and 21.8%, Northern Ireland – 33.3% and 15.4%, Scotland – 29.2% and 14..2%, Wales – 41.8% and 26.9%. Clearly, although recruitment figures are positive, given the timeframes to train consultant child and adolescent psychiatrists, and the current demographic of the CAP workforce, unless interventions are put in place to retain staff, workforce shortages in child psychiatry will be a long-term problem for the NHS.

Full-time equivalent child and adolescent psychiatrists, England, Sept 2009-Sept 2021

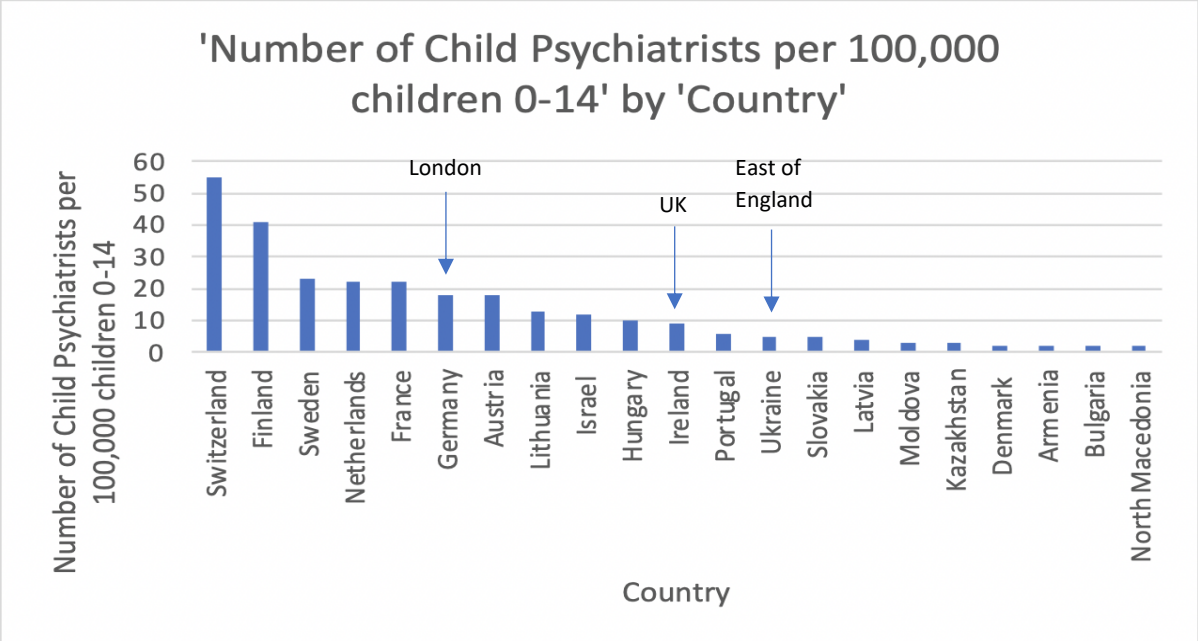


FTE child and adolescent psychiatrists per 100,000 0-17 year olds, by English region, March 2020 – September 2021



How does the UK compare to other countries?

WHO data (2018): https://gateway.euro.who.int/en/indicators/cahb_survey_39-rate-of-practicing-child-psychiatrist-per-100000-population-aged-0-14-years/visualizations/#id=34022)



RECRUITMENT

Due to the success of the Royal College of Psychiatrist's Choose psychiatry campaign – current data shows 100% core trainee recruitment for the last 3 years. This is highly positive, and although increased mental health awareness has increased service demand, it has also raised the profile of mental health as a specialty of interest to medical students and trainees. CAP faculty attention must now focus on moving onto recruitment to higher training in child psychiatry (currently 81%) and retention to training completion and transition to specialist workforce. Actions from "Continuing to Choose Psychiatry can be found through the following link; RCPsych Recruitment Strategy 2022-2027

Strategy for improving recruitment to consultant child psychiatry

Training

To prevent leakage from child psychiatry training schemes, training needs to be excellent, flexible and supportive. Time pressures on senior child psychiatrists may impact availability to provide this and can impact training experience affecting recruitment to training. At present we do not have fine grained knowledge of why trainees are not choosing child and adolescent psychiatry, leaving the system or choosing to reduce their sessions, this data should be collected by TPDs – e.g. from exit interviews. Pending this, current strategies to consider are below.

Action

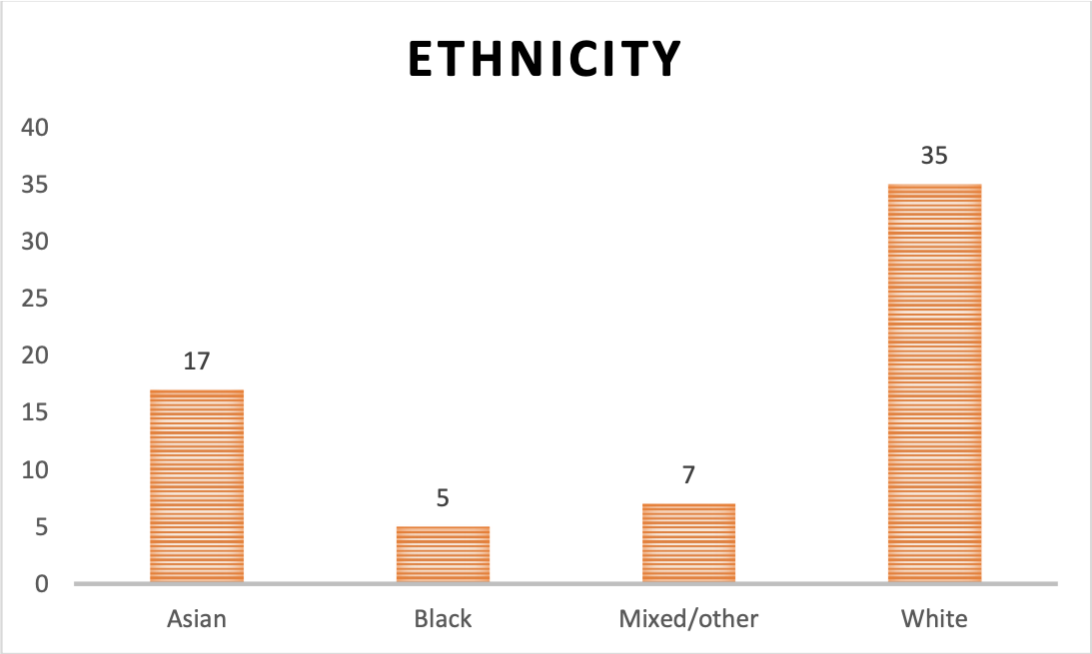
- **Recommend data to be collected by Training Programme Directors on reasons for the attrition from training via exit interview process. Information collected to influence future retention planning.**
- **RCPSYCH to re-emphasize to members and trusts that dedicated time in consultant job plans for teaching and training in Trusts linked to training programmes should not be eroded. Implementation through RCPSYCH approval of job adverts.**

- **Positive Role Models**

Research shows that exposure to child psychiatry placement during core training, increases the likelihood of child psychiatry as a choice for higher training. In recent years, however, it has been noted that exposure to high stress CAMHS has led to negative experiences for child psychiatry trainees resulting in reduced likelihood of selecting higher training in child psychiatry, despite initial interest. This could potentially drive a negative cycle, whereby stretched services lead to negative exposure for trainee, leading to reduction in CAP trainees fuelling further consultant shortages and stretching of services.

Potential strategies to prevent this cycle include promoting positive CAMH exposure, encouraging staff to present a positive, although authentic and realistic view of the nature of CAMH work. Ultimately, though a genuinely contented consultant workforce is the best recruiting sergeant and therefore, attention should be paid to factors listed below which may promote this in the consultant workforce. Role models in senior positions allow trainees to imagine their future careers, as such, diversity within role models is important to inspire retention of trainees from all backgrounds. This latter is particularly important as survey findings from a 2022 CAP conference survey (n = approx. 65; 80% consultant/ SAS grade) indicated 45% respondents did not identify as white.

Graph of 2022 CAP conference survey data on ethnicity (80% consultant/ SAS grade)



Action

- **CAMHS consultants and SAS doctors to actively present a positive but realistic view of working within CAMHS to medical students and doctors in training**
- **Implement top tips for educational supervisors (Appendix)**
- **Clinical managers to ensure attention is given to both Consultant and SAS doctor well-being and job satisfaction through the job planning process.**
- **Attention to NHS diversity and inclusion policies to promote diversity and representation at all levels within the NHS and related academic departments.**

- **Promotion of child psychiatry as a specialty and career**

There is an extremely wide variation in exposure to CAP at medical student level – with CAMHS placements ranging for a week (5 days) in a few med schools, to ½ a day or none at all (unless the med student actively opts for an elective day or so in CAMHS during their Psychiatry placement. There is an expansion ongoing in FY numbers, in addition to the increasing numbers of placements in Psychiatry. **Promotion through media, social media, podcasts and newsletters in the short term may help promote child psychiatry as a specialty amongst trainees. This has proven positive in the Choose Psychiatry campaign, and perhaps a focus on 'Choose Child Psychiatry' can make a positive difference. Inspirational speakers at trainee conferences to promote the variety of work and research available in the field are easy first steps, perhaps providing a broad view of the range of options available within a career in child psychiatry including NHS, private work, public engagement, policy, research and portfolio careers.**

Action

- **Work with colleagues within RCPsych and universities to ensure all medical students have exposure to child psychiatry**
- **Include CAP in the expanded national foundation programme**
- **CAF Exec committee to develop a promotional media plan alongside Continuing to Choose Psychiatry**
- **CAMHS Regional representative network to lead on facilitation/ promotion of plans at local level**

- **Mentorship, peer support and career guidance**

Without a doubt good mentorship and individualised career guidance would improve retention of trainees to schemes and the specialty. However, this is finely balanced against the time demands to over-stretched consultants who would be required to provide this.

Strategies to protect SPA time for consultants will help with this area. An exploration, given the technology now available, for remote mentorship or remote group mentorship, could be undertaken by RCPSYCH as this could allow trainees to seek mentorship from further afield. This may be of particular benefit for instance for trainees for whom there are a lack of suitable/ well-matched local mentors. Group mentorship could potentially also allow a peer network to develop that can provide additional support – feeling supported, valued and of belonging are probably the most critical factors to retention, likely far more critical than financial rewards.

Action

- **Regional representatives to continue to ensure appropriate use and protection of SPA time in new CAMHS job descriptions.**
- **RCPSYCH faculty to establish trainee access to a mentor network to include specialisms such as academia, medical education, or leadership.**

Supporting new consultants

Supporting new consultants with Start Well and consultant mentoring has been established by the Royal College and this programme helps facilitate the transition to consultant posts. For trainees, this provision may ease anxiety about moving to consultant posts and therefore facilitates retention, ensuring that the transition from trainee to consultant is smooth, keeping staff within the profession. Offering the programme to higher trainees will support them in this transition, promotes the substantive consultant role and may aide retention. It has now been agreed that trainees can access this from their last year of training to support their new role as consultant.

Action

- **RCPSYCH to ensure all higher trainees are encouraged to join the StartWell programme during their final year of ST training via engagement with Training Programme Directors.**

International training and recruitment

Given the national shortage of CAP staff, it is inevitable that the system should look outward to recruit trained and talented staff from beyond our borders. Facilitating the systems involved in recruiting from abroad, including visa applications, GMC registrations and supporting resettlement of foreign professionals and their families will facilitate overseas recruitment. Ensuring that British institutions value and support diversity, are culturally accepting, anti-racist and offer career progression without discrimination are likely to help attract the best candidates from abroad. Colleagues can access training in the UK as international medical graduates which supports international development in our speciality, as well as contributing to the workforce.

Action

- **RCPSYCH to continue to engage and support International Medical Graduates**
- **Encourage IMG participation in Faculty events and international training collaborations**
- **Attention to NHS diversity and inclusion policies to promote diversity and representation at all levels within the NHS and related academic departments.**

The following information may be useful:

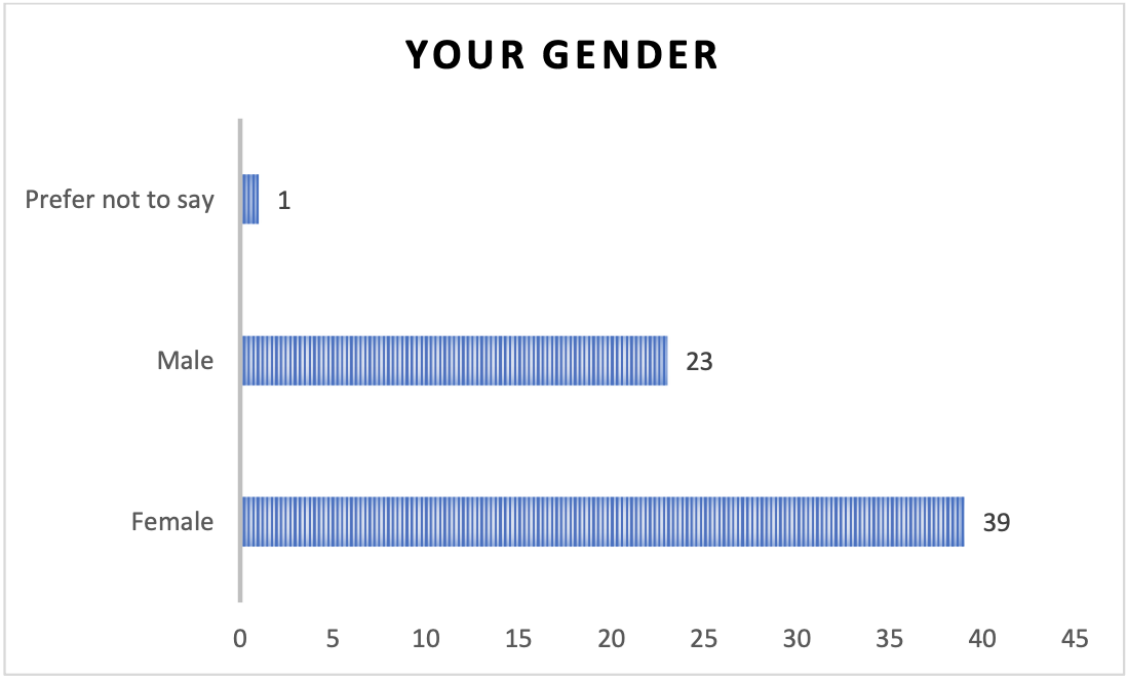
https://www.RCPSYCH.ac.uk/docs/default-source/training/img/RCPSYCH-img-guide.pdf?sfvrsn=af3b5e0a_6

Workforce Planning

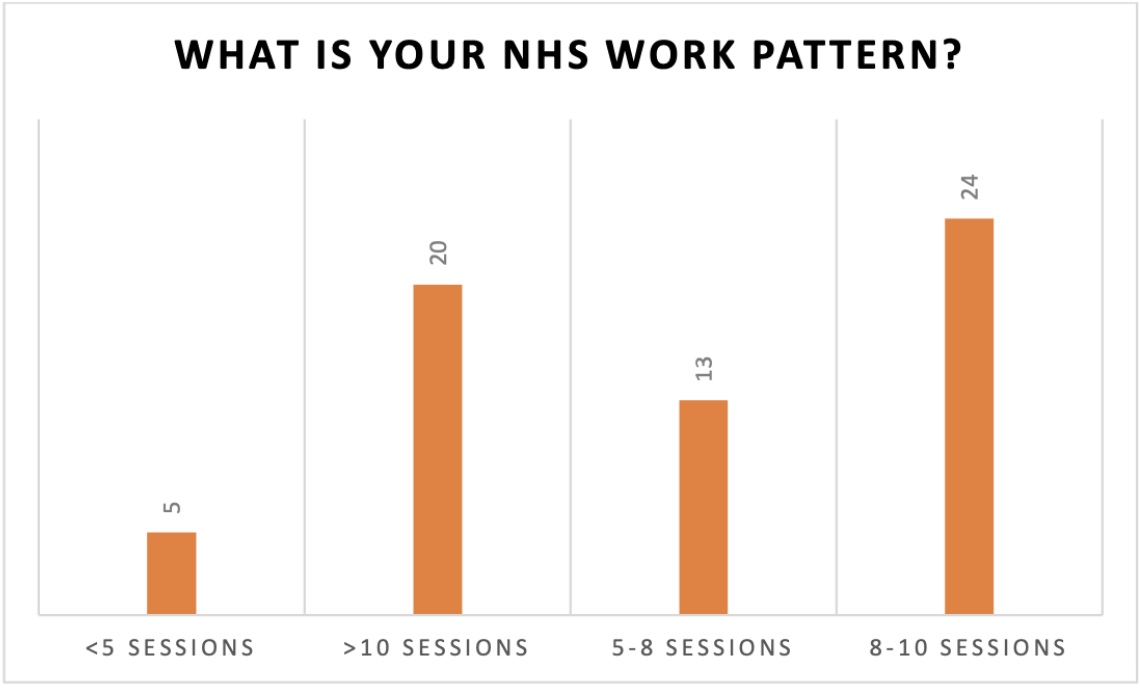
Understanding the extant and future workforce is critical for workforce planning. It is predictable that trainees attracted to child and adolescent mental health are interested in children and their outcomes. To this end, it is likely that for trainees interested in this specialty, the importance of family engagement in children's lives as a positive contributor to mental health will not be lost. It is therefore also predictable that trainees and future consultants in this field are more likely to pursue LTFT training and LTFT consultant contracts. Although currently, the societal bias is for parenting to fall mainly to women, the future likelihood is that parents of all gender configurations will tend towards more LTFT working patterns.

These considerations are borne out by survey at CAP faculty conference 2022 (n = approx. 65; 80% consultant/ SAS grade) where 62% of respondents were female and 29% were currently working <8 sessions/ week.

Graph of 2022 CAP conference survey data on gender (80% consultant/ SAS grade)



Graph of 2022 CAP conference survey data on work pattern (80% consultant/ SAS grade)



Without changes to workforce planning and recruitment to whole time equivalents rather than absolute consultant numbers, the workable wo/man hours available within the system will continually fall short, leading to continued stretched services, low morale, and retention difficulties. Recently there has been the establishment of 'Supported Return to Training' champions, and this may be helpful in retaining parents in training programmes.

More information available here: Our workforce census (RCPSYCH.ac.uk)

Action

- **Faculty to promote positive examples of varied job plans, portfolio careers and LTFT working within Child and Adolescent Psychiatry**
- **Faculty to continue to lobby Educational Organisations in all UK nations via RCPsych Dean and TPDs around changes to the training number allocation system, to recruit to WTE rather than consultant numbers**

RETENTION

Whilst much work has already been done on improving recruitment into child psychiatry, with the help of increased public awareness and appetite for understanding mental health, attention now critically needs to turn to retention. Continuing to fill a perpetually leaky bucket serves little long-term gain, and it is clear from data that for multiple reasons, both widespread throughout the NHS (low morale, high stress, stagnant pay, pensions debacle, culture of racism and bullying, withdrawal of support staff and structures), and specific to child psychiatry (high demand for LTFT, easy access to private practice, reduced parity of esteem compared to other medical colleagues due to flat hierarchy being the norm in CAMHS) that there is strong flow of qualified consultants leaving the NHS system. Understanding the push and pull factors involved in consultant decision making are important so that levers can be adjusted where possible to improve retention.

Understanding factors influencing staff retention within the NHS

Both push and pull factors are relevant to individual decisions to leave or remain working within the NHS. It is not possible to develop a successful retention strategy without understanding these factors.

Push factors for leaving the NHS

Work-stress

This is without a doubt the most common reason cited for leaving the NHS. Work-stress causes both physical and mental health problems which can lead to staff absence, leading to staff shortage, as well as decisions to work abroad, in the private sector or to leave the professional altogether. Colleagues are also suffering from the lack of an overall workforce strategy and working in teams which do not have adequate AHPs which can lead to the added stress of managing long waiting lists and inability to be responsive to patient needs leading to moral injury and burn-out.

- **Erosion of job plans**

With increased clinical demand within the system, many consultants are finding their job-plans eroded such that all their time is spent on face to face clinical work, with the balance between routine and high-risk work tipped towards risk management and ‘fire-fighting’. This shift in work type is clearly more stressful and without the mental ‘down-time’ to engage in other activities: routine clinical work, leadership, management, training, teaching, research – can lead to more work stress and faster burn-out. The loss of direct contact with other services risks further entrenching the increase in clinical demand.

- **Reduction of support staff**

NHS cost-saving has introduced savings by the reduction in administration support staff, resulting in many consultants with insufficient dedicated administrative support or reliance on an administration shared pool. This has contributed to an increase in the consultant work burden.

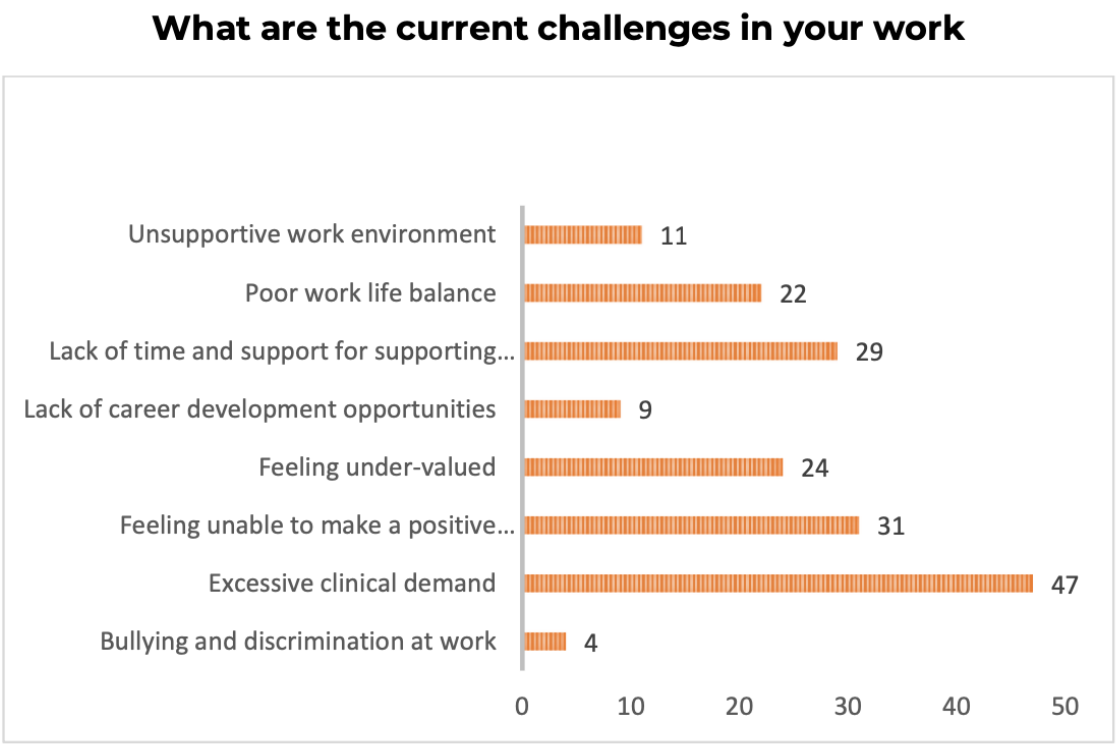
Whilst on the one hand the consultants' training and experience support their clinical leadership in cases with highly complex needs and risks, they also work in services without sufficient resources – which can lead to high stress at feeling clinically responsible and indeed significant adverse incidents being attributed to them. There may not be clarity of supervision, line management, and clinical responsibility processes within teams that will contribute to this stress. This may be particularly the case for BME consultants who will have experienced and seen data to support the notion that complaints made against them may be unfairly managed. Ref: https://www.gmc-uk.org/news/news-archive/gmc-targets-elimination-of-disproportionate-complaints-and-training-inequalities.

- **Esteem, agency, and power to effect change**

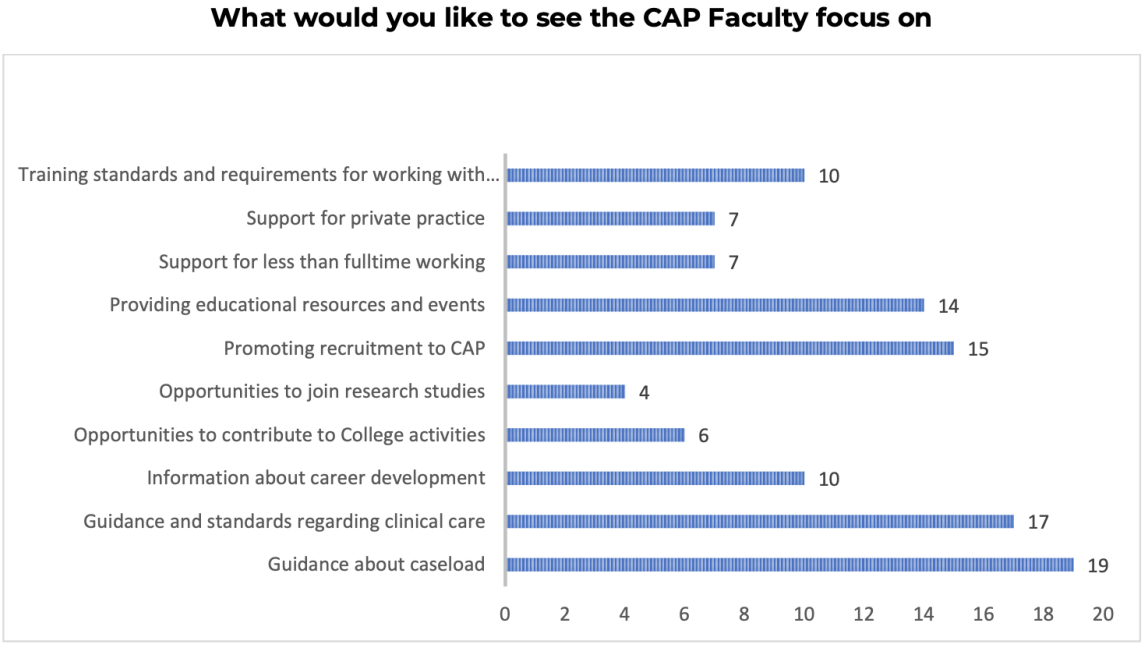
The 'flat hierarchy' said to be much more prevalent in CAMHS can be a source of collaborative and holistic ways of providing CAMHS. This flattened hierarchy balanced with a sense of agency which positively affects individual jobs and job-plans within the overall needs of the service would help Consultants feel valued. We have to acknowledge that this sense of loss of agency will be shared by a wide range of AHPs, and other professionals within CAMHS.

These factors are amongst those that were highlighted in the 2022 CAP conference survey and represent areas in which the RCPSYCH members most wish to be addressed.

Graph of 2022 CAP conference survey data on work challenges (80% consultant/ SAS grade)



Graph of 2022 CAP conference survey data on CAP faculty focus (80% consultant/ SAS grade)



Parenthood, carers, and flexible working

Work-stress is particularly heightened for parents of young children, particularly those who are the main parent responsible for childcare. At present, this is largely women, but this may shift over time. Employer flexibility, understanding and support at this vulnerable time can prevent burn-out and decisions to leave the NHS. Whilst this can cause an immediate burden on the system, not providing this will cause substantially more long-term staff shortages. Typically, reduced productivity due to parenting will impact a worker for approximately 10 years when staff are aged 30-40/ 35-45. These same staff, if supported over this period, can be very productive for a further 20 years within the NHS system – age 40-60/ 45-65. An ageing population with accompanying health burden has also increased the number of working carers for older adults within a family, who may need enhanced flexibility in work plans to enable them to continue to work. Losing staff, or staff loyalty at these critical times is therefore extremely short-sighted for the NHS, as once staff lose faith in a supportive system or find other opportunities elsewhere, this trust is likely not regained. Systems which fully support parents: maternity/ paternity leave, flexible/ hybrid working patterns, LTFT contracts are all highly beneficial in the long-term for staff retention.

Bullying, discrimination, and negative work-place culture

Much recent research has demonstrated that this exists widely within the NHS and RCPSYCH needs to work closely with other colleges to ensure that this is robustly tackled. Quantitative metrics to demonstrate reduction of bullying and improvement in workplace culture are difficult, however flattening ethnicity and gender pay gaps (https://www.gov.uk/government/news/new-data-on-gender -pay-gap-in-medicine https://www.bmj.com/company/newsroom/pay-of-nhs-doctors -varies-by-ethnic-group/) is a measurable starting point. Gender inequality in senior representation

and in academia are particularly problematic as are continued reports of workplace sexual harassment. Real, measurable, and visible progress needs to be made in these areas to retain women in this predominantly female workforce.

Financial considerations

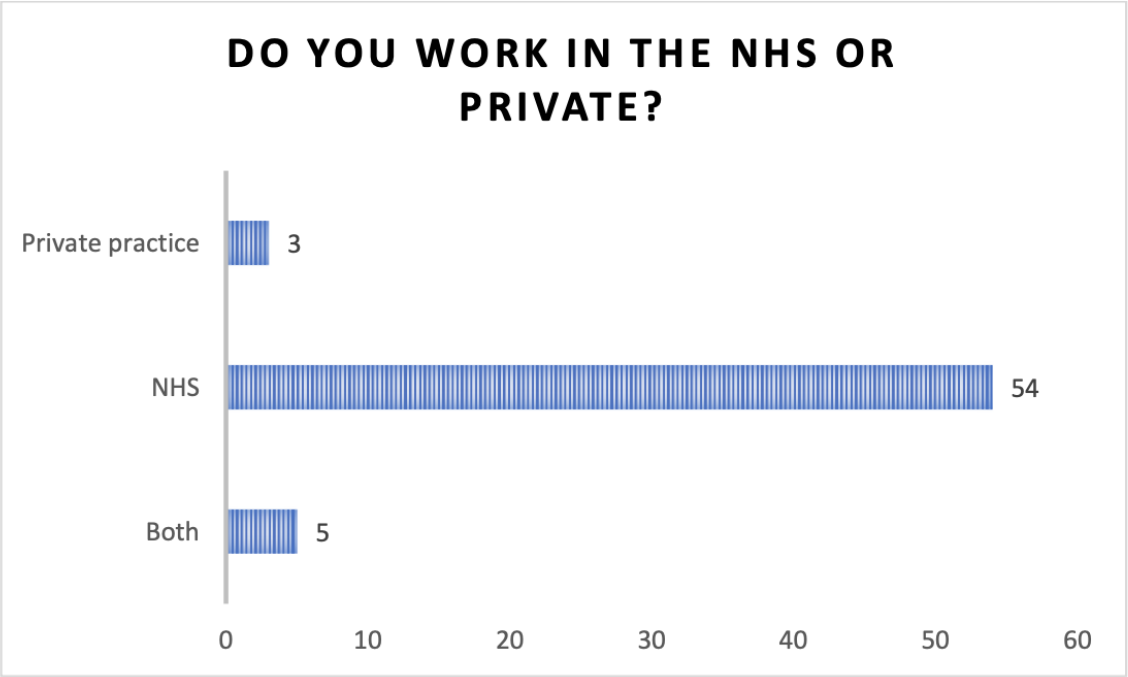
With the NHS pension problems seeing consultants penalised financially for NHS work, many senior consultants are taking early retirement and reducing sessions within the NHS compounding staff shortages as well as denying valuable training opportunity to upskill the future workforce. Solutions could include increased employer flexibility such as in job plans, pension contribution recycling, time in lieu, and non-pensionable pay as compensation for 'extra-contractual' clinical work.

Pull factors towards the private sector

For many consultants the pull factors towards the private sector mirror the push-factors from the NHS. Private practice, particularly within inpatient settings is not without its challenges. However, often it can provide flexibility in working hours, increased administrative support, experienced clinical teams, reduced clinical risk, agency, and ability to affect change, with equal or improved financial incentives. Opportunities for child psychiatry has risen exponentially over the last decade as CAMHS waiting lists have ballooned seeing the rise of independent outpatient providers and conglomerates of private child psychiatrists as well as increased private hospital posts. The knock-on impact on the NHS however is detrimental with brain-drain of qualified clinicians and the potential for low-risk areas of service provision being 'cherry-picked' to be provided by the private sector. This shift creates additional potential problems of a less regulated private sector with respect to patient care and safety, a higher risk patient cohort remaining in the NHS system increasing likelihood of job stress and burn-out and also a two-tier health service driving further societal inequality and perpetuating mental health need.

RCPSYCH represents both NHS and private child psychiatrists and recognises that a growing proportion of its members will be participating in private practice, and this should also be supported. This is indexed in the CAP faculty Conference 2022 survey where 13% of respondents were already engaged in private work.

Graph of 2022 CAP conference survey data on CAP places of work (80% consultant/ SAS grade)



Strategy for improving retention to consultant child psychiatry

Encourage and support child psychiatrists to think creatively about their careers and novel ways to balance their demands within child psychiatry

Action

- Faculty to promote positive examples of varied job plans, portfolio careers and LTFT working within Child and Adolescent Psychiatry. RCPSYCH can support the development of the consultant role over the course of a career, with opportunity for variety and progression within leadership, academia, public engagement and policy. This should include a 5 year forward developmental plan in appraisals and job planning. This could be facilitated by RCPSYCH mentoring, educational and supportive structures. Utilisation of regional representation and specialty leads to form inclusive and supportive groups with a more personal element where regional leads establish personal relationships with local consultants that can establish mentorship and offer localised career progression and development advice can make a difference. Technological advances in connecting people could be utilised to facilitate this.

- RCPSYCH faculty to establish trainee access to a mentor network to include specialisms such as academia, medical education, or leadership. Promote the importance of mentoring, leadership, research, teaching and training and put pressure on NHS employers to retain this in consultant job plans. Without this, staff shortages will become an increasing problem, either in real term numbers, or available staff being comparatively less well trained than previous generations (which is more likely). Ring-fencing time for these activities not only bolsters future mental health provision but allows consultants critical mental decompression

time within their working week, improving productivity and reducing burn-out. This action can be promoted by regional representatives.

Increased support to prevent burn-out/ job dissatisfaction

Ultimately, prevention of burn out and improvement of job satisfaction will occur by attention to the points in the above section, however the following additional areas may also help.

- Job flexibility should be encouraged including career breaks, sabbaticals, return from parental leave programmes, part time working, flexible hours, and virtual working. Promoting child and adolescent psychiatry as the 'Family Friendly' medical specialty is not only appropriate given the specialty but will likely attract future trainees from other specialties.
- RCPSYCH continues to work with Wellbeing Champion to promote a Well-being portfolio – this could include support groups with regional and local promotion. This can also include coaching on areas such as boundary setting/ time management and speaking up.
- RCPSYCH conferences could promote network building at conferences by allowing for networking sessions at conferences.
- Working as a psychiatrists can be difficult and any of us can experience poor mental health and mental. We need to talk about this openly and also provide help and advice when bad things happen e.g. a patient dies by suicide.
- Support is available here:
  Psychiatrists Support Service (PSS) | Royal College of Psychiatrists (RCPSYCH.ac.uk)
  Email: pss@RCPSYCH.ac.uk
  Website: https://www.RCPSYCH.ac.uk/members/workforce-wellbeing-hub

Work with organisations and medical managers regarding job plans, support staff and work culture

Understandably, this may not be an area in which RCPSYCH has much power, however where it is able to voice and reflect the pressures of working psychiatrists on factors which contribute to work-place shortages, it should and must. Many consultant psychiatrists have voiced that a competent administrator would be more helpful to them in their day-to-day jobs than a physician associate. A few competent and well-trained CAMHS practitioners who are well-paid and content in their roles (hence reducing turnover once trained) are often more helpful than the common experience of many inexperienced CAMHS practitioners who leave roles for better ones once trained, increasing both the training and risk burden which falls to consultant psychiatrists.

Team job planning by managers may be important to support fairer, flexible and more efficient job planning:

https://www.healthcareconferencesuk.co.uk/conferences-masterclasses/team-job-planning-learn-how-to-construct-implement-and-enable-a-team-through-team-job-planning

Action

- RCPSYCH to provide flexible working and team job planning exemplars for CAMHS.

- Attention to NHS diversity and inclusion policies to promote diversity and representation at all levels within the NHS and related academic departments.

- Faculty to continue to lobby HEE via TPDs around changes to the training number allocation system, to recruit to WTE rather than consultant numbers
- ??RCPSYCH to provide guidance about caseload??

Workforce Management

- RCPSYCH can provide information with respect to regional gaps in the workforce so that targeted promotion can take place with perhaps lobbying for incentives to work in less popular areas.
    - ?? Potentially add in workforce modelling projection here as suggested by Jose
- RCPSYCH can think about providing resources and guidance on retire and return schemes and share information on positive ways that retired psychiatrists can continue to contribute to clinical work, teaching, training and research.
    - ? Adding in examples of retire and return opportunities for CAMHS psychiatrists would be helpful here.
    - Information is available here: sw---guidance-for-retired-members-and-employer-organisations---august-2021.pdf (RCPSYCH.ac.uk)

Work with UK national health departments to promote the need for public health child mental health strategy, and to remove NHS wide barriers to staff retention

- Specialist CAMHS cannot meet the needs of all children and young people with mental health disorders with the current levels of demand and workforce. Instead of trying to see more and more patients, all grades of the psychiatry workforce should have time allocated in their job plan for offering consultation to other parts of the children's network e.g. supporting neurodevelopmental assessments and mental health interventions in paediatric services, school, children's units etc. Being supported to make links locally with partners allows the capacity of mental health provision to increase and makes good use of psychiatrists' extensive training.

- Work with NHS public health services to promote public mental health education and messaging to promote evidence based public mental health strategy. This space has often been occupied by psychology/ educational psychology of varying scientific quality and evidence base. The voice of child psychiatry in these areas is currently negligible.

- Support wider cultural change within the NHS – this is ongoing work within the Royal College and the CAP faculty will engage actively with working group to effect change in this area. Quantitative metrics to demonstrate reduction of bullying and improvement in workplace culture are difficult, however flattening ethnicity and gender pay gaps is a measurable starting point. Gender equality in senior representation and in academia are particularly problematic, as are continued reports of workplace sexual harassment. Real progress needs to be made in these areas to retain women in this predominantly female workforce.

Work with politicians to highlight the impact of their decision making on public policy (from social inequality to pensions) and its impact on national mental health and child psychiatrist retention

- Faculty to promote political understanding of knock-on effects of inequality, poverty and reduction in social care and education provision on child mental health
- Bring the voice of young people and parent/carers with experience of using CAMHS into our engagement with key policy makers and fundholders
- Faculty to use political levers to advise politicians of likely outcomes of continued pressures on NHS child psychiatrists and failure to support this sector of the NHS
- Faculty to support resolution to consultant pension issues affecting early retirement of senior child psychiatrists through available political and communications resources and promote increased employer flexibility such as in job plans, pension contribution recycling, time in lieu, and non-pensionable pay as compensation for 'extra-contractual' clinical work.

Work with media channels to improve the public perception of mental health, promote public health education and areas of evidence-based self-help, and promote careers in child psychiatry

- Work with NHS public health services to promote public mental health education and messaging to promote evidence based public mental health strategy.
- Engagement with the media about what CAMHS psychiatrists do can improve esteem in the speciality. Most lay people do not know the difference between a psychologist and a psychiatrist and most of the general public will use these terms interchangeably. Clarity through media engagement about the role of psychiatry in child mental health can improve understanding of their roles and value. This can be achieved through a targeted action in the Continuing to Choose Psychiatry plan.

- Ultimately, improvements in adult mental health, education, social care and poverty will improve child mental health and reduce demand. Meanwhile, expectation management is important to prevent unrealistic expectations and vitriol directed at mental health staff, further eroding staff morale. Media engagement to influence this narrative may help support the esteem and reduce demand on child psychiatrists.

- Improved public and professional education with respect to child mental health and the important roles of parents and educational environments to improve child mental health can reduce demand to services. At present the media focus on mental health is frequently about talking about mental health thereby encouraging presentation to child mental health services. A greater emphasis on what we can all be doing to improve our own mental health, and the mental health of our children so that we do not need to present to mental health services would be more positive. The RCPSYCH could have a major role in campaigning for better public mental health education for parents and schools.

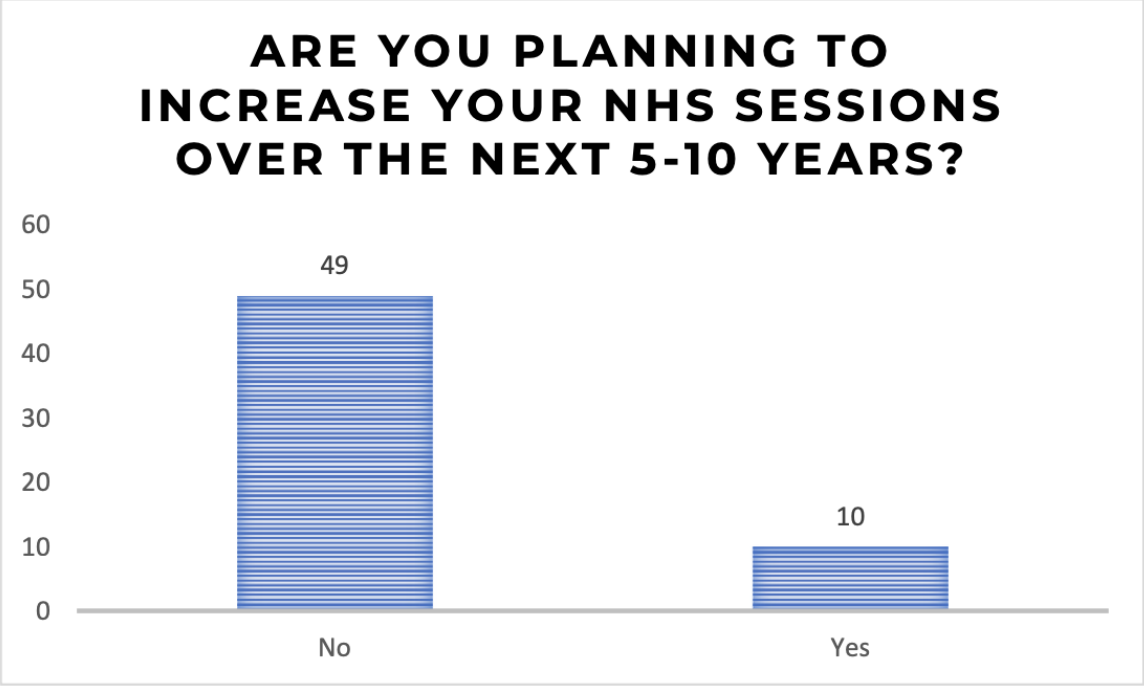
Support child psychiatrists working in the private sector

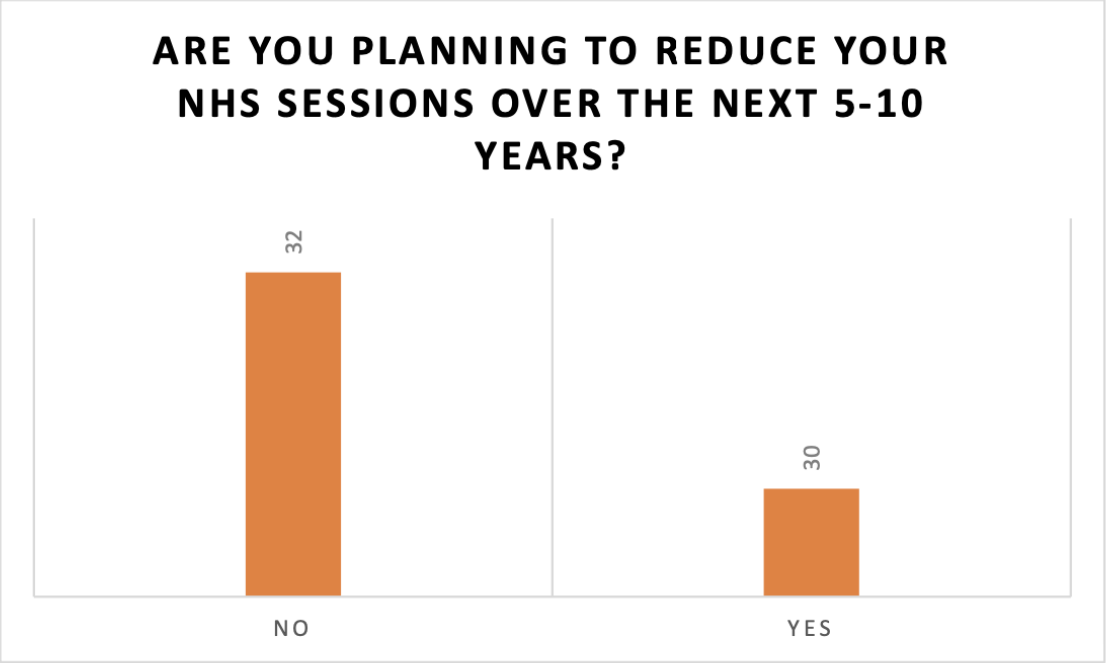
- As a substantial minority of members are working in the private sector, RCPsych should also be providing support for doctors working or intending to work in the private sector.

Horizon Scanning

It is important in any workforce plan to scan the horizon and the following slides are a salutary omen that workforce shortages may remain a problem in child psychiatry over the next 10 years. Regular review of retention and recruitment strategy will be required, particularly to influence a potentially changeable political landscape.

Graph of 2022 CAP conference survey data on CAP NHS session intentions (80% consultant/ SAS grade)




ARE YOU PLANNING TO REDUCE YOUR NHS SESSIONS OVER THE NEXT 5-10 YEARS?
32
30
NO
YES

Appendix 1; List of Actions

Agreed actions	Leads for actions
1. **CAMHS consultants and SAS doctors to actively present a positive but realistic view of working within CAMHS to medical students and doctors in training**	**All consultants and SAS doctors**
2. **RCPsych faculty to support trainee access to a mentor network to include specialisms such as academia, medical education, or leadership.**	**CAP Faculty Executive**
3. **Promote network building at conferences by allowing for networking sessions.**	**CAP Faculty Executive**
4. **Faculty to continue to lobby Educational Organisations in all UK nations via RCPsych Dean and TPDs around changes to the training number allocation system, to recruit to WTE rather than consultant numbers**	**CAP Faculty Executive**
5. **Support child psychiatrists working in the private sector**	**CAP Faculty Executive**
6. **Develop a media plan promoting child and adolescent psychiatry as the 'family friendly' medical specialty alongside Continuing to Choose Psychiatry**	**CAP Faculty Executive** **Comms strategy**
7. **Promote positive examples of varied job plans, portfolio careers and LTFT working within Child and Adolescent Psychiatry**	**CAP Faculty Executive** **Comms strategy**
8. **Encourage IMG participation in Faculty events and international training collaborations**	**CAP Faculty Executive**
9. **Implement top tips for educational supervisors of core trainees in CAP**	**Leads for core training**
10. **Data to be collected and shared by TPDs on reasons for the attrition from training via exit interview process. Information collected to influence future retention planning.**	**Chair of CAPSAC and TPDs**

11. Work with colleagues within RCPsych and universities to ensure all medical students have exposure to child psychiatry	Chair of CAPSAC, RCPsych Dean
12. Include CAP in the expanded national foundation programme	FY Lead for RCPsych and Heads of School RCPsych Dean and link with DME's
13. RCPsych to ensure all higher trainees are encouraged to join the StartWell programme during their final year of ST training via engagement with Training Programme Directors.	Chair of CAPSAC RCPsych Training and Workforce committee
14. RCPsych to re-emphasize to members and trusts that dedicated time in consultant job plans for teaching and training in Trusts linked to training programmes should not be eroded. Implementation through RCPsych approval of job adverts.	Regional Reps and External Advisors Dean's link with CMO's
15. Promote and support varied job plans, portfolio careers and LTFT working within Child and Adolescent Psychiatry	Dean's links with CMO's
16. Clinical managers to ensure attention is given to both Consultant and SAS doctor well- being and job satisfaction through the job planning process.	Dean's links with CMO's
17. Attention to equality, diversity and inclusion policies to promote diversity and representation at all levels within the NHS and related academic departments.	All in leadership positions in RCPsych, Medical Directors, University departments
18. RCPsych and employers to continue to engage and support International Medical Graduates	Local IMG support programmes
19. Support SAS doctors in their role and career progression	Training and Workforce committee Dean's links with CMO's
20. Provide information with respect to regional gaps in the workforce so that targeted promotion can take place with perhaps lobbying for incentives to work in less popular areas.	Training and Workforce committee Dean's links with CMO's

21. RCPsych continues to work with Wellbeing Champion to promote a Well-being portfolio	CAP Faculty Exec Wellbeing champion
22. Provide help and advice when bad things happen e.g. a patient dies by suicide.	CAP Faculty Exec Wellbeing champion RCPsych Psychiatrists' Support Service
23. Provide resources and guidance on retire and return schemes and share information on positive ways that retired psychiatrists can continue to contribute to clinical work, teaching, training and research.	Training and Workforce committee

Appendix 2;

Guidance for consultants and SAS doctors who are supervising core trainees in CAP

1. It is very helpful for the consultant with overall responsibility for core training placements in CAMHS in your area to meet with the trainees for induction, midterm review and end of placement review.
2. Trainees find it helpful to be given clear guidance about what they should do in what may feel like a very different clinical placement and to have a small number of patients allocated to them when they arrive. If possible, they could be asked to see older teenagers to review their mental states and medication initially and work their way down the age range as they progress.
3. Meeting and joining other team members allows them to develop their understanding of the clinical task and the developmental aspect of the work e.g. joining a nurse-led ADHD clinic or a school observation.
4. Telling them how many patients they are expected to see each day or over the course of the week helps them plan their other work.
5. Trainees can feel isolated when they arrive in a CAMHS clinic and being welcomed and included by the multi-disciplinary team in both clinical and social activities is important.
6. Whatever their training to date, many may feel deskilled especially if they don't usually have contact with children and young people and it is useful for them to develop an understanding of typical child development and how to communicate with children of different ages and communication abilities. Spending time with a Community Child Health service would add to this if it can be facilitated.
7. Weekly supervision is a cornerstone of psychiatric training and allows for their personal and professional development and wellbeing to be fostered. Higher trainees and SAS doctors are well placed, with support, to offer supervision of different aspects of the work.
8. Trainees may well witness CAMHS clinicians who are finding it hard to meet the increased demand on services. Talking openly about how our work can be both hugely rewarding and also frustrating at times when there are insufficient resources in services can lead to useful discussions about the role of the consultant within the MDT, how to maintain high quality service delivery, self-care etc.
9. Not all core trainees will wish to pursue a career in our specialty! Their training can be tailored towards their ultimate career with a focus on developing skills in developmental assessment, working with young people who present with high levels of risk etc. It can be helpful to emphasise the importance of multi-agency working, systemic thinking, being able to tailor their communication with people of all ages and supporting good transitions for whatever area of psychiatry they end up in.
10. Supervising core trainees well takes time and effort and is essential to the future of our specialty. This needs to be part of your job plan and seen as a core activity.

Appendix 3; Guidance for when there are gaps in the CAMHS medical workforce.

This guidance is based on advice from colleagues who have worked where there have been consultant gaps, is informed by feedback from multi-disciplinary colleagues and was developed by Child and Adolescent Faculty of the Royal College of Psychiatrists in Scotland in 2019.

Key recommendations;

1. Support for consultant and SAS doctors needs to come from senior managers within their service and wider organisation.
2. Consultants should be supported by the wider team to attend clinical meetings.
3. They should leave spaces in their diary to allow for urgent clinical discussions/patient reviews.
4. All cases should have another team member acting as a case manager.
5. Consultants should have a smaller caseload than usual.
6. Service managers need to manage expectations of what can be provided by the service.
7. Consultant job plans need more frequent reviews.
8. CPD activities should be encouraged and supported.
9. Use of locums unfamiliar with working in Scottish CAMHS can be unhelpful.
10. Consultants and other doctors should be offered additional PA's for covering gaps.
11. Rotas should have non-medical staff as the first line response.
12. Medical students and trainees should be given an interesting, rewarding experience of CAMHS.
13. Access to excellent admin support is key.
14. Consultants and SAS doctors should be encouraged and supported to meet, both within their organisation and with those from other areas for peer support.
15. Flexible working hours should be offered if possible.

1. Senior medical and service managers e.g. the Associate Medical Director and Head of Service within the wider organisation should be made aware of consultant psychiatry gaps and included early in discussions about workload and safe practice. Within CAMHS senior clinicians and managers should take a joint decision as to how limited consultant time is best used, so that they feel supported in declining appropriate requests to undertake work, which they simply have no time to do.

2. Multi-disciplinary colleagues consistently request that consultants are present at team meeting and case discussions and are available for consultation which is either time-tabled or unplanned. It is therefore essential that consultants do not fill up their diaries with direct clinical contact, but ensure that they have time for this work. This allows other members of the team who are themselves highly

trained and skilled to speedily access advice about complex and/or risky cases, the potential role of medication, admission or use of the Mental Health Act. Flexibility to join colleagues to see patients is also seen as time effective and clinically beneficial. Being available to MDT colleagues on both a regular and ad hoc basis makes good use of psychiatrists' extensive training and experience and provides containment to the wider team which facilitates safe and effective practice.

3. Consultant psychiatrists will need to prioritise seeing or advising on those children and young people who present with greatest risk to themselves and/or others due to their mental and physical disorders. This will require the full team, supported by their clinical managers, to agree that consultants are freed up to focus on the most complex presentations and other clinical, case management and admin tasks which do not require a consultant should be taken on by other colleagues. In practice this means that all patients should have a case manager/case co-ordinator who can take on all other tasks relating to clinical care, other than those which only a psychiatrist can do.

4. The RCPsych guidance on caseload recommends that a full-time consultant would see 40 new cases each year and 12 - 16 review appts/week. When there are medical gaps, we advise that a smaller caseload than this pro rata would facilitate the work described above and makes better use of their time to the wider team. This will probably lead to delays in accessing psychiatric input on a routine basis, when emergency/urgent work will trump this and waiting times will necessarily increase. At times of gaps in the consultant workforce, service managers will need to manage expectation on services to meet key performance indicators.

5. Job plans need to be reviewed and agreed more frequently when consultants are covering medical gaps in their services. It is important that consultants and SAS doctors are supported to access CPD activities during their working hours and that this is recognised by the MDT as an essential part of their work, not just for revalidation purposes, but also to recognise that their developing skills and knowledge brings added value to their service. A team culture of lifelong learning should be supported by senior clinicians and managers, especially where clinicians are hard pressed and at risk of burnout.

6. The experience of using unknown locum consultants has been that this is expensive and can be unhelpful and existing medical staff should be involved in vetting potential candidates. Unless there are colleagues who have worked successfully in UK CAMHS, it may be better to offer to pay the existing medical workforce additional PA's for covering medical gaps, while seeking to recruit permanent consultants, (although this might be challenging with the current tax arrangements). GP's or paediatricians with a special interest in child and adolescent psychiatry could offer sessional input e.g. to neurodevelopmental pathways and other routine work.

7. Where the CAMHS out of hours rota is hard pressed due to psychiatry gaps, other MDT members should be employed to provide the first response to emergency referrals, with consultants used in an advisory capacity.

8. It is important that consultants and SAS doctors are supported to take time to meet each other to discuss their clinical work, the overall service and for peer to peer support.

9. A flexible and considerate approach with regard to working hours is helpful from medical managers, for example, allowing late starts/ early finishes on certain days, and considering whether certain administrative/ SPA tasks could be undertaken flexibly/ off site.

10. Fostering good relationship with Primary Care colleagues is recommended. This takes some time and effort but having good working relationships with GP's and their practices when it comes to shared care of patients is very useful.

11. Carefully considered use of non-medical prescribers in the team may also be beneficial. Ideally the non medical prescriber would prescribe for routine and stable cases, for example, ADHD medications and Melatonin prescribing.

12. Excellent admin support has been found to play a key role in making the best use of medical time. This is especially important when consultants are working in teams, other than their own.

13. Child and Adolescent psychiatrists of the future will only come from medical students and trainee doctors. It is vital that they are given an encouraging and rewarding experience of working in CAMHS. Their clinical work should be appropriate to their training, with supervision accessible from other senior clinicians, as well as their consultant educational supervisor

It is clear from our work that the CAMHS medical workforce is highly valued by other team members and is seen as a precious resource. The best way forward is to actively support the ones we have and provide a positive experience for students and trainees to generate new SAS and consultant colleagues.

Finally preventions is, as we know, better than cure, so for all areas we suggest starting the recruitment process as soon as a consultant or SAS doctor gives their notice to allow some overlap between them. Overprovision of consultant posts. when there is more availability of candidates, can avoid gaps arising since it is inevitable that they will be go on leave or move from their posts over the course of their careers and services would benefit greatly from being covered by someone already working within them. With the proposed development of regional Tier 4 services, consultants could be supported to work across different Health Boards with arrangements made for Section 20 approval in each as required.