



Health Education England

HEE Workforce Planning and Strategic Framework (Framework 15)

2015/16 Call for Evidence

In 2015/16 we are inviting organisations for submissions which address not only immediate workforce planning and education commissioning but which look further ahead and cover wider workforce strategy. For this reason the 2015/16 form covers not only 'conventional' supply and demand concerns, but invites organisations to comment on the wider context of drivers of change and the strategic response. It is organised as follows:

Section 1: Current and future workforce demand and supply

Section 2: Drivers of service demand change

Section 3: Patients and population

Section 4: Models of care

Section 5: Future workforce characteristics

Section 6: Any other evidence

Submissions should be completed and returned to HEE, using this form, by 30th June 2015 (see below for more information).

We acknowledge that this is a bigger task than in previous years, and it may entail a higher level of internal deliberation and consultation for your organisation. This is deliberate: we want to learn as much as we can about what organisations are thinking about the long term and the big picture, while simultaneously gathering thinking about the here and now and the more immediate future which will be influenced directly by HEE's commissions in the short term.

Making your submission

- We ask that, to maximise input, your submission is completed and returned to HEE by **30th June 2015**
- To submit your evidence please, complete this form. You can provide extracts of reports into the free text boxes below, or submit whole reports. Where an extract is provided, please reference the source.
- In submitting evidence you are invited to take into account the following:

HEE's workforce planning guidance	HEE Planning Guidance. Due to the restrictions around the election we have not yet received permission to put the planning guidance on our web site. It has been widely circulated but please contact
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	mandy.knowles1@nhs.net if you do not have a copy.
HEE's strategic framework (Framework 15)	http://hee.nhs.uk/2014/06/03/framework-15-health-education-england-strategic-framework-2014-29/
The NHS Five Year Forward view	http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

- Once you have completed the form and/or prepared your 'pack', please embed it in an email and return it to hee.workforceplanning1@nhs.net and in the subject heading please use this convention:

HEE CFE 2015/16 from [your organisation's name in full – avoid acronyms] [Sub version x]

- Please note, it is not *compulsory* to complete all sections for you to submit a response, but **in order to maximise the value of your submission in informing HEE's 2015/16 education commissions, section 1 should be completed and returned by the 30th June 2015**. Later submissions are not wasted as we draw on Caff for Evidence returns throughout the year for a variety of purposes.

Your contact details

Before completing the form below please submit your contact details here:

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Submission version (if you resubmit at any point)	Version 1.1
Date	9 July 2015

Data Protection and Freedom of Information

The information you send us may be made available to wider partners, referred to in future published workforce returns or other reports and may be stored on our internal evidence database.

Any information contained in your response may be subject to publication or disclosure if requested under the Freedom of Information Act 2000. By providing personal information for this review it is understood that you consent to its disclosure and publication. If this is not the case, you should limit any personal information provided or remove it completely.

Section 1 – Current and future workforce demand and supply

Use this section to input evidence into the forecasting of future workforce numbers. Report here your perspectives on either;

- i) the high level indicators; supply, demand, and any forecast under / over supply or, if available;
- ii) the more granular components of these three components e.g. retirement rates, output from education relative to attrition

1.1 Summary forecasts

- Forecast Workforce Demand
- Forecast Workforce Supply and Turnover
- Forecast Under / Over Supply

ADDICTIONS PSYCHIATRY

Workforce Demand: Drivers increasing workforce demand include:

- There has been a steady increase in alcohol related harm over the last 20 years, with marked increases in alcohol attributable diseases. Hospital admissions with alcohol attributable conditions have doubled in the last 10 years in England to over 300,000 per annum and a further 700,000 admissions are reported to be partly attributable to alcohol (CMO report, 2014). CMO (2014) Public Mental Health: Investing in the Evidence.
- While there has been some decline in Class A drug misuse (heroin, cocaine and crack) in recent years, there has been a rapid growth in the range, availability and use of Novel Psychoactive Substances (NPS). A recent RCPsych report highlighted these trends and the impact on public health, including patients presenting with drug related mental illnesses to acute and mental health care. RCPsych (2015) One New Drug a Week: Why novel psychoactive substances and club drugs need a different response from UK treatment providers.
- Both prevalence trends will increase demand for specialist addiction psychiatry expertise in diagnosis and management of these conditions. In the case of alcohol, NICE and NHS evidence has highlighted the cost effectiveness of specialist alcohol services where for every £1 spent, £5 can be saved in reduced hospital admissions, A&E attendances and GP visits. Such services will require specialist addiction psychiatry consultants to develop and evaluate services, and to train the wider specialist workforce.
- Further, there will be increasing demands on the wider psychiatry workforce to manage patients with alcohol and drug problems more effectively. Specialist NHS addiction services have been an important training ground for both addiction specialists and non-specialists in general adult, child, forensic, old age and other specialisms within psychiatry. There will a continuing demand for non-addiction specialists to gain experience in addiction treatment as part of general psychiatry training.

Supply side issues:

- The Addictions Faculty has been increasingly concerned about the loss of NHS specialist addiction services over the last eight years as a consequence of changes in local service contracts and widespread re-tendering of addiction services. This has affected NHS addiction services to a much greater extent than any other speciality in psychiatry. In many cases the established NHS specialist addiction services have been replaced by non-statutory providers who either employ GPs rather than addiction psychiatry consultants or are unable to persuade experienced addiction psychiatry consultants to move from an NHS contract.
- This has had several negative impacts. We are aware that several experienced addiction consultant psychiatrists have left the field and returned to general psychiatry. Plus there has been a significant loss of training posts in addiction psychiatry at CT and ST level. A recent survey by the Addiction Faculty found that the number of filled addiction psychiatry ST posts has halved between 2007 and 2014 from 47 to 26. The reasons for the loss of posts is mainly the loss of NHS addiction services and consultants due to retendering and contracts going to the third sector, in which the posts are not replaced. We are also aware of some Deaneries in England advising trainees against a career in addiction psychiatry due to the ongoing upheaval of services and career uncertainties. In addition, many of the third sector providers do not provide attractive terms and conditions of service for medical staff compared to the NHS, making it a less attractive career option.
- We believe this will have important negative impacts. There will be fewer trained addiction psychiatry consultants with CCT and endorsement in addiction to meet the needs of a growing problem with alcohol and NPS. This will cause problems for both NHS and third sector specialist addiction services in having an appropriately trained and experienced workforce. Similarly there will be a reduction in the number of psychiatrists in other psychiatric specialities who previously gained experience in NHS addiction services as part of their training. This will leave the wider psychiatry workforce ill-equipped to deal with a growing number of patients with drug and alcohol comorbidities.
- The Addictions Faculty believes that this problem of loss of consultant and training posts in addiction needs to be urgently addressed, as if the current trend in loss of posts continues this will become an important speciality on the brink of extinction.

CAMHS PSYCHIATRY

- Workforce considerations are cogently explained in Chapter 3 of the Future in Mind DOH document 2015 (18)
- Recruitment of Child Psychiatrists should be considered alongside that of the multi-disciplinary teams and allied services such as social care and education.
- Funding has been pledged as specified in the Future in Mind Paper; this was pre-election 2015
- I have listed some other key documents below in addition to the Future in Mind DOH Paper

FORECAST DEMAND

Increasing rates of child and adolescent mental health morbidity

- Within the last decade Child and Adolescent Mental Health Services increased the age of referrals from 16 to 18 years. In the 2007 survey of adults in England, 4 in

the 16–24-year-old age group show mental health problems of approximately 20 % (McManus S, Meltzer S, Brugha T, Bebbington P, Jenkins R. Adult psychiatric morbidity in England, 2007. Results of a household survey. Leeds: The Health & Social Care Information Centre, 2009)

- Chief Medical Officer’s 2012 report Our Children Deserve Better: Prevention Pays
- This report highlights the under treatment of children and young people with mental health problems. This emphasizes the large deficit of the Child and Adolescent Mental Health Service (CAMHS) workforce. (1)
- The Treatment Gap; Only 23-35 % of children with a diagnosable mental health problem have contact with CAMHS (2, 16)
- Mental Health Strategy 2011 and 2014 No health without mental health Closing the gap: priorities for essential change in mental health (3)
- The Governments Mental Health Strategy clearly states “We are clear that we expect parity of esteem between mental and physical health services” With only 23% of children and young people with mental health problems accessing a CAMH service there is a clear lack of parity.
- The British Child and Adolescent Mental Health Surveys in 1999 and 2004 (3) found that 1 in 10 children and young people under the age of 16 had a diagnosable mental disorder. (National Office of Statistics (4)).
 - 9.6% or nearly 850,000 children and young people aged between 5-16 years have a mental disorder
 - 7.7% or nearly 340,000 children aged 5-10 years have a mental disorder
 - 11.5% or about 510,000 young people aged between 11-16 years have a mental disorder
- In the 2007 survey of adults in England, 4 in the 16–24-year-old age group show mental health problems of approximately 20% (5)
- The economic case for investment is strong. 75% of mental health problems in adult life (excluding dementia) start by the age of 18. (16)
- Rates of mental health problems in children and young people in the UK rose over the period from 1974 to 1999 CMO 2012 report recommended that the CAMHS survey was repeated. (1) The DOH have agreed to repeat this survey (16)
- Self-harm rates have increased sharply over the past decade, as evidenced by rates of hospital admission and calls to helplines, providing further indications of a possible rise in mental health problems among young people. However, in the absence of up to date epidemiological data, it is uncertain whether there has been a rise in the rates of mental health problems (1, 6, 7 and 17). The last national survey of mental health problems was published in 2004.
- The Health Behaviour in School-Aged Children (HBSC) report , (a research collaboration with the WHO Regional Office for Europe surveyed across England) due to be published in the autumn, will reveal that of the 6,000 young people aged 11, 13 and 15– up to one in five 15-year-olds say they self-harm. This is a threefold increase within the last decade. (8)
- In 2012/13, total admissions to inpatient CAMHS were 3,548, with emergency admissions making up 1,574 of the total. The number of admissions is now around double that at the turn of the millennium. These statistics do not represent the larger workload pressure on CAMHS community services which are not represented in the HES (9)
- The crisis with tier 4 inpatient beds for children and young people with mental health problems has been widely documented and subsequently reported in the national press. A recent survey from the Royal College of Psychiatrists describes the problem with 90% of the psychiatrists surveyed describing out of area placements. Risk is increased due to adolescents and their families refusing admission due to the distances from their homes. The YP themselves may be placed

hundreds of miles from their families which in effect denies them a right to a family life and delays their recovery. (10, 11)

- Results from the 2011 Census UK show that there are increased ethnic diversity in England and Wales; this adds to the complexity of mental health problems (13)
- There are increased rates of mental health problems arising from bullying including cyber bullying and internet sources.(18)
- Future in Mind DOH 2015 has 5 themes:
 1. Promoting resilience, prevention and early intervention
 2. Improving access to effective support – a system without tiers
 3. Care for the most vulnerable
 4. Accountability and transparency
 5. Developing the workforce

Some key recommendations necessitate an increase in staff e.g. increasing the age of vulnerable young people attending CAMHS until 25 years of age

Increasing CAMHS services with a crisis and step down from inpatient service

Some developments are predicted as cost neutral and some require investment / recruitment.

FORECAST UNDER SUPPLY

Building and sustaining specialist CAMHS to improve outcomes for children and young people. Update of guidance on workforce, capacity and functions of CAMHS in the UK November 2013 (14). This Royal College of Psychiatrists report is clear about the necessary workforce required to deliver a competent national CAMH service. This does not include improvements as described in Future in Mind (16)

- The retirement of CAMHS psychiatrists with MHO status will create a dearth of specialists.
- The centre for workforce intelligence has anticipated a shortage of CCT holders in child and adolescent psychiatry approximately between 60 and 230 FTEs by 2033. There has however been further implications for the workforce numbers due to the increased work defined in the Future in Mind DOH document (16)
- There has been investment in the Children and Young People's Increasing Access to Psychological Therapies (CYPIAPT) However CAMHS services have been effectively cut due to reduced budgets (12)
- Young Minds sent Freedom of Information (FOI) requests to every NHS Clinical Commissioning Group and every 'upper tier' local authority in England asking them what their budget is for CAMHS for the financial year 2014-15 (12). Key findings include:
 - 74 out of 96 (77%) NHS Clinical Commissioning Groups have frozen or cut their CAMHS budgets between 2014/2015 and 2013/2014
 - 59 out of 98 (60%) local authorities in England have cut or frozen their Children and Adolescent Mental Health Services (CAMHS) budgets since 2010/2011
 - 56 out of 101 (55%) local authorities in England that supplied data have cut, frozen or increased below inflation their budgets between 2013/2014 and 2014/2015.

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10. Survey of admissions to inpatient services for children and young people with mental health problems (2013): Royal College of Psychiatrists unpublished data
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http://www.centreformentalhealth.org.uk/pdfs/life_chances_summary.pdf
16. Future in Mind; DOH March 2015
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18. Copeland WE, Wolke D, Angold A, Costello EJ (2013). Adult psychiatric outcomes of bullying and being bullied by peers in childhood and adolescence. JAMA Psychiatry 70(4): 419-426.

FORENSIC PSYCHIATRY

Demand side issues:

- Burgeoning older population in forensic, patients living longer. Many are treatment resistant and care needs become more complex as for some risk does not reduce.
- Complexity of presentation increasing, with physical and mental health needs, learning disabilities and drug and alcohol issues.
- Delivering on physical health care needs of patients is impacting workload – primary care services are being developed in secure services.
- Technology has the potential to change the way we work; at the present time, however, the limitations of available IT slow down the work.
- There are serious concerns regarding patients with learning disabilities in forensic services whose needs cannot be met outwith secure service and more expertise and review of their risks and needs is required. Bed reductions will place increased demand on the system and may increase the risk to public. There is a need for dually trained forensic and LD psychiatrists.
- Expansion of number of forensic psychiatrists for new services - PD services and community developments will require more forensic psychiatrists due to risk and travel times.
- The number of patients in seclusion in high security is increasing; this population is now very labour intensive, resource intensive and high risk.

Supply side issues:

- Staffing levels in prisons are having a major impact on demand for psychiatric input as numbers of correctional staff reduce and prisoners' unmet psychological needs. There is also an increase in bullying, failure to detect depression, suicide risk and risk to others, and psychotic symptoms go undetected.
- There are currently no proposed changes to consultant working practice to deliver 7 day working.
- Mental Health Officer (MHO) status will lead to hump of retirements in next few years then slowing down.
- There is likely to be a reduction in the use of agency locums this may be a problem, especially for SASG doctors.
- Recruitment problems including SAS doctors (as above).
- Small number posts converted to dual GA/Forensic posts; these are popular due to greater flexibility for career development and fits with shape of training.
- Impact of outsourcing Drug and Alcohol services to third sector on the delivery of care in forensic services and on training of forensic psychiatrists - lack of services for patients, lack of training – increases length of stay and delivery of fragmented services.

GENERAL PSYCHIATRY

- There is unlikely to be a reduction in demand for general adult psychiatrists over the next 10-20 years. However there may be more variety in terms of specialisation, particularly at interfaces with adolescence and old age, so training will need to change. The increase in liaison psychiatry also raises the demand for this type of work in community settings.
- The high demand across secondary MH services has led to national bed shortages, even in the private sector, and continued use of out of area placements.
- Some problems with supply as there are already unfilled higher training and core training posts.
- There may be a major loss of experienced consultants who may retire as a result of MH officer status and others reaching normal retirement age; this may result in severe loss of workforce in next 5-10 years.
- The working and lifestyle conditions and salaries are perceived as being better in Australia, New Zealand and Canada where substantial numbers of consultants have already emigrated to.
- Working conditions are likely to improve in developing countries making the UK comparably less attractive.
- Recruitment to general adult consultant posts remains very variable, but in large parts of the country there continue to be difficult to fill vacancies - particularly outside academic centres (e.g. Teesside, North Yorkshire and Cumbria are clear examples). The north east does not have the higher training numbers to produce enough CCT holders to fill our upcoming vacancies.
- Psychiatry and general practice have traditionally competed for the same group of medical graduates. Both are currently unpopular but if GP recruitment improves, thanks to government incentives, then this will be likely to be at our expense. There is a clear message from GPs that they want more psychiatrists at the front line and available for liaison and consultation, offering some continuity of care.
- Issue of reducing hours / retiring early (in part because changes in job have greatly reduced attraction of post). Static pay rises and anxiety regarding future pensions etc playing a part.
- Low take up of Approved Clinician status by non-psychiatrists – perceived as a way of reducing dependency of psychiatrists
- Pressure will continue over the next few years at least as MHO status works through. The attrition might be as high as over a third of the existing workforce. In the longer term, the 'sustainable career' will become an important concept: just increasing the retirement age will not necessarily retain consultants in their existing jobs.

ISSUES IN THE SUPPLY OF CCT

Balance of Core and Higher and growth of Foundation

The current distribution between Core and Higher training shows a ratio of around 1.8:1.

Recent increases in Foundation numbers should serve to improve recruitment to Core training provided that the profession, provider organisations, patient and carer groups and national bodies and others are able to articulate a vision of the speciality as having an important role in service delivery and development into the future. A national tone of stigma and criticism will not improve recruitment.

At present, the attrition through Core Training of trainees does not lead to an oversupply of well qualified doctors applying for existing ST4 posts. The redistribution of Higher posts to Core Training has therefore been suggested although the argument for this at present is not strong as the available figures suggest an undersupply of CCT holders from the existing Higher posts. Some specialities, notably Old Age and Learning Disability, appear likely to continue to have significant under supply of CCT holders unless action is taken.

INTELLECTUAL DISABILITY

Workforce Demand:

Consequences of Winterbourne View & NHSE Transforming Care Programme for people with learning disabilities and/or autism:

- Continued impact on inpatient services - out of area placements, local inpatient services, general AMH wards, local community resources and challenging behaviour pathways due to the accelerated discharge plan for those with ID.
- New community models: in the process of being developed at pace to prevent or minimise need for hospital admission
- NHSE funding 5 areas with support to significantly close number of hospital beds and develop more robust community services. This means the closure of NHS and non-NHS beds, the latter being the largest provider of secure inpatient provision for people with ID and/or autism.
- Increasing recognition of the need to enhance capability across the NHS to manage people with autism, LD and challenging needs in line with the Green Light Toolkit
- Closures of inpatient facilities may threaten future training of psychiatrists and other clinicians specialising in the assessment and treatment of this complex and vulnerable group. Lack of experience in this area may then result in an increase in those detained or an increase in length of stay in general adult inpatient beds
- The continued emphasis on social inclusion and local services means generic mental health (and physical health) services will need to demonstrate reasonable adjustments within their own pathways to ensure greater access to their services for people with intellectual disabilities and/or autism. Services are not commissioned in this way resulting in a disconnect in national policy and local provision.

Workforce Supply and Turnover:

- 1:6 consultants are working at or beyond retirement age. The changes in pensions resulting in significant financial disincentive for senior experienced medically trained staff to remain in the NHS, at least until the cohort with MHO status retires.
- Recent guidance, Safe Services (CR174, RCPsych 2012), calls for a consultant delivered service with adequate senior presence to deliver quality care. The impact of this on future recruitment at consultant level is yet to be tested. There is also early evidence from some areas in England, that the implementation of the Autism Act has placed increased expectations on local ID services. It is likely that commissioners will seek to obtain additional sessions from ID psychiatrists and this will be a further pressure on consultant requirements.

Workforce under supply:

It is often the case that medical students, doctors and trainee psychiatrists do not choose psychiatry as a specialty, or psychiatry of intellectual disabilities, as a sub-speciality, if they have not had exposure or good exposure to this field early in their career path before choices need to be made. The GMC in their recent deep dive into the psychiatry of ID training (2015), reported very high standards of training offered, including excellent opportunities to develop specialist skills in related clinical, research, education and managerial areas. The recently revised requirement for psychiatry of ID in adults to be a mandatory component of CT training is very welcome but has yet to be formalised and implemented. However:

- Specialty posts remain hard to recruit to and more creative attempts (e.g. specialty grade rotations) have had variable success. In some areas, vacancies have been converted to trust funded ST4-6 or consultant posts.
- Inclusion of specialty posts in the CfWI Shortage Occupation List (SOL) was not supported.
- This is a relatively small specialty. NTN's are static and there is pressure to reduce training numbers at CT and ST level. The fill rate at ST4 recruitment increased from 29% in 2014 to 44% in 2015. However, this is not evenly distributed across the country and ranges from 0-100%
- The Faculty of Psychiatry of ID has a working group specifically targeting recruitment and retention at medical school and Foundation year level.
- The drive to limit training numbers and the current cap on migration for trainees is likely to have a disproportionately significant impact on this specialty. The UK is the only country to provide specialist training for Psychiatrists in ID – colleagues other countries do not have training in this area unless they have a special/personal interest in it. Outside of the UK, general psychiatrists, neurologists and community paediatrics tend to pick up the demand but services are very patchy and inconsistent. Many countries also continue to either operate an institutionalised model of care or leave families to cope unsupported. Therefore it seems only reasonable that training numbers are expanded to ensure increased numbers of consultants, able to provide acceptable and equitable quality of healthcare for people with ID.

LIAISON PSYCHIATRY

There has been progressive development and expansion of Liaison Psychiatry provision nationally over the past few years following the economic evaluation undertaken by the London School of Economics, which demonstrated the RAID Liaison Psychiatry service in Birmingham returned £4 to the health economy for every £1 invested. The Department of Health has set the expectation that all acute trusts will have effective models of Liaison Psychiatry in place by 2020 and NHS England have supported this aim with £30 million of targeted investment in 2015/16 (Achieving Better Access to Mental Health by 2020, Department of Health / NSH England, 2014). From 2015/16, the CQC will also be focusing on the provision of effective Liaison Psychiatry services when it inspects acute trusts. However, the National Census Survey of Effective Liaison Psychiatry provision (2015) demonstrated that whilst most acute hospitals with A&E departments have Liaison Psychiatry provision, the vast majority are not resourced or staffed to the level that would be likely to provide a tangible benefit. Given the strategic drivers and current inadequacy of provision, it is expected that there will be sustained need for recruitment and workforce development with Liaison Psychiatry services over the next 5 years.

Liaison Psychiatry services often incorporate a number of clinical disciplines, which can include psychiatry, mental health nursing, psychology, occupational therapy and social work. The training and expertise required by professionals working in Liaison Psychiatry services include the ability to work independently in a variety non-mental health clinical setting and having the ability to deal with the complexity of physical and mental health co-morbidities occurring together and often interfacing with a range of psychosocial factors. Liaison Psychiatry is therefore likely to face workforce challenges in relations to:

- Recruiting experienced clinicians from a range of disciplines into expanding services in the short to medium term (with possible knock on impact on other areas of mental health that these experienced clinicians may currently be working in).
- Ensuring that staff working in services have the appropriate skills to be able to manage complex cases and co-morbidities in non-traditional mental health settings and in conjunction with a range of health care professionals from other clinical backgrounds.
- Meeting the increased demand for specialists in Older Adult Liaison Psychiatry, and, in particular, the urgent need for doctors training in Old Age Psychiatry to be able to receive accredited training in Liaison Psychiatry.

MEDICAL PSYCHOTHERAPY

Workforce Demand:

Drivers increasing workforce demand include:

- Expansion of demand for psychological therapies on the basis of policy/effect of IAPTS etc.;
- Roll out of tier 4 PD units and commissioning and local expansion of tier 3 provision;
- Implementation of RCPsych training requirements for psychotherapy experience; and
- Aging and retiring current practitioner profile.

OLD AGE PSYCHIATRY

- Workforce demand in Old Age Psychiatry will continue to increase as our population ages.
- Supply is not predicted to meet this demand with a significant shortfall.
- Retirement rates of old age psychiatry consultants have increased as has the vacancy rate.

PERINATAL PSYCHIATRY

The main issue for perinatal psychiatry is that at present there is not specific endorsement or training curriculum. The curriculum for perinatal remains lodged in that for

general adult psychiatry - and that this is not a suitable situation to train future perinatal psychiatrists.

Training posts in perinatal psychiatry, however, are viewed as specialised - and therefore may be seen as not suitable for giving general adult experience. Training posts are also not geographically well distributed around the country with many deaneries not have posts for trainees who would like to get experience in perinatal psychiatry. There are many difficulties therefore in matching up existing training places with those trains who would like to train in perinatal psychiatry.

Due to the expansion of perinatal services, including £75m additional funding promised in the last budget, there has been an expansion of posts. At present at least 8 consultant jobs will be advertised in the near future and due to the situation described above, there are serious concerns about filling these existing posts. If, as is likely, the expansion of perinatal services will result in many more posts it is unlikely that they will be able to be filled by consultants with adequate training in perinatal psychiatry. Although we do not have detailed workforce predictions for perinatal psychiatry posts, recent mapping of England has revealed 50% of trusts do not have any specialist perinatal psychiatry provision.

As a way forward, the faculty is exploring other options, including post CCT credentialing which may be an option in the absence of a specific perinatal endorsement. However, the Faculty are keen to also continue to pursue pre-CCT perinatal endorsement linked to a specific perinatal curriculum.

1.2 Detailed / Component forecasts

Forecast Workforce Demand

- Service Demand drivers
- Change in use of temporary staff
- Addressing historic vacancies
- Skill Mix / New Roles
- Workforce Productivity

ACADEMIC PSYCHIATRY

Recruitment: we find that offering clinical academic training posts – NIHR or local ACF/ACL posts – attracts promising trainees. Although on a couple of occasions we have not been able to recruit, we generally have more qualified candidates than available places. Recruitment has been easiest to posts in adult psychiatry. We have been able to recruit to CAMHS, LD and Old Age but we have had fewer applicants and on several occasions have had to re-advertise.

The career goals of the majority of our academic trainees are for senior clinical academic posts but a significant minority aim for clinical consultant posts but would like to remain research-active within those posts.

Having reviewed the document it has been difficult to respond to specific domains as there is no mention of Academic Psychiatry within any area of the document. This is a short-sighted approach as academic practice is central to psychiatry and many of the drivers around service change will develop as a direct consequence of research. Possible examples of this could include specialised services such as improved screening for dementia and memory clinic services, personalised medicine and pharmacogenomics. We would advocate for the RCPsych to raise this directly with HEE and NIHR to incorporate Academic careers with the workforce planning strategy. The issue of the numbers for IATs is really key, not just to psychiatry but across all of medicine. They have a separate funding scheme (via NIHR) but by the time they reach the large LETBs this finding seems to be subsumed into the bigger pot and clinical rotational slots get transformed into academic ones. I am deputy chair for the national grouping of IAT leads and we have found it very difficult to find a way to meaningfully engage with HEE around this issue, so any push/support at the level of the colleges would be very welcome. Please let me know if there are any other ways I can contribute to this

Integrated Academic Training Programme (IAT): While the total numbers of IATs are set by NIHR the allocation to specialities is determined at a Medical School level and reflects the academic strengths of the Institutions. Without continuing to support and value an academic workforce at a senior level we will reduce the number of trainees being able to follow an academic training path and hence reduce the number of future academics. Since the start of the IAT program there has been a lack of clarity around funding for trainees. NIHR/TCC describe the academic trainees as “supernumerary” with a separate funding scheme, but many LETBs continue to include the academics within the total number of trainees rather than in addition to them. This leads to an effective reduction in both in clinical training positions and in the

clinical service provided by trainees. We would strongly advocate for HEE to review these arrangements and allow for all IATs to be appointed to NTN posts which are in addition to commissioned clinical posts.

OOPEs: At any given time approximately 15% of trainees will be on an OOPE or some sort of out of program experience. This is to be encouraged as through OOPEs trainees can develop skills in research, medical education and management and leadership all of which will improve the future Consultant workforce. However, OOPEs can present a challenge to workforce management as trainees moving away from clinical posts into (independently funded) OOPE posts leave time limited vacancies within training schemes which can be hard to fill. Given that the notion of non-clinical training is central to the Shape of Training proposals we would advocate for HEE to increase the number of NTN posts available to training programs to compensate for the number of trainees who are on OOPE.

CAMHS PSYCHIATRY

Service Demand drivers; see above

- Addressing historic vacancies I do not have data; anecdotally CAMHS have not filled historic vacancies; including consultant vacancies.
- Skill Mix / New Roles; anecdotally some CAMHS staff are trained in assessing risk, there are a few non-medical prescribers. Some services have recruited senior mental health practitioners from social care. Some services, particularly with an outreach component have some band 3s for basic tasks.

GENERAL PSYCHIATRY

- With increasing pressure on GPs there are more referrals to be expected into Psychiatry.
- New developments i.e. youth mental health services, transition services may require more double qualified psychiatrists, i.e. CAMHS and GA psychiatrists.
- Increased demand and need alongside economic and migration changes.
- An ageing population will require more support for functional mental health disorders.
- Alcohol and physical health related cognitive and psychological disorders will increase in an ageing population; this may have to be delivered by more liaison psychiatrists.
- Historic and recurring vacancies in more rural areas, Cumbria, North East and Yorkshire will need to be filled with substantive consultants.
- Administrative requirements by regulators, commissioners, and legal services will reduce the time and workforce necessary for direct patient-services.

Other issues:

- IT and the electronic patient record system in particular adds to the consultant workload.
- Increasing patient movement between functional teams leads to reduced continuity of care; a number of consultants therefore need to familiarise themselves with each patient's history.

- Reduction in locations where patients can be seen, leading to increased travel time, home visits etc.
- Reduction in bed availability so patients discharged too soon and readmitted, increased time dealing with patients who need a bed but can't get one.
- Reduction in appropriate medical staffing and appointment of unsuitable / inappropriately qualified locums.
- Increased educational demands on training grade staff so they are less available for service work.
- Increased pressure on “coping skills” as care moves to the community.
- Medical staff increasingly aware of high psychiatric morbidity but need support in managing risk, safeguarding, and medico-legal issues etc., which are skills psychiatrists are more comfortable with.
- AAC interview panels appear to have plenty of appropriately qualified applicants. There is a trend for the field to reduce on the day due to withdrawals.
- Consultant productivity being pressured upwards, often picking up more admin burden and clinical work as teams are cut. Knock on effect on morale / burnout / retirement.

INTELLECTUAL DISABILITY

Service Demand drivers: (as above)

Consequences of Winterbourne View & NHSE Transforming Care Programme for people with learning disabilities and/or autism. Backlash against ‘psychiatry’ and the ‘Mental Health Act’ provisions for detaining people with ID and ASD in general.

Concern from trainees about the long term future of the specialty – as a result of closure of specialist inpatient services, mainstream/social inclusion agenda, role of the misunderstood ‘medical model’, future uncertainty re community service models especially in light of Five Year Forward View (NHSE 2014).

In 2009/2010, it was estimated that there were over 250 community learning disability teams and approximately 2,300 assessment and treatment hospital beds for people with a learning disability in England. In addition, 48 high secure, 414 medium secure and 1,356 low secure hospital beds were also identified as a best estimate of specialist forensic provision for this group. This assessment provided an essential first step in determining the distribution of the workforce across the country (Alexander et al, 2011). The Transforming Care Agenda is likely to result in secure and long stay inpatient beds being decommissioned at pace, and will impact on the distribution and recruitment into the workforce. The change in commissioning of secure services over to NHSE from CCGs and potential national re-commissioning of secure services will have a further impact if NHS providers do not win the tenders.

Ascertaining workforce demands and planning:

It is of concern that national planning of future need is based on data sets that are known to be a poor reflection of real need, due to difficulties with consistent coding and recognition of ID need by non-ID specialist colleagues. Development work on MHSDS dataset continues but is fraught with difficulties as it strives to deliver on multiple agendas.

According to the 2011 Census, there were 306 substantive consultant posts (230 FT and 76 PT) in the Psychiatry of ID in England, Northern Ireland and Wales. In addition, there were 42 locum posts (22 FT and 20 PT). Data is dependent on Trusts/Hospitals/Independent Sector declaring workforce intelligence and the RCPsych does not have a robust system to capture this.

There continues to be a small number of psychiatrists applying for specialist registration via the CESR (Article 14) route. Roughly half of applications are approved.

The Royal College of Psychiatrists reported in 2007 that there were 52 psychiatrists employed in the independent and charitable sector (Marston et al 2010). Of these, 40 were recorded as consultants (approx. 15% of the consultant workforce using 2011 census figures). Many were previously employed within the NHS. It was also reported that a number of registrars moved from training positions in the NHS to employment in the independent sector. The private sector has until very recently, continued to expand its provision, which is mainly hospital-bed based, especially in the low-secure settings. Private providers are also increasingly providing specialist, rehabilitative, long-term, step-down services, together with residential nursing care units able to support detained patients (for community treatment orders/guardianship) All of these services require consultant cover. Increasing numbers of trainees have been moving directly from CCT to private sector employment (RCPsych, 2011). The planned accelerated closure of inpatient bed provision across England post Winterbourne View, is likely to see an increase in workforce demand.

Skill Mix/New Roles

Psychiatry of ID is a specialty of psychiatry involved with assessment and treatment of emotional, behavioural and psychiatric disorders associated with intellectual disability. The workforce additionally provides advice and education on behavioural aspects of intellectual disability to parents, carers and to other professionals that may have an interest. The nature of problems dealt with is broader than in other psychiatric specialties and includes psychiatric disorders such as dementia and delirium, functional psychiatric disorders such as affective disorder and schizophrenia, autism, challenging behaviour and epilepsy. Much of the work takes place in settings other than hospitals, including clinics, daycentres, family homes and community homes (CfWI, 2012).

People with Intellectual Disability are some of the most disadvantaged members of society. They experience poorer health outcomes, some of which are avoidable. The Equality Act requires health services to make 'reasonable adjustments' to ensure equity of access and experience for this group. 'Equal' does not necessarily mean 'the same' generic service, hence specialism is required in psychiatry (Safe Patients and High Quality Services, RCPsych 2012).

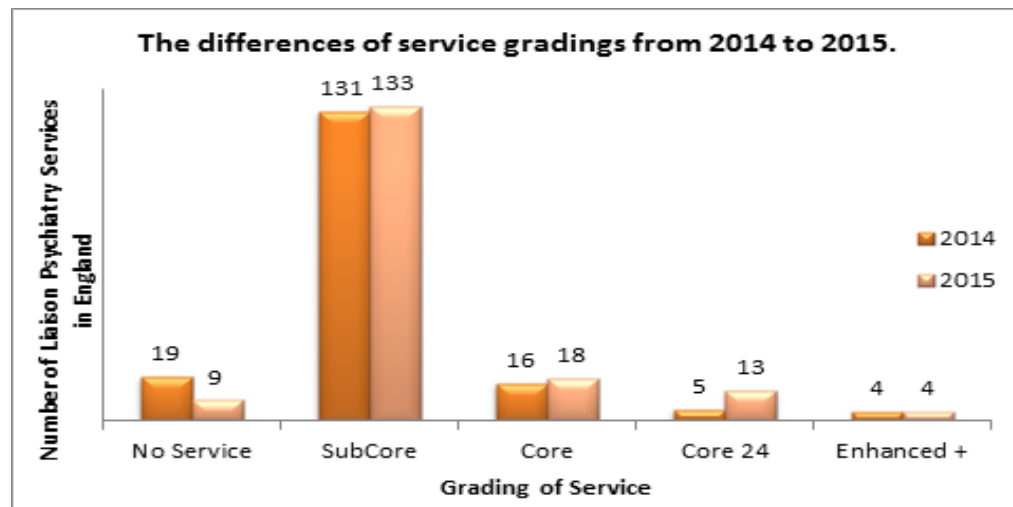
There are additional factors that may influence the work of psychiatrists in ID: Patient factors, geographical and demographics, local Trust service models and its interface with social care, wider MDT, general adult psychiatry, CAMHS, forensic services, inpatients units. Work is being undertaken at pace within NHSE and in June 2015 5 Fast Track sites across the country currently with a significant ID inpatient provision have been targeted to co-produce a different model of service to reduce reliance on inpatient beds and increase resilience in the community. Feedback from this early work suggests there will need to be a partnership model between community and hospital services, local specialist ID inpatient provision when reasonable adjustments are not enough within a mainstream adult mental health setting, and that it will not be a 'one size fits all' approach. This makes workforce planning more challenging. However, it is likely to require medically trained clinicians with core specialist skills in ID psychiatry (encompassing a biopsychosocial approach) who are able to liaise with consultants in other branches of medicine and psychiatry such as liaison psychiatry, neuropsychiatry and brain injury services as well as medical consultants caring for long term conditions and health problems with a high comorbidity in people with ID.

Consultants in Psychiatry of Intellectual Disability have a unique role in education and service development both in the UK and internationally as we are the only country that specifically trains in this specialty. The curriculum is very broad, covering the wide range of skills needed to support this complex population. The future is likely to see the need for wider neurodevelopmental disorders training, a focus on physical and mental health, and wider collaborative leadership. At the same time, the exposure trainees are likely to have in the specialist secondary/tertiary inpatient assessment and treatment of very complex individuals with or without a significant forensic history is likely to be compromised as such experiences are likely to be scarce and out of area.

LIAISON PSYCHIATRY

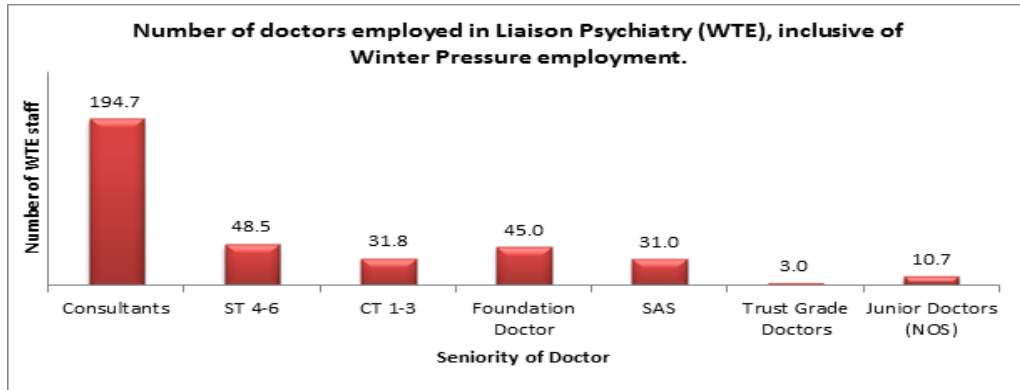
The Department of Health has set the expectation that all acute trusts will have effective models of Liaison Psychiatry in place by 2020 and NHS England have supported this aim with £30 million of targeted investment in 2015/16 (Achieving Better Access to Mental Health by 2020, Department of Health / NHS England, 2014).

The (unpublished) data from the 2015 National Census Survey of Effective Liaison Psychiatry provision, demonstrates that the vast majority of hospitals in England with A&E departments still have an inadequate level of Liaison Psychiatry provision, with either no service or 'sub core' teams that are not resourced to the minimum level that is required to be able deliver tangible benefits.



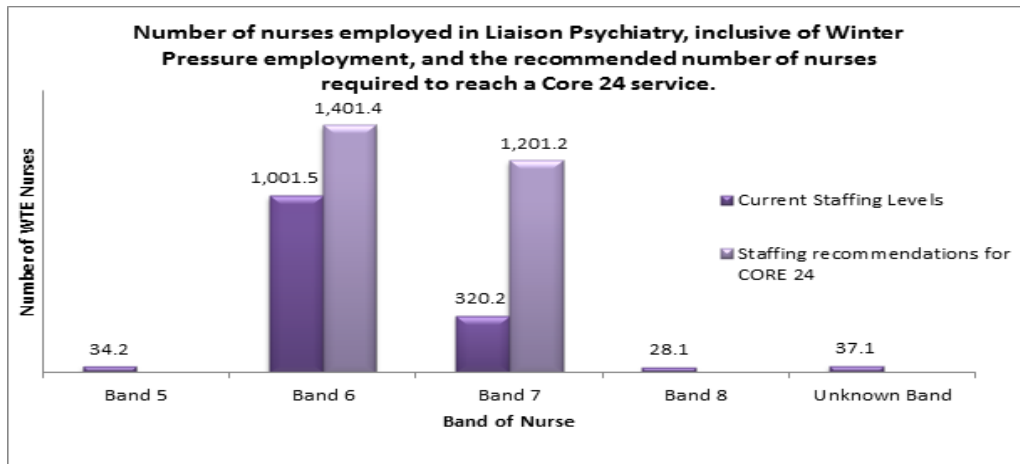
Within existing service provision, there are currently ~195 WTE consultants working within Liaison Psychiatry services nationally. In order to develop services into 'Core' services (which would be likely to show some of the return in value demonstrated by services such as the RAID model evaluated in Birmingham) would require this number to rise to ~400 WTE posts, i.e. a doubling of current provision. Furthermore, there currently 167 doctors of non-consultant grade working within Liaison

Psychiatry services and this would have to more than double to fill the ~400 posts that would be required to provision adequate staffing to all hospitals.



Therefore, there are currently not enough doctors with appropriate training in Liaison psychiatry to meet demand as service provision expands to provide adequate levels of cover to all hospitals. This is true both of current consultants with formal training in Liaison Psychiatry and doctors training in psychiatry.

Similarly, numbers of nurses currently working within Liaison Psychiatry services nationally are also significantly below the levels need for adequate provision in all hospitals, with an extra ~1300 nurses being needed to be able to provide effective 24 hour services to all acute hospitals.



Although as defined, the Core Liaison Psychiatry service does not include any Therapy or Allied Professional posts, the RAID service included one WTE Consultant Psychologist and one Social Worker. If Trusts are following the RAID model to achieve the savings that such a service offers, there will be a need for an expansion in Clinical Psychologist posts and other Therapy/Allied posts (such as Social Work and Occupational Therapy). Each service would include only a few such posts, but the

starting point is that such posts are very rare in Liaison Psychiatry teams, so recruitment would be from a low base.

In addition to the increase in absolute staffing levels needed with Liaison Psychiatry services, there is also the consideration that Liaison Psychiatry clinicians need to be able to independently manage acute and complex presentations in non-mental health settings. For this reason the vast majority of nursing posts in Liaison Psychiatry are at Bands 6 and 7. They therefore are often experienced staff recruited from other mental health setting, such as Home Treatment or Crisis Teams. Expansion of Liaison services will therefore generate the potential challenges of:

- Drawing experienced staff away from other areas of mental health.
- Developing the skills of staff recruited into Liaison Psychiatry services to understand the complexity associated with managing physical and mental health co-morbidity and being able to work in acute medical and primary care clinical environments.

There likely to be an ongoing increase in Liaison Psychiatry provision over the next 5 year cycle, partly to address the unmet need of treating mental health co-morbidity in long term conditions, and in efforts to support acute hospitals manage the increased workload of acute care currently being seen in urgent and emergency care settings. This will require significant recruitment into the speciality from a range of clinical disciplines and the workforce will require ongoing development to be able to deliver effective services.

MEDICAL PSYCHOTHERAPY

- General development of psychological formulation for milder and more severe psychological disturbance and psychiatric illness expanding demand for psychiatrically informed psychological therapy.
- Retiring practitioner posts at times are not replaced, or this is done at a reduced sessional commitment or with special interest sessions
- Skill mix includes general psychiatrists carrying out the training function in a special interest session; this activity may be transferred to psychotherapy 'credentialed' general psychiatrists.

OLD AGE PSYCHIATRY

- The older population has rapidly grown by 17.9 per cent between 2003 and 2013, nearly three times faster than the general adult population over the same period (ONS, 2014).

1.3 Forecast Supply from HEE commissioned education

- Assumed training levels
- Under recruitment
- Attrition
- Employment on completion of training

ADDICTIONS PSYCHIATRY

- Attrition of full-time consultants from addiction psychiatry into other specialities as a result of retendering will have an immediate impact on the provision of specialist care.
- In the medium term the current 50% reduction in ST training posts and loss of CT posts in addiction psychiatry will have an impact on recruitment into addiction consultant posts and the training of psychiatrists planning careers in other psychiatry specialities but who need addictions training.
- In the longer term if this problem is not addressed, addiction psychiatry risks disappearing altogether as it becomes a less attractive career option compared to other specialities. Addiction psychiatry was traditionally a difficult speciality to recruit into but the Addiction Faculty and wider College and government initiatives had managed to largely overcome recruitment problems, until the intensification of retendering and the loss of NHS specialist addiction services. We feel this needs to be addressed strategically by NHS England, Health Education England and Public Health England in view of the considerable and increasing burden of addictions on the NHS and wider society.

GENERAL PSYCHIATRY

- There is no major drive to change supply of young doctors into psychiatry.
- Attrition of full-time consultants into part-time roles will continue to increase. Younger consultants appear to be focussing increasingly on a good work / life balance and putting more emphasis on family life and family roles.
- Training positions in psychiatry have been historically been taken by young doctors completing the PLAB exam. A drive to one common UK exam may reduce this resource for recruitment.
- The drive to international positions post qualification may increase if psychiatry does not improve its stigmatised image in the student population.
- There are areas of the UK where recruitment is difficult (e.g. Humber, North East)

- Under-recruitment at CT and specialty doctor grades.
- Rise in BBTs and FTs – verdict out on whether this will translate into better recruitment

INTELLECTUAL DISABILITY

The Faculty Executive is considering the potential implications of ‘shape the training: securing the future of excellent patient care’ review and the move to consultant delivered, 7 day working. In particular, there is uncertainty about what services the College should be responding to ... community ID services, community mental health ID services and/or specialist inpatient mental health ID services and the different requirements and potential implications of each and their interdependence on other services being available at the same time, such as alternative social care options.

‘Transforming Care’ post Winterbourne View requires the expansion of multi-professional community teams and networks able to support people with highly complex needs in their local environment, avoid out of area hospital admissions, and prevent or reduce length of stay where admission to local facilities are necessary. This will mean new commissioning models, new innovative service models and a robust examination and challenge (external and internal) to care pathways.

Several high profile reports and scandals over the past few years have called for equality of access (and outcome) for people with ID with regard to physical or mental health and wellbeing. PWID are an increasing population. They are living longer and often with severe and several health problems. They also have high rates of co-morbid autism spectrum and related neurodevelopmental disorders. It will be important to have an early dialogue with HEE who are charged with delivering education to the entire clinical workforce. The interface with social care should not be forgotten.

The social inclusion and mainstream agenda relies heavily on mainstream services having the necessary skills and knowledge, as well as ‘reasonable adjustments’ being implemented and supported by community ID services where needed. The evidence base for this in mental health services is lacking, and indeed ID services and specialist mental health ID services, have developed over the years in response to the poorer quality of care and outcomes people with ID experienced when accessing mainstream services. It is important to acknowledge that people with ID often have very complex health needs requiring specialist MDT assessment, expert formulation, intervention, support and longer term case-management. The Greenlight Tool Kit approach has had minimal success, and it will be a considerable challenge for HEE to address this in the workforce.

The significant service changes and financial climate means that specialist psychiatry of ID services will need stronger leadership locally at a time when some areas have limited services and senior clinical staff. Some colleagues have expressed the view that it is important to emphasise our wider social, leadership and advocacy roles rather than focussing on (and perhaps overplaying) our medication and risk prevention roles.

The attraction of young doctors into this specialty is an important consideration given the significant uncertainty and scrutiny that we have been under in recent years.

LIAISON PSYCHIATRY

A particular area of concern in relation to workforce development in Liaison Psychiatry is the rapid development of demand for specialist in Older Adult Liaison Psychiatry. The economic evaluation of the RAID (Rapid Assessment, Interface and Discharge) Liaison Psychiatry service by the London School of Economics demonstrated the cost effectiveness of mental health care in physical health settings, with significant savings being attributed to the impact of specialist input in Older Adult Liaison being available within the team. A significant proportion of new Liaison Psychiatry services are either entirely dedicated to the care of elderly patients or age inclusive services. As 70% of all inpatients in acute hospital are over 65 with multiple morbidities there is a pressing need to develop a fit for purpose future psychiatric workforce to have the right capabilities to work primarily in an acute hospital setting.

A recent survey (2015) by the Liaison Psychiatry Faculty of the Royal College of Psychiatrists noted that there are 170 Liaison Psychiatry services across England and Wales.

- 166 (98%) services have an Old Age Liaison component to their service.
- 96 (56%) services are fully dedicated to Old Age Liaison Psychiatry
- There are 50 FTE consultant posts dedicated to Old Age Liaison Psychiatry
- There are 78 FTE consultant posts with an Old Age Liaison Psychiatry component

A freedom of information request at the end of 2013 to the GMC revealed that there were 15 doctors who held an endorsement in Liaison Psychiatry as part of dual training in Old Age and Adult Psychiatry.

Currently specialist training in Liaison Psychiatry is accessed as part of training in General Adult psychiatry; however there is currently an increased need for doctors with specialist training in Old Age Liaison Psychiatry. There is therefore urgent need for doctors training in Old Age Psychiatry to be able to receive accredited training in

MEDICAL PSYCHOTHERAPY

- Trainee numbers broadly matched with training post numbers.
- Increasing focus on dual accreditation combining a medical psychotherapy CCT with a general adult psychiatry one to potentiate flexibility of employment given the number of fractional medical psychotherapy posts.

OLD AGE PSYCHIATRY

Psychiatry of old age recruitment figures show the lowest fill rates amongst all the psychiatry specialties. This is of concern in view of the ageing population (the older population increased by 17.9% between 2003 and 2013) and actual and predicted demand. Recruitment numbers from the RCPsych (2014) show an increase in fill rate from 56 per cent in 2013 to 67 per cent in 2014. The number of advertised offers increased by 31 per cent over this period (Centre for Workforce Intelligence In-depth Review of the Psychiatrist Workforce: Main report, 2014). The baseline demand and supply projection contained in this report anticipates a shortage of around 315 CCT holders in old age psychiatry by 2033 with some estimates of shortage as high as between 500 and 680 FTEs. It was noted that 'Of all six psychiatric specialties,

psychiatry of old age faces the strongest risk of a large demand-supply shortfall, with weak workforce growth failing to keep up with the strong growth of this age group'.

1.4 Forecast Supply – Other Supply and Turnover

- From other education supply
- To/from the devolved administrations
- To/from private and LA health and social care employers
- To/from the international labour market
- To/from other sectors / career breaks and ‘return to practice’
- To/from other professions (e.g. to HV or to management)
- Increased / decreased participation rates (more or less part time working)
- Retirement

ADDICTIONS PSYCHIATRY

- There has already been an impact of transferring commissioning of addiction services from PCTs to Local Authorities which has resulted in disinvestment in addiction treatment, and increasingly contracts are awarded to third sector providers who either do not employ addiction psychiatrists or provide less attractive terms and conditions of service.
- Parallel problems are being experienced for the same reasons in training and recruitment of specialist addiction nurses, clinical psychologists, pharmacists and occupational therapists. NHS specialist addiction services have traditionally been the training ground for the whole field across disciplines, including the NHS and the third sector workforces.
- Further, the loss of investment in addiction services has led to the loss of most of the established and recently commissioned specialist NHS inpatient treatment units in England, with loss of services for patients and a loss of a valuable training and research resource.

CAMHS PSYCHIATRY

- From other education supply; there are not any clinical assistants that I am aware of in CAMHS
- To/from the devolved administrations?
- To/from private and LA health and social care employers; there are colleagues employed by CAMHS who were previously employed as social workers.
- To/from the international labour market; there are some psychiatrists from the international labour market. There are fewer due to changes in the immigration

laws which do not allow as many doctors from South East Asia.

- To/from other sectors / career breaks and 'return to practice'?
- To/from other professions (e.g. to HV or to management). Some clinical staff progress to management and sometimes it is the only way to obtain a wage increment.
- Increased / decreased participation rates (more or less part time working)? We have many part time workers.
- Retirement Mental Health Officer status will result in significant increase in retirement imminently – some forecasts are in the order of 30%.

GENERAL PSYCHIATRY

- The international labour market has been a provider of consultant psychiatrist for many years. For ethical reasons that may not be in the interest in the countries who lack doctors.
- Over the long term, developing countries may become more attractive for new qualified doctors to stay.
- Posts outside NHS are becoming increasingly attractive. For psychiatrists wanting to work with NHS patients, this is now much more possible through private sector employers.
- The current workforce is very likely to be reduced by consultants entering retirement, alongside those with MHO status.
- The threat of changing pension conditions may motivate many to retire early or in time.
- Impact of increasing feminisation of the medical student population (over 50%) – maternity leave, LIFT, part time, career breaks etc.
- Anxiety amongst trainees to commit to certain specialties because of changes especially old age and addictions

INTELLECTUAL DISABILITY

A number of significant uncertainties and challenges remain which will need to be considered:

Environment under which services are delivered will impact on the attractiveness of this specialty in the future:

- Models of care (as discussed in 1.2 and 1.3)
- Eroding of Local Authority budgets and their ability to put in place packages of care that will prevent placement breakdown and challenging behaviours.
- Intense scrutiny of hospital admissions may inadvertently deny or delay a hospital admission
- Continued scrutiny of the role of psychiatry and consultant psychiatrists

Potential impact from 'Shape of Training':

Will credentialing help increase awareness and skills in the wider workforce? Will it encourage interest and awareness and be enough to meet the complex needs of this population? Will it be to the detriment of training skilled specialist in this area?

Non-medical Approved Clinicians (Mental Health Act):

Currently there are a small number of non-medical ACs (clinical psychologists, nurse consultants, OTs) and in some areas of the country this is being actively encouraged, even where consultant psychiatrists are available. With nurse prescribers also increasing, there may be pressure to review the role/need for costly medically and psychiatrically qualified clinicians.

'New' type of clinician or practitioner: able to coordinate complex physical and mental health/behavioural needs – now being considered to address care of complex multi-morbid long term conditions in the elderly. There is no such equivalent in ID after the person leaves the care of a community paediatrician, and there has been little evidence to suggest primary care has been able to deliver this. Historically this was the remit of 'superintendents' in large ID institutions until the 1970s/80s and since then, with psychiatrists focussing quite rightly on mental health and physical health as it relates to mental health, there has been a gap which families find particularly difficult during the transition from child to adult services.

In the past many ID services particularly outside of London, worked across the age span, but was then criticised as an undesirable 'cradle to grave' provision. There are current plans to deliver a younger people (19-25 years) transition model which may be better aligned to the new Education, Health and Care Plans (EHC). However, there will always be interfaces to be negotiated so understanding and working across boundaries will need to be supported in new commissioning arrangements.

MEDICAL PSYCHOTHERAPY

- The medical psychotherapy profession is not particularly mobile. There are more extra-NHS training opportunities in the London area, and this provides a hub of training with qualified trainees then going to posts in the periphery, including to the devolved administrations.
- The tendency for fractional appointments enables work to be continued alongside other commitments for example family, such that there is not a large returning workforce.
- The development of PD treatment units in the independent sector draws practitioners into that area from the NHS.
- Part time working is more common and combined with private psychotherapy or analytic practice more in the urban areas.

OLD AGE PSYCHIATRY

Results from the 2013 Royal College of Psychiatrists census (RCPsych) indicate the retirement rate of old age psychiatry consultants increased from 2012 to 2013. Additionally, results from the 2011 RCPsych census (RCPsych, 2011a) found there were 22 vacant posts versus 45.3 in the 2013 census. Therefore, there is existing evidence to indicate that there are retention issues in the old age psychiatry consultant workforce, which include low joining rates and high vacancy and retirement

rates.

Section 2 - Drivers of service demand change

Timescale/time horizon		
Framework	Longer term – to 15 years	Shorter term to 5 years
15 message:	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the longer term	Please detail your evidence about the shorter term , specifically:
	We believe that our population is getting older , and that for our workforce, preferences for a change in patterns in working is increasing.	How do you think this will have an impact as a driver of service demand ?
	ADDICTIONS PSYCHIATRY Increased alcohol related problems and hospital admissions to acute and mental health care The rise in availability, diversity and use of novel psychoactive substances in the UK is well documented.	ADDICTIONS PSYCHIATRY There will be a need for greater access to specialist addictions expertise in the development of effective treatment services, research and training of personnel across the NHS workforce.
		CAMHS PSYCHIATRY MHO status leading to increased retirements
	GENERAL PSYCHIATRY The increase of female medical staff may increase the need to plan and account for a better more family orientated work-life balance Ageing population – dementia Increased comorbidity Complex drug regimens Older workforce – need to have more flexibility to manage this Demand for reduced working patterns nearer to retirement?	
	INTELLECTUAL DISABILITY PSYCHIATRY People with ID are living longer, with multi-morbidity. 1:10 carers identify themselves as having ID. Increasing community resilience to care for people with ID and severe challenging needs will require high levels of support, supervision and respite for carers and staff (who are at the front end, often the least trained and least paid). This will mean specialist ID teams needing to offer more flexible support and training to ensure a continued capable environment	

Timescale/time horizon		
Framework 15 message:	Longer term – to 15 years	Shorter term to 5 years
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the longer term	Please detail your evidence about the shorter term , specifically:
	<p>LIAISON PSYCHIATRY</p> <p>Forward-looking commissioners are recognising that the artificial divide between physical and mental health services is not in the interest of patient care. The Oxford University Hospitals Group are leading the field in developing integrated physical and mental health services for hospital inpatients. This has been made possible by a significant investment in additional consultant posts in Liaison Psychiatry, expanding from 1-2 posts to a full complement of 10 WTE (as currently funded in 2015).</p> <p>Cancer services have very patchy provision for the psychological needs of their patient group. 150,000 cancer patients suffer clinically significant psychological symptoms each year (www.macmillan.org.uk). In many parts of the country, less than 25% of people with cancer get the psychological support they need.</p>	<p>LIAISON PSYCHIATRY</p> <p>The prevalence of dementia is increasingly massively with an ageing population. The Mental Health Observatory predicts that between 2015 and 2025, the number of people with dementia in England will increase by around 200,000: http://www.nepho.org.uk. People with dementia are frequently admitted to hospital, and in hospital they require co-ordinated treatment by physicians and clinicians skilled in dementia care. Specialist teams in Old Age Liaison Psychiatry are developing to meet this need. As detailed above, there is currently increasing demand for doctors with accredited training in Old Age Liaison Psychiatry, however the training structure in place do not meet this need.</p>
	<p>MEDICAL PSYCHOTHERAPY</p> <p>No clear driver</p>	<p>MEDICAL PSYCHOTHERAPY</p> <p>Not clear</p>
	<p>OLD AGE PSYCHIATRY</p> <p>I believe that the workforce will need training to meet the needs of patients with multiple conditions in a flexible and holistic fashion.</p>	<p>OLD AGE PSYCHIATRY</p> <p>I believe activity will increase.</p>
	The influence of technology is growing in healthcare and beyond, with staff and patients using it to increase personalisation and control in their life. What will be its possible impact in healthcare in the years ahead? The influence of genomics and research will also play a vital part.	How will technology and innovation impact on service demand in the near future, and what education/training will the current workforce need to meet that demand?
	<p>ADDICTIONS PSYCHIATRY</p> <p>Improved access to technology provides opportunities to reach a wider target population for addiction treatment interventions. This could in turn increase demand on in person treatment services. In addition the internet has created a growing online market in legal and illicit drugs, increasing demand and supply.</p>	<p>ADDICTIONS PSYCHIATRY</p> <p>Research is needed to study the potential benefits and harms of e-technology on addictions. Early indications suggest that internet access to psychoactive drugs manufactured outside of the UK is increasing demand and use of NPS and prescription drugs.</p>
	<p>CAMHS PSYCHIATRY</p> <p>Our CAMHS service users are more IT savvy than the staff. There should be increased use of apps</p>	

Timescale/time horizon		
Framework 15 message:	Longer term – to 15 years	Shorter term to 5 years
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the longer term	Please detail your evidence about the shorter term , specifically:
	for delivering mental health interventions and recording data and monitoring mental health Genomics and research will also play a vital part	
	<p>GENERAL PSYCHIATRY</p> <p>Pharmacogenomics may make treatment more personalised and efficient but may need a more specialised workforce.</p> <p>The need for evidence in all areas of services will increase the need for research in all areas of psychiatric services.</p> <p>Personalisation and control - will patients see value in using psychiatrists?</p>	<p>GENERAL PSYCHIATRY</p> <p>There will be a need to continuously retrain staff on new developments.</p> <p>electronic patient records hopefully will become time saving rather than increasing inefficiency (with patient near recording and access to electronic systems)</p>
	<p>INTELLECTUAL DISABILITY PSYCHIATRY</p> <p>As above</p> <p>Personalised budgets: realities of implementation will be challenging for patients, their families, statutory and non-statutory providers.</p> <p>Research to provide the evidence-base for interventions in people with ID is embryonic but growing. However, findings are often not taken into account when developing or commissioning services. E.g. evidence people with ID will continue to have significant mental health problems means there need to be a blend of ‘episodes of care’ with longer term support and review.</p> <p>Technology may allow people with ID and their carers to be better informed, to increase self-management of common long term conditions or risk factors, aid communication.</p> <p>Early detection in utero will allow for more choices to be offered to expectant couples.</p> <p>Potential intervention at earlier stage for inherited genetic conditions related to ID.</p>	<p>INTELLECTUAL DISABILITY PSYCHIATRY</p> <p>Workforce will also need to be research aware and develop a scholarly approach – a real challenge when historically only medically trained staff are exposed to this in any consistent way.</p> <p>Also requires support from wider community to be aware that this can have significant benefit, perhaps not to the individual themselves, but to people with ID.</p> <p>Commissioning of services is not based on outcomes; there is no incentive to add to the evidence based through research</p>
	<p>LIAISON PSYCHIATRY</p> <p>Technological medicine creates super-specialists, and it becomes increasingly difficult for such clinicians to take a holistic view of patients and their needs.</p> <p>Clinicians working in Liaison Psychiatry teams are usually generalists who are able to participate in the assessment and management of a wide range of psychiatric presentations and incorporate</p>	<p>LIAISON PSYCHIATRY</p> <p>An example of a technological development in Health Services provision is the innovation in treatment of patients following major physical trauma, which is now being concentrated in Major Trauma Centres. A significant percentage (10-20%) of major trauma patients have a mental health problem or substance misuse problem as a</p>

Timescale/time horizon		
Framework 15 message:	Longer term – to 15 years	Shorter term to 5 years
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the longer term	Please detail your evidence about the shorter term , specifically:
	relevant psychosocial factors when developing management plans.	factor in their injuries. These patients require assessment by Liaison Psychiatry teams before they leave hospital, to assess their risks and mental state, and arrange follow-up psychiatric care.
	MEDICAL PSYCHOTHERAPY Unlikely to be a significant driver	MEDICAL PSYCHOTHERAPY Not a significant driver.
	Wider factors are creating global pressures to constrain the cost of publicly funded healthcare, with the wider concept of wellness increasingly taking root which people will expect health service to respond to.	Economics will play a part in influencing service demand and NHS funding will shape service demand in the near future (QIPP, funding, economics).
	ADDICTIONS PSYCHIATRY The provision of addiction treatment services is reducing whereas prevalence of particularly alcohol dependence has been increasing.	ADDICTIONS PSYCHIATRY There is a strong economic case for funding increased access to addiction treatment services as a means of containing healthcare costs in both acute and mental health care. This case needs to be made to commissioners of services and requires a workforce trained and equipped to respond to patients with addiction problems. There needs to be parity of esteem in the provision of healthcare for patients with addiction problems relative to care of patients with physical illness.
		CAMHS PSYCHIATRY There appears to be a psychologicalisation or medicalisation of many of societal short comings and service users expectations have increased.
	GENERAL PSYCHIATRY The concept of wellness in all aspects of life will increase the request for help, support and services. increasing split between those served by generic NHS may lead to flight to private as only option The rise of self-management and MH service provision by third sector may decimate secondary NHS MH as we know them now. Jobs will remain for acute psychiatrists, but CMHT posts will	GENERAL PSYCHIATRY Increasing social inequality leading to increased demand for mental health care (including psychotic conditions). Changes to benefits increasing stress/relapse for people with chronic severe problems.

Timescale/time horizon		
Framework 15 message:	Longer term – to 15 years	Shorter term to 5 years
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the longer term	Please detail your evidence about the shorter term , specifically:
	reduce and integrate with primary care. This will begin to impact in the next 5 years.	
	INTELLECTUAL DISABILITY PSYCHIATRY There are some key public health messages, for people with ID and for staff/carers ... in terms of physical and mental health and wellbeing. Looking after our staff and then being able to support carers, will benefit people with ID. However, this a longer term strategy, difficult to demonstrate outcomes and currently this approach is not commissioned.	INTELLECTUAL DISABILITY PSYCHIATRY Probably unaffordable for ID services/teams to continue to spread themselves thinly to cover all gaps/functions. Important core specialist functions are agreed, and their interface with other services/adult mental health detailed and gaps acknowledged.
	LIAISON PSYCHIATRY The LSE evaluation of the RAID (Rapid Assessment, Interface and Discharge) model of Liaison Psychiatry has demonstrated that a well-resourced service providing integrated care can provide significant economic benefits (returning £4 for every £1 of investment) as well as improved quality and outcomes.	
	MEDICAL PSYCHOTHERAPY Psychotherapy delivered by psychiatrists may increasingly be self-funding.	MEDICAL PSYCHOTHERAPY Cost efficiency savings at trust level may erode medical psychotherapy sessions as these are less linked to trust income generation.
	Patients are going to want high quality services anytime, any place, anywhere , with a more equal (and challenging) relationship with staff, but one still based on care and a better work life balance.	What is the shorter term impact of changing patterns of expectations on service demand ?
	ADDICTIONS PSYCHIATRY Access to addiction services is decreasing during a time of increasing prevalence.	ADDICTIONS PSYCHIATRY Services need to be adequately resourced to meet the level of need in the population.
	CAMHS PSYCHIATRY This is huge – see above.	CAMHS PSYCHIATRY This is huge – see above.
	GENERAL PSYCHIATRY There is a large amount of subjective unhappiness and lack of wellbeing by persons with traumatic experiences, social isolation, and increased expectations on life which may want help	GENERAL PSYCHIATRY We currently cannot supply enough support for people with minor mental health problems which may be amenable to psychotherapy.

Timescale/time horizon		
Framework 15 message:	Longer term – to 15 years	Shorter term to 5 years
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the longer term	Please detail your evidence about the shorter term , specifically:
	by psychiatric services. Is there any evidence that people want any time / any place? Or is this a demand artificially introduced politically? Indeed, very aspiration and laudable but this demand is at odds with the continued squeeze, as above.	
		INTELLECTUAL DISABILITY PSYCHIATRY 7-day working, consultant led/delivered service, real recruitment issues and small training numbers all present challenges locally and nationally.
	LIAISON PSYCHIATRY Mental Health crisis care out of hours tends to be provided by Crisis Home Treatment teams (based in the community) and Liaison Psychiatry teams (based in A&E departments). As the demand increases for services any time, there will additional demands on both these services.	
	MEDICAL PSYCHOTHERAPY Psychological therapies represent higher quality therapy, and will be more demanded.	MEDICAL PSYCHOTHERAPY Feeding up from increased psychological awareness following the IAPT developments, service demand likely to increase.

Section 3 – Patients and population

Timescale/time horizon		
Framework	Longer term – to 15 years	Shorter term to 5 years
15 message:	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the longer term	Please detail your evidence about the shorter term , specifically:
	With people living longer with more people living with multiple and complex conditions (and with our workforce being currently predominantly trained to treat distinct and different disease in isolation after a health crisis has occurred). How can we educate/train the workforce to support the prevention of ill health and, where ill health occurs, support staff to work across organisational boundaries to support high quality care for people with a range of health needs (across physical, mental health and social care)?	
	<p>ADDICTIONS PSYCHIATRY</p> <p>NHS addiction services have a long history of working across organisational boundaries in the community and within acute healthcare, with the development e.g. of addiction liaison services. Often addiction patients in acute care have multiple and complex mental physical and social care needs which require specialist expertise and support.</p>	<p>ADDICTIONS PSYCHIATRY</p> <p>Not all NHS trusts have alcohol care teams providing liaison support and often these services are under-resourced, with a lone specialist nurse covering an entire general hospital. Services should be developed to allow 7 day access to such care, led by consultant addiction psychiatrists.</p>
	<p>CAMHS PSYCHIATRY</p> <p>CAMHS boundaries have increased from 16-18 years. We know that in this age group the level of pathology (between 16 and 25) is 20%. With no extra resources we have become adolescent crisis services. We are unable to deal effectively / or at all with perinatal or 0-4 years. Therefore they will graduate into adolescents in crisis.</p>	<p>CAMHS PSYCHIATRY</p> <p>CAMHS boundaries have increased from 16-18 years. We know that in this age group the level of pathology (between 16 and 25) is 20%. With no extra resources we have become adolescent crisis services. We are unable to deal effectively / or at all with perinatal or 0-4 years. Therefore they will graduate into adolescents in crisis.</p>
	<p>GENERAL PSYCHIATRY</p> <p>The need for continuous training, research and lifelong learning has to be extended to all parts of the workforce including medics, nurses, psychologists, OT and management.</p>	<p>GENERAL PSYCHIATRY</p> <p>The service demands will increase continuously, but also extend into areas where informal family related help and support was sufficient.</p> <p>Need staff with more comprehensive training and experience so response can be</p>

Timescale/time horizon		
Framework 15 message:	Longer term – to 15 years	Shorter term to 5 years
	<p>Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the longer term</p>	<p>Please detail your evidence about the shorter term, specifically:</p>
	<p>Not easily amenable to guideline based approach - psychiatrist's role maybe more important here. Development of peer to peer support may help quality and reduce professional demand for people with long term conditions. Current practice of discharging patients with stable chronic conditions may increase rather than decrease long term workload. Ageing population more multiple conditions. OA psychiatrists already feeling the pressure, likely to knock back into GA services</p>	<p>tailored to individual - psychiatrists are only member of team with across board training, particularly where psychiatric training has included development of psychological therapy skills.</p>
	<p>INTELLECTUAL DISABILITY PSYCHIATRY</p> <p>'New' type of clinician/practitioner at all levels of service delivery able to recognise and care for at a basic level, common physical and mental health comorbidities in people with ID.</p> <p>There is however, a need to retain specialism and not go down a solely generic path. The GP role is vital in providing the oversight required but disease/condition specific financial incentives currently in place work against this.</p> <p>All medical staff should be required to have basic ID-awareness training and experience, and a tiered approach could be adopted related to the area of clinical practice.</p> <p>Evidence that people with ID are admitted into physical care hospitals for ACSCs which are amenable to early community intervention, e.g. epilepsy, constipation, respiratory disease. The Confidential Inquiry into Premature Deaths (CIPOLD 2013) identified the delay in treatment is often after the person presents to a healthcare professional.</p>	<p>INTELLECTUAL DISABILITY PSYCHIATRY</p> <p>Already increased demand on consultant time to consult, advise or liaise on capacity assessments and issues unrelated to mental illness or indeed sometimes physical healthcare.</p> <p>Increasing as call on liaison psychiatry provision and 7/7 working are introduced</p> <p>Diversely different on call arrangements exist across the country, based on service model, interfaces with other mental health provision and availability of staff. It is likely there will be a need for increased provision as community and non-health services support people with ID locally who in the past might have been admitted into hospital, locally or out of area.</p>
	<p>LIAISON PSYCHIATRY</p> <p>"Many people with long-term physical health conditions also have mental health problems. These can lead to significantly poorer health outcomes and reduced quality of life. Costs to the health care system are also significant – by interacting with and exacerbating physical illness, co-morbid mental health problems raise total health</p>	

Timescale/time horizon		
Framework 15 message:	Longer term – to 15 years	Shorter term to 5 years
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the longer term	Please detail your evidence about the shorter term , specifically:
	care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem.” “This suggests that between 12-18% of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing – between £8 billion and £13 billion in England each year. The more conservative of these figures equates to around £1 in every £8 spent on long-term conditions.” “Care for large numbers of people with long-term conditions could be improved by better integrating mental health support with primary care and chronic disease management programmes, with closer working between mental health specialists and other professionals.” (The King’s Fund & Centre For Mental Health 2012) Liaison Psychiatry services aim to promote and deliver integrated healthcare for people with long term conditions and complex co-morbidity in a variety of clinical settings, including a focus on the training and development of all professionals to understand and meet the mental health needs of this clinical populations.	
	MEDICAL PSYCHOTHERAPY Medical psychotherapists are trained to treat holistically and to work with multisystem complexity rather than isolated diagnosis groups.	MEDICAL PSYCHOTHERAPY Unclear.
	Our patients and population are likely to be at different stages of being informed, active and engaged in their own healthcare (including using for example, data and online records), with our challenge being to support the development of a workforce which can support high quality care for all patients.	
	ADDICTIONS PSYCHIATRY There is good evidence that alcohol screening and brief interventions in acute and primary care have a positive impact and are cost effective. However their implementation is patchy and suboptimal. Also only a small proportion of patients with alcohol dependence are referred to specialist treatment, partly through under-	ADDICTIONS PSYCHIATRY Addiction psychiatry expertise will be crucial in training the wider NHS workforce to “make every contact count” and maximise the early identification, brief intervention and referral to specialist care.

Timescale/time horizon		
Framework 15 message:	Longer term – to 15 years	Shorter term to 5 years
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the longer term	Please detail your evidence about the shorter term , specifically:
	resourcing.	
	CAMHS PSYCHIATRY This is already happening	
	GENERAL PSYCHIATRY The concept of lifelong training of all workforce needs to be implemented. <ul style="list-style-type: none"> Negative views of psychiatry amongst patient and other professions may influence demand. increased demand for control/follow up by primary care /personalisation by patients at odds with changes in practice e.g. clustering/ shared care / discharge See evidence from USA on those whose MH problems are forgotten when services are limited because of finances.	GENERAL PSYCHIATRY An increase is to be expected. Increased demand for psychological treatments. Increased demand for flexible, individualised approach - not necessarily diagnosis based
	MEDICAL PSYCHOTHERAPY Likely to increase demand for psychiatrically sophisticated psychological therapies.	MEDICAL PSYCHOTHERAPY Patient preference is for medically delivered services and for psychological therapy.
	OLD AGE PSYCHIATRY I believe our patients and public will be the primary driving force in identifying priorities for services in the long and short term.	OLD AGE PSYCHIATRY I believe our patients and public will be the primary driving force in identifying priorities for services in the long and short term

Timescale/time horizon		
Framework 15 message:	Longer term – to 15 years	Shorter term to 5 years
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the longer term	Please detail your evidence about the shorter term , specifically:
	<p>Patients will increasingly be members of a community of health, with the number of carers projected to rise significantly in the years ahead. Five Year Forward View highlights four ways in which we can engage with communities and citizens in new ways, to build on the energy and compassion that exists in communities across England, namely:</p> <ul style="list-style-type: none"> • better support for carers • creating new options for health-related volunteering • designing easier ways for voluntary organisations to work alongside the NHS using the role of the NHS as an employer to achieve wider health goals 	How will these trends affect service demand in the short term and how can we support patients and communities of health through our lever of workforce planning ?
	<p>ADDICTIONS PSYCHIATRY</p> <p>The third sector is increasingly replacing specialist NHS addiction services, creating a loss of expertise and an imbalance in the provision of specialist care for patients with more complex needs.</p>	<p>ADDICTIONS PSYCHIATRY</p> <p>The workforce and the service configuration should be strategically planned to have an adequate level of specialist addiction services supported by a thriving third sector response around counselling and recovery services.</p>
		<p>CAMHS PSYCHIATRY</p> <p>The main challenge is good shared clinical governance. Some voluntary organisations are good at this. I have come across some who do not keep adequate records and work outside service agreements on age and do not collect outcome data. This means that it can be impossible to work with them on grounds of safety.</p>
	<p>GENERAL PSYCHIATRY</p> <p>Active involvement of family members in people with chronic conditions may reduce ultimate service demand (from patient and carer). NHS could more actively seek to employ staff with personal experience of mental health problems. Creative ways of involving families emerging e.g. Open Dialogue approach</p> <p>No evidence, all aspirational?</p>	
	INTELLECTUAL DISABILITY PSYCHIATRY	INTELLECTUAL DISABILITY PSYCHIATRY

Timescale/time horizon		
Framework 15 message:	Longer term – to 15 years	Shorter term to 5 years
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the longer term	Please detail your evidence about the shorter term , specifically:
As above		As above Someone to help navigate the system and the different fragmented service provision. Currently part of the CPA care coordinator role but not all ID community teams are commissioned to implement this. There is a gap for those not on CPA or equivalent This role takes time, often not factored in, particularly at time of financial constraint, scrutiny on face to face contacts, short term interventions etc.
MEDICAL PSYCHOTHERAPY		MEDICAL PSYCHOTHERAPY
Unclear impact.		Unclear impact.
Developing substantial community provision to bring about a substantial reduction in the numbers of people with learning disabilities placed inappropriately in institutional care is a central part of Sir Stephen Bubb's report in 2014 (<i>'Winterbourne View – time for change'</i>).		What will be the service demand impact of the changes to transform care for people with Learning Disabilities (such as those outlined in <i>Transforming Care for people with Learning Disabilities</i>)?
		CAMHS PSYCHIATRY There is a shortage of mental health staff who work with children with LD.
INTELLECTUAL DISABILITY PSYCHIATRY		INTELLECTUAL DISABILITY PSYCHIATRY
As in 1.2 Work is being undertaken at pace within NHSE and in June 2015 5 Fast Track sites across the country currently with a significant ID inpatient provision have been targeted to co-produce a different model of service to reduce reliance on inpatient beds and increase resilience in the community. Feedback from this early work suggests there will need to be a partnership model between community and hospital services, local specialist ID inpatient provision when reasonable adjustments are not enough within a mainstream adult mental health setting, and that it will not be a 'one size fits all' approach.		Likely to require: Medically trained clinicians with core specialist skills in ID psychiatry able to assess and formulate an understanding and care plan based on an integrated biopsychosocial model. Able and confident in liaising with consultants in other branches of medicine and psychiatry such as liaison psychiatry, neuropsychiatry and brain injury services as well as medical consultants caring for long term conditions and health problems with a high comorbidity in people with ID. Clinicians who are experienced in ID and related conditions: syndromes, neurodevelopmental disorders, impact of stigma, socioeconomic deprivation and

Timescale/time horizon		
Framework 15 message:	Longer term – to 15 years	Shorter term to 5 years
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the longer term	Please detail your evidence about the shorter term , specifically:
		vulnerability in the ID population. Clinicians able to support the team in an integrated way to manage risk and complex needs.
	MEDICAL PSYCHOTHERAPY Unclear impact.	MEDICAL PSYCHOTHERAPY Unclear impact.
	Parity of esteem for Mental Health will be supported through delivering improvements in areas such as integration, waiting and access targets and in the area of psychiatry liaison	What education/training does the current workforce require to be able to make parity of esteem a reality?
		CAMHS PSYCHIATRY This is huge. Education is the key and this is filtering down from post grad training to those at medical school. However, there is the thorny issue of educating those currently in physical medicine.
	GENERAL PSYCHIATRY Clearly would need more parity in resources including workforces.	GENERAL PSYCHIATRY Psychiatrists of the future may need 1-2 years of training in medicine and neurology.
		INTELLECTUAL DISABILITY PSYCHIATRY Early exposure to high quality training, strong public health messages reinforced by tangible change in commissioning.
		LIAISON PSYCHIATRY There is a current need to develop both the recognition and management of mental health issues in all clinical settings as evidenced by the significant untreated mental health morbidity in a range of patient groups (e.g. depression and anxiety in people with long term conditions) This would require both: <ul style="list-style-type: none"> • Training to provide an improved understanding of mental illness by all

Timescale/time horizon		
Framework 15 message:	Longer term – to 15 years	Shorter term to 5 years
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the longer term	Please detail your evidence about the shorter term , specifically:
		healthcare professionals; and <ul style="list-style-type: none"> Upskilling and developing a mental health workforce able to work effectively in a range of (non-mental health clinical) settings. Currently, Liaison Psychiatry services that are starting to expand into these settings are being staffed by health professionals with expertise in treating mental health problems but with limited understanding of physical health care settings and problems.
	MEDICAL PSYCHOTHERAPY Unclear impact.	MEDICAL PSYCHOTHERAPY Awareness of policy direction.
	Five year forward view draws attention to the NHS being committed to making substantial progress in ensuring that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve, and that the NHS provides supportive and non-discriminatory ladders of opportunity for all its staff, including those from black and minority ethnic backgrounds.	How can we use our levers in the short term to support this commitment?
		CAMHS PSYCHIATRY Monitoring and encouragement of a diverse population. Better education for all generally.
	GENERAL PSYCHIATRY Poorer services and outcomes for people from BAME groups make this important to address. Also not sure that NHS does as much as it could in employing people with personal experience of mental health problems. BME populations traditionally under-access MH services, further progress may well increase demand	
		INTELLECTUAL DISABILITY PSYCHIATRY Ensure recommendations of the Michael's Report (Healthcare for All, 2008) are

Timescale/time horizon		
Framework 15 message:	Longer term – to 15 years	Shorter term to 5 years
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the longer term	Please detail your evidence about the shorter term , specifically:
		implemented, including an identified Executive Board member being held to account for the delivery of services to people with ID.
MEDICAL PSYCHOTHERAPY Likely to increase demand for more holistic psychiatric care including psychological therapies.		MEDICAL PSYCHOTHERAPY Unclear.
		OLD AGE PSYCHIATRY Engagement with local communities is paramount as is the identification of local representatives to reflect and represent diverse communities.

Section 4 – Models of care

Timescale/time horizon		
Framework 15 message:	Longer term – to 15 years	Shorter term to 5 years
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the longer term	Please detail your evidence about the shorter term , specifically:
<p>Five Year forward View outlines a number of possible future service models including</p> <ul style="list-style-type: none"> • multispecialty community providers (MCPs), which may include a number of variants • integrated primary and acute care systems (PACS) • additional approaches to creating viable smaller hospitals • models of enhanced health in care homes <p>The expertise to support the piloting and introduction of these models need to be considered. Existing NHS services and areas of the healthcare workforce may work with others in new and different ways (e.g. community pharmacy).</p>		How could future service models develop in the short term in line with these developments and the learning from the Vanguard sites, and what education/training will the current workforce need to make these models work?
<p>ADDICTIONS PSYCHIATRY</p> <p>We are rapidly losing the necessary addiction specialist expertise to support such developments.</p>		<p>ADDICTIONS PSYCHIATRY</p> <p>The NHS needs a critical mass of adequately trained addiction specialists to support and train non specialists, to advice on local and national strategic development, and to evaluate the impact of changes in service configuration.</p>
		<p>CAMHS PSYCHIATRY</p> <p>I think that the natural place for CAMHS to outreach initially are educational facilities of all types. MCPs perhaps thereafter</p>
<p>GENERAL PSYCHIATRY</p> <p>Integration of care crucial. Alternatives to inpatient admission needed. Need option of inpatient admission within reasonable distance. Reorganisations need piloting, need to take account of how reorganisation diverts resources from care.</p> <p>These models are generally resource intensive in the community though further reduction in beds may be achievable.</p>		

Timescale/time horizon

Framework 15 message:	Longer term – to 15 years	Shorter term to 5 years
	<p>Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the longer term</p>	<p>Please detail your evidence about the shorter term, specifically:</p>
<p>These models are generally resource intensive in the community though further reduction in beds may be achievable.</p>		
<p>INTELLECTUAL DISABILITY PSYCHIATRY See 1.2 and section 3</p>		<p>INTELLECTUAL DISABILITY PSYCHIATRY Clinicians and commissioners working together in a collaborative, no-blame way, and understanding the data and local need, would go a long way to co-producing with service users and their families, locally responsive services as well as serve to increase understanding of those needs that require more specialist provision including local inpatient services.</p>
<p>MEDICAL PSYCHOTHERAPY Unclear.</p>		<p>MEDICAL PSYCHOTHERAPY Medical psychotherapists in trusts often take leadership roles, being able to negotiate and lead complex changes in systems.</p>
<p>Services are likely to become increasingly integrated in the future, enhanced through policies such as the Devolution of Local health and social care budgets, the integrated care pilots and integrated personal commissioning. Partnerships will become increasingly important, including with partners beyond NHS and social care.</p>		<p>How could future service models develop in the short term in line with these drivers, and what education/training will the current workforce need to make these models work?</p>
		<p>CAMHS PSYCHIATRY CAMHS is small – it has 6% of the mental health budget. It is particularly challenging for us to move in this direction at the moment.</p>
<p>INTELLECTUAL DISABILITY PSYCHIATRY See 1.2 and section 3</p>		
<p>MEDICAL PSYCHOTHERAPY Medical psychotherapeutic approach to care is integrative, and will be professionally synergistic.</p>		

Timescale/time horizon		
Framework 15 message:	Longer term – to 15 years	Shorter term to 5 years
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the longer term	Please detail your evidence about the shorter term , specifically:
We may increasingly see centres of specialisation in some specialties in some areas.		How could future service models develop in the short term in line with these drivers?
ADDICTIONS PSYCHIATRY The current specialist addictions workforce was largely trained in regional centres of specialism. With the localism agenda this infrastructure has gradually been dismantled such that few such centres now survive in England. This has resulted in a loss of specialist expertise and research and training capacity.		ADDICTIONS PSYCHIATRY A strategic approach is needed to support re-establishment of regional centres of excellence to support the development and training of a specialist workforce in addictions and to provide specialist addictions experience for psychiatrists and other health professionals to gain experience
		CAMHS PSYCHIATRY This is often dictated by geography making this easier in a large urban area – but is possible.
GENERAL PSYCHIATRY Fragmentation of care in mental health is a major issue - good care depends on building therapeutic relationship, and for longer term problems needs continuity		
MEDICAL PSYCHOTHERAPY Specialist provision of services for complex and PD patients.		
We will see the ongoing development of services in the area of urgent and emergency care		How could future service models develop in the short term in line with these drivers?
ADDICTIONS PSYCHIATRY NHS addiction psychiatrists have led the development of outreach and liaison services in urgent and emergency care, reaching a high need population. However this infrastructure is gradually being dismantled as a result of short term local decision making by Local Authority commissioners some of whom do not see acute care as being in their responsibility.		ADDICTIONS PSYCHIATRY Specialist NHS addiction service provision needs to be resourced from within NHS commissioning to ensure that this is expanded rather than lost, as is taking place at the moment. There is a strong economic case for the NHS to support this to reduce A&E attendances and repeated alcohol related admissions.
		CAMHS PSYCHIATRY

Timescale/time horizon		
Framework 15 message:	Longer term – to 15 years	Shorter term to 5 years
	Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15? Please detail your evidence about the longer term	Please detail your evidence about the shorter term , specifically:
		We need more crisis/ outreach / step down and on call services.
GENERAL PSYCHIATRY Resource intensive but may assist further diversion from inpatient care		
		LIAISON PSYCHIATRY The expansion of Liaison Psychiatry services in recent years has provided an increased provision of urgent and emergency mental health input to emergency departments; however the 2015 Census Survey of Liaison Psychiatry provision demonstrates that the vast majority of A&E departments still do not have 24 hour mental health cover. The Crisis Care Concordat is a nationwide initiative to promote improved cross-discipline approaches to the provision of mental health crisis services. Individual localities are now creating action plans to address these needs locally.
Five Year Forward View highlights new developments such as the evidence based diabetes prevention service and encouraging new capacity in under doctored areas.		How could such approaches affect service models in the near future?
		CAMHS PSYCHIATRY We need prevention and resilience services – to be developed in schools and by some projects e.g. troubled families with consultation from CAMHS.

Section 5 – Future workforce characteristics

Timescale/time horizon		
Framework 15 message:	Longer term – to 15 years	Shorter term to 5 years
<p>Below are the 5 future workforce characteristics set out in Framework 15</p>	<p>In your evidence please highlight any or all of the following:</p> <ul style="list-style-type: none"> - Are these workforce characteristics still valid? - Any evidence you are aware of work which is underway and which contributes to the achievement of the workforce characteristics - Any gaps you are aware of <p>Please detail your evidence about the longer term</p>	<p>Please detail your evidence about the shorter term education and training needs required for the current workforce to meet these characteristics:</p>
<p>The workforce will include the informal support that helps people prevent ill health and manage their own care as appropriate.</p>	<p>CAMHS PSYCHIATRY</p> <p>There needs to be resources available to support our most vulnerable clients. The children may have differing views about help from their parents or carers. This is a deficit in current training.</p> <p>GENERAL PSYCHIATRY</p> <p>We lack access to peer support, workforce not trained to make use of what is available. Family carers taken for granted, not supported - training needs to address family involvement - psychiatrists currently rarely trained to work systemically</p> <p>MEDICAL PSYCHOTHERAPY</p> <p>Core professional value of adoption of personal responsibility can care.</p>	<p>MEDICAL PSYCHOTHERAPY</p> <p>Unclear.</p>
<p>Have the skills, values and behaviours required to provide co-productive and traditional models of care as appropriate.</p>	<p>GENERAL PSYCHIATRY</p> <p>I don't think psychiatric training can discourage the attitudes necessary for this, e.g. reducing respect for alternative ways of understanding problems</p> <p>MEDICAL PSYCHOTHERAPY</p> <p>Facilitation of co-working</p>	

Timescale/time horizon		
Framework 15 message:	Longer term – to 15 years	Shorter term to 5 years
Below are the 5 future workforce characteristics set out in Framework 15	In your evidence please highlight any or all of the following: <ul style="list-style-type: none"> - Are these workforce characteristics still valid? - Any evidence you are aware of work which is underway and which contributes to the achievement of the workforce characteristics - Any gaps you are aware of Please detail your evidence about the longer term	Please detail your evidence about the shorter term education and training needs required for the current workforce to meet these characteristics:
Have adaptable skills responsive to evidence and innovation to enable ‘whole person’ care, with specialisation driven by patient rather than professional needs.	<p>CAMHS PSYCHIATRY</p> <p>I am unsure nationally about this. CAMHS staff tend to work collaboratively.</p> <p>GENERAL PSYCHIATRY</p> <p>Psychological skills not always well developed through current training.</p> <p>LIAISON PSYCHIATRY</p> <p>The RAID (Rapid Assessment, Interface & Discharge) model of Liaison Psychiatry developed at the City Hospital in Birmingham which is based on core principles of responsive, person centred care.</p> <p>This service has shown through an LSE economic evaluation that there are significant economic benefits to this approach with £4 of value returned to the health economy for every £1 invested.</p> <p>MEDICAL PSYCHOTHERAPY</p> <p>Holistic clinical approach.</p>	<p>MEDICAL PSYCHOTHERAPY</p> <p>Unclear.</p>
Have the skills, values, behaviours and support to provide safe, high quality care wherever and whenever the patient is, at all times and in all settings.	<p>CAMHS PSYCHIATRY</p> <p>Not every CAMHS service has on call or outreach or crisis.</p> <p>MEDICAL PSYCHOTHERAPY</p> <p>Unclear.</p>	<p>MEDICAL PSYCHOTHERAPY</p> <p>Unclear.</p>

Timescale/time horizon		
Framework 15 message:	Longer term – to 15 years	Shorter term to 5 years
<p>Below are the 5 future workforce characteristics set out in Framework 15</p>	<p>In your evidence please highlight any or all of the following:</p> <ul style="list-style-type: none"> - Are these workforce characteristics still valid? - Any evidence you are aware of work which is underway and which contributes to the achievement of the workforce characteristics - Any gaps you are aware of <p>Please detail your evidence about the longer term</p>	<p>Please detail your evidence about the shorter term education and training needs required for the current workforce to meet these characteristics:</p>
<p>Deliver the NHS Constitution: be able to bring the highest levels of knowledge and skill at times of basic human need when care and compassion are what matters most.</p>	<p>CAMHS PSYCHIATRY</p> <p>The findings from Winterbourne need to be considered.</p> <p>GENERAL PSYCHIATRY</p> <p>Need to attend to how systems support or undermine compassion.</p> <p>MEDICAL PSYCHOTHERAPY</p> <p>Understanding impediments to compassionate caring a core area of work.</p>	<p>MEDICAL PSYCHOTHERAPY</p> <p>Unclear.</p>

Section 6 – Any other evidence not included elsewhere

GENERAL PSYCHIATRY

Impact of society wide changes - social inequality, austerity, increased top down control (exponential growth of guidelines and monitoring replacing respect for professional skill, attitudes)

Opportunities for prevention - big gap in mental health services in considering needs of people with serious mental health problems as parents, and the support given to their children. Also social issues above and role of child abuse.

Changes in attitudes towards psychiatry/psychiatrists - pressures to decrease role of psychiatrists, psychiatric training needs to take this on board, including through increased attention to psychological and social aspects

INTELLECTUAL DISABILITY

Legislation

Both the Mental Capacity Act 2005 and the Equality Act 2010 put pressure on the workforce. This includes in cases where support from other specialties is required because of capacity issues, Best Interests decisions and Deprivation of Liberty Safeguards.

Expertise in autism within Psychiatry of ID has been enhanced as a result of the Autism Act 2009. Additionally, the role of Psychiatry of ID is often called upon for those people without formal ID but who may benefit from consultation, liaison or specific joint-working arrangements with other services.

We have yet to consider the potential impact of the Care Act (2014).

Department of Health Learning Disability Strategy

The Valuing People (DH, 2001) and Valuing People Now strategies (DH, 2009) have initiated progression of health action plans in primary care within England through directed enhanced services. These have led to upward pressure on the workforce as a result of successful identification of people with challenging behaviour, poor mental health, autism and epilepsy, requiring expertise of psychiatrists (RCPsych, 2011).

Investigations into complaints made against healthcare providers

Conclusions from both Six Lives: the provision of public services to people with learning disabilities (Local Government Ombudsman, 2009) and Healthcare for all: report of the independent inquiry into access to healthcare for people with learning disabilities (Healthcare for All, 2008) have led to increasing Liaison Psychiatry links with Psychiatry of ID in secondary care (RCPsych, 2011).

Local Green Light for Mental Health initiatives

Though access to services for people with ID is encouraged, mainstream services may struggle to support some patients, especially if there are co-morbid conditions such as autism. This can generate high demands for both second opinions from clinicians and for co-management (especially in patients requiring intensive support at high cost), which is putting pressure upon the workforce (RCPsych 2011) especially at a time when specialist inpatient provision is regarded as an undesirable option.