CHOOSE PSYCHIATRY in Scotland

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

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State of the nation report:
The psychiatric workforce in Scotland

An insight into the shape of the workforce: why doctors join, why they leave, and solutions for reversing a declining trend

Contributors

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State of the Nation working group: Dr Ihsan Kader, Susan Richardson, Laura Hudson, Dr Julie Langan-Martin, Dr Ahmad Allam, Dr Karyn Ayre, Dr Alan Mackenzie, Dr Rosemary Gordon, Dr Jess Sussman, Dr Shoshana Cross.

Undergraduate and Foundation Year Workshop
Format: semi-structured virtual workshop.
Participants: Consultant psychiatrists and trainees together representing RCPsych in Scotland, University of Aberdeen, University of Dundee, University of Edinburgh, University of Glasgow.

Core Trainee focus groups
Format: two virtual workshops chaired by trainees
Participants: Core and higher trainees; representation from all four deaneries.

Trainee workshop
Format: semi-structured virtual workshop.
Participants: Core and higher trainees, consultants, SAS, medical managers; representing trainees, supervisors, training programme directors and faculties

Consultant Workshops
Format: semi-structured virtual workshop.
Participants: Consultant psychiatrists; representation from medical managers, faculties, Health Board recruitment leads, working retired members; newly qualified consultants and RCPsych in Scotland.

SAS workshop
Format: semi-structured virtual workshop.
Participants: SAS doctors, consultant psychiatrists, trainees.

Thanks also to: Members of the RCPsych in Scotland Devolved Council; members of the Scottish Workforce and Careers Committee (RCPsych in Scotland); members of the Medical Managers Group, colleagues who shared their views in various other ways and colleagues who provided clinical cover to allow this work to take place.

Contents

Introduction

Psychiatric services in Scotland are in a precarious state. The psychiatric workforce is not growing sufficiently to keep pace with the demands on services. The problems with recruitment and retention of psychiatrists and vacancy rates across the country and in all subspecialties is of grave concern. The usual pathway from medical students to consultant psychiatrists cannot fill the gap in sufficient numbers or in a timely manner. This further adds to pressure on services and perpetuates the problem. All this is self-evident if you are a user, provider or commissioner of services.

We have been hearing of the various challenges across psychiatry for many years. The consistency of the narrative and the visible evidence around us should have been enough to highlight the severity of the problem. Anecdote alone, no matter how consistent and powerful, will not effect the large-scale changes that are needed. This report backs anecdote and experience with data to produce a narrative report that explains the issues and makes real world recommendations.

We opted for the life span approach, starting with the basics, explaining roles and pathways before delving into the problems and crucially, trying to identify solutions. Each section of the report describes and summarises the challenges at each career stage of the pathway, from medical undergraduates and foundation doctors through to core and higher trainees, SAS doctors and consultants (including the retired and returned group). Each section then recommends solutions and actions, with a final set of overarching recommendations at the end of the report.

As we expected, there were no real surprises. These are issues that have long been discussed, but this must not become yet another report that simply highlights the problem and makes aspirational recommendations. Unless we completely reimagine how we do things we are not going to be able to make meaningful change. For instance, we need to reimagine how we deliver psychiatric services in the community, how posts are structured equitably, and whether psychiatrists are working to the top of their experience.

We need to look at job plans for consultants, at training numbers given the increasing number of less than full time doctors, at reasons for core to higher attrition, and challenges in especially hard to fill areas. We need a radical look at the way locum posts are configured before they are advertised. We need to reimagine how we engage with our retired and returning colleagues, this highly experienced group of clinicians and educators who still have a lot to give but on different terms. Not least we need to think about the SAS group without whom many services will collapse.

Each part of the pathway needs to be looked at in its own right, but also as a whole. This will require close and transparent working between the main stakeholders – the Scottish Government, NHS Education for Scotland (NES), health boards and the Royal College of Psychiatrists in Scotland (RCPsychiS) – at whom we have targeted the recommendations.

Gathering evidence for this report has also laid bare the dearth of consistent and meaningful data to inform clinicians and managers. We have highlighted where more is required.

We are conscious that additional investment at a time of funding crisis will be required to fully progress these recommendations. This will require new funding as well as reimagining finances, for example the way we employ expensive agency locums at a cost of millions.

We tried to keep this report to a manageable length, but the wealth of information justified the size of report. We have structured it such that readers can look at the entire report or pick out aspects relevant to them.

This report offers potential solutions to the challenges faced. It needs to be seen as a long-term ongoing project, updated every 18-24 months. In rebuilding the workforce, we want to acknowledge the good work taking place in psychiatry in Scotland, the everyday hard work and innovation that keeps services running and does the best for patients.

This work would not have happened without the support and hard work of colleagues at the RCPsychiS, colleagues in the workforce report working group and those who shared their time and expertise at the workshops, focus groups, Scottish Workforce and Careers Committee (RCPsychiS), Devolved Council (RCPsychiS) and everyone who contributed to informal discussions.

I hope you find this report helpful in understanding the current state of the psychiatric workforce in Scotland. I hope it stimulates discussion. I hope that the various stakeholders can work together to reimagine how the treatment of mental illness is delivered. I hope the recommendations are useful in moving forward to a self-sustaining workforce model for the future.

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Executive summary

This report brings together information about recruitment and retention of the psychiatric workforce in Scotland. It tells the story of a doctor's journey from undergraduate to consultant and the challenges: challenges that compel more and more psychiatrists to leave Scotland's workforce. At the same time, this country is seeing long waiting lists for mental health services. There is a widely acknowledged discrepancy between what is needed to face today's mental health crisis and what workforce resources are in place.

The story is a circular one. Medical students and psychiatric trainees require teaching from consultant psychiatrists and other senior specialists to progress to become expert practitioners and mentors. The quality of this consultant input makes the difference between retention and drop out for the speciality. At the same time, consultant morale and well-being are equally crucial in preserving and enhancing the workforce of medical teachers as well as delivering high quality service to mental health patients – potentially all of us.

Students can study medicine at five universities in Scotland: Aberdeen, Edinburgh, Dundee, Glasgow, and St. Andrew's. Although evidence suggests that early exposure to psychiatry makes it more likely doctors will make this their specialty, psychiatry is not covered in depth in the early years. Exposure is concentrated in clinical practice during the later years. Stigma against the speciality means students are less likely to want to study psychiatry as they move through their undergraduate years –nearly 80% of year five students had encountered negative attitudes to psychiatry from other specialties[1].

All universities report limitations in clinical and teaching experiences due to the lack of available consultants. ACT (Additional Cost of Teaching) monies intended for the creation of teaching time in job plans are often absorbed into general service budgets instead.

Positive placement experiences at undergraduate level can be instrumental in a student pursuing a specialty. However, remote locations, a lack of belonging and purposefulness and inadequate supervision are barriers to a good experience.

After graduating, students start their training at foundation level. This combines learning and working and is a general education covering many specialties. Only 2.5% of Foundation Year 1 (FY1) students take part in a psychiatry placement but nearly 1 in 3 students at Foundation Level 2 (FY2) will experience psychiatry in 2023. Markers of a good foundation training post include good supervision from a consultant or higher

[1] Quinn, C. Hegde, R and Langan-Martin, J. (2020) *Repositioning psychiatry in medical school curricula: a study of medical students' attitudes*. https://eprints.gla.ac.uk/222659/5/222659.pdf

trainee and a positive work culture that encourages experience in psychiatry rather than performing routine medical tasks.

Around two-thirds of trainees in Scotland leave training after FY2. The largest proportion opt for a service appointment in the UK or take a career break. They take a break for a number of reasons: it is a natural point to pause; wanting to travel; needing a break from studying, working and constant assessment; needing a break for their mental wellbeing; and being unsure of their next steps into Core Training.

After the broad experience of foundation training, core training (CT) (3 years full time) is the start of the process of specialist training. Demand for core training in psychiatry has improved: data for the UK shows the number of applications for core training in psychiatry has increased by 130% in the last eight years across all nations, from 797 in 2014 to 1,876 in 2022[2]. However, the number of CT places available in Scotland has reduced from 68 in 2020 to 46 in 2023. This is partly because doctors who work less than full time stay in core training for longer than three years, making posts unavailable to new trainees. Training posts are allocated to individuals rather than to full-time equivalent posts. 81% of CT places are allocated to the West and South East of Scotland leaving only 19% for more rural areas.

On completing core training, and passing professional higher examinations, trainees enter higher specialist training (ST) (3 years full time equivalent) which leads to qualification as a consultant. The transition from core to higher training in Scotland is a key attrition point in the workforce pipeline: around a third of higher training posts were vacant last year. This has been the case since 2018. ST posts in general adult psychiatry are disproportionately likely to be unfilled. Location also plays a part. The West and South East had at least 80% posts filled last year, but figures for the North and East were 20% and 55% respectively.

Core trainees cite a number of reasons for not moving on to higher training: the need for more experience in their chosen field; a lack of time to complete professional exams and competencies; challenges with their training and risk of burnout; not wanting to uproot as they have settled in a region during core training; an inflexible exam and assessment system.

At CT and ST levels trainees increasingly work less than full time (LTFT). This means they stay in training for longer, however due to the way National Training Numbers (NTN) are administered, their place cannot be released or shared with another doctor until they complete training.

Once doctors have successfully completed higher training and satisfied the requirements to enter the GMC specialist register, they become eligible to apply for NHS consultant posts. Official data from 31 December 2022 suggests a 14.9% whole

[2] Competition ratios for 2022 from Health Education England. https://medical.hee.nhs.uk/medical-training-recruitment/medical-specialty-training/competition-ratios/2022-competition-ratios

time equivalent (WTE) vacancy rate (93.9) with 8.2% of posts vacant for over six months (51.8) for psychiatry consultants compared to a rate of 6.5% for all medical specialties. However, a BMA report[3] suggests that the consultant vacancy rate in Scotland was more than double the official government figures. This may be because government data also includes locums alongside substantive consultants, but as they do not perform many of the extra roles of a consultant (teaching, supervision, research, service development), their inclusion is misleading.

Key challenges for consultants include: 9:1 job plans that do not allow time for training, teaching, supervision, service development and research; inflexible working patterns (options to work LTFT, remote working); complex pension systems; and lack of opportunity to extend their earnings through Discretionary Points.

Many doctors who do not pursue training toward consultant roles are employed as Specialty and Associate Specialist (SAS) doctors. They span a range of experience and expertise and can hold senior non-consultant posts in teams. Latest data[4] suggests there are 195 SAS doctors in the psychiatric workforce in Scotland, most of whom (174) hold the title Specialty Doctor, since progression to the senior role of Associate Specialist was discontinued some years ago.

SAS doctors may be career-grade doctors who choose the SAS role as it allows for a better work/life balance and focus on patient care, or doctors taking a break from the demands of constant assessment or pausing training to gain experience in a particular area.

Concerns over lack of opportunity to progress and pay disadvantages have driven recent changes to SAS contracts. A new contract offers a higher starting salary, quicker progression to higher pay and the creation of a new grade of 'Specialist', as a potential route for career progression for experienced specialty doctors.

An alternative route of entry to the GMC Specialist Register for doctors that have not completed specialist training in the UK is via the CESR process (Certificate of Eligibility for Specialist Registration). This is an expensive, challenging and largely unsupported (in Scotland) process which could turn out to be a lost opportunity here if not addressed. CESR Fellowships as offered in one Board are another way forward particularly for international recruits.

[3] BMA Scotland: Consultant vacancies "more than double" official figures, BMA Scotland Media Team. https://www.bma.org.uk/bma-media-centre/bma-scotland-consultant-vacancies-more-than-double-official-figures

[4] Collated by NES's SAS Development programme (collected from regional HR teams).

42% of consultants in Scotland are over 50 and, according to a recent *Intention to Retire (ITR) survey* conducted by the University of Dundee[5] nearly half of them intend to retire before normal retirement age. In addition, most consultants (of all ages) intend to transition to retirement by scaling down work commitments. The main reasons for scaling down work commitments and then retiring early are organisational disillusionment and disidentification, and financial concerns, including the pension taxation regime.

Around one in five doctors in Scotland are International Medical Graduates (IMGs). They face the challenges described in this summary, and more. They are more likely to fail their MRCPsych examination and to be reported and investigated by the GMC in fitness to practice areas[6]; they face the additional burden of settling into a new country; and planning ahead is made more difficult by doubts over renewal of visas.

Psychiatrists have a role beyond their core work as managers, leaders and contributors to national policy, strategy, clinical guidelines and public health. This work needs to be funded to make it sustainable and allow experts to actively contribute in these important areas.

Wellbeing of staff is essential to all that is said in this report. It requires providing staff with the tools to do their jobs and treating them with respect. This makes for a healthier and happier workforce, improve recruitment and retention and ultimately lead to excellent patient care.

Scotland's psychiatric workforce aspires to treat and care for some of the most severely ill and vulnerable people in the land. Bringing this narrative together gives us a sense of the scale of the challenge to ensure that the psychiatric workforce in Scotland is sufficiently staffed and resourced to deliver this. We conclude each section of this report with recommendations for next steps and ideas to help reverse the dangerous trend of a diminishing workforce.

[5] Senior Hospital Doctors Intention to Retire Survey, University of Dundee: https://www.dundee.ac.uk/corporate-information/senior-hospital-doctors-intentions-retire

[6] General Medical Council. *Fair to Refer?* GMC, 2019. https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/fair-to-refer

The workforce pipeline

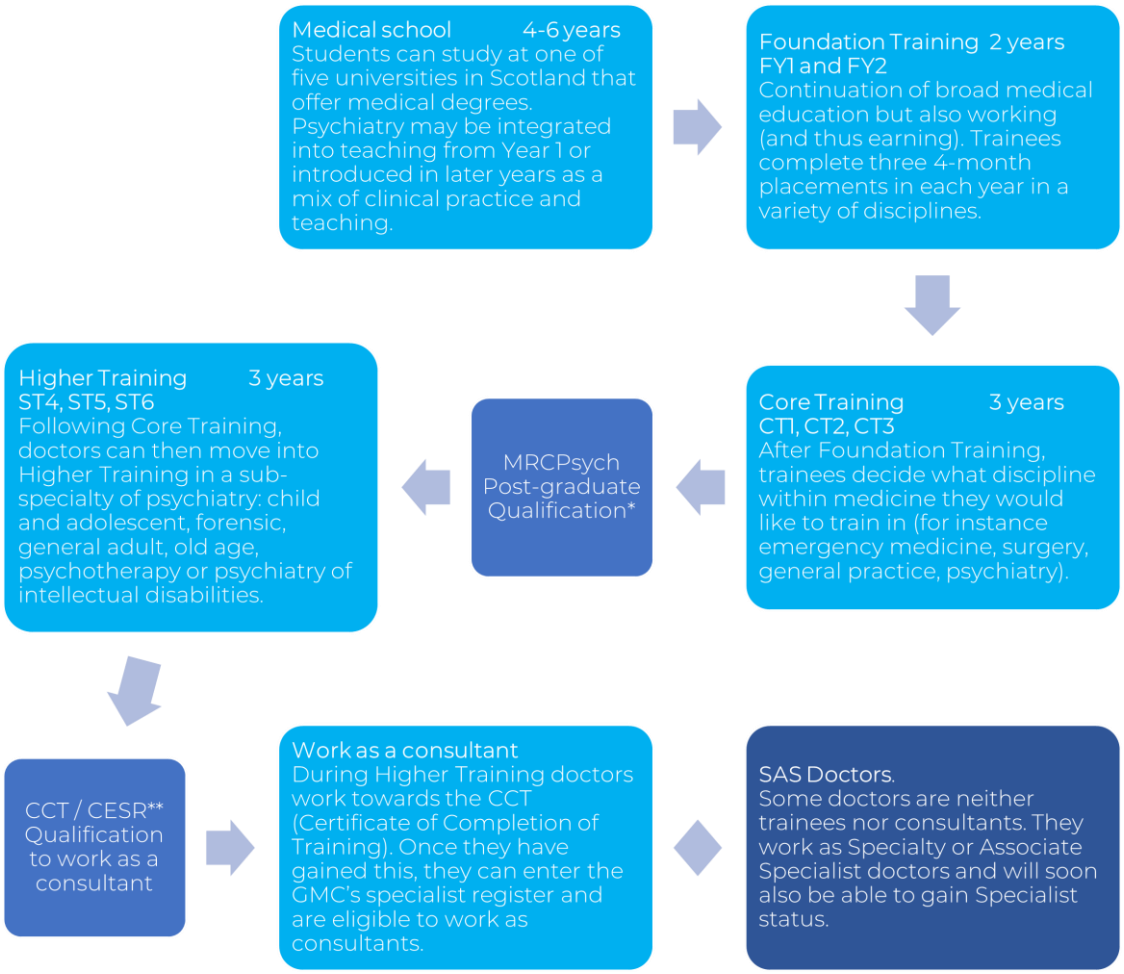
From undergraduate to consultant

This section presents the mechanics of the workforce – the study, training and examinations individuals need to complete to become members of the psychiatric workforce. The next sections look at all the other factors and influences that impact on their involvement in – or, perhaps, decision to leave – the Scottish psychiatric workforce.

Becoming a psychiatrist

A psychiatrist is a medical doctor with special expertise in the diagnosis and treatment of mental disorder. Psychiatrists are trained to use a bio-psycho-social model to fully understand all aspects of a patient's presentation and to either directly deliver or recommend appropriate treatments including pharmacological, psychological, and social interventions.

Diagram 1: The route to becoming a psychiatrist



Qualifications

*Member of the Royal College of Psychiatrists (MRCPsych)

Doctors need to pass this qualification to move from core training to higher training. The MRCPsych is the post graduate qualification awarded to physicians who have completed a core training programme (or equivalent) and exams specified by the Royal College of Psychiatrists (RCPsych). The exam part of the qualification consists of two written papers (A and B) and a practical exam – Clinical Assessment of Skills and Competencies (CASC).

**CCT or CESR

To move from higher training to apply for work as a consultant (and entry on to the specialist register), doctors need a further qualification, either a Certificate of Completion of Training (CCT) or a Certificate of Eligibility for Specialist Registration (CESR) in one of the six psychiatry specialties.

Certificate of Completion of Training (CCT)

This is for doctors who complete all or part of their specialist psychiatric training in GMC-approved training posts.

Certificate of Eligibility for Registration (CESR)

The CESR provides a route for doctors who do not hold a CCT to obtain the equivalence of specialist registration.

Relevant European Qualification (Specialist)

Another route to the same end-point – practising as a consultant in the UK - is a relevant specialist European qualification meeting GMC criteria.

Average duration of training

Trainees must undertake a minimum of six years training after a completed foundation programme before they are able to practice as a consultant psychiatrist. In practice only 27% of psychiatry trainees complete core and higher training within the minimum six-year timeframe[7]. This could be a result of trainees working less than full time, taking

[7] NES Digital Data Group using data from GMC National Training Survey and TURAS

career breaks and/or failing to achieve the required competencies such as RCPsych exams, particularly for IMGs.

Undergraduate snapshot

- Students can study medicine at five universities in Scotland: Aberdeen, Edinburgh, Dundee, Glasgow, and St. Andrew's.

- Universities in Scotland do not cover psychiatry in any great depth in the early years. Exposure is concentrated in clinical practice during the later years.

- Universities report limitations in their delivery of clinical and teaching experiences due to the lack of available consultants.

- Students experience negative narratives around psychiatry as a specialty – a survey showed that nearly 80% of year five students had encountered negative attitudes to psychiatry from other specialties – and are increasingly unlikely to follow it as their chosen field the further they progress through their studies.

- ACT monies intended for the creation of teaching time in job plans are often absorbed into general service budgets instead.

- Positive placement experiences at undergraduate level can be instrumental in a student pursuing a specialty. However, feedback suggests remote locations, a lack of belonging and purposefulness and inadequate supervision are barriers to a good experience.

Undergraduates

The beginning of the workforce pipeline – studying medicine

Students can study medicine at one of five universities in Scotland: Aberdeen, Dundee, Edinburgh, Glasgow, and St Andrew's. As medical students at St. Andrew's have their clinical placements elsewhere, they have not been included in this report.

Universities take different approaches to teaching psychiatry: Aberdeen and Dundee introduce elements of psychiatry in the early years of the course, with Dundee integrating psychiatry into their clinical-based curriculum. Edinburgh and Glasgow deliver very little psychiatry training before the clinical years. All universities deliver at least four weeks in a psychiatry clinical placement in the last two years of medical school. For details of teaching in each university see Table A in Appendix 1.

Student Selected Components (SSC) are special projects in an area of interest and can be valuable in enhancing a student's understanding of a specialty. Whilst there is little empirical evidence of the effectiveness of psychiatry teaching, anecdotally the universities report that '*general feedback is usually very positive*' (Professor Daniel Smith, Edinburgh University) and '*our most common feedback is that students enjoyed it a lot more than anticipated – partly low expectations but also testament to having a good experience in psychiatry*' (Dr Richard Day, Dundee University).

Teaching, clinical supervision and ACT monies

Universities report limitations in their delivery of clinical and teaching experiences due to the lack of available consultant time. In Aberdeen, a high rate of locum consultants means year four and five students on clinical placements are mentored by a retired consultant; in Dundee, a lack of substantive consultants available (due to clinical demands) to teach and a clinical reliance on locums means small group teaching is delivered by doctors in training. Dundee's final year sub-specialty options are similarly limited.

The Scottish Government via NES provides Additional Cost of Teaching (ACT) monies to cover the cost of teaching medical undergraduates in the NHS. These funds should go towards service budgets to ensure dedicated time in job plans to teach medical

students. However, it appears that these funds are often absorbed into general service budgets instead[8].

Undergraduate teaching is often delegated to trainees to deliver. Consultant led teaching and supervision is valuable for all grades including medical undergraduates and should not be routinely delegated to trainees.

The role of placement experiences

Clinical placements can greatly influence future career choices and opinions of psychiatry[9,10]. Improving a medical student's experience during clinical psychiatry placements can be an effective recruitment tool. Even if students do not wish to become psychiatrists, good experiences can educate students on the value of psychiatry and make them better future referrers. The RCPsychiS (Undergraduate and Foundation Year Working Group) identified three main factors that influence the quality of a student's experience:

- **Location**

  Many placements are perceived as remote and inaccessible, especially for students relying on public transport.

- **Belonging**

  A student's perception of involvement, usefulness and belonging to the team are fundamental to their quality of experience.

- **Supervision**

  A major contributing factor to placement experience is the quality of supervision in both teaching and clinical settings. Feedback from the workshop suggested that there are a limited number of educators, many are transient (locums may not be in post for the duration of the placement) and those available to

[8] *Follow the money: how is medical school teaching funded?* Aileen O'Brien, Ania Korszun. Journal: BJPsych Bulletin/Volume 45/Issue 2/April 2021. https://www.cambridge.org/core/journals/bjpsych-bulletin/article/follow-the-money-how-is-medical-school-teaching-funded/34F8F1E840F037CE20342A8C7B0BF24D

[9] Simon Budd, Rachael Kelley, Richard Day, Hannele Variend & Nisha Dogra (2011) *Student attitudes to psychiatry and their clinical placements*, Medical Teacher, 33:11,e586-e592. https://pubmed.ncbi.nlm.nih.gov/22022911/

[10] Economou, M., Kontoangelos, K., Peppou, L. E., Arvaniti, A., et al. (2017). 'Medical students' attitudes to mental illnesses and to psychiatry before and after the psychiatric clerkship: Training in a specialty and a general hospital.' Psychiatry Research. 258, pp. 108-115. https://www.sciencedirect.com/science/article/abs/pii/S0165178117305504?via%3Dihub

supervise have limited capacity. Anecdotal evidence suggests supervision is delivered by a cohort of very dedicated consultants and trainees but that this is not sustainable. Supervisors themselves said that when there is an attached medical student other work had to be put to one side to accommodate the student's needs.

The workshops identified a range of changes that can potentially improve the quality of a placement:

- **The provision of good quality hospital accommodation**
- **Flexibility over face-to-face clinic time (allowing for remote appointments)**
- **A centralised allocation of placements so each university has access to central belt placements**
- **Support with travel expenses and use of other incentives such as promotion of the leisure activities available in more remote locations**
- **Giving students a clear programme of what to expect in placement and ensuring they work (under supervision) as part of the clinical team**
- **Funded sessional time for clinical educators and placement supervisors, or an exploration of alternative models including the involvement of working retired supervisors, remote supervision and teaching**
- **Offering teacher training sessions on a regular basis to increase the pool and confidence of trainers**

There are also examples of shifting work from substantive to locum consultants in lieu of teaching which could mitigate problems with consultant shortages in some areas.

Student perceptions of psychiatry

Early exposure to psychiatry through experiential learning in medical school increases positive attitudes toward and interest in psychiatry as a career choice[11]. However, a study of Glasgow medical students in 2017[12] suggests that positive opinions about psychiatry diminish as students' progress through their learning:

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[11] Petkari, E., Gutierrez, M. A., Xavier, M., and Kustner, B. M., (2018). *'The influence of clerkship on students' stigma towards mental illness: a meta-analysis.' Medical Education.* 52 (7), pp.694-704. https://asmepublications.onlinelibrary.wiley.com/doi/10.1111/medu.13548

[12] Quinn, C. Hegde, R and Langan-Martin, J. (2020) Repositioning psychiatry in medical school curricula: a study of medical students' attitudes.

- **In the first four years of medical school, 55 to 75% of students believed, psychiatry is as prestigious as other specialties. By year five the figure was less than 20%.**
- **Nearly 80% of year five students had encountered negative attitudes to psychiatry from other specialties compared to around 35% in years one and two.**
- **The desire to pursue a career in psychiatry decreased: in year one 37% of students were interested in the specialty as a career, but in year five this dropped to 27%.**

Almost a third of participating students (across all year groups) said they were interested in a career in psychiatry, but many said they would not pursue this because of lack of exposure.

The RCPsych and RCPSychiS has run many 'Choose Psychiatry' campaigns focused on undergraduates (and sometimes high school students) to counter negative narratives and 'specialty bashing'.

Undergraduate recommendations

To address these issues we suggest:

- **Explore recruitment opportunities in the ScotGEM programme**

  ScotGEM is a four-year graduate-entry medical programme offered jointly by St Andrews and Dundee Universities to help with recruitment to General Practice (GP) posts and support rural and remote medicine. Many applicants have a background psychology degree which lends itself to training in psychiatry.

- **Make psychiatry teaching part of the curriculum in year one in all Scottish universities**

  Psychiatry teaching needs to be part of the medical undergraduate curriculum in all Scottish universities from year one. The outcomes need to be gathered and discussed with universities, especially as curricula changes are a lengthy process requiring negotiation with multiple stakeholders.

  The Psychiatry Early Experience Programme (PEEP) based in London has demonstrated this. In the meantime, Scotland needs to look at the positive impact of early exposure to psychiatry on attitudes towards psychiatry. There is also limited evidence from elsewhere about early exposure contributing positively to attitudes towards psychiatry as a speciality.

  PEEP Scotland (PEEPS) has been trialled in Edinburgh and is currently being evaluated. Expansion to other medical schools will require additional capacity within consultant job plans as well as input from trainees to provide the increase in teaching and mentoring capacity that will be required.

- **Commit to teaching time in job plans**

  Provision of undergraduate teaching requires protected time within consultant job plans. The current 9:1 contract does not allow adequate Supporting Professional Activities (SPA) time and adjustments to the duration of clinics to allow for time to teach. This is unlikely in the current 9:1 contract which allows only one half-day session for all non-clinical duties including administration. Continued workforce gaps further impact on already stretched consultants being able to undertake both formal and informal teaching. Those consultants with a special interest in teaching should be offered job plan time to take up formal university roles as honorary tutors, lecturers, and module organisers.

  Higher trainees already take on teaching and leadership roles and should be encouraged and supported in committing in tangible ways to undergraduate teaching such as tutorials and lectures.

- **Focus on improving medical student placement experiences by engaging with medical schools and boards in incorporating the findings from the workshops.**

- **Counter 'specialty-bashing' by campaigning with other specialties**

  The impact of stigma towards psychiatry from other medical practitioners negatively impacting students from considering psychiatry as a career is well documented. The RCPsychiS has a key role in engaging with other medical royal colleges in addressing this toxic problem. There is a need for ongoing monitoring of attitudes through repeat surveys and further research into the effectiveness The survey[13] needs to be repeated at regular intervals to gauge whether *Choose Psychiatry* and other campaigns are effective.

  Scottish University Psychiatric Societies are potentially useful in engaging the wider medical student body, but engagement varies. The RCPsychiS needs to work more proactively with these societies to identify their needs, support their activities and involve them in their activities.

- **Review of ACT monies**

  We recommend a comprehensive review and continued scrutiny of the way that ACT monies are utilised to ensure that ACT monies directly or indirectly contribute to dedicated teaching time in consultant job plans rather than being absorbed into wider service budgets.

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[13] Quinn, C. Hegde, R and Langan-Martin, J. (2020) *Repositioning psychiatry in medical school curricula: a study of medical students' attitudes.* https://eprints.gla.ac.uk/222659/5/222659.pdf

Foundation trainee snapshot

- Only 2.5% of Foundation Year 1 (FY1) students have an opportunity to take part in a psychiatry placement. In Foundation Year 2 (FY2) the figure is 27%.

- Good supervision from a consultant or higher trainee and a positive work culture that encourages experience in psychiatry (rather than performing repetitive medical procedures) are seen as markers of a good foundation training post.

- Around two-thirds of trainees in Scotland are taking a break from training after foundation training. There are several reasons: it is a natural point to pause; wanting to travel; as a break from studying, and assessment; a break for wellbeing; and feeling unsure about core training. The largest proportion opt for a service appointment in the UK or take a career break.

- This break is often referred to as Foundation Year 3 (FY3). It may last longer than a year, but GMC data shows that 90% of FY2 trainees obtain a specialty training post in the UK within three years of completing foundation training.

- FY3 posts are individual six-to-twelve-month roles created by Health Boards in response to demand. They are usually at CT1 level pay scale, but are unbanded with no on-call.

Foundation trainees

Next steps – from undergraduate to doctor in training

Students graduate from medical school after five or six years and move on to a two-year foundation training programme. This is a paid, work-based training programme which bridges the gap between medical school and specialty training.

After completing FY1, a doctor gains full GMC registration and is considered able to practice independently as a doctor. After completing FY2, doctors may enter core training, which is the first three years (or full time equivalent) of specialty training.

Applying for foundation training – how it works

A student applies to the UK Foundation Programme (UKFPO).

They are allocated to a Foundation School – Scotland is one such School.

The Scottish Foundation School covers the whole of Scotland and is divided into North, East, South East and West regions.

Each region offers a set of foundation programmes.

Each programme is an approved series of six 4-month posts (or three 4-month plus two 6-month posts) which make up a two-year foundation training programme.

Opportunities to study psychiatry during foundation training

Around 2.5% of trainees nationally have an opportunity to experience psychiatry in FY1. Trainees are inexperienced at this stage and limited in their medical practice. As they cannot prescribe medication or detain people under the Mental Health Act, they are usually placed in liaison psychiatry posts.

As a trainee's experience grows so do their opportunities to practice psychiatry. Around 27% FY2 trainees take a four-month psychiatry post.

Table 1: Exposure to psychiatry in F1 and F2 (2023)[14]

Area	Total posts (FY1)	Total FY1 psychiatry posts	% exposure	Total posts (FY2)	Total FY2 psychiatry posts	% exposure
East	105	9	9%	111	18	16%
North	162	3	2%	174	51	29%
South East	222	12	5%	231	69	30%
West	465	0	0%	489	138	28%
Total	954	24	2.5%	1005	276	27%

In 2019, the Scottish Government announced an increase in the number of foundation posts available to new medical graduates, recognising the increased intake to Scottish medical schools in recent years. These new posts were to be prioritised for community facing specialties such as GP and psychiatry. However, most new posts have been allocated to GP, with only modest increases in the number of new psychiatry places coming on stream in 2021 and 2022.

Foundation Priority Programmes (FPPs)

FPPs are offered to trainees of all specialities across the UK to support areas that find it hard to recruit and retain doctors. Scotland offers five foundation priority programmes (FPPs), four in the West and one in the North.

Both regions have been selected for their persistent problems in recruiting to posts because of their remote and rural locations. The North FPP, delivering six remote and rural posts, has a particular focus on psychiatry and offers: a 'remote and rural' bootcamp; immersive simulation and clinical skills; six themed psychiatry rotations;

[14] Figures provided by Foundation STB, April 2023 and further updated June 2023 to include increased FY2 posts to account for over-subscription.

enhanced psychiatry supervision; access to RCPsychiS events; and an allocated psychiatry mentor/educational supervisor.

Experience of foundation training posts

The workshop convened by the RCPsychiS (Undergraduate and Foundation Year Working Group) discussed the experience of foundation year trainees. They agreed with medical students that positive placement experiences are likely to persuade trainees to pursue psychiatry as a career. They noted similar themes around what constitutes an effective psychiatry post:

- **Supervision**

  Contributors noted the importance of engaged clinical supervisors who planned placements well. As is the case for undergraduates, this is difficult where health boards are forced to rely on a locum workforce and where the contracts of substantive consultants oblige them to prioritise clinical activity over planned supervision and training time.

- **Culture**

  Some participants felt that sub-specialties such as liaison psychiatry were better suited to Foundation Year trainees. Others believed the working culture engendered by the lead clinician determined the success of the post and that specialty was irrelevant. Some reflected that foundation posts may see trainees left to manage routine physical healthcare, with little exposure to psychiatry. Conversely if they are placed on the same on call rota as a Core Trainee despite their limited training, they become stressed to the detriment of their placement experience. The most important factors were a post that was well-planned, clearly defined, and where interpersonal dynamics fostered a strong sense of belonging to a team.

Attrition point – from foundation to core

If doctors follow the conventional route for medical training, they move on to Core Training after completing FY2 and must make the significant commitment to start to focus their training on a particular specialty.

The UK Foundation Programme Career Destinations survey[15] found that a quarter (24.6%) of foundation trainees did not think their Foundation Years provided a good

[15] UK Foundation Programme, 2019 F2 Career Destinations Survey. https://foundationprogramme.nhs.uk/resources/reports/

work-life balance. The majority thought they would have a better work-life balance if they did not enter specialty training.

Indeed, the survey reveals that trainees (in all disciplines) are increasingly likely to take a break between an FY2 post and specialty training. In 2019, 34.9% (35.7% in Scotland) of FY2 doctors declared they were appointed to specialty training in the UK. In 2018 the figure was 37.7% but back in 2010 it was 83%.

Table 2: Reported career destinations at the end of F2 2019 (whole of UK)

Area	Total posts	Total FY1 psychiatry posts
Specialty training in the UK	2,173	34.2%
Service appointment in the UK	1,448	22.8%
Career break – not practising medicine	878	13.8%
Still seeking appointment	534	8.4%
Other appointment in UK	479	7.5%
Service outside UK	364	5.7%
Other reasons	483	7.6%

This data is supported by anecdotal evidence from the RCPsych in Scotland Undergraduate and Foundation Year Working Group.

> *"There have been some really interested F2s, but I think every single one has either taken a break after F2 to go locum or has gone to Australia…I feel like if we could keep up the momentum we'd be able to recruit quite a few, but nobody here is going straight from FY to Core Training."*

Other research quoted by the UK Foundation Report in the same survey indicates that:

- **Over half of trainees are planning a career break of one to two years (only 1.5% were planning three years).**

- **46.9% reported that there is a natural break at the end of FY2 and this is the first/best opportunity to take a career break before committing to a longer programme.**
- **33% reported that part of the reason for a break was to take time away from the rigidity of assessment processes associated with formal training programmes.**
- **26.1% indicated a desire to travel.**
- **22.8% indicated the need to take a break for their health and wellbeing.**

Trainees also reported feeling unsure about their choice of specialty so soon.

Foundation Year Three (FY3) – an emerging choice

This break between foundation and core training, often referred to as FY3, may last longer than a year, 90% of FY2 trainees have obtained a specialty training post in the UK within three years of completing the Foundation Programme[16].

FY3 posts are not administered by the Foundation School in Scotland but are created by health boards in response to demand. Discussions with medical managers in psychiatry reveal a wide variation in the way FY3 posts are offered. They can vary from six- to twelve-month posts and are usually at CT1 level pay scale, but unbanded and with no on call.

Recruitment can be local or at board level. Some of these roles are used to fill existing vacancies while others are created to support services. The doctor has a named supervisor and is offered an appraisal. These posts tend to be highly competitive with most applicants IMGs from outside Europe looking to gain UK experience. Informal evidence suggests that the majority have gone on to core training in psychiatry.

Foundation trainee recommendations

To address these issues we suggest:

- **Rethink clinical supervision models to support an increase in FY2 psychiatry placements from a third to a half of all trainees**

  There is a recognition at Scottish Government of the need to increase the numbers of FY2 psychiatry placements. A major barrier is the lack of consultant

[16] GMC Training Pathways 2: why do doctors take breaks from their training (Working paper 7, July 2018) https://www.gmc-uk.org/-/media/documents/dc11392-training-pathways-report_pdf-75268632.pdf

supervisors and there is a need to consider alternative models of supervision in the short term to provide additional supervision capacity.

One possible solution, particularly in areas with a large number of locums, is for substantive consultants to take on a greater role in weekly supervision of foundation doctors with a commensurate amount of clinical work taken up by locums where necessary. Daily case supervision would remain with the locum. Consultant trainers should be offered time in their job plans for this supervision. If this can be guaranteed by health board managers, we would recommend that half of all foundation doctors have a FY2 post in psychiatry. Weekly supervision should be seen as mandatory, and time given in job plans for this.

The RCPsych has recently released guidance on supervision of trainees[17] which clarifies that SAS, and retired and returning doctors can also be supervisors. This is an avenue that should be encouraged and supported. Remote supervision options should also be considered.

- **Review Foundation Year job descriptions and commit to mid-point and exit interviews to allow for posts to evolve**

  The experience of the foundation doctor in post plays a significant part in whether they choose psychiatry as a career.

  We recommend:

  - Mid-point and exit interviews with foundation year doctors to build in reflection and reaction opportunities and allow changes to be made based on feedback.

  - A review of the job description of a foundation doctor in psychiatry with health boards ensuring that the placement experience is geared more towards psychiatry and less towards repetitive procedural tasks. To this end Boards should look at introducing Advanced Nurse Practitioners (ANPs), Physician Associates (PAs) and analogous roles to support routine medical care.

- **Standardise, accredit, quality assure and expand FY3 posts**

  FY3 posts need to be standardised and quality assured so that doctors are offered the same high quality of training as a core psychiatric trainee. These posts also need to be accredited so that aspects of the training can count towards the portfolio requirements of core training. Health boards should ensure

[17] RCPsych Guidance - Recognition and Approval of Trainers: Guidance on supporting a standardized approach. https://www.rcpsych.ac.uk/docs/default-source/training/letb/rcpsych-guidance-for-recognition-of-trainers.pdf

that these doctors are offered weekly supervision and end of placement appraisals.

FY3 data should be analysed to identify the training destinations of these doctors.

- **Invest in additional FY3 posts**

  Given the significant demand for FY3 posts – up to 100 applicants for one post in some areas including outside the central belt – we recommend that the Scottish Government invest in additional FY3 posts. Health boards could use this money to create sustainable posts and fund time in consultant job plans to offer dedicated supervision and support, as would be expected for any training post.

Core trainee snapshot

- Psychiatric core training posts across Scotland have been 100% filled for the last three years.

- Demand for core training in psychiatry is very high: data for the UK shows the number of applications for core training in psychiatry has increased by 130% in the last eight years across the UK from 797 in 2014 to 1,876 in 2022.

- There has been an overall expansion in the numbers of core training posts of 18% between 2014 and 2022, and a further 10 posts in 2023. Despite this, the number of posts available in 2023 was 46. This is partly because doctors are staying in core training for longer than three years, making posts unavailable to new core trainees.

- The allocation of core training places is weighted towards to the West and South East of Scotland, together accounting for 81% of core places.

Core trainees

Next steps – starting to specialise

Following foundation training, doctors enter core training and start to focus on their chosen specialty. During core psychiatry training, doctors work and train in a number of different sub-specialties within psychiatry. The training lasts three years or full-time equivalent, referred to as CT1, CT2 and CT3. By the end of CT3, doctors need to have passed the MRCPsych exam to apply for the next stage of training.

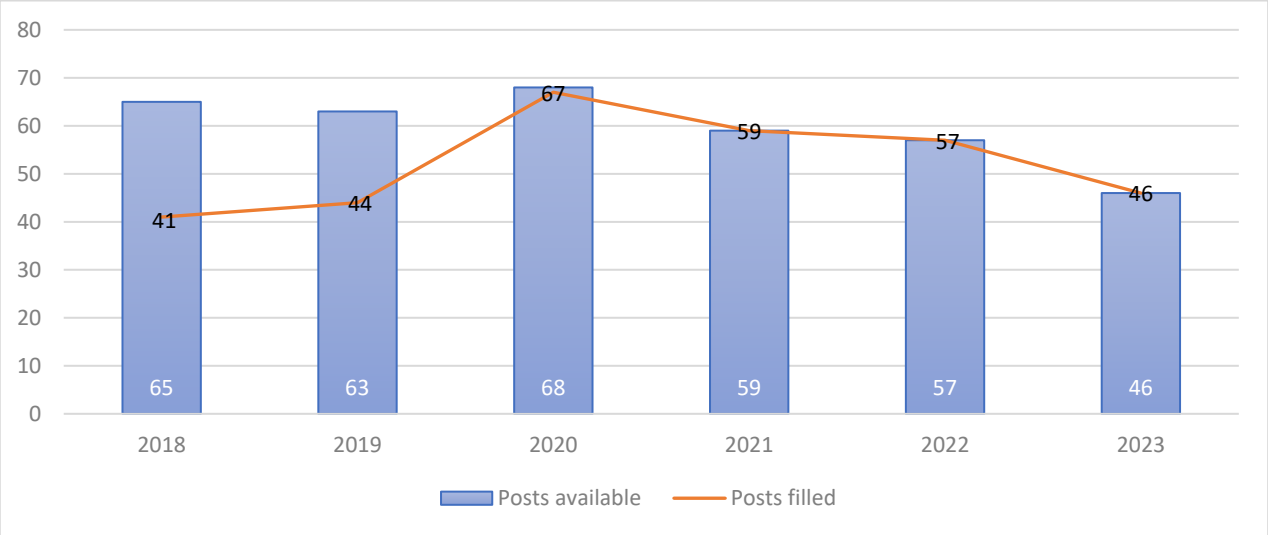
Core training numbers in Scotland

Core training posts across Scotland have been 100% filled for the last three years (including this year) and had only one vacancy in 2020. The reasons for this are uncertain but could be linked to the COVID-19 pandemic (trainees were less likely to travel so took up a core place in the UK), to fewer posts being available (in 2023) or to the success of campaigns by the RCPsych and RCPsychiS to attract people to the specialty (although there has been no official evaluation yet of these campaigns).

More broadly, data[18] shows that the number of applications for core training in psychiatry has increased by a staggering 130% in the last eight years across all nations, from 797 in 2014 to 1,876 in 2022. The number of core training places available in any one year has remained largely stable, ranging from 410 to 611. These statistics are for the whole of the UK (the Scottish breakdown is not known), but indicative of a need for more core training places in psychiatry.

[18] Competition ratios for 2022 from Health Education England. https://medical.hee.nhs.uk/medical-training-recruitment/medical-specialty-training/competition-ratios/2022-competition-ratios

Chart 1: Number of core training places in Scotland and fill rate 2018-2023[19]



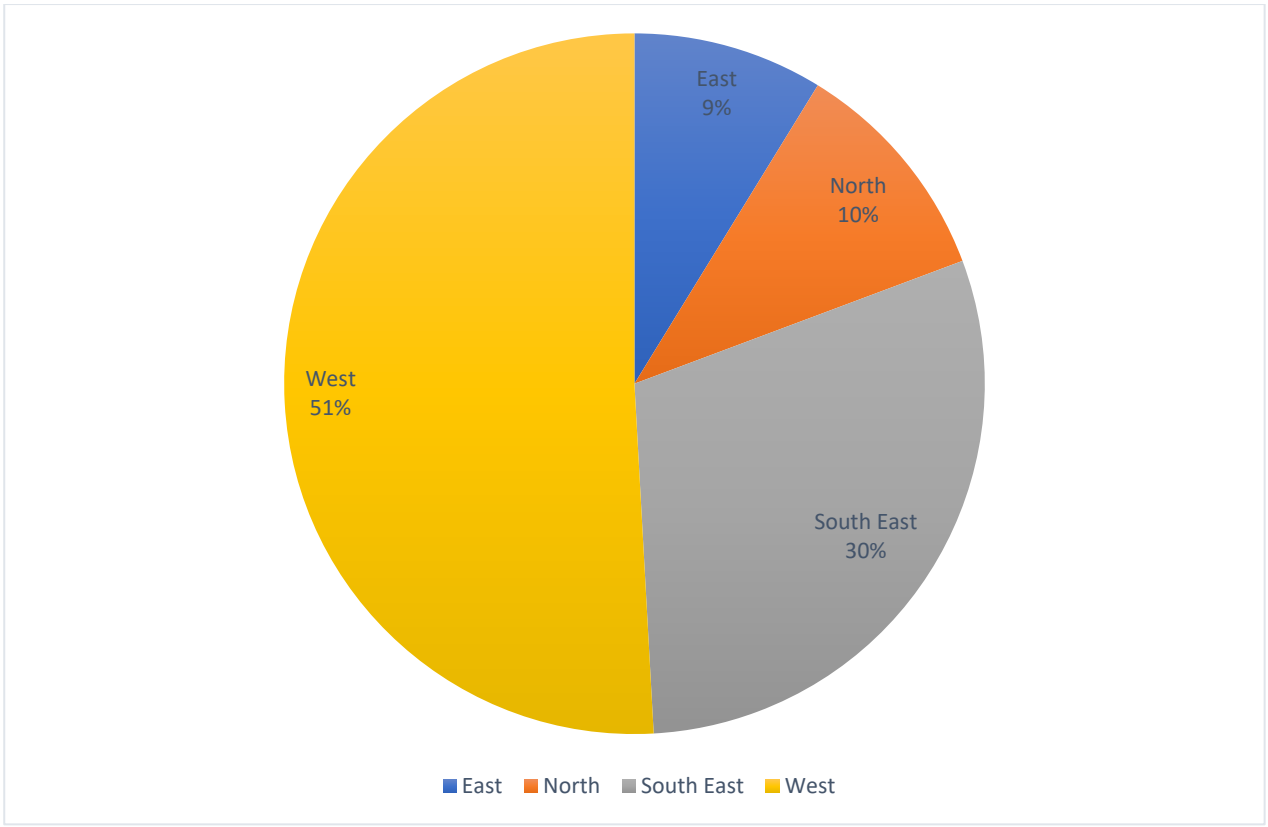
Despite the apparent increase in interest, in Scotland the number of core training places is decreasing. This is in part due to the fact that posts are for three years and can only be re-advertised when the trainee has moved on. Increasingly, trainees are staying in post for longer, some because they need more time to complete their exams, others because they take a break for personal or health reasons, and many actively choosing to work less than full time.

It is, of course, less surprising to achieve 100% fill rate given the striking fall in the number of posts available in Scotland, from 68 in 2020 to 46 in 2023. It is therefore self-defeating and a concern that while there is clear evidence for an increase in demand for core psychiatry training for a variety of reasons, the numbers of posts available have remained static and, indeed, reduced in real terms. This needs to be rectified.

[19] Data from NHS Education Scotland Specialty Training Board (MH) Recruitment Update, December 2022.

Regional differences in Core Training numbers

Chart 2: Breakdown of core training posts by region 2022[20]



Core trainee recommendations

To address these issues we suggest:

- **Collate and monitor Scotland specific data on application and fill rates for core training posts in psychiatry including relevant regional differences**
- **Expand core training places in psychiatry, especially in areas that find recruitment harder**

  The 100% fill rate in successive years appears promising. However, in 2019 we had only about 70% fill rate but 44 CT trainees. We now have 100% fill rate but almost exactly the same number - 46 trainees in post. There has been a steady decline over the past four years in the number of core training places available in

[20] Data from Specialty Training Board (MH) Recruitment Update, December 2022.

Scotland despite 100% fill rates over this period. This is a retrograde step given the context of workforce challenges and there is an urgent need to expand core training places in psychiatry to ensure sustainability. This would also need to include a proportionate increase in core training places outside the 'central belt' which find recruitment challenging and supervision and training limited in capacity.

- **Rethink clinical supervision models to allow for an increase in Core Training places**

  If more core training posts are created, supervision capacity needs to increase. A major barrier to doing so in some areas is the lack of consultant supervisors. Health boards should look at alternative models of clinical supervision similar to the recommendations made within for foundation training. Substantive consultants taking on a greater role with a commensurate amount of clinical work undertaken by locums. Consultant trainers should be offered time in their job plans for this supervision. Daily case supervision will remain with the locum. Weekly supervision should be seen as mandatory and time given in job plans for this.

  As mentioned previously, the RCPsych has recently released guidance on supervision of trainees[17] which clarifies that, SAS and retired and returning doctors acting as supervisors, remote supervision options across health boards might also be encouraged. There are some examples of this in the North.

Higher trainee snapshot

- Around a third of higher training posts were vacant last year. This has been the case since 2018. The transition from core to higher training in Scotland represents a key attrition point in the workforce pipeline.

- Location plays a part in how many higher training places are filled. The West and South East had at least 80% of their posts filled in 2022. However, the figures for the North and East were 20% and 55% respectively. In 2023, there has been improvement with the West and South East filling 100% of ST posts, however the figures for North and East remain lower at 40% and 33% respectively. It must be noted however that fewer posts were available to fill.

- By the time they have completed core training, doctors have often settled in a region. Consequently, they would often rather wait until a higher training post becomes available in their area than relocate.

- Some specialties attract higher trainees more than others: even where high fill rates are achieved overall, ST posts in general adult psychiatry are as low as 60%.

- Core trainees cite the need for more experience in their chosen field or a lack of time to complete professional exams and competencies as two key reasons for delaying moving on to higher training.

- Positive experiences during core training encourage trainees to move on to higher training, but many trainees are reporting challenges with their training.

- Doctors find the assessment and exam process inflexible and often cite requiring more time than they can give when working in demanding clinical settings.

- Applications for higher training rely heavily on a candidate's CASC score. Trainees have reported that they feel too much emphasis is placed on this, and they feel unprepared to approach the application process.

- Trainees are increasingly working less than full time. This means they stay in training for longer, however, due to the way National Training Numbers are administered, their place cannot be released or shared with another doctor until they complete training.

Higher trainees

Committing to a specialty

Higher (or Specialty) psychiatry training normally takes three years, known as ST4, ST5 and ST6. The training reflects the sub-specialty a doctor has chosen to pursue: child and adolescent (CAMHS), forensic, general adult, old age, psychotherapy or psychiatry of intellectual disability (ID).

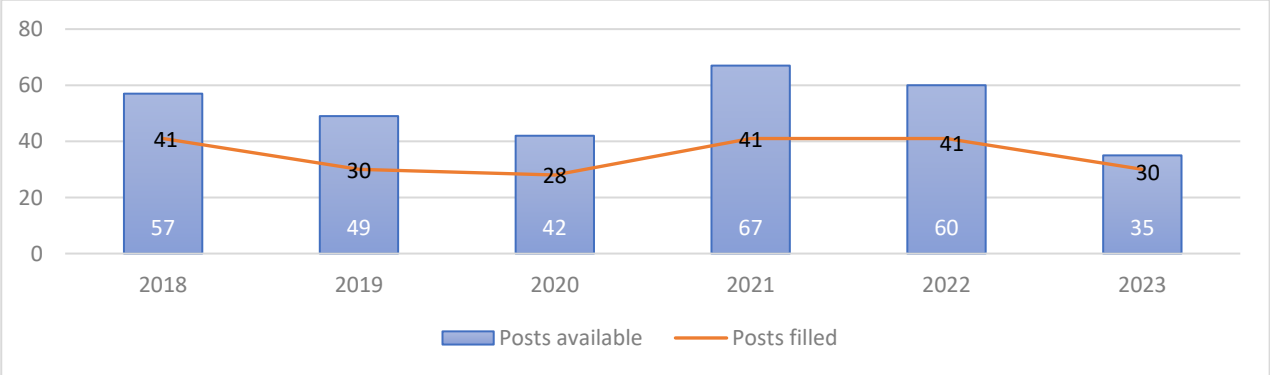
There will also be opportunities to work in other sub-specialties including addictions, liaison psychiatry, eating disorders, neuropsychiatry, perinatal psychiatry, and social and rehabilitation psychiatry.

On satisfactory completion of higher training, evidenced in an official portfolio, doctors receive their CCT.

Higher training numbers and fill rate

Whilst core training for psychiatry has seen increasing fill rates over the past five years and has been 100% subscribed since 2021, higher training posts are consistently under-subscribed. As the information in the table below shows, around a third of higher training posts were vacant last year. This has been the case since 2018. The transition from core to higher training in Scotland represents a key attrition point in the workforce pipeline.

Chart 3: Number of higher training places and fill rate 2018-2023[21]



[21] Data from Scottish Medical Training 2023 Recruitment R1+R2. https://www.scotmt.scot.nhs.uk/media/2824282/2023-Recruitment-Data-with-2022-for-comparison_FINAL.pdf

Variations in fill rate by location and specialty

Whilst the general picture for higher training is not positive, it is even more acute in some areas and specialties. The chart below shows the fill rates for specialties and regions in 2022; any in red have at least half their posts vacant. The East and North have noticeably fewer filled vacancies: overall the fill rate in the East is 55% and for the North 20%. This is indicative of a key reason why people are not moving from core to higher training – location.

Table 4: Fill rates for higher training by location and specialty, 2022[22]

	East			North			South East			West			Total		
Specialty	**Posts**	**Accepts**	**Fill**	**Posts**	**Accepts**	**Fill**	**Posts**	**Accepts**	**Fill**	**Posts**	**Accepts**	**Fill**	**Posts**	**Accepts**	**Fill**
Child and adolescent psychiatry	2	1	**50%**	2	0	**0%**	5	3	60%	5	4	80%	14	8	57%
Forensic psychiatry	1	1	100%	1	0	0	1	1	100%	1	1	100%	4	3	75%
General psychiatry	5	2	**40%**	4	1	**25%**	6	6	100%	9	9	100%	24	18	75%
General psychiatry and medical psychotherapy	1	1	100%										1	1	100%
General psychiatry and old age psychiatry				1	0	**0%**							1	0	0%
Medical psychotherapy							1	1	100%	1	1	100%	2	2	100%
Old Age psychiatry				2	1	**50%**	1	1	100%	5	3	60%	8	5	63%
Psychiatry of Learning Disability							1	0	0%	5	4	80%	6	4	67%
Totals	9	5	55%	10	2	20%	15	12	80%	26	22	85%	60	41	68%

[22] Data from Specialty Training Board (MH) Recruitment Update, December 2022.

Attrition between core and higher training – why is it happening?

The Core Trainee Working Group (see contributors for details) commissioned by the RCPsych in Scotland used two focus groups sessions to explore some of the reasons behind the attrition between core and higher training.

A full summary is explored in the resulting Psychiatry Training Attrition Report[23], what follows is a snapshot of the reasons behind attrition and the recommendations for its reversal. The five main reasons people do not move on are:

- **Unprepared for higher training and greater responsibility**

  Many core trainees felt that core training did not provide them with enough experience in their desired specialty or were undecided on which specialty to pursue. They believed a break in training by taking up non-training posts – especially SAS posts – would allow a more informed decision on the choice of psychiatric sub-specialty without training obligations such as being on call.

  Trainees expressed anxieties around the on-call and leadership aspects of higher training. They felt having clarity on the role in advance and an opportunity to gain some experience could help prepare them.

- **The inflexibility of existing exam and assessment processes**

  Only 14.7% of psychiatry trainees complete training within six years[24]. This reflects time out to gain further experience, working less than full-time, needing a break, or needing to extend core training because they have not passed the MRCPsych examination or demonstrated psychotherapy competencies.

  During the COVID pandemic, applicants could sit the three parts of the MRCPsych exams in any order (currently trainees must have passed the written papers (paper A followed by paper B) prior to sitting the clinical exam (CASC)). Respondents felt sitting exams in any order made it more realistic to complete core training without an extension. Due to the high service provision

[23] A Threatened Species: Where have all the Higher Trainees gone? A Core to Higher Training Attrition Report, RCPsych in Scotland, September 2023: https://www.rcpsych.ac.uk/docs/default-source/members/divisions/scotland/2023/scotland-psychiatry-training-attrition-report.pdf?sfvrsn=d4760008_8

[24] Silkens MEWM, Sarker SJ, Medisauskaite A. *Uncovering trends in training progression for a national cohort of psychiatry trainees: discrete-time survival analysis.* BJPsych Open [Internet]. 2021 Jul 28 [cited 2023 Jun 12];7(4):e120. https://www.cambridge.org/core/journals/bjpsych-open/article/uncovering-trends-in-training-progression-for-a-national-cohort-of-psychiatry-trainees-discretetime-survival-analysis/282E0B6106C6B2E73E029256002C6194

requirements in core training, trainees have proportionately less time to prepare for, and flexibility around, sitting exams.

Trainees cite the demands of portfolio requirements for delays in progression. Trainees struggle to meet all requirements in the time frame with competing demands such as clinical work and exams, and often service demands mean they often need more than three years to complete psychotherapy competencies.

Many feel that they gain valuable experience when they step off the training pathway after core training and queried whether some of their experience could count towards higher training requirements.

- **Experiential demotivators – risk of burnout, non-psychiatric tasks and the example of consultants**

  Experiences during core training have a significant impact on the likelihood of trainees applying for higher training. According to the GMC National (UK) Trainees' Survey (2022)[25], two-thirds of trainees reported feeling 'always' or 'often' worn out at the end of their workday, 13% of psychiatry trainees were assessed as being at high risk of burnout. In our workshops, trainees reported feeling mentally exhausted after the rigours of core training.

  Workshop discussions confirmed that those who shared positive experiences during core training were more likely to continue into higher training and to remain in their core specialty. Negative experiences included little exposure to psychiatry (instead being given often repetitive general medical tasks), minimal autonomy and '*lots of hoops to jump through*'. Trainees acknowledged the value of routine medical tasks, but felt other professionals were better placed to complete them.

  Trainees' choices were also influenced by the example of the consultants they worked with, both positive and negative. Some were dissuaded from continuing into higher training after seeing the stress, workload and responsibilities of their consultants, and consequent impact on their physical and mental health.

- **Demographic motivators – being settled and needing to plan ahead**

  By the time they have completed core training, doctors have often settled in a region, have partners with their own careers, children at school, homes, and relationships which they do not wish to leave. Consequently, they would often

[25] Massey C. *GMC National Training Survey 2022 results*. 2022. https://www.gmc-uk.org/-/media/documents/national-training-survey-summary-report-2022-final_pdf-91826501.pdf

rather wait until a higher training post becomes available in their area than relocate.

Knowing where you are going to be throughout your training is appealing to trainees. It allows them to concentrate on training without the distractions of relocating or the pressure involved in applying for higher training posts. It also allows for forward planning beyond training.

Trainees talk about a lack of real understanding about opportunities in other regions - for instance, what special interest sessions, research and teaching opportunities, and future consultant posts will be available.

- **Stressful higher training application criteria**

  The procedure of applying for higher training has been described as anxiety-inducing. In 2020, the ST4 application criteria underwent changes[26]. Feedback from focus groups and other discussions shows that trainees do not place the same value as assessors on different application criteria. They often realise only when applying that they lack certain requirements by which time it is too late.

- **The bottleneck of places for higher training**

  Core trainees are increasingly looking at LTFT[27] options and this is likely to continue into higher training and beyond. It obviously takes longer to train LTFT. However, due to the way NTNs are administered, their training place cannot be shared and is only available again when the holder completes training.

[26] NHS Health Education England. *Applying for Higher Training* [Internet]. 2022 [cited 2023 Jun 12]. https://medical.hee.nhs.uk/medical-training-recruitment/medical-specialty-training/psychiatry/higher-psychiatry-training/overview-of-higher-psychiatry-training/applying-for-higher-training

[27] NHS Education for Scotland. NHS Scotland Workforce [Internet]. 2022 [cited 2023 Jun 12]. https://turasdata.nes.nhs.scot/data-and-reports/official-workforce-statistics/all-official-statistics-publications/06-june-2023-workforce/dashboards/nhs-scotland-workforce/?pageid=9432

Higher trainee recommendations

To address these issues we suggest:

- **Improved core trainee experience to prepare them for higher training**

  Trainees at all levels need to gain experience focused primarily on psychiatry and associated medical responsibilities. Other professionals such as Physician Associates might be employed to appropriately undertake routine medical tasks.

  Mid-point and end of placement interviews could provide information to iteratively improve placement experience.

  Consultant psychiatrists must have adequate time in job plans to offer supervision, guidance, training and pastoral support.

  Trainee knowledge and experience should be reviewed prospectively and taster sessions offered in areas of less experience in readiness for higher training.

- **Overhaul the exam and assessment process and educate trainees on how to navigate the system**

  Supervisors of core trainees need time and training to make trainees aware of curriculum requirements, and exam sittings from early on.

  The RCPsych should be urged to reconsider flexible order of exams as offered during COVID-19.

  Opportunities to undertake mandatory supervised psychotherapy cases need to be expanded.

  The RCPsychiS, and at UK level, should actively consider how relevant experience obtained in SAS posts and other out of programme placements could be counted towards training requirements.

  The RCPsychiS should offer annual information and networking sessions on application to, and what to expect during, higher training. These could be open to CTs and SAS/out of programme doctors and could include interview skills practice.

  Information should be held centrally and accessibly about ST opportunities available in each region, including special interest sessions, teaching, research and quality improvement opportunities.

- **Experiential motivators**

  Core trainees, especially in their CT3 year, should be offered more autonomy in decision making, and have options to shadow higher trainees on call in readiness for higher training. Offer opportunities to lead multi-disciplinary team (MDT) meetings, contribute to mental health teams, join consultants at

management and service improvement meetings to improve their confidence in areas of leadership and management.

- **Demographic motivators – Increase the number of 'run through' posts especially outside the central belt**

  'Run through' training, offering both CT and ST posts has been piloted in CAMHS and ID. We recommend increasing the number of run through training posts in all psychiatric specialties and especially in areas of higher trainee and consultant vacancies outside the central belt of Scotland.

  A separate workstream is needed to understand IMG specific issues and provide information on housing, local schools and other amenities and on claimable expenses for all trainees moving to a new health board.

  Given the demand for higher training places in the central belt of Scotland there is an argument for temporarily over recruiting to these areas, whilst remaining sensitive to the workforce needs of more remote health boards.

- **The bottleneck of places for higher training**

  Training numbers – and indeed all staffing numbers – need to be expressed in terms of WTE rather than headcount.

  The way in which NTNs are allocated should be reviewed so that a LTFT trainee does not take up a whole training post number. Relevant stakeholders – NES, the Scottish Government, RCPsychiS - need to work together to ensure full usage of available NTNs. If this is not feasible an increase in NTNs should be made available to reflect the impact of LTFT training.

  Alternative models of clinical supervision should allow expansion of higher training posts even in areas with consultant vacancies. Such models might include employing retired consultants and use of remote supervision and have been discussed elsewhere in this report.

Consultant snapshot

- A BMA report from 2021 suggested that the consultant vacancy rate in Scotland was more than double the official government figures.

- Data from 31 December 2022 suggests a 14.9% WTE vacancy rate (93.9) with 8.2% of posts vacant for over six months (51.8) for psychiatry consultants, compared to a rate of 6.5% for all medical specialties.

- Most job plans in England are split as 7.5:2.5 DCC:SPA, which means a quarter of the week is protected for teaching and other non-clinical activities. In Scotland the common 9:1 job plan means that 90% time must be spent on direct patient care. It is unpopular with doctors who find it does not allow them enough time to engage in training, teaching, supervision, service development and research.

- Interview for consultant posts in psychiatric sub-specialties are more likely that those in all other specialties to be cancelled. In 2022, 57% were cancelled, a quarter of these because there were no applicants.

- There has been an increasing demand on psychiatric services for conditions that were hitherto not considered to be within the remit of psychiatry, such as adult ADHD, and an increase in referrals to psychiatrists that would previously have been managed in primary care.

- Clinicians and medical managers often work in silos which operate separately and share little information. Medical managers in Scotland are given less time than their counterparts in England to complete service management work, hindering their ability to lead, manage and develop services.

- Consultants as well as trainees expect more flexible working arrangements. They are increasingly taking breaks at various points in their careers and opting to work less than full time.

- Flexible remote working models have been successfully employed in some areas but not universally adopted.

- Financial remuneration for consultants, including the discretionary points system appears to lag behind opportunities elsewhere in the UK. Pension arrangements currently cause confusion and act as a deterrent to continuing work.

Consultants

Entering the specialist register

When doctors have successfully completed their training, they receive a CCT and are entered on to the GMC's specialist register. They are eligible to apply for consultant positions from six months before their expected CCT date. Consultant psychiatrists play an essential role that extends far beyond their clinical expertise and holding responsibility for patients. They are engaged in clinical governance, research, quality improvement, service planning, and, most importantly, training and supervision of the next generation of psychiatrists.

Consultant numbers in Scotland

It is harder to present an accurate number of consultants in Scotland as positions are created, advertised and appointed by individual health boards rather than one central body. The last census of consultant numbers by RCPsychiS in 2021 provides an incomplete picture as four of the 14 health boards failed to submit information. The last census for NES[28] is a more comprehensive reflection of numbers.

Unfortunately, available data includes positions held by locums. For the purposes of this report, we consider locum posts as vacancies, as locums do not carry out the same work as a substantive consultant. Generally, locums focus on clinical work and do not deliver teaching, training, supervision, service development and research. Indeed, they may not hold the qualifications that equip them to apply for the substantive post. Official data may also overestimate the numbers if they rely on a headcount of consultants rather than on WTE.

[28] NHS Education for Scotland Workforce Data [TURAS]. 2022. https://turasdata.nes.nhs.scot/data-and-reports/official-workforce-statistics/all-official-statistics-publications/06-june-2023-workforce/dashboards/nhs-scotland-workforce/?pageid=9432

Table 5: Consultants by specialty adjusted for locum numbers (2021/22)*

	All	General	CAMHS	Forensic	Old Age	Psychiatry of Learning Disability	Psychotherapy
Dec 2022 (Estab*)	631.7	368.7	79	41.2	80.3	48.4	14.1
Dec 2022 (in post)	537.9	318.2	62.4	32.4	63.7	47.1	14.1
% locums*	20%	24%	4%	5%	28%	56%	0%
Adjusted totals	430.32	241.83	59.90	30.78	45.86	20.72	14.1

*Notes on data used in Table 5

The figures above combine two different sources of information. The first row shows WTE establishment figures from December 2022[29] – in other words the number of funded posts available to carry out the work. The second row shows WTE in post numbers for each specialty for comparison. These count both substantive and locum posts in the same way.

To adjust the figures to reflect the number of substantive consultants in post more accurately, we've used data collected in the RCPsych Workforce Census 2021[30], although this omits information not supplied by four health boards and uses headcount rather than WTE. Based on the % of locums per specialty, we have adjusted the totals above to provide an estimate of the situation, as illustrated below.

[29] Royal College of Psychiatrists Workforce Census 2021. https://www.rcpsych.ac.uk/docs/default-source/improving-care/workforce/census-2021-completed-draft.pdf?sfvrsn=191319cb_2

[30] Royal College of Psychiatrists Workforce Census 2021. https://www.rcpsych.ac.uk/docs/default-source/improving-care/workforce/census-2021-completed-draft.pdf?sfvrsn=191319cb_2

Table 6: Proportion of the workforce staffed by locums (2021)[30]

	All	General	CAMHS	Forensic	Old age	Psychiatry of learning disability	Psychotherapy
Dec 2021 Totals	396	155	49	40	54	25	12
Locums	79	37	2	2	15	14	0
% locums*	20%	24%	4%	5%	28%	56%	0%

Further evidence of consultant shortages

Numerical evidence of a severe consultant shortage is reinforced by feedback from medical students and trainees, who consistently report that there is far too little consultant time to provide adequate supervision and teaching.

Waiting lists for CAMHS and Psychological Therapies are another marker of consultant shortages. In the quarter ending March 2023, only 74.2% of children and young people were seen within 18 weeks of referral, despite the Scottish Government standard that 90% of children and young people should meet this target. In the same period, 79.8% of people were seen within 18 weeks of referral for Psychological Therapies: again not reaching the 90% target. For other subspecialities of psychiatry we can only rely on anecdotal evidence of very long waiting lists as data is not collected routinely and in a systematic manner across health boards.

A BMA report[31] which outlined the most up-to-date figures obtained through an FOI (Freedom of Information) request suggests that the consultant vacancy rate was more than double the official government figures, and higher than in 2019. Their report notes:

> *"The way in which Scottish Government collects and records its vacancy figures fails to capture the true extent of consultant vacancies across the country. This means that a significant number of posts where someone has left but the*

[31] *Consultant Retention in Scotland in 2021*. BMA. https://www.bma.org.uk/media/3840/bma-scotland-consultants-retention-report-feb-2021.pdf

advert for their replacement has not been authorised, or vacant posts which an NHS board has tried and failed to fill and are not currently being advertised, are not included. The real number of vacancies is therefore likely to be far higher than reported figures, which significantly underestimate the scale of the problem and therefore reduce the urgency to mitigate the true impact on the service."

They estimated the overall consultant vacancy rate to be 15.2% in 2020. More recently, TURAS data[32] from the census of 31 December 2022, suggests a 14.9% WTE vacancy rate (93.9) with 8.2% of posts vacant for over six months (51.8). In comparison, the WTE vacancy rate for all medical specialities was 6.5%. This shows a significant gap in the psychiatry workforce at consultant level.

Attrition at consultant level

The RCPsych in Scotland's Consultant and SAS Working Group (see contributors for details) found four key challenges in recruiting and retaining doctors to consultant posts in Scotland: job plans; service models; job flexibility and financial considerations.

Job plans

Job plans set out the duties, responsibilities and objectives of a role. Programmed activities (PAs) are the four hour blocks of time in which contractual duties are performed. A standard full-time job would consist of 10 PAs (five mornings, five afternoons in a week). The blocks of time are divided into direct clinical care (DCC) and supporting professional activities (SPAs).

91% of consultant psychiatrist job descriptions in England are advertised with a DCC:SPA balance of 7.5:2.5. In Scotland, a balance of 9:1 is by far the most common. Doctors told the working groups that they dislike 9:1 job plans which provide little time for anything other than direct patient care. There is too little time for training, teaching and supervision, departmental meetings, management roles, service development, quality improvement activity, research or agreed special interests. Insufficient time to train has a direct impact on the quality of core and higher training posts and will be an obstacle to expansion of training posts at all levels as no time from trainers mean no additional posts can be approved.

[32] NHS Education Scotland Workforce Data (TURAS) 2022. https://turasdata.nes.nhs.scot/data-and-reports/official-workforce-statistics/all-official-statistics-publications/07-march-2023-workforce/dashboards/nhs-scotland-workforce/?pageid=8738

Consultants on 9:1 contracts are left feeling dissatisfied, disenfranchised and disengaged with their peers and the wider service. This provides poor role modelling for trainees.

There are clear benefits to involving clinicians in service development, yet this does not seem to happen consistently and is a lost opportunity. Clinicians are well placed to share knowledge and real world experience with managers to help develop and sustain services. Additionally, medical managers in Scotland have far less time in their job plans for management work than in the rest of the UK. This hinders their ability to lead, manage and develop services, affects retention and continuity, and discourages others from taking up management and leadership roles.

The Academy of Medical Royal Colleges and Faculties in Scotland[33] (known as the "Scottish Academy") notes that while the number of splits advertised as 9:1 decreased in the past five years, the number denoted 'unknown' increased by a similar amount, commenting that:

> *"Further analysis of the data may be needed as many Health Boards could be opting for 'not known' as they do not want to be seen offering 9:1."*

The Scottish Academy also reports that of all the panels convened to interview for consultant posts, more were cancelled for psychiatry than for any other speciality, as illustrated below.

Table 7: Number of consultant psychiatry interview panels cancelled (2021)

Subspecialty	Completed	Cancelled	% Cancelled
Old-Age Psychiatry	6	37	86%
Child and Adolescent Psychiatry	13	14	52%
General Psychiatry	30	31	51%

[33] Academy of Medical Royal Colleges and Faculties in Scotland *External Adviser Service Annual Report 2022* https://www.scottishacademy.org.uk./sites/default/files/External%20Adviser%20Service%20Annual%20Report%202022.pdf

In 2022, it was noted that 65 of the 80 panels (57%) were cancelled as there were no applicants for the post.

In a 2022 survey[34] of mostly Scottish based trainee psychiatrists and medical students considering a career in psychiatry, respondents were twice as likely to aspire to a career in England than to one in Scotland. This may reflect differing job plans. Psychiatrists are increasingly attracted by work outside the UK. For example, consultant posts in Australia promise excellent salaries, flexible working patterns and extensive wellbeing initiatives.

Participants also noted that job plans in England are kitemarked by RCPsych according to aspects of the job such as DCC:SPA split, office space and wellbeing clauses. Trainees are actively discouraged from applying to posts that do not carry this stamp of approval. This can mean further disadvantage to recruiting in Scotland where job descriptions are not kitemarked.

Survey respondents agreed that after appointment, jobs needed to be reviewed periodically to adapt to interests and specialist skills and generate more job satisfaction. Even if a 9:1 contract was accepted consultants should be able to negotiate changes to better serve their development and that of the service.

In services running on reduced capacity, existing consultants are often asked to pick up extra clinical activity to reduce the impact on patients so that their job plans become 10:1 or even higher ratios.

Consultant posts that are difficult to recruit to and/or have had locums in place for long periods of time need to be deconstructed to understand the recruitment issues – work load, team support, community support – and modified before being advertised as a substantive post. These posts will need an adequate amount of SPA time in line with the rest of the service or else they are being set up to fail. These SPA sessions cannot simply be added to the post. Instead, clinical sessions released by restructuring these posts will need to be funded and delivered by the service.

When consultants reduce their clinical sessions for any reason – work/life balance, taking on additional responsibilities, working towards retirement – the 'lost' sessions are often expected to be absorbed by the service instead of being offered as additional funded sessions.

[34] RCPsychiS MyPsych Career Aspiration Survey (awaiting publication - available on request)

Service models: general psychiatry

Until around a decade or so ago adult psychiatric care in Scotland was delivered according to geographical sectors, each with its own multi-professional team.

Consultant psychiatrists provided leadership and psychiatric expertise to each Community Mental Health Team (CMHT). The consultant would be responsible for both an outpatient case load and for hospital inpatients in their sector. The psychiatrist was the common denominator in the pathway, providing continuity for the patient and their family and referring GP.

However, with increasing demands on services there was a gradual move to separate teams – inpatient, community, and crisis and home treatment. Whilst this brought about some early benefits in terms of availability of psychiatrists, our members tell us that pressures have returned to previous levels – if not worse – and previous continuity has been lost. There is ever-increasing demand on services together with reductions in bed numbers. Furthermore, pressure on primary care and other community services has resulted in psychiatrists having to spend a lot of time triaging referrals.

Consultants often carry outpatient caseloads in excess of 300 patients. This is hard to address even in the 9 or 10 weekly four hour sessions of typical job plans, and as described leaves them with little time to engage in all the other activities demanded of a consultant if services are to be sustainable. This has an impact on stress, morale and ultimately retention of psychiatrists. In turn, recruitment suffers. Inpatient psychiatrists also experience constant pressure on throughput and such posts are unpopular.

Service models: psychiatric specialities and diagnostic issues

As diagnostic systems expand psychiatric services have been increasingly divided into sub-specialities. Some of these attract resource and staffing that in times of financial deprivation risk impoverishing general services. At the same time there has been an increasing demand for general psychiatric services to offer assessment and treatment for conditions that were hitherto not considered to be within the remit of psychiatry, such as adult ADHD.

Finally, our members report an increase in referrals to psychiatrists that would previously have been managed in primary care. A recent Mind[35] study showed that 40% of all GP appointments are mental health related. It suggests that for many GPs such situations are beyond their level of expertise, hence the increase in referrals to secondary care. The RCPsych is aware of workforce issues in General Practice which may also contribute. However, there needs to be a review of referral criteria in terms of

[35] 40 per cent of all GP appointments about mental health, Mind, 5 June 2018 [Internet] https://www.mind.org.uk/news-campaigns/news/40-per-cent-of-all-gp-appointments-about-mental-health/

both diagnosis and severity. Appropriate care pathways can then be developed and appropriately funded so that patients see the right clinician in the right place at the right time.

Job flexibility

Alongside this background of increased demand there is a growing trend[36] for doctors to work LTFT. This needs to be considered when collecting and reporting data and when planning services. It is hard to fill small numbers of clinical sessions, so total numbers of sessions needed for a service needs to be taken into account (rather than staff head count) and then divided up to provide attractive posts.

Beyond job plans, the workshop participants agreed that flexibility and innovation around consultant roles needed to be the watchword in future. Consultants usually have areas of special interests that need to be supported and encouraged. As well as seeking LTFT work, doctors increasingly take career breaks.

Remote working models were also discussed as a way of providing more flexible working. There are several examples in mental health services of staff who live in one part of the country and offer a service elsewhere. NHS Grampian, NHS Highland and the three Island Health Boards have been practising remote psychiatry since the millennium and find it more economic and convenient since the COVID-19 experience introduced newer technology.

Health boards need to ensure that all services have up-to-date service plans that are available to all consultants in the service. These plans should be transparent and accurately detail the total numbers of PAs and SPAs available within the service. They should be reviewed annually to include changes within the service for any reason – reduction in sessions, retirements, locum usage, increased demand – and arguments made for post expansion where service review and redesign alone does not provide solutions.

Other flexible ways to cope with pressures psychiatrists may involve considering making the most of new and redefined roles that complement traditional medical roles. These include Advanced Nurse Practitioners (ANPs), Non-Medical Prescribers (NMPs) and Physician Associates (PAs)[37]. Some Scottish boards have made use of ANPs to work in crisis situations. The uptake of PAs is currently much lower than in England[38]. The effectiveness of new roles has not been evaluated. Anecdotally, our members tell

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[36] Patterns of less-than-full-time working by NHS consultants, Institute for Fiscal Studies, 30 May 2023 https://ifs.org.uk/publications/patterns-less-full-time-working-nhs-consultants

[37] About Physician Associates, RCPsych [internet] https://www.rcpsych.ac.uk/improving-care/physician-associates/about-physician-associates

[38] RCPsych census 2019, 2021 https://www.rcpsych.ac.uk/improving-care/workforce/our-workforce-census

us that these roles can free up psychiatrists' time by taking on more routine medical tasks. They were never intended to fully replace the medical role, particularly within psychiatry.

Financial considerations

Discretionary points

Discretionary points are financial awards awarded competitively to medical consultants in Scotland. Each NHS Board is required to make discretionary points available to reward excellence in service delivery or other contributions.

In England, discretionary points are known as National Clinical Excellence Awards (CEAs) and are available after a doctor has been a consultant for one year compared with five years in Scotland. In Scotland there is a maximum of eight points which can be offered but this is not the case in England where merit awards are available beyond CEAs. The Scottish Government withdrew distinction awards in 2010[39].

To gain discretionary points, consultants need to present evidence to show they are working over and above their job plans across several domains. The time and commitment to collate and submit this evidence is not available to many consultants.

Workshop participants also agreed that training needs to be offered in how to apply for points and the most effective ways of gathering a portfolio of evidence.

Pensions

There was consensus in the workshop that the possibility of punitive taxation on pensions has an impact on retaining people in the workforce. There is a lack of clarity on who would be impacted by any changes to thresholds and when they would be impacted. It was noted that there was variable support for people in post as to how they manage their pensions. This has been partly resolved by the UK Government removing limitations on pension pots, but threshold allowances remain unchanged so will continue to have an impact.

Consultant recommendations

Consultant psychiatrists work at the top of their discipline, personally treating the most complex patients and working with junior doctors and the wider team in a supervisory and consultative capacity. There is no easy or single solution to the consultant

[39] Doctors distinction awards suspended in Scotland, the BMJ [2010] https://www.bmj.com/content/341/bmj.c6613.full

shortage. It will require investment in the wider team as well as an expansion of consultant posts to keep up with the demand on services.

Alongside this, increasing demand on services, whatever the service model, will require a fundamental change in the way services are set up, consultant posts are viewed and significant investment in the form of service reconfiguration and new posts. This will make jobs more 'doable' and improve retention and consequently recruitment.

However, there is a lot that can be done now to measure, review and improve consultant roles to make them more attractive:

- **Engage with Scottish Government and NES to ensure consistent data collection and recording of workforce data through use of WTE figures and recording locum posts as vacancies**

  Quarterly publication of workforce data broken down by speciality and region including reference to trends to enable more accurate workforce planning.

- **Ensure consistency of consultant job plans through review of 9:1 plans with a view to making 7.5:2.5 the expected ratio as a way to more accurately reflect consultant roles and responsibilities**

  This is critical to ensuring the longer-term sustainability of the teaching and training pathways as well as ensuring capacity for service-critical leadership and governance.

- **Introduce kitemarking of job descriptions, which is well established in England and Wales, as a means of ensuring consistency of newly advertised posts**

- **Strengthen role of External Advisors to ensure job descriptions meet adequate standards around sessional splits and wellbeing clauses**

- **Continue to support LTFT working but reinvest 'spare' sessions thus generated in the service**

- **Urgently adopt an evidence-based approach to reviewing and modernising service models and support consultants to work to the 'top of their license' by ensuring that consultant's skills and expertise are utilised optimally within MDT structures**

  Service models should not be changed without a pre- and post- hoc analysis of the existing models and benchmarking them to other areas with a similar demography.

  Health board managers need to review the caseloads of consultants and CMHTs in their organisation to ensure an equitable distribution of clinical work whilst maintaining sufficient SPA time. Consultants should treat the most complex patients directly and using their expertise to supervise and support the wider multi-disciplinary team.

- **The bed base in health boards to meet demand and its impact on consultant workload needs to be reviewed and addressed**

- **Develop service specification for Adult and Older Adult Mental Health Services to help define role and remit of CMHTs**

- **Support greater flexibility in consultant job planning to support retention especially among consultants at the end of their career**

  This can include supporting consultants develop more focussed non-clinical responsibilities, stepping down from on-call rotas and developing areas of special interest.

- **Harness the opportunities offered by digital or remote services for remote working models including options for working across health boards**

- **Development of competency-based workforce tools to support expansion of professional roles within the MDT**

  This would allow for development of roles such as ANPs, NMPs and PAs that can complement current models of multi-professional working through a more coherent workforce planning approach.

- **Review the use of the Locum Consultant title for doctors not meeting the expected criteria of specialist registration nor completing the equivalent appointment process as a matter of urgency given the impact on patient trust and transparency, quality assurance and diverting resource from the substantive workforce**

- **Review and reconfigure jobs that are perennially hard to recruit/have had successive locums in place**

  Any clinical session released through reconfiguration of posts, whether through converting locum to substantive posts, consultants working LTFT or for any other reason will likely require additional funding. An expansion of the establishment is likely to be needed to meet the demand caused by increase in clinical activity and reduction in WTE consultant availability. This will also require working in tandem with other disciplines.

- **Review, develop and expand CESR opportunities and Fellowships**

  Health Boards need to invest in CESR Fellowship and general CESR support programmes. CESR trainers and mentors should be given dedicated time in job plans for this work. The RCPsychiS should set up a formal CESR Committee to promote CESR, offer mentoring, and training.

- **Boards to ensure that all services have up-to-date service plans that accurately detail the total number of PAs and SPAs within the service**

  These service plans need to be transparent and accurately detail the total numbers of PAs and SPAs available within the service and made available to all consultants.

- **One-stop recruitment shop**

  Health boards need to work together with the Scottish Government and the RCPsychiS to create a one-stop shop for all matters related to psychiatric recruitment. This should provide information on all psychiatric vacancies in Scotland across the grades and relevant to those applying from within the UK and internationally. We recommend that this is modelled on the GP jobs website.[40]

[40] GP Jobs [internet] https://www.gpjobs.scot/

SAS doctor snapshot

- SAS is a broad term for staff, associate specialist and specialty doctors. They sit outside trainee posts and are not consultants but can hold senior posts in teams.

- There are currently around 3,000 SAS psychiatrist posts in the UK. The most recent psychiatric workforce census showed a 15.4% increase in SAS posts between 2019 and 2021.

- Latest data suggests there are 195 SAS doctors in the psychiatric workforce in Scotland, most of whom (174) hold the title Specialty Doctor.

- SAS doctors are generally either career-grade doctors who choose the SAS route as it allows for a better work/life balance and focus on patient care or doctors taking a break from training to gain more experience in a certain area or take a break from the demands of constant assessment.

- Concerns over lack of opportunity to progress and pay disadvantages have driven recent changes to SAS contracts. The new SAS contract promises a higher starting salary and potential for much quicker progression to higher pay.

- The creation of a new, promoted grade of 'specialist' provides a potential route for career progression for experienced SAS doctors. They must apply for specialist roles through open recruitment processes but creating such posts is at the discretion of health boards.

Specialty and Associate Specialist (SAS) grade doctors

A key part of the psychiatric workforce

SAS is a broad term for staff, associate specialist and specialty doctors. They sit outside training posts and are not consultants but can hold senior posts in teams. They are an essential part of the workforce, representing 16%[41] of the total psychiatric posts in Scotland.

SAS doctors must have at least four years of postgraduate training, two of which are in a relevant specialty, but represent a diverse group with a wide range of skills, experience and specialties. The Associate Specialist (a stop off point between specialty doctor and consultant) role was discontinued in 2008. Doctors still retain this role but there have been no new appointments to this grade since its discontinuation. As a result, the body of SAS doctors has grown even more diverse and contains both extremely experienced specialists and much newer specialty doctors. The BMA's Scottish SAS Committee (SSASC) has been lobbying for some time on the need for the re-introduction of a higher SAS grade following the closure of the associate specialist grade and highlighting the impact of low pay and slow pay progression on SAS recruitment and retention.

Numbers

The composition of the medical workforce, including that of the psychiatric workforce, is changing. GMC data shows that the number of doctors choosing to spend time outside training programmes grew significantly from 16.9% in 2010 to 62.5% in 2018, with significant growth in the SAS group further predicted[42]. There are currently around 3,000 SAS psychiatrist posts in the UK. The most recent psychiatric workforce census showed a 15.4% increase in SAS posts between 2019 and 2021[43].

Information collated by NES's SAS Development programme (collected from regional HR teams) suggests there are a total of 195 doctors classed as SAS working as part of

[41] NES/Turas data shows 1,205.5 psychiatrists in all grades in post in Dec 2022. Latest figures from NES's SAS Development programme (collected from regional HR teams) suggests there are a total of 195 doctors classed as SAS. 195/1205 = 16%.

[42] General Medical Council (2021) *The State of medical education and practice*. https://www.gmc-uk.org/-/media/documents/somep-2021-full-report_pdf-88509460.pdf

[43] Royal College of Psychiatrists (2021) Census 2021: Workforce figures for consultant psychiatrists, specialty doctor psychiatrists and Physician Associates in Mental Health

the psychiatric workforce in Scotland, most of whom (174) hold the title Specialty Doctor[44], as illustrated below.

Table 8: Number of SAS doctors in Scotland (by grade)

Grade	Number
Specialty	174
Associate Specialists (closed, legacy grade)	20
Staff (closed, legacy grade)	1
Specialists (new grade)	0

*Note – these are approximations based on latest data provided by regional HR teams.

[44] Collated by NHS Education Scotland SAS Development Team (collected from regional HR teams)

Table 9: Regional distribution of SAS doctors in Scotland

Region	Number
North (Grampian, Highland, Orkney, Shetland and W. Isles)	30
East (Forth Valley and Tayside)	18
South East (Borders, Fife, Lothian, NSS)	66
West (Ayrshire and Arran, Dumfries and Galloway, Greater Glasgow and Clyde, Lanarkshire, Golden Jubilee, State Hospital)	81
Total	195

*Note – these are approximations based on latest data provided by regional HR teams.

Who are SAS doctors?

Participants in the workshop (see contributors) identified two main types of doctors working within the broad SAS grade:

- **Established career grade**

  Doctors that are experienced and established who choose to take a SAS role are motivated by the prospect of a better work-life balance and less responsibility or wanting to focus more on patient care and areas such as service development and teaching without becoming a consultant.

- **Time away from training**

  Usually, though not exclusively, these are doctors who have completed core training and are not progressing into higher training. Doctors in this category are generally motivated to take on a SAS role to re-charge or learn more about their chosen specialism before moving on to higher training.

Key to the issues identified and the narrative around SAS posts was that despite this disparity in experience, "*the jobs advertised are the same, the responsibilities are the same*". There was a desire to see recognition in the difference between the two groups, financially and reputationally, "*it would be nice to see some grading in the SAS grade*".

Attrition from SAS grade jobs – why is it happening?

Experience is not recognised or rewarded

Despite attracting doctors with very different levels of experience, as detailed above, this is not clearly reflected or recognised at SAS grade. The group also noted that those who chose SAS as a career (rather than as a break from training and progression) contribute hugely to services but are disadvantaged in terms of pay and career scale and progression. They are often not offered the status in organisations that parallels their contribution.

There is also disparity between SAS and consultants in terms of reward: SAS doctors cannot apply for discretionary points and so are more limited in their earning potential.

Participants acknowledged that some who take on the role simply want to provide a service and career progression is not their primary aim, but without fully understanding everyone's motivation and treating all SAS doctors the same, services could be ignoring an untapped resource and doing a disservice to SAS doctors.

Job plans do not allow time for anything but clinical work

As with consultants and trainees, SAS job plans in Scotland are often 9:1 (compared to 8:2 or 7.5: 2.5 in England) and present challenges similar to those explored in the previous section: namely, insufficient time to work on supporting SPAs or take on additional work and responsibilities.

During Covid, some SAS doctors were asked to take on extra sessions, with some committing to 12 in a week. It was suggested that this could be continued and thus increase the capacity of SAS doctors. However, it was the balance of job plans that drew most comment, with suggestions that the SPA session in a 9:1 job plan was often not ringfenced meaning career progression, research and management activities must be put aside in preference to clinical duties.

Many SAS doctors are also not aware of the fact that they are entitled to negotiate extra programmed activities (EPAs) for work done beyond their job plan, a key point considering they are not eligible to apply for discretionary points.

The impact of newly negotiated SAS contracts

The new offer for SAS grade doctors addresses the need for better pay and conditions and recognises the varied experience of doctors at this grade. The main outcomes are a new specialty doctor contract offering a better starting salary and faster pay progression, and the creation of a new grade of specialist doctor providing a potential route for career progression for more experienced SAS doctors.

Key details about new contracts[45] are as follows:

- **Specialty doctors**

  A new specialty doctor contract (for those currently employed as SAS doctors) with (up to) a 21.5% increase in starting salary (£54,903) and an earning potential of £85,554 at the top of the pay scale. Progression through the pay scale can now be achieved in 12 rather than 17 years.

- **New Specialist grade**

  The creation of a new grade of 'Specialist' providing a potential route for career progression for experienced SAS doctors. The pay scale for those on the new specialist grade will run from £83,130 to £94,350. Existing Associate Specialists can, if they meet the entry criteria, transfer to this specialist grade as part of transitional arrangements. However, current Specialty Doctors (even if they are very experienced) cannot do the same. Instead, they must apply through open recruitment processes and only if a health board decides to create a specialist role.

Whilst the new SAS contracts address many of the concerns discussed in the RCPsychiS workshop, there is one key aspect that may be an issue going forward: specialist posts will be created by health boards solely in response to workforce need and will be subject to open recruitment processes.

This could mean that doctors continue to work at specialty grade but deliver the work of a specialist unless they are able to advocate for a more senior position to be created or this is recognised by the health board who employs them. There is potential for competition between health boards to be deepened if some are willing (and able) to create specialist posts (allowing specialty doctors to progress in their career and through pay grades) and others are not.

SAS doctor recommendations

To address these issues we suggest:

- **Review job plans to provide time for teaching, training and quality improvement and additional clinical work**

  SAS doctors who wish to take on teaching/training/service development/QI work will need to be given time in their job plan. These job plans need to be urgently reviewed to identify those that are already working to the Specialist level. SAS

[45] SAS Contract, BMA [internet] https://www.bma.org.uk/pay-and-contracts/contracts/sas-doctor-contract/sas-contract

doctors needs to have their job plans reviewed so that those taking on additional responsibilities are remunerated accordingly, for example via EPAs.

- **Identify posts for specialist grade**

  The new specialist grade needs to be a standardised offering within services. Boards should review current SAS posts and identify ones to be converted to the new specialist grade. Senior SAS doctors need to be supported to apply for these posts.

  As part of service reconfiguration to manage vacancies, Boards should consider the creation of Specialist Doctor posts to work in addition to or instead of consultant psychiatrist posts.

- **Differentiate types of SAS doctors and offer appropriate responsibility**

  Boards also need to make a clear distinction between those career SAS doctors and those stepping off the training pathway temporarily. The experience and expertise of the former group differ from the latter and needs to be acknowledged.

- **Continue contract negotiations regarding remuneration**

  Specialist grade SAS doctors do not have access to discretionary points unlike the previous Associate Specialist grade. This needs to be addressed in further discussions between BMA and Scottish Government.

- **Offer structured CESR support regionally and set up RCPsychiS CESR committee**

  SAS doctors may wish to progress to consultant roles via the CESR pathway, and these doctors need to be supported in this. CESR mentors, CESR training, help in meeting curriculum requirements as required by the CESR application, for example sessions in emergency psychiatry, on call, use of mental health act, management and leadership experience, audit and research, etc should be made available to SAS doctors applying for CESR. The RCPsychiS should establish a CESR committee to support CESR.

Certificate of Eligibility of Specialist Registration (CESR)

The conventional training pathway we have outlined is not the only pathway to a substantive consultant post in Psychiatry. CESR[46] is an important route into the workforce for doctors who do not hold a CCT to get on to the GMC specialist register and contribute as a substantive consultant.

The process involves completing a structured portfolio to demonstrate that the applicant has satisfied the equivalent criteria and reached a standard of practice that would be expected of a higher trainee. Applicants will not necessarily hold the MRCPsych qualification although this and other qualifications and experience can be taken into account. The success rate for first application ranges from 0%-20% and for review applications is around 75%[47].

The costs of the CESR process (£1781 for a new, and £773 for a review, application), the amount of evidence required to be submitted and the difficulty in gathering various pieces of evidence have all been cited as obstacles. It is extremely difficult to reach the same standard as trainees on formal programmes when most CESR applicants are working in service-focussed roles and struggle to obtain supervision and study leave. This is a lost opportunity as these are usually highly experienced doctors already working in the NHS in a non-consultant grade.

The GMC has reviewed the CESR application process so that medical royal colleges are required to update their processes to make the application simpler without compromising on quality assurance.

In England and Wales there are several examples of regional CESR mentors, support groups and workshops to guide and support applicants through the process.

There is now a thriving CESR Fellowship scheme in the North of Scotland showing early evidence of the success of supportive approaches[48]. It is particularly useful for IMGs with experience in psychiatry as the successful candidates are registered with a licence to practice with the GMC and would not be required to take the PLAB test.

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[46] Certificate of Eligibility of Specialist Registration, RCPsych [internet] https://www.rcpsych.ac.uk/international/CESR

[47] Internal Equivalence Committee (RCPsych) communication

[48] CESR Fellowship in Psychiatry: First in Scotland, RCPsych in Scotland [internet], 25 November 2022 https://www.rcpsych.ac.uk/news-and-features/blogs/detail/rcpsych-in-scotland-blog/2022/11/25/cesr-fellowship-in-psychiatry-first-for-scotland

There are also examples of some health boards appointing doctors to SAS or locum consultant posts while supporting them to meet the CESR requirements, following which they are eligible to apply to substantive consultant posts.

Doctors intending to retire, and retired and returning doctors snapshot

- 42% of all consultants in Scotland are aged over 50 and, according to a recent *Intention to Retire (ITR) survey* conducted by the University of Dundee, nearly half intend to retire before normal retirement age.

- Less than 30% of doctors over the age of 50 intend to work to, or beyond normal pension age. Estimates show doctors in the over-55 cohort intend to retire at 58, whilst the 50-54 age group, as well as those under 50, estimate they will retire at 60.

- Most consultants (of all ages) intend to transition to retirement by scaling down work commitments.

- 40% of all RCPsych in Scotland members are 50 years and over.

- Doctors say the sole or main reason for scaling down work commitments and then retiring early was financial concerns, including the pension taxation regime.

- The second most important reason for scaling down and then retiring was given as organisational disillusionment and disidentification.

- Doctors who return to work after retirement provide an invaluable service but face multiple challenges in workload, accessing CPD, appraisals and revalidation, and a sense of belonging and acceptance.

- Retired and returning doctors could contribute in several ways including clinical, teaching, trainee supervision, mentoring, appraisals, and incident reviews.

Doctors intending to retire, and retired and returning doctors

The voice of experience

42% of consultants in Scotland are over 50[49] and, according to a recent *Intention to Retire (ITR) survey* conducted by the University of Dundee[50], nearly half of them intend to retire before normal retirement age. This presents a huge challenge to the psychiatric workforce when higher trainee posts remain unfilled and thus impacting the pipeline towards consultant posts.

Consultants also represent a valuable resource for training and teaching the next generation of psychiatrists, a resource that could be lost when more senior members of the workforce scale down their work or take early retirement.

Retirement age and intention to retire

With most consultant pension schemes setting a retirement age of 60 (1995 scheme), 65 (2008 scheme) or 68 (2015 scheme) – few consultants remain on the Mental Health Officer status scheme setting a retirement age of 55 – scaling down work commitments or choosing to retire early represents a considerable drain on the psychiatric workforce in the next 10-15 years. The ITR report further noted that:

- **the research was conducted with just under 1,700 doctors from a total consultant population in Scotland of 6,474 (26% response rate)**
- **less than 30% of doctors over the age of 50 intend to work to, or beyond normal pension age. Estimates show doctors in the over-55 cohort intend to retire at 58, whilst the 50-54 age group, as well as those under 50, estimate they will retire at 60.**
- **most consultants (of all ages) intend to transition to retirement by scaling down work commitments**

[49] NNH Education Scotland, Freedom of Information request June 2022: 2,704 consultant population over 50 out of a total of 6,474.

[50] *Senior Hospital Doctors' Intentions to Retire in NHS Scotland*. Graeme Martin, Harry Staines and Stacey Bushfield, University of Dundee https://www.dundee.ac.uk/corporate-information/senior-hospital-doctors-intentions-retire

NHS Pensions – mental health officer status (1995)

Previous pension arrangements allowed for retirement at 55 if a doctor carried mental health officer (MHO) status without any reduction to their benefits, providing they were still in pensionable MHO employment on the day before they retired. After 20 years of continuous MHO status, each subsequent year counted as two for benefit purposes (known as doubling).

However, if a doctor returned to work after retiring, and they retired under the conditions described, their whole pension was subject to abatement (i.e., they had to pay some of it back). This meant many who retired under the scheme chose not to return to work as it would impact them financially.

The majority of the consultant workforce in Scotland are now covered by a different scheme (only 38 of the 1,700 ITR survey respondents were on the MHO scheme with a retirement age of 55).

Whilst these are statements that cover the whole of the consultant workforce, data in the ITR survey verifies that these are reflective of the trends and challenges facing psychiatry. In addition, RCPsychiS membership data shows that 40% of members are over 50, a snapshot reflective of the psychiatry consultant workforce in Scotland.

In research with the RCPsychiS's working retired group in 2018, those present noted that despite the fact that a significant percentage of the Scottish psychiatry workforce are aged 50 or over there has been no drive to reliably capture career plans including retirement, reducing sessions and changing roles. The ITR report goes some way to addressing this and looking at the reasons behind consultant's intentions to retire early.

Why consultants are scaling down or retiring early

The ITR report noted that the sole or main reason for scaling down work commitments and then retiring early was financial concerns, including the pension taxation regime. It should be noted that this research was conducted prior to announcements around changes to pension law.

The second most important reason for scaling down and then retiring was given as organisational disillusionment and disidentification. This combination of factors was described as a breach of a 'psychological contract':

> *"Doctors feel they have undergone many years of demanding training, relatively low pay compared to other professions, and long, often unsociable, hours. In return, they came to expect clinical autonomy, high status and*

meaningful work when fully trained as consultants, accompanied by good pay, conditions and pensions.

"Most senior hospital doctors, however, have come to feel that these reasonable expectations have been severely breached. Changes to the pension and taxation regime are interpreted as 'the straw that broke the camel's back', which has already been strained by progressive disillusionment with the system's failure to provide sufficient resources to meet ever-escalating demands.

"Thus, senior hospital doctors are responding by expressing a reduced sense of meaningfulness of their work, reduced levels of work engagement, and significant levels of burnout in some cases. The outcomes are that doctors are increasingly seeking to withdraw from or exit from full time work."

The narrative of the research also noted that generational attitudes could create significant problems in recruiting, engaging, and retaining newer generations, as 'their expectations may well be different and whose opportunities for alternative employment may be great'.

In other words, if the issues outlined by today's consultant population, whose expectations around work and reward are different to younger doctors, are not addressed now, it will present further challenges when the current cohort of trainees look to the future.

Appraisal and revalidation

For some retired and returning doctors, there are issues accessing appraisals and having a Responsible Officer (RO) for the purpose of revalidation. Some health boards do offer this, but it is a challenge and Boards need to think about how to support this highly experienced group. The GMC describe a mechanism[51] for identifying Ros, but this is not always adhered to by health boards.

Some also face difficulties accessing CPD outwith what the RCPsych offers. It needs to be made easier for these doctors to attend teaching locally, e.g., case conferences and journal clubs. These are increasingly hybrid or online.

[51] Find your connection for revalidation, GMC [internet] https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/my-db-tool/12668-scotland-locum?previousPc=70

Post-retirement jobs

The type of jobs offered to retired and returning psychiatrists needs to be reviewed. In addition to routine clinical jobs such as sector-based work, they could also be offered waiting list initiatives e.g. neurodevelopmental disorder clinics, holiday cover, locum cover, etc. They could be offered roles as trainee supervisors (as per new RCPsych guidance). They could do appraisals or serious adverse event reviews. They could be involved in teaching, and in mentoring.

There is also work needed to identify those planning to retire and work with them to plan what kind of work they could do if they wished to return.

There are practical issues such as access to an NHS email which excludes them from a lot of communication and these need to be urgently addressed.

The RCPsychiS should also be looking at 'FinishWell' for anyone over 50 years. The RCPsych currently have a StartWell[52] programme for new consultants during their first five years in post. A similar programme needs to be developed for consultants who identify as being in the last 5-10 years of their career.

Doctors intending to retire, and retired and returning recommendations

The ITR report referenced above, and research with the working retired group at the RCPsychiS (2018) were united in their suggestions for addressing the issues around consultants retiring early. The following combines the responses to address each of these areas proposed in both reports.

For consultants intending to retire:

- **Continue to engage with other stakeholders to lobby for changes to pension taxation regime including reducing the complexity of the current regime**
- **Explore feasibility of developing "StartWell" type programme to support consultants in the last 5-10 years of their career – a 'Finish Well' programme**
- **Support consultants to stay in post by proactively addressing workload issues, ensuring jobs are fit for purpose and more explicitly recognising their experience and seniority within the organisation**

[52] New Consultants (StartWell), RCPsych [internet] https://www.rcpsych.ac.uk/members/supporting-your-professional-development/new-consultants-startwell

- **Engage with medical managers and health boards to:**
    - **commit to sensitive and flexible late career job planning – such as allowing senior clinicians to cease on-call in pre-retirement years, greater options for flexible working and using their experience and breadth of knowledge to focus on aspects of the role beyond clinical work**
    - **introduce better designed and consistently implemented retire and return plans in partnership with senior doctors**

For retired and returning consultants:

- **Expand range of available roles to include non-clinical activities such as supervision, teaching, training, appraisals and adverse event reviews**
- **Cover outlay on full fees e.g. GMC, medical defence unions, Royal College of Psychiatrists membership fees, and revalidation costs which must be paid to return to practice**
- **Appraisal and revalidation**
    - **Reduce the burden of appraisal and revalidation. For instance, in some areas a minimum of 50 sessions for each annual appraisal is required, which might not be achievable if working less than full time. This could be averaged out over a number of years instead to make it possible.**
    - **Ensure equity of access to CPD resources and study leave for retired and returning (including locum)**
- **Work and workload**
    - **Address workload issues – consultants highlighted that gaps in staffing and persistent underfunding and de-professionalisation of their roles meant they were covering clinical and other work instead of, or as well as, doing their own. They felt that if these gaps were filled, they could focus on delivering their own role and thus stay in post until retirement.**
    - **Recognition of their experience and seniority by the organisation. Demonstrate that consultants are valued through methods such as an appraisal/exit interview to find out the opinions of experienced doctors or something as simple as a letter of thanks for the doctor's contribution to the NHS.**
- **Offer consultants option of honorary or emeritus consultant status for retired consultants to make a clear distinction from locum posts.**

We also acknowledge the specific needs of non-consultant grade doctors who are either due to retire or have 'retired and returned' in addition to the issues highlighted

above. There is an urgent need to explore this further and would recommend a focus on this area in the next stage of this process.

International Medical Graduates (IMG) snapshot

- In 2021, doctors who gained their primary medical qualification (PMQ) outside of the UK made up over a third of licensed doctors in England (37%) and Wales (35%) and almost a fifth (18%) of licensed doctors in Scotland.

- RCPsych in Scotland membership figures show that, beyond the UK and Ireland, our biggest cohorts of members are from India, Pakistan, Nigeria, South Africa and Malaysia.

- Differential attainment at the MRCPsych examination and ARCP outcomes are among the main reasons IMGs do not progress from core to higher training. IMG doctors are also more likely to be reported and investigated by the GMC in fitness to practice areas.

- Finding suitable housing, opening a bank account, childcare and education issues, alongside understanding local culture and customs, acclimatisation and social isolation are all issues that make it difficult for IMGs to settle in when they first move to Scotland. They can all have an impact on personal wellbeing and performance at work.

- Uncertainties over visas can lead to doubts over employment, as the two are intrinsically linked. Planning and applying for posts can be more complex if the outcome of visa applications is not known. Recent changes in regulations around family visas have made it more difficult for IMGs to bring their wider families over to Scotland, in many cases to support them with childcare while they work.

International Medical Graduates

The contribution of doctors from outside the UK

International Medical Graduates (IMGs) are doctors with a primary medical qualification from outside the UK. In 2021, doctors who gained their primary medical qualification (PMQ) outside of the UK made up over a third of licensed doctors in England (37%) and Wales (35%) but represented only 18% of licensed doctors in Scotland[53].

RCPsychiS membership figures[54] show that, beyond the UK and Ireland, our biggest cohorts of members are from India, Pakistan, Nigeria, South Africa and Malaysia.

The majority of IMGs obtained their GMC registration via the PLAB[55] test route and receive their psychiatric training in the UK. A significant proportion work as SAS doctors. A smaller number of IMGs join the workforce via sponsorship routes including the Medical Training Initiative[56] (around 35 per year[57]) and CESR Fellowships (10 since 2021 intake[58]).

Challenges faced by IMGs

IMG doctors form an integral part of the psychiatric workforce in Scotland but face a number of unique challenges – ones that need to be addressed if we are to retain and nurture this important workforce sector.

[53] The state of medical education and practice in the UK: The workforce report. GMC, 2022 https://www.gmc-uk.org/-/media/documents/workforce-report-2022---full-report_pdf-94540077.pdf

[54] RCPsych in Scotland figures correct as of June 2023 when accessed via membership database.

[55] Professional and Linguistic Assessment Board, GMC [internet] https://www.gmc-uk.org/registration-and-licensing/join-the-register/plab

[56] Medical Training Initiative, RCPsych [internet] https://www.rcpsych.ac.uk/training/MTI

[57] Internal RCPsych communication

[58] Information provided by NHS Grampian.

- **Differential attainment**

  Differential attainment at the MRCPsych examination and ARCP outcomes[59] are among the main reasons IMGs do not progress from core to higher training. IMG doctors are also more likely to be reported and investigated by the GMC in fitness to practice areas[60].

- **Cultural and practical barriers**

  Finding suitable housing, opening a bank account, childcare and education issues, alongside understanding local culture and customs, acclimatisation and social isolation are all issues that make it difficult for IMGs to settle in when they first move to Scotland. They can all have an impact on personal wellbeing and performance at work.

- **Visa issues**

  Uncertainties over visas can lead to doubts over employment, as the two are intrinsically linked. Planning and applying for posts can be more complex if the outcome of visa applications is not known. Recent changes in regulations around family visas have made it more difficult for IMGs to bring their wider families over to Scotland, in many cases to support them with childcare while they work.

Addressing the challenges faced by IMGs

There are several UK- and Scotland-wide initiatives designed to help IMG doctors settle and integrate, and the GMC and NES websites offer information to doctors in advance of moving. The GMC Welcome to the UK[61] information is very useful in helping IMGs

[59] General Medical Council. *What are we Doing to Address Differential Attainment?* GMC, 2020. https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/tackling-differential-attainment/what-are-we-doing-to-address-it

[60] General Medical Council. *Fair to Refer?* GMC, 2019. https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/fair-to-refer

[61] Welcome to UK practice. GMC [internet] https://www.gmc-uk.org/about/what-we-do-and-why/learning-and-support/workshops-for-doctors/welcome-to-uk-practice

plan their move to the UK. Psych Steps[62] (based on GP Steps[63]) by NES helps both IMG trainees and trainers.

Other potential opportunities

Looking to the future, creating options such as time limited three-year contracts (with the opportunity to extend if they wish, or return to their home country), would allow trained IMG psychiatrists to live and work in Scotland, gain some experience of UK psychiatry, life and culture, while keeping the option to return home open.

There are examples of doctors coming to the UK on sabbatical and making successful and meaningful contributions for NHS Scotland. Such IMG doctors provide stability in a post in the short term and reduce the need for an expensive locum until they can be filled substantively by local trainees.

Posts will need to be made fit-for-purpose and reimagined as substantive rather than locum positions to make them a viable option for incoming IMGs.

Ethical considerations

Whilst we recognise the opportunity IMG doctors present, it is important to bear in mind the ethical considerations of actively recruiting IMG doctors from their home countries where the shortage of psychiatrists is often far greater than here in the UK[64].

The RCPsych is clear that we should not recruit from the UK Government's red-list countries[65] and that any active recruitment should be ethical with reciprocity in relation to teaching and training. We believe this is also the model of international recruitment that Scotland should follow.

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[62] Doctors and Dentists remuneration (DDRB) review body- 2022-2023 pay round: evidence. Section G - 191. Scottish Government [internet] 2022 https://www.gov.scot/publications/scottish-governments-written-evidence-review-body-doctors-dentists-remuneration-ddrb-2022-23-pay-round/pages/8/

[63] Trainee Information (Scottish Trainee Enhanced Programme), Scotland Deanery [internet] https://www.scotlanddeanery.nhs.scot/trainee-information/gp-specialty-training/scottish-trainee-enhanced-programme-step/

[64] The Countries Experiencing Doctor Brain Drain. Statista [internet] 2023 https://www.statista.com/chart/29667/doctor-brain-drain/

[65] Guidance: Code of practice for the international recruitment of health and social care personnel in England. Gov.uk [internet] 2023 https://www.gov.uk/government/publications/code-of-practice-for-the-international-recruitment-of-health-and-social-care-personnel/code-of-practice-for-the-international-recruitment-of-health-and-social-care-personnel-in-england#annex-a-red-and-amber-list

International Medical Graduate recommendations

To address these issues we suggest:

- **Create an IMG information hub**

  Have a clearly signposted one-stop-shop for all information related to living, training and working in Scotland as a psychiatrist. This should cover all stages of the workforce pathway, from undergraduate to consultant, how to prepare for re-locating to Scotland, living in the country, and supports available in and outside of work. This should be part of the one-stop recruitment shop referenced earlier in the report.

- **Promote Psych Steps**

  This should be more widely promoted, and trainers encouraged to attend. Trainers and trainees need to be released from their roles to attend.

- **Explore and address complaints**

  GMC and RCPsych need to understand why IMGs are more likely to be referred to them and why more complaints against IMGs are upheld and look at what can be done to change this statistic.

- **Share work done on differential attainment**

  RCPsych and GMC need to be explicit on the work they have done in relation to differential attainment and what has been put in place to address this.

- **Put practical support in place**

  NES and health boards need to offer practical support to IMGs with the basics of housing, schools, bank accounts, local amenities and social activities.

- **Offer named support**

  NES and health boards should identify a named person to be the contact point for any incoming IMG trainees or consultants/SAS doctors. There should also be a mentor on hand to introduce them to the local service and area.

- **Build in reflection and review opportunities**

  As with all other sectors of the workforce, we believe mid-point, exit interviews, and annual reviews are crucial for iterative understanding and improving the working lives of IMG doctors.

- **Lobby Government about visas**

  We believe that the Scottish Government should lobby the UK Government regarding visa limitations for IMG doctors and their immediate family.

- **CESR Fellowships**[66]

  CESR Fellowships are currently only offered by NHS Grampian. Other Boards need to look at the Grampian experience and offer an appropriate number of CESR Fellowships relevant to their service plans.

[66] See Appendix 2

Psychiatrists as medical managers and leaders, in national roles and in the RCPsych in Scotland

The wellbeing, retention, and attractiveness of the psychiatric workforce to potential recruits depend on supportive staff management, active service improvement, and a sense of being part of a profession that is respected and influential on strategy and policy nationally and beyond.

Medical managers

Psychiatrists are professionally managed by other doctors (usually other psychiatrists) known as medical managers. They support psychiatrists to work to their full potential, safely and to agreed standards and job plans. The medical manager role is crucial to the safe organisational provision of good patient care. In Scotland, medical managers are usually expected to take on these roles in addition to full-time clinical and other responsibilities of a consultant. We believe that medical managers should be allocated appropriate non-clinical sessional time to be devoted fully to their management role for the benefit of the workforce.

Other leadership roles

In addition to their clinical, teaching, training and service improvement roles, psychiatrists are called upon to contribute expertise at a national level – beyond their individual health boards though ultimately of benefit to all health boards. Such contributions may include:

- **work with partners to influence national mental health policy and strategy, mental health law reforms and collaborating in setting national quality standards for services**
- **developing clinical guidelines with Scottish Intercollegiate Guidelines Network and Health Improvement Scotland**
- **quality assurance of consultant appointments via the external advisor role**
- **taking on senior RCPsychiS roles including chairing faculties, being members of College committees (Scotland and UK) and Managed Clinical Networks.**

One major conduit for such work is the RCPsychiS, often in partnership with other stakeholders such as the Scottish Academy, the RCPsych and the Mental Health Partnership. Such work attracts a high profile within and beyond Scotland, and both retains and recruits psychiatrists. However, this work is usually unfunded. As a result of very tight job plans few psychiatrists take on this vital work without sacrificing their own time and energies, perhaps to the detriment of their own well-being. This is not sustainable.

We believe that such additional work should be formally funded in the interests of the individuals concerned, to allow them to contribute to these vital pieces of work and in turn helping both retention and recruitment of the workforce.

Equitable resourcing for the Royal College of Psychiatrists in Scotland

The RCPsychiS is a Devolved Council of the UK RCPsych which provides the leading quality controls on the profession, setting exams and hallmarking training to international renown. The RCPsychiS is obliged to manage psychiatric practice and training according to the legal, social, health and educational systems of two different governments, to provide training and conferences, and respond to consultations and media requests.

This is currently the task of a staff contingent of only 3 WTE for a membership of more than 1400 psychiatrists. Staff expansion is essential for succession planning and to enable a gallant team to support Scotland's psychiatric workforce to full potential.

Recommendations

In summary, we recommend:

- **more appropriate paid sessional time for medical managers**
- **allocated sessions for psychiatrists contributing to regional and national leadership roles**
- **an increase in staff resources to the RCPsychiS.**

Wellbeing

Workforce wellbeing is essential to all that is said in this report. It is a self-evidently desirable and even necessary state, but in fact represents a complex blend of physical, environmental, interpersonal, managerial, and psychological experiences that must be adapted to each particular workforce.

Psychiatrists, like professional and lay colleagues, have mobilised immense altruism which has allowed services to survive beyond the loss of the wellbeing that would normally be expected in a healthy workplace. Throughout this report we have seen examples of issues that impact on staff wellbeing and morale. These are often ignored.

Indeed, there is a risk of making things worse and triggering cynicism with well-intentioned but ultimately token gestures, such as provision of resilience interventions, wellbeing spaces or relaxation activities for a workforce that has no spare time and lacks basic facilities.

The very term 'resilience' is cited by trainees as a way to demand overstretched workers take responsibility for coping, without proper support. The recent GMC work[67] on wellbeing showed a clear link between doctor wellbeing and patient safety. The importance of being respectful and civil to staff[68] and its impact on patient care is increasingly acknowledged. Addressing the core issues is what leads to staff wellbeing.

A reasonable provision for staff wellbeing would include manageable workloads, well-staffed teams, time to develop professionally, good balance between personal and professional life, and the feeling of being respected and valued at work. Basic facilities should include office space, meeting space and confidential interview space, IT tools – computers, phones and online systems that reliably capture and share clinical information, facilities for rest, good food at all hours, parking facilities and good travel options. All these things can and do make a difference in staff welfare and wellbeing.

It is important to note however that when staff do experience difficulties with their mental health and wellbeing, services such as the Psychiatric Support Service[69], the

[67] West, M. Prof & Coia, D. Dame (2019) Caring for doctors caring for patients. GMC https://www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients_pdf-80706341.pdf

[68] Civility Saves Lives [internet] https://www.civilitysaveslives.com/

[69] Psychiatrists Support Service. RCPsych [internet] https://www.rcpsych.ac.uk/members/workforce-wellbeing-hub/psychiatrists-support-service

Workforce Specialist Service[70], NHS Practitioner Health[71] and the National Wellbeing Hub (Scotland)[72] can be a great source of advice, support, signposting and treatment.

If staff are listened to, treated with respect, and given the tools they need to do their jobs it will make for a healthier and happier workforce, improve recruitment and retention, and ultimately lead to excellent patient care.

[70] The workforce specialist service (WSS). National Wellbeing Hub [internet] https://wellbeinghub.scot/the-workforce-specialist-service-wss/

[71] NHS Practitioner Health [internet] https://www.practitionerhealth.nhs.uk/

[72] National Wellbeing Hub [internet] https://wellbeinghub.scot/

Summary of recommendations

For undergraduates

- **Explore recruitment opportunities in the ScotGEM programme.**
- **Make psychiatry teaching a part of the curriculum in year one in all Scottish universities.**
- **Commit to teaching time in consultant job plans.**
- **Focus on improving medical student placement experiences.**
- **Counter 'specialty-bashing' by campaigning alongside other specialties.**
- **Review of ACT monies.**

For foundation trainees

- **Rethink clinical supervision models to allow an increase in FY2 psychiatry placements from a third to half of all trainees.**
- **Review Foundation Year job descriptions and commit to mid-point and exit interviews to allow posts to evolve.**
- **Standardise, accredit, quality assure, and expand FY3 posts.**
- **Allow other career grades to provide supervision (as per new RCPsych guidance).**
- **Expand remote supervision options and learn from experience in Scotland.**

For core trainees

- **Continue to advocate for more core training posts in psychiatry.**
- **Debate the pros and cons of rigidly assigning training posts to areas that struggle to fill them, whilst giving consideration to the workforce and succession needs of those areas.**
- **Rethink clinical supervision models to allow for the proposed increase in both core and higher training posts, including supervision from non-consultant grades and use of remote supervision.**
- **Improve training experiences to encourage core trainees to move on to higher training.**

- **Overhaul the exam and assessment process and educate trainees on how to navigate the system.**
- **Provide information and support when moving between areas, allowing trainees to find out about the posts that are available and practical information about schools, housing and social activities.**
- **Give early advice about applying to higher levels of training, give longer lead times for any changes around the ST4 higher training application and enable regular higher training interview skills and practice sessions.**

For higher trainees

- **Review the content and delivery of training to ensure that trainees are supported to work LTFT, extend their training if needed, experience autonomy and are prepared for moving on from specialty training.**
- **Reduce the bottleneck on training places by considering training numbers as WTE rather than headcount and consider whether they can be shared or moved to areas of high demand.**

For consultants

- **Engage with Scottish Government and NES to ensure consistent data collection and recording of workforce data through use of WTE figures and recording locum posts as vacancies.**
- **Quarterly publication of workforce data broken down by specialty and region including reference to trends to enable more accurate workforce planning.**
- **Ensure consistency of consultant job plans through review of 9:1 plans with a view to making 7.5:2.5 the expected ratio as a way to more accurately reflect consultant roles and responsibilities.**
- **Introduce kitemarking of job descriptions as a means of ensuring consistency of newly advertised posts.**
- **Strengthen role of External Advisors to ensure job descriptions meet adequate standards.**
- **Continue to support LTFT working but review the management of 'spare' sessions thus generated.**
- **Urgently adopt an evidence-based approach to reviewing and modernising service models and support consultants to work to the 'top of their license' by ensuring that consultant's skills and expertise are utilised optimally within MDT structures.**

- **Urgently review and address the hospital bed base to ensure it meets demand.**
- **Develop service specification for Adult and Older Adult Mental Health Services to help define role and remit of CMHTs.**
- **Support greater flexibility in consultant job planning to support retention especially among consultants at the end of their career.**
- **Harness the opportunities offered by digital or remote services for remote working models including options for working across health boards.**
- **Development of competency-based workforce tools to support expansion of professional roles within the MDT.**
- **Review the use of the Locum Consultant title for doctors not meeting the expected criteria of specialist registration nor completing the equivalent appointment process as a matter of urgency.**
- **Review jobs that are perennially hard to recruit to/have successive locums in place and make subsequent changes.**
- **Review, develop and expand CESR opportunities and Fellowships.**
- **Ensure that all services have up-to-date service plans that accurately detail the total number of PAs and SPAs within the service.**
- **One-stop recruitment shop for national and international recruitment.**

For SAS doctors

- **Review job plans to provide time for teaching, training and quality improvement, and additional clinical work.**
- **Identify posts for specialist grade.**
- **Differentiate types of SAS doctors and offer appropriate responsibility.**
- **Continue contract negotiations regarding remuneration.**
- **Offer structured CESR support regionally and set up RCPsychiS CESR committee.**

For doctors intending to retire, and retired and returning doctors

For consultants intending to retire

- **Engage with other stakeholders to lobby for changes to pension taxation regime**

- **Explore feasibility of developing "StartWell" type programme to support consultants in the last 5-10 years of their career- a 'Finish Well' programme**
- **Support consultants stay in post by proactively addressing workload issues, ensuring jobs are fit for purpose and more explicitly recognising their experience and seniority within the organisation.**
- **Medical managers and health boards to commit to sensitive and flexible late career job planning – cease on-call in pre-retirement years, flexible working and using their experience and breadth of knowledge to focus on aspects of the role beyond clinical work.**
- **Introduce better designed and consistently implemented retire and return plans in partnership with senior doctors.**

For retired and returning consultants

- **Expand range of available roles to include non-clinical activities such as supervision, teaching, training, appraisals and adverse event reviews.**
- **Cover outlay on full fees e.g. GMC, medical defence unions, RCPsych membership fees, and revalidation costs**
- **Reduce the burden of appraisal and revalidation. Ensure equity of access to CPD resources and study leave for retired and returning (including locum).**
- **Address workload issues – gaps in staffing and persistent underfunding and de-professionalisation of roles.**
- **Recognition of experience and seniority by the organisation – exit interview and letter of thanks for the doctor's contribution to the NHS.**
- **Offer option of honorary or emeritus consultant status for retired consultants to make a clear distinction from locum posts.**

For International Medical Graduates (IMGs)

- **Create an IMG information hub.**
- **Promote Psych Steps.**
- **Explore and address complaints.**
- **Share work done on differential attainment.**
- **Publicise both within the profession and beyond, the research work done on differential attainment and complaints and develop plans to address this.**
- **Put practical support in place.**
- **Offer named supporters and mentors.**

- **Build in reflection and review opportunities.**
- **Lobby government on visa issues.**
- **Review and expand CESR Fellowships in a structured manner.**

For psychiatrists as leaders, medical managers and RCPsych in Scotland work

- **More appropriate paid sessional time for medical managers.**
- **Allocated sessions for psychiatrists contributing to regional and national Leadership roles.**
- **Increase in staff resources to the RCPsychiS.**

Glossary

AoT	Assessment of Teaching
ACT	Additional Cost of Teaching
ARCP	Annual Review of Competency Progression
ANPs	Advanced Nurse Practitioners
CAMHS	Child and Adolescent Psychiatry (Child and Adolescent Mental Health Services)
CASC	Clinical Assessment of Skills and Competencies
CCT	Certificate of Completion of Training
CESR	Certificate of Eligibility for Registration
CMHT	Community Mental Health Team
CS	Clinical Supervisor
CT	Core Training
DCC	Direct Clinical Care
ES	Educational Supervisor
EPA	Extra Programmed Activity
FPP	Foundation Priority Posts
FY1 (or F1)	Foundation Year 1
FY2 (or F2)	Foundation Year 2
GMC	General Medical Council
GP	General Practice
HT	Higher Training (also known as Specialty Training)
ID	Psychiatry of Intellectual Disability
IMG	International Medical Graduates
LTFT	Less Than Full Time
MDT	Multi-Disciplinary Teaching
MHT	Mental Health Tribunal
NES	NHS Education Scotland
NTN	National Training Numbers
NMPs	Non-medical Prescribing
NP	Nurse Practitioner
OSCE	Objective Structured Clinical Examination
PAs	Programmed Activities
PA	Physicians Associate
PEEP(S)	Psychiatry Early Experience Programme (Scotland)

PLAB	Professional and Linguistics Assessment Board
PMQ	Primary Medical Qualification
RCPsych	Royal College of Psychiatrists
RCPsychiS	Royal College of Psychiatrists in Scotland
SAS	Specialty and Associate Specialist Doctors
ScotGEM	Scottish Graduate Entry Medicine
Scottish Academy	Academy of Medical Royal Colleges and Faculties in Scotland
	Supporting Professional Activities
SPA	Specialty Training (also known as Higher Training)
ST	

Appendix 1 – How psychiatry is taught in Scottish universities

Table A

	Aberdeen	Dundee	Edinburgh	Glasgow
Years 1-2	Psychiatry introduced in Year 1 as online platforms and Q and A sessions.	Some aspects of psychiatry included in communications and ethics teaching in first two years, as well as minor snippets in some of the other systems teaching.	**Year 1:** Lecture on ethics and mental health **Year 1 and 2:** Problem based learning – psychological aspects of clinical problems	**Year 1:** Eating disorders lecture. **Year 2:** 4-week 'People and Illness' block (80% psychiatry) Topics include: Adolescent Brain Development, Depression and Adjustment, Alcohol and Substance Misuse, and Cognitive impairment.
Year 3	Psychiatry continued in Year 3 as online platforms and Q and A sessions.	4-week long block. **Week 1:** Mental state, mood disorders, eating disorders. **Week 2:** Psychosis, law and ethics, intellectual disability. **Week 3:** Anxiety and addictions. **Week 4:** Old age psychiatry, risk assessment and formulation.	Problem based learning – psychological aspects of clinical problems.	Half-day workshop. Morning or afternoon session on Mental State Examination.

Year 4	7-week clinical placement. Opportunities to work in chosen sub-specialities in psychiatry.	4-week long block. (Part of the 8-week GP/psychiatry block. Psychiatry supervisor assigned to students. Expected to spend at least 60% of the block face-to-face with patients either in clinic or ward. Students work to a logbook and complete Case-based discussions.	5 psychiatry tutorials. Tutorials for students to gain working knowledge of Mental State Examination (MSE) – recognition, terminology and presentation to other healthcare professionals. 1. Psychiatric Presentations in GP – Crash Course 2. MSE - Appearance, Behaviour, Speech and Mood 3. MSE - Thought and Perception 4. MSE - Cognition, Insight and Consolidation 5. Patient experience (EPPSAT patient)	5-week clinical attachment In phase 4 (years 4-5): Half-day academic session on personality disorders. 5-week psychiatry clinical attachment. One lecture on 'When to refer to psychiatry', focused on liaison psychiatry and psychiatry in hospital, as part of the Preparation for Practice 8-week block after finals.
Year 5	Clinical placement. Further psychiatry placement as a common block with GP placement.	Sub-specialty courses. Options to study one or more sub-specialties of psychiatry e.g., dementia, liaison psychiatry.	5-week psychiatry placement 5 weeks based in a psychiatry placement gaining clinical exposure across various areas. One or two weekly tutorials which focus on different conditions and are taught by a specialist in that field.	5-week clinical attachment In phase 4 (years 4-5): Half-day academic session on personality disorders. 5-week psychiatry clinical attachment. One lecture on 'When to refer to psychiatry', focussed on liaison psychiatry and psychiatry in hospital, as part of the Preparation for Practice 8-week block after finals.

Appendix 2 – NHS Grampian CESR Fellowship programme

Situation

The medical workforce of NHS Grampian (NHSG) General Adult Psychiatry (GAP) has been severely affected over the last few years with significant impact on both quality of service delivery, and financial implications of over reliance on locum senior medical staff.

Currently 70% of the General Adult Psychiatry Consultant workforce is complemented with locum staff with an enormous excessive spend in annual budget.

Only two of the locum Consultants are on the speciality register due to lack of agency locums that are on the specialist register. This potentially not only raises concerns about service and quality governance and indirectly impacts quality of teaching and training, as several of the career grade locums are not keen to engage with teaching or service development activities.

There are five SAS doctors working in NHSG with three current vacancies.

Background

The Speciality doctor posts have always provided an important buffer for service delivery gaps and there are eight such posts in GAP including three vacant posts.

Speciality doctors are experienced senior medical practitioners with at least three years of psychiatry training. However, they do not hold speciality registration with the GMC to work at consultant grade. These doctors need to gain CESR through the RCPsych and GMC. This process is an evidence-based competencies assurance of equivalence and considered to be a rigorous process.

As a service, usually there is no specific guidance or support available to ensure attainment of competencies towards CESR resulting in several speciality doctors aspiring to apply for CESR but finding it extremely difficult to gain the relevant competencies due to lack of organisational structures that help promote and guide CESR aspirants.

Assessment

There are several measures we are already taking in managing our medical workforce shortages and they include service redesign with increasing skill mix of other non-medical professionals of the CMHT to move towards newer ways of working, investments in positions like senior nurse practitioner, nurse prescribers and nurse consultant posts, increasing recruitment of physician assistants and associates in providing support to the medical workforce, etc.

One of our extremely popular initiatives to recruit medical talent, the Virtual Clinical Observership programme has attracted high demand from international highly qualified psychiatrists keen to work in the U.K. These doctors have a real difficulty in gaining access to the U.K. due to lack of knowledge of systems, arduous and punitive process of immigration, and most importantly GMC registration.

The CESR Fellowship programme comes with assurance of GMC registration for selected candidates and provides a clear structured route of entry into U.K. and a defined outcome of gaining specialist registration to be eligible for substantive consultant posts. These doctors are primarily motivated by career enhancement and look for work environments which can support them achieve their goals.

Recommendations

The current proposal is to consider utilisation of current specialty doctor permanent positions to be transformed into fixed term speciality doctor posts of three years as a CESR Fellowship programme. There may also be consideration for utilisation of consultant posts to be redesigned for some monies to be utilised for CESR Fellowships. Substantive consultants can expand their catchment with excess caseloads being managed by supervised CESR fellows.

This programme will help recruit experienced psychiatrists who wish to develop their CESR portfolio and gain necessary experience for CESR application during the course of the programme.

The programme will be locally managed with development of a CESR tutor role to help assess and streamline experience as necessary for the attainment of competencies needed for CESR. There will also be support from a local CESR Evaluator who has direct experience of CESR applications and the assessment process and can provide succinct support for the CESR fellows with the aim of high success rate of CESR attainment. This will generate a gradually expanding medical workforce initially at speciality doctor level and in the future help with consultant recruitment. This will also have a tremendous benefit on the financial spend of the service in recruiting expensive agency locums.

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