HSC Leadership Centre

Medical Workforce Plan for Psychiatry Specialties 2022 – 2031

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EXECUTIVE SUMMARY AND RECOMMENDATIONS

This exercise has been undertaken to analyse the current medical workforce across the six psychiatry specialties, focussing on career grade doctors and specialist trainees. Data on these staff groups in late 2021 were provided by Trusts and the Northern Ireland Medical and Dental Training Agency. Lead clinicians from these organisations and the local branch of the Royal College of Psychiatrists were consulted to quality assure the data provided and provide insight into factors that might impact on future workforce requirements in these staff groups. Documentary evidence relevant to workforce needs in the specialties, notably the Department's Mental Health Strategy, was reviewed.

Key findings were a significant level of vacancies across all specialties, sites and grades together with limited prospect of current training programmes addressing these shortfalls in a timely manner.

The report recommends short term actions to support the current workforce and sizeable and sustained investment in additional training capacity to address shortfalls in the medium term and work towards meeting need associated with changing demography, strategic aims and professional practice.

Recommendation 1
Trusts, in considering an international recruitment exercise for consultants across all psychiatry specialties should, as a first step, undertake an assessment of the likelihood of success in terms of securing sustained consultant level service provision.

Recommendation 2
All trusts should explore retirement plans with each of their consultants over 50 years of age with a view to extending their continuing in the Service.

Recommendation 3
Trusts collectively should identify and engage with any consultants in the specialty who have retired from the HSC in the past three years with a view to determining on what basis they might return to provide some element of service.

Recommendation 4
Trusts, ideally collectively, should determine the need for and explore the feasibility of recruiting specialty and specialist doctors in supporting consultant psychiatrists. The local training programme in core psychiatry has proven a source of possible candidates for specialty doctors and is likely to remain so. In addition, international recruitment (if considered worthwhile) should seek to recruit specialty and specialist doctors as well as consultants.

Recommendation 5
Trusts, ideally collectively, should determine the need for and explore the feasibility of recruiting Physician's Associates in supporting medical staff in mental health. Given this is a novel approach locally, this might be best taken forward on an individual prototype basis initially.

Recommendation 6
Exit interviews should become a routine component for all doctors who exit the training programme prior to completion of training or, having completed training, do not seek a consultant post in the HSC. The findings of these interviews will provide valuable intelligence in informing workforce needs.

When conducting exit interviews as recommended above, those leaving training should be asked if they would consider a career as a specialty doctor in psychiatry as a positive career choice. The potential of eligibility for the specialist grade in the future might enhance take up of this option.

Such interviews could also be conducted to explore factors that might improve retention within psychiatry training.

Recommendation 7
It is recommended that action is taken to establish additional posts in each of these specialist areas;

- **Two in addiction psychiatry**
- **One in Eating Disorders**
- **One in Peri-natal Psychiatry.**

Recommendation 8
It is recommended that trusts advise NIMDTA, on an annual basis, of their anticipated needs for consultants across psychiatric specialties/sub-specialties/special interests for the subsequent three years. As a result NIMDTA should orientate the programmes accordingly and advise trainees appropriately.

Where this engagement suggests the need for additional investment or other strategic issues, NIMDTA should raise this with the Department as part of sponsorship arrangements.

Recommendation 9
Establishment of a number of training posts dedicated to psychiatry of old age as a matter of urgency is recommended. The current output of the core training programme should allow for these posts to be established at ST4 level initially.

Recommendation 10
It is recommended that the complement of psychiatry of old age training posts is increased by 9 posts, over a three year period, ideally with an initial increase in 2022 or as soon as practicable thereafter.

Recommendation 11
It is recommended that two additional posts in each of medical psychotherapy and forensic psychiatry are established as soon as practicable.

Recommendation 12
It is recommended that the complement of training posts in child and adolescent psychiatry is increased by 9 posts, over a three year period, ideally with an initial increase in 2022 or as soon as practicable thereafter.

Recommendation 13
It is recommended that the complement of training posts in psychiatry of intellectual disability is increased by 9 posts, over a three year period, ideally with an initial increase in 2022 or as soon as practicable thereafter.

Recommendation 14

Given the potential output of the core training programme in 2022 and 2023, it is recommended that NIMDTA undertake an exercise to firmly determine the excess (if any) of those completing the core training programme over available ST4 specialist training opportunities and seek to establish posts in line with any excess identified for recruitment in the relevant years.

Recommendation 15

A minimum of five additional CT1 posts in core psychiatry should be established in 2022 (or as soon as feasible thereafter) as the beginning of an on-going investment to address deficiencies in specialist training in a sustainable manner.

1. INTRODUCTION

This planning exercise is the most recent in a series commissioned through the Public Health Agency to examine the medical workforce in specific service or specialty areas. The psychiatry specialties were selected at this time as it has been some considerable time since they have been examined. It is also timely, as the Department's mental health strategy, published in June 2021, sets out a number of commitments related to the workforce generally. More specifically, the strategy commits to a comprehensive workforce plan in mental health. Whilst this exercise is confined to specialist medical practitioners, it can inform that more comprehensive piece of work. In determining the current and future needs for doctors in the psychiatry specialties, an approach based on the Six Step Model to Integrated Workforce Planning has been adopted.

2. PURPOSE AND SCOPE

The primary purpose of this exercise is to determine the need for specialist trainees in the psychiatry specialties (and, where feasible, any relevant sub-specialties or special interest areas) based on an assessment of current and future consultant needs. The relevant specialties are;

- General (Adult) Psychiatry
- Psychiatry of Old Age
- Forensic Psychiatry
- Medical Psychotherapy
- Child and Adolescent Psychiatry
- Psychiatry of Intellectual Disability.

The on-going need for other grades of doctor will also be examined. Whilst the key focus is inevitably on medical staff, opportunities for alternative provision will be highlighted, where appropriate.

The report will be of interest to, and support the work of, provider trusts, service commissioners and the Northern Ireland Medical and Dental Training Agency (NIMDTA).

3. DETERMINANTS OF FUTURE NEED

There are a wide range of factors that impact on future needs for doctors in this specialty. These include;

- Demographic Factors
- Regional Strategic Drivers
- Professional Standards
- Clinical guidelines
- Learning from incidents and National Audits
- Work-related factors

3.1 DEMOGRAPHIC FACTORS

Table 1 - Projected Population

Age group	2022 (thousands)	2026	2031	Percentage change 22- 31
0-9	236	218	199	-16%
10-19	249	260	250	-
20-44	597	588	588	-2%
45-64	492	493	489	-
65-79	247	266	297	+20%
80+	86	98	113	+31%

The trends in the population above show significant increases in the elderly population which will have important implications for aspects of mental health services, particularly old age psychiatry. A projected decline in the number of women in the 20-44 age range will impact on projected future births, which show a steady decline for the remainder of this decade. This will have implications for perinatal mental health services when these are fully established.

3.2 REGIONAL STRATEGIC DRIVERS

The principle strategic drivers influencing the direction of acute services generally are *Systems not Structures* (The Bengoa Report) and the Ministerial response to it; *Health and Well-being 2026: Delivering Together* (2016). These set the broad strategic context for the recently published mental health strategy which is of most specific relevance to psychiatry.

The mental health strategy acknowledges higher levels of mental ill-heath in Northern Ireland in comparison to England and the historic lesser pro rata spend on mental health services in comparison to neighbouring jurisdictions; a position that persists.

The strategy seeks to address the full spectrum of mental ill-health through preventative measures, early intervention, resilience building and responsive specialist services. On specialist services it seeks to;

"*Ensure there are specialist interventions available to those who need it. In particular:*

- *Continue the rollout of specialist perinatal mental health services.*
- *Ensure access to evidence based treatments and interventions for people presenting with a first episode psychosis and develop a regional psychosis network.*
- *Enhance the provision of personality disorder services regionally through the formation of a Personality Disorder Managed Care Network.*
- *Enhance the regional eating disorder service.*
- *Further develop specialist interventions with a lifespan approach to ensure that those who require specialist interventions will receive them when needed."*

With reference to the workforce, the strategy aims for;

"*A well supported workforce that is fit for the future and meets the needs of those who are mentally ill.*
An increase in the number of training places for mental health professionals.
An increase in the number of staff employed in mental health services and a development of new professions and practices across services."

The strategy is supported by a detailed funding plan which itemises anticipated expenditure against 35 actions. Action 32, on the workforce of the future, anticipates an annual spend of £12.1m.

3.3 PROFESSIONAL STANDARDS

A variety of professional bodies, principally Royal Colleges and Specialist Societies, produce statements and recommendations which may directly or indirectly impact on workforce numbers. The Royal College of Psychiatrists (Psych) has published over 200 College Reports (CR) covering a vast range of topics relevant to mental health, psychiatric practice and service provision for the mentally ill. Amongst those of relevance to this exercise are the following;

CR 173: Delivering Quality Care for Drug and Alcohol Users – the roles and competencies of doctors (2012)

CR 188: Service Models in Adult Psychiatry (2014)

CR 198: Peri-natal Mental Health Services (2015)

CR 207: Safe patients and high-quality services: Job descriptions for consultant psychiatrists (2017)

CR 228: Psychiatric treatment of autism in adults.

The full list of Psych College Reports is available at https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports?searchTerms=college%20reports

3.4 CLINICAL GUIDELINES

Whilst professional bodies produce a wide range of guidelines on practice aimed at their members, The National Institute of Health and Care Excellence (NICE) develop guidelines based on a systematic, evidence-based methodology aimed principally at service providers. Their guidelines will have significant professional input in their development. In Northern Ireland, The Department endorses NICE guidelines for implementation across Health and Social Care (HSC) locally.

A significant number of guidelines relevant to mental health services have been issued covering similar ground to College reports, such as;

Addiction/Alcohol-use disorders/Drug misuse
Anxiety
Attention deficit disorder/Autism
Dementia
Depression/Bipolar disorder/Psychosis and Schizophrenia
Eating disorders
Personality disorders
Self-harm/Suicide prevention

A sample of those relevant to Mental health services include

Table 2 – A sample of relevant NICE guidance

Title	Reference number	Published	Last updated
Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services	CG136	14 December 2011	
Antenatal and postnatal mental health: clinical management and service guidance	CG192	17 December 2014	11 February 2020
Violence and aggression: short-term management in mental health, health and community settings	NG10	28 May 2015	
Transition between inpatient mental health settings and community or care home settings	NG53	30 August 2016	
Mental health of adults in contact with the criminal justice system	NG66	21 March 2017	
Preventing suicide in community and custodial settings	NG105	10 September 2018	
Decision-making and mental capacity	NG108	3 October 2018	

A full list of relevant guidelines is included in the **Appendix**.

Service Commissioners and providers are charged with implementing these guidelines and specific reference to them features in annual commissioning plans, which have made reference to one or more of these as the basis for service development. Specific elements of guidelines will impact on workforce requirements.

3.5 LEARNING FROM INCIDENTS AND NATIONAL AUDITS

In keeping with a culture of improvement, learning from incidents is important whether at a team, organisation, system or national level. The specialty has a long history of involvement in this area including the National Confidential Inquiry into Suicide and Safety in Mental Health which has been in operation for twenty five years. At present, The Health Quality Improvement Programme commissions the Inquiry from the University of Manchester who provide aggregate data on suicide and related topics together with recommendations on improving outcomes.

Locally, there is learning from incidents. The PHA summarises learning from incidents in its regular publication *Learning Matters*. Notably, one issue in January 2020, was devoted to mental health services.

Among the issues that have been identified through the investigation of incidents are the involvement of families in safety plans, access to liaison psychiatry and the practice of assessment and onward referral without intervention or engagement.

Mental Health services at various sites throughout the UK have been, and continue to be, the subject of high profile inquiries which have made recommendations that may have relevance to workforce numbers and organisation.

3.6 WORK-RELATED FACTORS ASSOCIATED WITH THE DEVELOPING WORKFORCE

The workforce in the specialty is not immune to the generic factors that impact on staffing requirements. These include a desire for improved work-life balance, the need to effectively contribute to multi-disciplinary/multi-sectoral teams, the need to review and improve practice and the demands of leadership roles. These factors may be off-set by the on-going devolution of elements of doctors' work to other staff groups.

The Department's Workforce Strategy aims to address these issues, and in relation to mental health services states;

"*Achieving parity of esteem for mental health will require sustained investment in care and the development of a flexible, fit-for-purpose mental health workforce to deliver modern effective care. The establishment and integration of multi-disciplinary teams and the development of integrated practice models for all condition-specific and high intensity teams will be important*."

More generally, the Strategy seeks to:

- Ensure staff want to keep working in health and social care.
- Provide opportunities to return to work for experienced colleagues who have left service.
- Value the contribution that all make to delivering excellent, compassionate care and to improving the health, quality of life and wellbeing of the people of Northern Ireland.
- Devolve decision-making to the appropriate levels, including locally where possible.
- Respond to the changing needs and expectations of the workforce over time.

Similarly, the Department's Collective Leadership Strategy highlights the need to:

"*Recognise that leadership is the responsibility of us all and we all need to develop our leadership skills, behaviours and capabilities.*"

It further states:

"Our leaders at all levels need to develop strong networks, supportive alliances and trusting relationships within and across organisational, professional, and geographical boundaries.

To discharge a leadership role adequately, whether formal or informal, requires the necessary capacity in terms of time, capability and support.

3.7 ROLES SPECIFIC TO PSYCHIATRISTS

There are a range of activities that fall exclusively to psychiatrists, such as those emanating from the Mental Health Order in relation to the detention of patients. Similar roles/duties may arise through the implementation of the Mental Capacity Act.

There are other roles for which consultant psychiatrists are necessary which are not commissioned by the HSC Trusts. These include:

- Members of Review Tribunals
- Providing assessments for civil litigation as well as assessments for the Crown Courts.
- Parole Commission
- Troubles Permanent Disablement Payment Scheme
- Work for the RQIA in Northern Ireland

Limited availability of psychiatrists with the requisite expertise has impacted adversely on the smooth delivery of these services. The Judiciary have raised the issue with the local branch of the Psych regarding the effective running of various court proceedings.

3.8 CONCLUSION

The drivers listed in this section point to a need to increase numbers, primarily in the consultant grade to address some of the issues identified and meet the aims of the various strategies referred to.

4. WORKFORCE AVAILABILITY IN ADULT PSYCHIATRY

4.1 CURRENT CONSULTANT WORKFORCE

Table 3 - Consultant workforce in the adult specialties (December 2021)

	Number in post	WTE	vacancies*
Belfast	45	40.6	5
Northern	27	25.4	6
South Eastern	20	18.2	7
Southern	18	17.6	6
Western	15	14.7	7
Total	**125**	**116.5**	**31**

* A sizeable proportion of consultant vacancies recorded here are occupied on an on-going (but not substantive) manner - through agencies, re-employing retired consultants or temporarily "promoting" specialty doctors.

The most striking feature in this table is the 20% consultant vacancy rate with a range across trusts of 10% - 32%.

In addition, it is important to distinguish specialties to inform workforce planning as the training in each of these is governed by separate curricula.

Table 4 -Consultants by age-band

AGE	number (headcount)	General adult psychiatry (vacancies)	Psychiatry of old age (vacancies)	Medical Psychotherapy (vacancies)	Forensic Psychiatry (vacancies)
30-34	11	9	2		
35-39	28	18	9		1
40-44	31	20	9	1	1
45-49	28	23	2	1	2
50-54	18	13	4		1
55-59	**4**	**3**		**1**	
60-64	**4**	**4**			
65 +	**1**	**1**			
	125	91 (23)	26 (6)	3 (1)	5 (1)

Data quoted for consultant medical staff generally, indicate an average age at retirement for men of just under 60 years of age and 59 for women. Historically, psychiatrists tended to retire earlier than their consultant peers, at least partly due to their Mental Health Officer status.

On that basis it is assumed that all those currently 55 and over will retire in the next five years as will 50% of those currently in the 50-54 year age-band. The remainder of those currently in that age band will retire in the subsequent five years. On that basis, 18 retirements are anticipated up until 2026 and a further 9 in the subsequent five years.

4.2 TRAINING OUTPUT

In all likelihood, the HSC will have to depend on the output of the local training programme for the overwhelming bulk of its consultant appointments. Whilst there have been appointments out with the programme, these have been relatively rare, however welcome and inward recruitment could never form a sufficiently reliable source on a continuous basis. Indeed, for a prolonged period, psychiatry training programmes throughout the rest of the UK have experienced persistent difficulty in recruiting a full complement of trainees – with obvious consequences for the subsequent output of trained individuals available for consultant practice.

Table 5 –Projected dates of completion of training for current trainees (as at September 2021)

	Number of trainees completing training*	GAP	POA	GAP/POA	GAP/For	GAP/Path
2022	11	8		3		
2023	7	5	1	1		
2024	15	8		4	2	1
2025	7	3	2	1		1
2026	3	3				

*Based on 4 years to complete training

The profile above suggests a sizeable output (40) by 2025. Whilst the projected output by then in general adult psychiatry (24 – 37) is well in excess of projected retirements (c. 15) over that timeframe, this is not the case in the other adult specialties where projected output will barely meet projected retirements. Projected output by 2026 will not address current demand as manifested by consultant vacancies at present across the adult specialties (31).

However, dates for completion of training can be deferred, rarely brought forward and attrition from training should be considered. To better model the output of the training programme, it is worth allowing for a degree of deferral. Similarly, an element of attrition from training might be allowed for. However, interviews with senior clinicians suggests little or no such loss from specialist training in recent years. This likely reflects the availability of consultant posts locally over this period where those completing training have had a wide range of consultant opportunities to pursue at any point in time. The current number of consultant vacancies suggest this position will continue for several years and consequently no loss from specialty training has been factored in. These assumptions create the following scenario;

Table 6 -Anticipated future consultant numbers

	Number of trainees currently projected to complete training[1]	**Number who gain CCT if assume 50% expected to complete in a given year defer CCT for a further year**	**Projected consultant retirements**	**Projected consultants in post**
2022	11	5*	4	126
2023	7	6**	4	128
2024	15	11#	4	135
2025	7	9##	3	141
2026	***8****	8	3	146
2027	***6****	7	2	151
2028	***11****	9	2	158
2029	***12****	11	2	167
2030	***7***	9	2	174
2031	***6***	7	1	180

[1]Numbers in bold italics assume all (projected) vacancies in the training programme are filled from August 2022 onwards

*/**/#/## denotes “source” of training place vacancies and anticipated completion 4 years subsequently.

This scenario suggests that, relying solely on the output of the current training programme will take until 2028 to fill the current complement of consultant posts. It also suggests the potential for 15% growth on the current complement of consultant posts over the next decade with this growth materialising in the later years of the decade.

However, this table covers all the adult specialties as a single group and may obscure the position in individual specialties.

4.3 PROJECTIONS IN GENERAL ADULT PSYCHIATRY

The following projections are further confounded by a sizeable proportion of trainees pursuing joint training programmes encompassing general adult psychiatry as one element.

Table 7

	Number of trainees currently projected to complete training		**Number who gain CCT if assume 50% expected to complete in a given year defer CCT for a further year**	**Projected consultant retirements**	**Projected consultant in post**
	GAP	joint with GAP			
2022	8	3	4-5*	3	92-93
2023	5	1	4-5**	3	93-95
2024	8	7	6-10#	3	96-102
2025	3	2	5-8##	3	98-107
2026	7*	1*	6-8	3	101-112
2027	4**	1**	5-7	2	104-117
2028	6#	4#	5-8	1	108-124
2029	5##	3##	5-8	1	112-131
2030	6	2	6-8	1	117-138
2031	5	2	5-7	1	121-144

This scenario suggests it will be between 2027 and 2030 before the current complement of consultant posts would be filled relying solely on the output of the current training programme. Thereafter, a growth in consultant numbers of anything between 6% and 26% could be generated.

4.4 PROJECTIONS IN PSYCHIATRY OF OLD AGE

Similarly, projections for old age psychiatry are confounded by the majority of trainees currently pursuing joint training programmes with general adult psychiatry.

Table 8

	Number of trainees currently projected to complete training		**Number who gain CCT if assume 50% expected to complete in a given year defer CCT for a further year**	**Projected consultant retirements**	**Projected consultant in post**
	POA	joint with GAP			
2022	-	3	0-1*	1	25-26
2023	1	1	0-1**	1	24-26
2024	-	4	0-3#	-	24-29
2025	2	1	1-2##	-	25-31
2026	-	1*	1-2	-	26-33
2027	-	1**	0-2	1	25-34
2028	-	3#	0-2	1	24-35
2029	1##	2##	1-2	-	25-37
2030	1	2	1-2	-	26-39
2031	-	2	0-2	-	26-41

These projections suggest the potential for anything between a shortfall of 19% on the current number of posts to an increase of 28%.

4.5 MEDICAL PSYCHOTHERAPY AND FORENSIC PSYCHIATRY

A similar analysis to that in the tables above suggests that the current training programmes in each of these specialties will, at best, maintain current consultant numbers over the course of the next decade. Such a position will leave little opportunity to respond to potential demand for input to strategic development in forensic/medium secure/personality disorder services as envisaged in the mental health strategy. Similarly, the ability to provide psychotherapeutic input to a range of services (such as eating disorders, peri-natal, personality disorders, addiction) may be compromised.

5. WORKFORCE AVAILABILITY IN CHILD AND ADOLESCENT PSYCHIATRY

5.1 CURRENT CONSULTANT WORKFORCE

Table 9 - Consultant workforce (December 2021)

Trust	consultants		
	Number in post	WTE	vacancies
Belfast (includes South Eastern)	19	14.7	-
Northern	6	5.3	-
Southern	5	4.2	1
Western	3	2.0	2
Total	**33**	**26.2**	**3**

The consultant vacancy rate (8% with a range across trusts of 0% - 40%) is significantly lower than in psychiatry specialties generally. Current vacancies are confined to the Southern and Western Trusts reflecting the position in the psychiatry specialties more generally where vacancy rates tend to be higher outside the greater Belfast area.

Table 10 – Consultants by age-band

AGE	number (headcount)
30-34	1
35-39	5
40-44	8
45-49	6
50-54	8
55-59	4
60-64	1
65 +	0

5.2 TRAINING OUTPUT

Table 11 - Projected dates of completion of training for current trainees (as at September 2021)

	Number of trainees completing training
2022	2
2023	3
2024	1
2025	1

5.3 PROJECTED CONSULTANT NUMBERS

Table 12 –Anticipated future consultant numbers

	Number of trainees currently projected to complete training	Number who gain CCT if assume 50% expected to complete in a given year defer CCT for a further year	Projected consultant retirements	Projected consultant in post
2022	2	1	2	32
2023	3	2	2	32
2024	1	1	2	31
2025	1	1	2	30
2026	1	1	1	30
2027	2	2	1	31
2028	1	1	1	31
2029	1	1	1	31
2030	1	1	1	31
2031	2	2	-	33

This scenario makes it clear that, relying on the output of the current training programme is highly unlikely to address the present need for consultants (36 as a minimum) let alone that which may arise from the implementation of the mental health strategy.

6. WORKFORCE AVAILABILITY IN PSYCHIATRY OF INTELLECTUAL DISABILITY

6.1 CURRENT CONSULTANT WORKFORCE

Table 13 – Current consultant workforce (October 2021)

Trust	consultants		
	Number in post	WTE	vacancies
Belfast (includes South Eastern)	6	5.8	5
Northern	3	2.7	1
Southern	6	4.7	1
Western	1	1.0	2
Total	**16**	**14.2**	**9**

As with psychiatry specialties generally, the most striking feature in this table is the high consultant vacancy rate (36%) with a range across trusts of 14% - 66%.

Table 14 –Consultants by age-band

AGE	number (headcount)
30-34	2
35-39	6
40-44	2
45-49	2
50-54	4
55-59	0
60-64	0
65 +	0

6.2 TRAINING OUTPUT

Table 15 - Projected dates of completion of training for current trainees (as at September 2021)

	Number of trainees completing training
2022	0
2023	2
2024	2
2025	0
2026	1 (joint with CAMHS)

6.3 PROJECTED CONSULTANT NUMBERS

The following table seeks to illustrate likely future consultant numbers based on assumptions regarding retirement set out earlier and projected output of the current training programme, assuming a degree of deferral of completion of training.

Table 16

	Number of trainees currently projected to complete training	Number who gain CCT if assume 50% expected to complete in a given year defer CCT for a further year	Projected consultant retirements	Projected consultant in post
2022	-	-*	1	15
2023	2	1**	-	16
2024	2	1#	1	16
2025	0	1##	-	17
2026	1 (joint with CAMHS)	1	1	17
2027	***1****	1	-	18
2028	***1**#*	1	1	18
2029	***1**##*	1	-	19
2030	***1***	1	-	20
2031	***1***	1	-	21

[1]Numbers in bold italics assume all (projected) vacancies in the training programme are filled from August 2022 onwards
*/**/#/## denotes "source" of training place vacancies and anticipated completion 4 years subsequently.

This scenario makes it clear that, relying on the output of the current training programme will not address the present need for consultants (25 as a minimum) let alone that which may arise from the implementation of the mental health strategy and HSCB work on a new model for Intellectual Disability services.

7. ACTION TO MAINTAIN/ENHANCE CURRENT CONSULTANT NUMBERS IN THE SHORT TERM

The previous projections suggest the current training programmes have not been able to meet demand for consultants in each specialty and are, for the most part, highly unlikely to keep pace with future demand. This points to a need to increase the output of the various programmes. However, this action alone will only impact on consultant numbers in the medium term, necessitating more immediate action to mitigate the impact of a shortfall in consultant numbers in the short to medium term.

These measures fall into three broad categories;

- Direct recruitment of consultants
- Action to retain current consultants through;
    - Changing the nature/volume of their current work; and
    - Improving the degree of support they receive.

7.1 RECRUIT CONSULTANTS FROM OUTSIDE NI

This approach might provide the most immediate means of increasing the number of consultants in post. However, experience suggests any resultant increase might be limited. International recruitment requires a concerted effort and can be resource intensive for those involved. Those considered suitable for appointment will have to meet professional regulatory and immigration requirements and, in all likelihood, will need a bespoke induction programme.

Consequently, if trusts, collectively, feel there is merit in undertaking such an exercise, it should be dependent on an initial assessment of likely success.

Recommendation 1
Trusts, in considering an international recruitment exercise for consultants across all psychiatry specialties should, as a first step, undertake an assessment of the likelihood of success in terms of securing sustained consultant level service provision.

7.2 OFFSET CONSULTANT RETIREMENT

There are two ways in which trusts might draw on currently available consultant staff to maintain or build on current numbers in the short to medium term;

- Solicit interest of recently retired consultants in returning to the workforce, identifying on what basis they might consider a return.

- Support current consultant approaching retirement age in deferring their retirement, identifying on what basis they might consider deferral.

Consultants may be willing to continue in work or return with limited duties or time commitment. This already happens to a degree as referred to earlier but might benefit from a more planned approach, allowing consultants to explore their options. Similarly, trusts will have a clearer picture of their medium term recruitment needs. Exploration of these issues with all consultants over 50 years of age should take place at the earliest opportunity. Annual job plan review or professional appraisal would be a suitable vehicle to explore the possibilities on an individual basis.

A key confounding factor cited frequently is taxation associated with the HSC superannuation scheme, seen as an impediment to medical staff extending their working lives in the HSC and, possibly, complicating working post retirement. However, the age profile of consultants in post and the fact that a sizeable number of recently retired consultants continue in work suggest there may be ways to mitigate the impact of this issue. Again, consideration of the issue well in advance of actual retirement allows individuals to seek appropriate advice in order make an informed and timely decision.

Recommendation 2
All trusts should explore retirement plans with each of their consultants over 50 years of age with a view to extending their continuing in the Service.

Recommendation 3
Trusts collectively should identify and engage with any consultants in the specialty who have retired from the HSC in the past three years with a view to determining on what basis they might return to provide some element of service.

7.3 IMPROVE SUPPORTIVE INFRA-STRUCTURE

It was apparent from interview with trust clinical leads that consultants enjoy a variable degree of support (in terms of medical and non-medical staff) across mental health specialties. Where such support is limited, this results in them performing tasks which would be more appropriately performed by other medical or non-medical staff. In addition, Physicians Associates are an emerging staff group that might prove valuable in freeing time for all grades of medical staff to focus on more appropriate activities. They have been little used in the HSC although numbers in mental health services are growing across the UK.

Recommendation 4

Trusts, ideally collectively, should determine the need for and explore the feasibility of recruiting specialty and specialist doctors in supporting consultant psychiatrists. The local training programme in core psychiatry has proven a source of possible candidates for specialty doctors and is likely to remain so. In addition, international recruitment (if considered worthwhile) should seek to recruit specialty and specialist doctors as well as consultants.

Recommendation 5

Trusts, ideally collectively, should determine the need for and explore the feasibility of recruiting Physician's Associates in supporting medical staff in mental health. Given this is a novel approach locally, this might be best taken forward on an individual prototype basis initially.

8. SPECIALTY, ASSOCIATE SPECIALIST AND SPECIALIST (SAS) DOCTORS

An analysis of one aspect of the supportive infra-structure is within the scope of this report – SAS doctors. Mental Health services, particularly adult services, exhibit a high reliance on SAS doctors. Specialty Doctors require four years' postgraduate training including two in a relevant specialty. Doctors in the Specialist grade (termed specialist psychiatrists) need to have completed a minimum of 12 years' work with a minimum of six years in a relevant specialty.

Trusts can therefore, specify their own requirements dependent on the role they need to be undertaken or, alternatively, recruit and then develop the successful appointee into the role required.

Where doctors have opted to take up these posts as a positive career decision, they tend to remain in post with obvious benefits for continuity/consistency of care and the maintenance of effective teams. In other scenarios, whether resulting from employers seeking to fill posts on a temporary basis or applicants with alternative career intentions, results in inevitable high turnover.

SAS doctors are highly valued within the service, although they themselves rarely perceive this to be the case. Trusts that have had more success in retaining these doctors have supported them in developing specialist skills in specific areas of practice including working towards a Certificate of Eligibility for Specialist Registration (CESR).

Interviews with clinical leads drew a variable response on the value of recruiting SAS doctors as a means of addressing medical workforce pressures. However, there was a sense that in those service areas that had had on-going difficulty in securing consultant appointments and/or allocation of specialist trainees, specialty doctors provide an invaluable contribution and support to consultants.

8.1 CURRENT SPECIALTY DOCTOR WORKFORCE

Table 17 - SAS Doctors (and equivalent) – November 2021

	Adult Psychiatry			Child and Adolescent Psychiatry			Psychiatry of Intellectual Disability		
	Number in post	WTE	vacancies	Number in post	WTE	vacancies	Number in post	WTE	vacancies
Belfast	11	9.0	-	3	1.8	-	1	1.0	2
Northern	11	9.05	5	-	-	-	-	-	-
South Eastern	10	8.65	2	Provided through BHSCT					
Southern	9	8.15	-	6	5.1	-	-	-	-
Western	9	9.0	6	1	1.0	1	-	-	-
Total	**50**	**43.85**	**13**	**10**	**7.9**	**1**	**1**	**1.0**	**2**

8.2 POTENTIAL SOURCES OF SAS DOCTORS

One clear source of specialty doctors in psychiatry is the core training programme. NIMDTA undertook an analysis of the period 2009 – 2014. Over that period, of 82 trainees recruited to the core training programme, 8 subsequently took up specialty doctor posts. In 2021, of those completing the third year of core training, four pursued specialty doctor posts either on a substantive or locum basis, suggesting this remains a viable (if not numerically predictable) supply route for this grade of doctor in these specialties.

The possibility of remaining in psychiatry as a specialty doctor should be explored at exit interviews prior to leaving training. Doctors with two or more years' experience in the specialty would prove an invaluable asset.

Recommendation 6
Exit interviews should become a routine component for all doctors who exit the training programme prior to completion of training or, having completed training, do not seek a consultant post in the HSC. The findings of these interviews will provide valuable intelligence in informing workforce needs.

When conducting exit interviews as recommended above, those leaving training should be asked if they would consider a career as a specialty doctor in psychiatry as a positive career choice. The potential of eligibility for the specialist grade in the future might enhance take up of this option.

Such interviews could also be conducted to explore factors that might improve retention within psychiatry training.

9. CURRENT TRAINING PROGRAMME

9.1 NATURE OF TRAINING PROGRAMMES

On completion of the Foundation Programme doctors compete for entry into the specialist training programme in the specialty. If successful, they are awarded a National Training Number (NTN) which they retain throughout the remainder of their training.

Psychiatry trainees have to successfully complete the three-year Core Psychiatry Training programme before applying in open competition for a place in a programme leading to a Certificate of Completion of Training (CCT) in one of the six psychiatry specialties. The six psychiatry specialties are;

- Child and Adolescent Psychiatry,
- Forensic Psychiatry,
- General Psychiatry,
- Old Age Psychiatry,
- the Psychiatry of Learning Disability and
- Medical Psychotherapy.

The Advanced Training Programme in Psychiatry is comprised of a minimum of 36 months of training in one of the six GMC approved psychiatric specialties listed above from levels ST4 to ST6.

There are two sub-specialties of General Psychiatry; Substance Misuse Psychiatry and Rehabilitation Psychiatry. In addition, Liaison Psychiatry is a sub-specialty of both General Psychiatry and Old Age Psychiatry. These sub-specialties involve one year's training in the final year of the parent specialty training. Combined training, involving two specialties, can also be pursued which adds to the training period; one year in the case of general/old age psychiatry and two years for other combinations.

Academic trainees need to complete the academic curriculum.

As with specialist training generally, trainees may take time out of training for a variety of reasons – to gain academic qualifications or take up other development opportunities.

Taking all these elements into account suggests that, for planning purposes an overall time in higher training of 4 - 5 years appears reasonable.

10. MEETING FUTURE NEEDS

Demography, strategic priorities, good practice guidance and the drive to improve quality and safety together with the inter-linked improvement in the nature of work all point to a need for more medical staff, particularly consultants.

Key points supporting this assessment include;

- A significant growth in the elderly population with obvious implications for the need for psychiatrists of old age. This was possibly the issue most consistently raised by interviewees.
- Current and future ability to meet demand for addiction services was an issue frequently raised.
- As stated earlier, the mental health strategy makes reference to service developments that will benefit from suitably trained consultant input, including;
  - peri-natal mental health
  - eating disorder services and
  - the proposed personality disorder managed care network.
- NICE guidelines point to greater involvement of psychiatrists in the management of autism and associated conditions.
- The growth in care experienced children and young people

As ever, what all these factors mean in terms of a definitive need is open to debate and ultimately the extent to which that need will be met is dependent on resource availability and competing service development priorities. It is, however, possible to be more definitive about the potential of the current training programme to address current demand in terms of consultant posts (as illustrated in sections 4.3, 4.4, 5.3, and 6.3) and, as a result, infer what might be necessary to meet future need.

10.1 TAILORING THE OUTPUT OF THE TRAINING PROGRAMME TO ANTICIPATED NEED

10.1.1 GENERAL ADULT PSYCHIATRY

As set out earlier, the general adult programme has the ability to generate a variable degree of consultant growth over the next decade, dependent on the extent to which trainees undertaking joint training take up consultant posts under the "general adult" umbrella.

However, there were areas where a clear concern was expressed over a current lack of capacity in training. Those most frequently mentioned were addictions, eating disorders and peri-natal psychiatry.

Recommendation 7
It is therefore recommended that action is taken to establish additional posts in each of these specialist areas;

- **Two in addiction psychiatry**
- **One in Eating Disorders**
- **One in Peri-natal Psychiatry.**

It is beyond the scope of an exercise such as this to be prescriptive across the full range of sub-specialty/special interest areas. The need for these will undoubtedly change as priorities change and are addressed and the workforce evolves. Consequently, these sub-specialty/specialist interest designations should not remain in perpetuity but change in response to evolving need. One such area of practice that arose during engagement with clinical representatives was liaison psychiatry.

Such an alignment, and its evolution, would be facilitated by regular engagement between trusts setting out their needs and NIMDTA, advising of the projected output of the programme with a view to better alignment.

Recommendation 8
It is therefore recommended that trusts advise NIMDTA, on an annual basis, of their anticipated needs for consultants across the "adult" psychiatric specialties/sub-specialties/special interests for the subsequent three years. As a result, NIMDTA should orientate the programme accordingly and advise trainees appropriately.

Where this engagement suggests the need for further investment or other strategic issues, NIMDTA should raise this with the Department as part of sponsorship arrangements.

10.1.2 PSYCHIATRY OF OLD AGE

A consistent comment from all trusts was the particular need for old age psychiatrists and limited capacity of the current training programme to generate the numbers required. NIMDTA has re-orientated the programme to the fullest extent possible in response to this need but it clearly isn't meeting demand. This re-orientation has also impacted detrimentally on general (and all associated sub-specialty and special interest) output.

Recommendation 9

Establishment of a number of training posts dedicated to psychiatry of old age as a matter of urgency is recommended. The current output of the core training programme should allow for these posts to be established at ST4 level initially.

The scenario in table 18 illustrates the impact of recruiting an additional three POA trainees annually for three years from 2022. Such action will begin to alter the position from 2026 onwards.

Table 18

	Number of trainees currently projected to complete training		Number who gain CCT if assume 50% expected to complete in a given year defer CCT for a further year	Projected consultant retirements	Projected consultant in post
	POA	joint with GAP			
2025	2	1	1-2*	-	25-31
2026	3	1	2-3	-	27-34
2027	3	1**	2-3	1	28-36
2028	3	3#	3-5	1	30-40
2029	1##	2##	2-4	-	32-44
2030	2	2	2-4	-	34-48
2031	2	2	2-4	-	36-52

* see Table 8

These projections serve to illustrate the potential for growth of 13% to 63% over the current number of posts.

Recommendation 10

It is recommended that the complement of psychiatry of old age training posts is increased by 9 posts, over a three year period, ideally with an initial increase in 2022 or as soon as practicable thereafter.

10.1.3 PSYCHOTHERAPY AND FORENSIC PSYCHIATRY

A doubling of current numbers, whilst modest, could provide some capacity to meet demand in service areas set out previously. Given the unpredictability of opportunities in these specialties, training should continue to be offered jointly with a "general" element (whether in adult or child/adolescent psychiatry).

Recommendation 11
It is recommended that two additional posts in each of medical psychotherapy and forensic psychiatry are established as soon as practicable.

10.1.4 CHILD AND ADOLESCENT PSYCHIATRY

If we examine the potential impact of recruiting 3 extra trainees in each of the next three recruitment rounds and apply the previous assumptions on progress through training, the following scenario emerges.

Table 19

	Projected output from training programme	Projected consultant retirements	Projected consultant numbers
2026	2	1	31
2027	3	1	33
2028	4	1	36
2029	2	1	37
2030	2	2	37
2031	3	-	40

This projection represents a growth of 11% on the current complement. Clinical leads felt this scenario might better address service developments envisaged in the mental health strategy, highlighting improved crisis response, services for looked after children and eating disorder services.

Recommendation 12
It is recommended that the complement of training posts in child and adolescent psychiatry is increased by 9 posts, over a three year period, ideally with an initial increase in 2022 or as soon as practicable thereafter.

10.1.5 PSYCHIATRY OF INTELLECTUAL DISABILITY

Assuming three additional recruits to training annually in the period 2022 – 2024 leads to the following scenario. Clinical leads felt a complement of 30 whole time equivalent consultants was a pragmatic target to aim for. The following projection suggests increasing training numbers by nine may still lead to a shortfall on this aspiration.

Table 20

	Projected output from training programme	Projected consultant retirements	Projected consultant numbers
2026	2	1	18
2027	3	-	21
2028	4	1	24
2029	2	-	26
2030	2	-	28
2031	3	-	31

Recommendation 13

It is recommended that the complement of training posts in psychiatry of intellectual disability is increased by 9 posts, over a three year period, ideally with an initial increase in 2022 or as soon as practicable thereafter.

10.1.6 SUMMARY OF SPECIALIST TRAINING NEEDS

The foregoing has indicated a need for the following increases in specialist training numbers across each of the psychiatry specialties.

Table 21

Psychiatric specialty	**Suggested increase**
General adult	2 in addiction psychiatry 1 in Eating Disorders 1 in Peri-natal Psychiatry
Psychiatry of old age	9 (over three years)
Medical psychotherapy	2
Forensic psychiatry	2
Child and adolescent psychiatry	9 (over three years)
Psychiatry of Intellectual Disability	9 (over three years)
Total	**35**

The aggregate projections represent a substantial increase (c. 80%) on current numbers of specialist training posts (44). Ultimately meeting these numbers of specialist trainees will depend on two factors;

- Available resource to establish the required training posts (estimated at more than £2m for the 35 posts identified); and
- A reliable source of suitably qualified doctors to take up specialist training (predominantly the output of the local core training programme).

It is likely that the necessary resource (both financial and human) will, of necessity, become available over a number of years. Consequently, prioritisation will be required. The analysis in this exercise would suggest according priority to posts in old age psychiatry, child and adolescent psychiatry and psychiatry of intellectual disability in the first instance with review as further resources become available.

10.2 CORE TRAINING PROGRAMME

10.2.1 OUTPUT OF CORE TRAINING PROGRAMME

At present there are 51 training posts in the core programme with 47 trainees across years 1-3. On average, the programme has capacity to generate 17 trainees eligible for entry to the specialist training programme. In reality, however, a significant percentage of trainees do not progress to ST4 for a variety of reasons and pursue other career options, such as specialty doctor or training in another specialty.

An analysis by NIMDTA of trainees recruited in the period 2009-14 demonstrated that of 82 trainees recruited over that period, 51 were eligible to enter higher training after 3 years, 11 left to pursue training in another specialty (most frequently General Practice) and 8 took up specialty doctor posts.

In September 2021, there were 18 and 19 trainees in CT2 and CT3 respectively. Allowing for historic attrition, this suggests 12 trainees will be available for recruitment to ST4 in 2022 and 14 in 2023. If this output materialises, there may be suitably qualified trainees available to take up (admittedly a limited number of) additional posts projected in Table 21, if it is possible to establish these in the time available.

Recommendation 14

Given the potential output of the core training programme in 2022 and 2023, it is recommended that NIMDTA undertake an exercise to firmly determine the excess (if any) of those completing the core training programme over available ST4 specialist training opportunities and seek to establish posts in line with any excess identified for recruitment in the relevant years.

The current specialty programmes have 44 posts available. The projection above across all specialist programmes suggests the need for an additional 35 posts, generating a need for 18 recruits per year on average to maintain. Taking account of the historical pattern of attrition in the core programme suggests an overall size of 75 posts. This scenario suggests an annual intake of 23 - 24 to the core programme, 9 - 10 per year above the historic average and 4 - 5 beyond the average number of applicants considered “appointable” in recent years.

Table 22 - Recruitment to the core training programme over recent years

Year	Posts available	Applications	Interviewed	Considered appointable
2020	13	76	25	22
2019	14	41	25	20
2018	12	47	18	15
2017	16	33	27	Not recorded
2016	17	46	30	Not recorded
2015	11	50	28	Not recorded
Average '15 -'20	**14**	**49**	**26**	**19**

This table suggests it may be impractical to move from historic recruitment levels to those considered necessary in a single step. Aside from the financial considerations (the projected additional core trainee numbers would cost in the order of £1.9m) there is a question over the availability of suitably qualified applicants. That said, there will be a need for significant and on-going investment at all levels in the core programme if the identified need for specialist trainees is to be met on a sustainable basis.

Recommendation 15

A minimum of five additional CT1 posts in core psychiatry should be established in 2022 (or as soon as feasible thereafter) as the beginning of an on-going investment to address deficiencies in specialist training in a sustainable manner.

This investment should be accorded a similar priority to those suggested for psychiatry of old age.

11 FUTURE REVIEWS

Given the inherent uncertainties in an exercise of this nature, the position should be kept under review. A number of recommendations, if adopted, will take several years to have a discernible impact. **Consequently, it is suggested that any review should not take place prior to 2026.**

Appendix

NICE GUIDELINES RELEVANT TO MENTAL HEALTH SERVICES

Title	Reference number	Published	Last updated
Drug misuse in over 16s: opioid detoxification	CG52	25 July 2007	
Drug misuse in over 16s: psychosocial interventions	CG51	25 July 2007	
Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence	CG115	23 February 2011	
Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings	CG120	23 March 2011	
Coexisting severe mental illness and substance misuse: community health and social care services	NG58	30 November 2016	
Drug misuse prevention: targeted interventions	NG64	22 February 2017	

Anxiety

Title	Reference number	Published	Last updated
Obsessive-compulsive disorder and body dysmorphic disorder: treatment	CG31	29 November 2005	
Generalised anxiety disorder and panic disorder in adults: management	CG113	26 January 2011	26 July 2019
Common mental health problems: identification and pathways to care	CG123	25 May 2011	
Social anxiety disorder: recognition, assessment and treatment	CG159	22 May 2013	
Post-traumatic stress disorder	NG116	5 December 2018	

Attention deficit disorder/Autism

Title	Reference number	Published	Last updated
Autism spectrum disorder in under 19s: recognition, referral and diagnosis	CG128	28 September 2011	20 December 2017
Autism spectrum disorder in adults: diagnosis and management	CG142	27 June 2012	18 August 2016
Autism spectrum disorder in under 19s: support and management	CG170	28 August 2013	
Attention deficit hyperactivity disorder: diagnosis and management	NG87	14 March 2018	13 September 2019

Depression/Bipolar disorder/Psychosis and Schizophrenia

Title	Reference number	Published	Last updated
Depression in adults: recognition and management	CG90	28 October 2009	
Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings	CG120	23 March 2011	
Depression in adults with a chronic physical health problem: recognition and management	CG91	28 October 2009	
Bipolar disorder: assessment and management	CG185	24 September 2014	11 February 2020
Coexisting severe mental illness and substance misuse: community health and social care services	NG58	30 November 2016	
Depression in children and young people: identification and management	NG134	25 June 2019	
Rehabilitation for adults with complex psychosis	NG181	19 August 2020	

Eating Disorders

Title	Reference number	Published	Last updated
Eating disorders: recognition and treatment	NG69	23 May 2017	6 December 2020

Mental Health Services

Title	Reference number	Published	Last updated
Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services	CG136	14 December 2011	
Antenatal and postnatal mental health: clinical management and service guidance	CG192	17 December 2014	11 February 2020
Violence and aggression: short-term management in mental health, health and community settings	NG10	28 May 2015	
Transition between inpatient mental health settings and community or care home settings	NG53	30 August 2016	
Mental health problems in people with learning disabilities: prevention, assessment and management	NG54	14 September 2016	
Mental health of adults in contact with the criminal justice system	NG66	21 March 2017	
Preventing suicide in community and custodial settings	NG105	10 September 2018	
Decision-making and mental capacity	NG108	3 October 2018	

Personality Disorder

Title	Reference number	Published	Last updated
Antisocial personality disorder: prevention and management	CG77	28 January 2009	27 March 2013
Borderline personality disorder: recognition and management	CG78	28 January 2009	

Self Harm/Suicide

Title	Reference number	Published	Last updated
Self-harm in over 8s: long-term management	CG133	23 November 2011	
Preventing suicide in community and custodial settings	NG105	10 September 2018	

Looked After Children

Title	Reference number	Published	Last updated
Looked-after children and young people	NG205	20 October 2021