Royal College of Psychiatrists in Scotland
NHS Reform Wishlist

May 2024

Overview

The notion of NHS reform must be embraced by all political parties in Scotland. The Royal College of Psychiatrists in Scotland (RCPsychiS) considers this an exceptional opportunity to implement essential changes within existing structures. These modifications are critical for mitigating the current, unsustainable escalating demand for NHS mental health services and addressing the departure of our substantive workforce.

RCPsychiS has produced an abundance of research into the current state of mental health services in Scotland, and the present obstacles that inhibit a suitably resourced workforce; such as our State of the Nation Report and Workforce Census.

From these reports, we have developed six pragmatic recommendations that would fit into the NHS reform programme, and we have highlighted these below. Whilst they are linked, they are distinct, and can be split into three strands:

1. Leadership
    a) Make sure psychiatrists, as senior doctors, are at the heart of decision making within NHS Mental Health services.

2. Funding and Finance
    a) Ringfence the promised 10% of the NHS budget for mental health and 1% for CAMHS through a covenant.
    b) Dedicated investment and service reform to adequately address the needs of individuals with neurodevelopmental disorders.

3. Workforce
    a) Establish a Cabinet Secretary-led Psychiatric Workforce Remediation Group, empowered to deliver immediate directives to Health Board.
    b) Taper out the use of under-qualified locums as consultant psychiatrists.
    c) Rebalance psychiatrists working patterns to accommodate patient care, leadership, research and teaching roles.

Whilst these policies can work individually, they would work better as a package or suite of reform measures, providing a multiplying or cumulative benefit.

Introduction and benefits:

These policies can be introduced with relative ease, minimal cost, and if implemented correctly bring numerous benefits, such as:

- Starting to address the demoralisation and burnout of the substantive psychiatric workforce,
- Reducing spending on temporary staff; opening up funding for improved services,
- Enhancing the overall standard of psychiatric service delivery, and
- By reversing the exodus of highly trained experts, preserve and future-proof the delivery of quality mental health services in quantities that meet Scotland's needs.

All of these contribute to the national priority to improve the patient experience, provide better mental health, social engagement and productivity for people with mental illness.

NHS Reform Wishlist – Recommendations in Detail

1. Leadership

a) Make sure psychiatrists as senior doctors are at the heart of decision making within NHS Mental Health services.

It is becoming more commonplace for service-impacting decisions by Health Boards to be made without input from senior clinicians, including Psychiatrists.

In other words, experts at the coal-face have been side-lined, resulting in overstretched budgets and departments across the NHS. By consequence, service delivery has flatlined – regardless of any budgetary increases.

The NHS needs to use the expertise of Psychiatrists to build a system based on evidence. It is notoriously difficult to decipher what works in mental health treatments; all too often an approach that is described as "life-saving" based on one person's account can be hugely harmful to another group of people.

Psychiatrists, like other senior medical professionals, hold deep knowledge and expertise in mental health care, practice and service delivery, and can provide a voice of experience of conditions *on the ground*. This latter element is crucial to devising delivery structures to meet the needs of people in all of Scotland, yet Psychiatrists are seldom included in the operational decision-making.

This is backward.

Recommendation

Psychiatrists, and other senior clinicians, should be empowered to be at the heart of decision making around reform and development of services. This will ensure that any funding spent has the greatest impact and is targeted to the areas of greatest need.

This NHS reform programme should result in Consultant Psychiatrists, and other senior clinicians, holding positions within decision-making bodies, such as commissioning consortiums.

2. Funding and Finance

a) Ringfence the promised 10% of the NHS budget for mental health and 1% for CAMHS through a covenant.

In their manifesto for the Scottish Parliamentary Election 2021 the SNP committed to directing 10% of the total NHS budget to mental health; with 1% allocated for CAMHS by 2026. Indeed, all political parties took forward the proposal, which was backed by Scotland's Mental Health Partnership (SMHP).

Whilst Scotland is facing challenging economic circumstances that require difficult budgetary decisions, mental health services were, once again, disproportionately disadvantaged in the Scottish Budget 2024/25.

It is well-evidenced that poor mental illness has a detrimental effect on the Scottish economy. Research by the Mental Health Foundation shows mental health problems cost Scotland £8.8bn per year. This conservative estimate does not include costs associated with dementia, intellectual disabilities, alcohol or substance misuse, and deliberate self-harm or suicide, all of which are managed by Psychiatric services. If it did, the cost would be much higher.

Unfortunately, every year since this commitment was made, the Scottish Government has failed to get close to this very modest proposal. The Royal College's analysis of Public Health Scotland's Health Service Costs Summary for 2022/23 found that NHS frontline spend is moving away, not toward, the Government's own spending commitments - the share of overall NHS funding further decreased from 8.66% in 2021/22 to 8.53% in 2022/23. This compares negatively to NHS England reporting 14% on mental health spending, and Wales NHS expenditure reporting mental health spend of 11.0%.

The 2024/25 budget cuts will only escalate the present issues without robust intervention.

Recommendation

Government representatives have explained to us that the onus is on individual Boards to enact the division of NHS funding, but our own Managers in the Boards tell us they have no clout to insist on their share of funding and are often expected to shoulder disproportionate cuts to mental health services.

Pointing the finger at Health Boards is not a plausible excuse for budget cuts and the annually unattained commitment.

It is clear, that a "commitment" is not strong enough. The reform of the NHS must find a way to introduce a stronger guarantee that 10% of the total NHS budget will be directed to mental health services. An approach which has already been taken, with some success, in England and Wales.

We urge the Government, and all political parties, to agree to a covenant that ringfences 10% of the NHS Budget for mental health services and 1% for CAMHS, and addresses the shortfall in successive mental health funding packages to ensure parity of esteem with physical health.

2. Funding and Finance

b) Dedicated investment and service reform to adequately address the needs of individuals with neurodevelopmental disorders.

There is a recognised need to improve experiences and outcomes for autistic adults, adults with ADHD, and those with co-occurring neurodevelopmental conditions in Scotland - before, during and after diagnosis.

Shockingly, in some areas of Scotland there is no service at all, and where there is provision, waiting lists can be long and only accessible to people meeting particular thresholds for access. Waits of over 2 years for assessment are not uncommon. This is unacceptable.

Existing service models that are geared for the needs of people with mental disorders are neither suitable nor appropriately resourced to meet the needs of individuals with neurodevelopmental disorders (NDD).

In 2021, the National Autism Implementation Team feasibility study report identified a need for accessible NDD approaches in all 14 Health Board areas, in addition to a need to develop local, stepped care pathway models. This, in turn, means forming new teams and partnerships to meet a need not currently met.

At this stage, Scotland's 14 Health Scotland are at different stages in development around delivery of the adult NDD need.

None, however, have an existing strategy or action plan, and none have comprehensive resourced pathways that can meet the emerging and anticipated need.

Recommendation

There is an urgent need for a whole-system, cross-sector approach to address the needs of individuals with neurodevelopmental disorders. We recommend a role for national leadership and focus from Scottish Government:

- Develop self-help and third sector commissioned resources on a 'Once for Scotland' basis to support people before, during and after diagnosis.
- Prioritisation of investment for the development of multi-disciplinary primary care adult neurodevelopmental teams as part of the development of mental health capacity within primary care.
- Establishing a multidisciplinary design team to radically reform services for neuro diverse people. Psychiatrists should be part of this group.

3. Workforce

a) Establish a Cabinet Secretary-led Psychiatric Workforce Remediation Group, empowered to deliver immediate directives to Health Board

As described previously, the senior psychiatric workforce in Scotland is in crisis. Vacancies and posts filled only by doctors without the full training to take senior responsibilities puts the safety and mental health of patients at high risk.

The weight of responsibility to manage service gaps and bridge the difference between expectations and actual resources allocated falls to individual Health Boards, services and clinicians. This can no longer be sustained.

RCPsychiS and the Senior Medical Managers in Psychiatry (SMMP) Group have recently written to the Scottish Government to outline concerns regarding the need for a coordinated, national workforce strategy for psychiatry in Scotland.

It is clear that Scotland needs a broad package of recruitment and retention measures, progressed at pace, to fill the dangerous gaps in our workforce.

We are aware that other UK nations and regions have recruited international doctors by developing a centrally-led wider strategy. An example of this is the Welsh '*Train Work Live*' initiative and their programme of direct recruitment with the Government of Kerala. We were encouraged to learn that the Scottish Government has been undertaking an exercise in learning from the team behind this. We are not seeking emulation; but is important that all avenues for workforce remediation are explored.

Indeed, we would encourage the Scottish Government to make the psychiatric workforce shortage a priority and explore all possible solutions.

If recruitment from outwith Scotland is seen as part of the solution to the current workforce crisis in psychiatry, it needs to be professionally presented to reflect our range of opportunities, sustained, internationally-focused, centrally coordinated and funded, clinically fronted, supported by knowledgeable HR and associated with assertive 'through care'.

Recommendation

This suggested solution is aimed at the recovery of NHS psychiatric services. It is therefore appropriate that the group is led by the Cabinet Secretary.

Once established, this group would work towards developing a strategy that would assist the delivery of the solutions outlined in positions (3.b) and (3.c) below, and have key objectives covering the aforementioned concerns and issues.

If the Government doesn't move quickly in establishing this group, Scotland could fall behind other nations and regions that already have a strategy in place.

If the Government doesn't move on establishing such a group at all, psychiatry departments across Scotland will struggle to meet increasing demand.

Finally, it is imperative that this group is standalone. By that, we mean this group must not be watered down into a generic NHS workforce remediation group (or similar). The psychiatric workforce is on its knees and requires undivided attention and action in the immediacy.

3. Workforce

b) Taper out the use of under-qualified locums as consultant psychiatrists

Psychiatry departments across all NHS Boards in Scotland are suffering from increasing waiting lists and times, and a reduced and strained workforce.

In addition to the Workforce Census, RCPsychiS' State of the Nation report highlighted a number of concerns around Scotland's psychiatry workforce, including the overreliance on underqualified locums and the need for retention of senior consultants.

At present, such seniors are often expected to mentor and supervise locum colleagues whilst balancing their own unrelenting workload.

Agency staff, who are often less qualified than their substantive colleagues, can demand significantly more pay – as highlighted in numerous recent newspaper articles – whilst, as reported by colleagues and other staff, being unable to deliver the continuity, expertise and teaching and training demands on consultant staff.

This is a real cause of demoralisation for substantive staff.

Furthermore, we also fear for recruitment and retention of trainees to the future workforce. Our qualitative research tells us that many trainees feel embittered to see under-qualified colleagues rewarded financially for roles for which they themselves are undertaking arduous training. Increasingly they are having to take non-training roles whilst awaiting the limited supply of suitable higher training places. This has significant negative ramifications on the future talent pipeline of the profession and, by consequence, the delivery of psychiatric services.

Recommendation

Ultimately, the NHS in Scotland has become overdependent on agency staff or locums, and this comes at a great cost – not just financially.

The most pragmatic approach would be the gradual cessation of new appointments to Consultant Psychiatrist posts of people without the necessary expertise. This might involve a transition period of two to three years. From this time, Boards would insist that all Consultant Psychiatrists hold both MRCPsych and either a CCT or CESR qualification.

This solution should be brought about by Government directive without the need for legislation and requires no additional funding. In fact, it is likely to bring a modest financial saving whilst improving morale and so retention in the substantive workforce.

We are not seeking to make the designation of unqualified post holders as 'consultants' illegal; and don't demand an immediate prohibition of underqualified agency Locum Consultants.

Furthermore, we do not wish to demean the status of all locum consultants, whether employed by agencies or directly by Health Boards. Indeed, in many instances, NHS locums provide a much-needed cover for the gaps in services, accrue longer local experience, and offer greater continuity than generally seen in the present transient Agency Locum climate.

Whilst Employment Law may allow locums already in post to remain, their status will be better respected if the public can have confidence that all those accorded the title of Consultant hold the appropriate qualifications for the role. It is often the case that patients, and members of the public, are unaware that a locum consultant psychiatrist is not suitably qualified. This may mean criteria for informed consent to treatment are not met.

3. Workforce

c) Rebalance psychiatrists working patterns to accommodate patient care, leadership, research and teaching roles.

The most common job plan advertised for a Scottish Consultant Psychiatrist post are 9:1. This arrangement stipulates that 90% of the job time involves face to face clinical work, leaving only 10% (one half day session a week) for teaching and training, supervision, the doctor's own CPD, research, administration and any participation in College or other Public Service work.

In short, the conventional, and unpopular, 9:1 job plan inhibits time for any activity beyond direct patient care.

Scotland is unique in this. In Wales, standard plans are 7:3, whilst most in England are 7.5:2.5.

Both quantitative and anecdotal evidence demonstrates a clear trend of substantive consultants resigning their hard-won NHS Consultant posts to work in the private sector, through agencies, or in other countries whether in the UK or abroad. The issue is often not money, but the protection of boundaries an agency can set, and the recovery of lost work-life balance.

The issue was also highlighted in our State of the Nation Workforce report. Without change the entire workforce could turn to agencies and private employers to ensure that the demands on their expertise do not spiral out of control. The impact of this outcome on NHS psychiatry services would be catastrophic.

Recommendation

We know that job plan changes are possible. We know that NHS Lanarkshire have introduced an 8:2 plan, and we applaud this important step in the right direction. Increasing time for consultant psychiatrists to undertake non-patient care activities will allow for enhanced opportunity for the training and mentoring of future professionals and department management whilst still maintaining a high quality of service.

However, it is important that we emphasise here that introducing more balanced job plans will not be easy. They are in place because they *have* to be in place – reducing consultant psychiatrist face to face time with patients is not an option for medical managers due to high vacancy rates. We look at this issue in more detail in our State of the Nation Workforce report.

Furthermore, reconfiguring job plans would tackle just one strand of the multifaceted issues that form the substantive workforce's burnout and demoralisation; other strands include decreases in workspace, confidential office space, and neglected wards (to name a few).

Not all the above changes can be managed in one stage; further steps will take time. As a starting point, we would like to see 9:1 job plans replaced by 7:3; and this would complement the cessation of unqualified locums.

Gaining the benefit will take time, so there is a need to start immediately.

Fortunately, this solution can be introduced through Government directive, without the need for legislation or extra funding.