Royal College of Psychiatrists in Scotland – Briefing on motion S6M-14408 – Improving Access to Health and Social Care in Rural Scotland

About the College in Scotland:

Who we are – The Royal College of Psychiatrists is the professional medical body responsible for supporting the psychiatry profession to develop standards and act collectively to improve clinical care and treatment for people with mental ill health. This support extends throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in Scotland and the United Kingdom.

What we do – The College aims to improve the outcomes, not just of people with mental ill health, but to also positively address the mental health of all individuals, their families and communities. To achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

1. **The current state of psychiatry in Scotland**

Scotland's mental healthcare system is in crisis. Our psychiatric workforce is not growing sufficiently to keep pace with the well-documented rising scale of demand for services. Our workforce has been stretched to its absolute limit and is now overwhelmed. Whilst the College's highly successful 'Choose Psychiatry' campaign has supported the recruitment of record numbers of trainees into Psychiatry, the investment in more than a decade of training these doctors is increasingly lost - as they experience the untenable working conditions they then face as consultants. As a result, Scotland faces a critical loss of the substantive psychiatric workforce, drastically reducing the scope for prevention and early intervention, jeopardising provision of safe care and treatment, and increasing chronicity and suffering in the community.

2. **Inequities across Scotland, particularly in rural areas**

Scotland's central belt and diverse urban populations experience their own characteristic challenges, but benefit to some extent from a larger pool of workforce to cushion shortages. The loss of a single senior Consultant in an urban area may represent a 10% reduction in consultant cover, and one which can be repaired by advertising for successors, often from amongst existing Higher Trainees. In an island community, the retirement of a single consultant psychiatrist can mean the end of the entire service. Without unusually fortunate succession plans, a whole network of

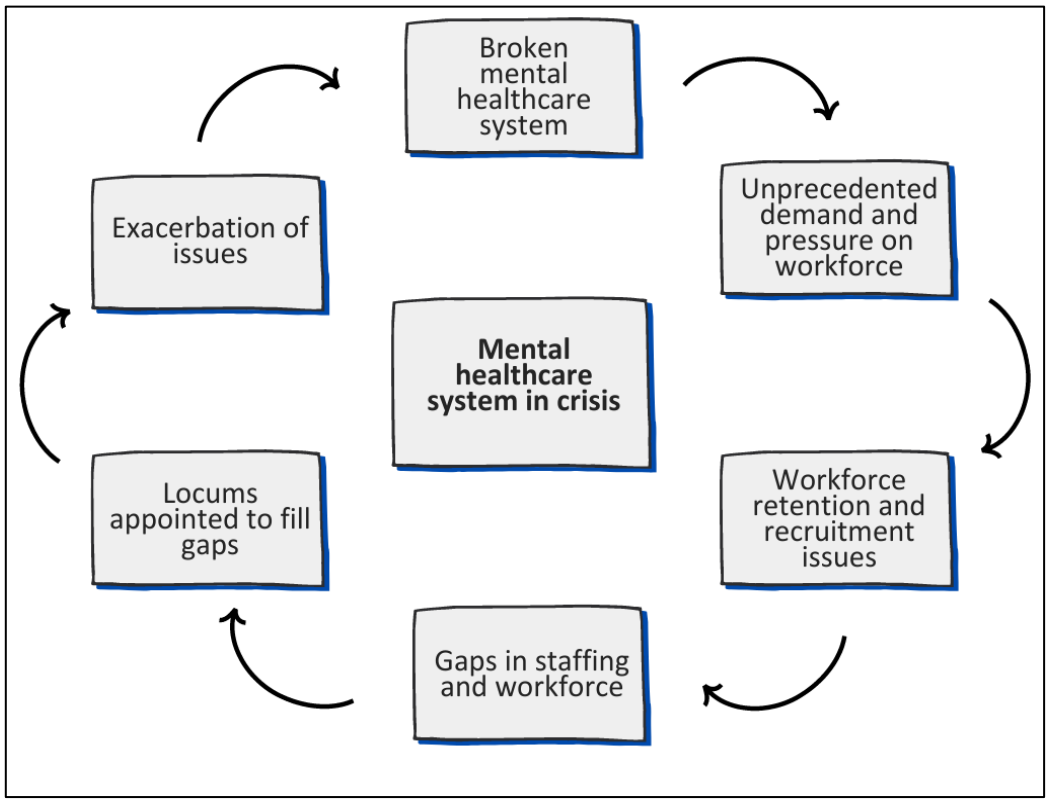
integrated support potential can be lost at a stroke, with mental health care then falling back to already similarly overburdened GPs.

More remote and rural areas of Scotland face much greater workforce shortages, with over-reliance on agency locums, limited access to specialist services, transport and travel challenges, social stigma and community sensitivity, and a lack of integrated support services. Despite creative and positive use of telemedicine, good mental health care in remote parts of Scotland relies heavily on relationships, communications, links, and expert management of the inevitable transitions involved.

Continuity of psychiatric consultant leadership, embedded over time in the medical and social networks of remote and rural communities, improves quality of care, improves outcomes, and saves financially - in contrast with repeated short-term appointments of locums.

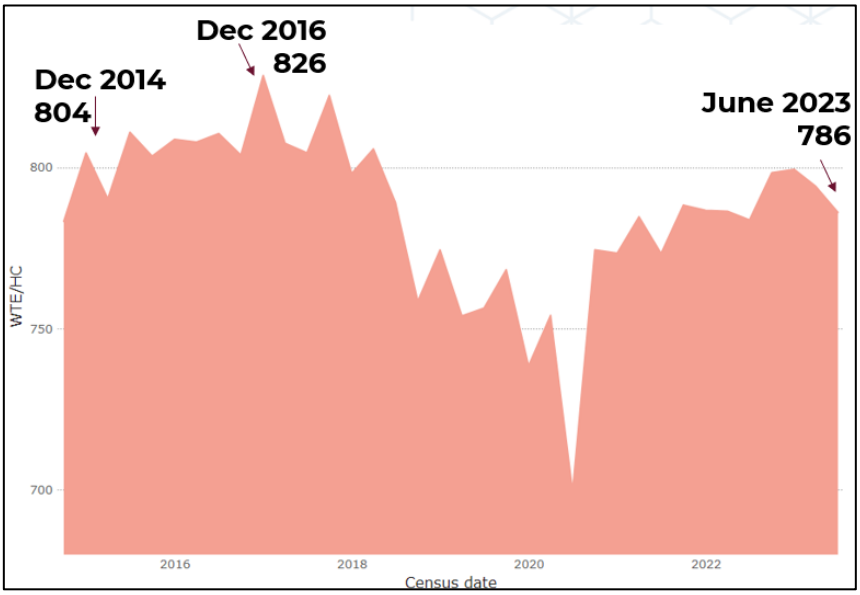
3. **Workforce retention**

Despite the recruitment efforts mentioned above, the psychiatric workforce in Scotland is in a critically precarious state. We find ourselves in a cycle whereby our workforce is under so much unprecedented demand and pressure that substantive psychiatric staff are leaving. This leads to workforce gaps, and locum psychiatrists, when available, are appointed to fill these gaps (see Image 2). However, even with locum appointments, a large workforce gap remains (see Image 1).



(Image 1: the psychiatry workforce issues cycle)

The number of psychiatrists in Scotland has decreased over time, even accounting for locums employed (Image 2). According to the NHS Scotland Workforce Census data, the number of WTE general psychiatry posts has decreased from 826 in December 2016 to 786 in June 2023.



(Image 2: the number of psychiatrists employed over time)

Remote and rural areas have both a chronic and now more acute workforce shortage: with a disproportionately high number of both unfilled posts and posts filled by agency locums. In some health boards, more than half of the psychiatry positions are vacant or held by a locum.

Cost of locums

In 2022/23, Scotland's 14 health boards spent nearly £30 million on locum psychiatrists. This is diverting essential resources from the substantive workforce and wider mental health budget. These critical resources must be better spent during a time of financial austerity. We should be prioritising this spend on tackling the systemic issues, rather than patching over the by-product issues.

Quality assurance, patient safety, and morale of substantive colleagues

It is not only the cost of agency-employed locums which concerns the College. Loopholes in hiring legislation have allowed for the appointment of Consultant Psychiatrists who do hold the appropriate qualifications for the role. This has major implications for patient safety and quality of care. Too often locums do not have the training prescribed and moderated by the Royal College to ensure that consultant-level responsibilities can be safely discharged by the individual. Substantive staff report high levels of stress/burnout due to patient safety concerns caused by staffing issues. Additionally, substantive staff are experiencing frustration with having to take on extra work and responsibilities, whilst often being paid less and having less autonomy around

working boundaries in comparison to their locum colleagues. This is causing major disillusionment within the workforce and is worsening retention issues.

Breaking the cycle

In order to break this cycle, a **focus on workforce retention is required**. We must address the untenable working conditions our psychiatric workforce are experiencing. Ironically, our members tell us that the worst aspect of the role is the reduction in consultant colleagues to share the workload, but other factors are crucially important too. These include adequate secretarial and administrative provision, protected private individual office space, and respect for the role of the Psychiatrist as a Leader.

A key challenge faced by our workforce is the structuring of roles. Our substantive psychiatrists are increasingly having to work inflexible working patterns. Psychiatry job plans in Scotland are most commonly 9:1 (compared to 8:2 or 7.5:2.5 in England). This means that 90% of time must be spent on direct patient care and leaves almost no time for anything but clinical work. The current 9:1 contract allows only one half-day session per week for all non-clinical duties, including administration: therefore not permitting time for training, teaching, supervision, service development or research. Consultants on 9:1 contracts are left feeling dissatisfied, disenfranchised and disengaged with their peers and the wider service.

It is likely that we now have too few substantive consultants to collectively provide supervision and training from a 9:1 consultant job plan to meet the needs of the future generation of psychiatrists. This risks being unable to continue the recent optimistic trend of increased recruitment to Psychiatry.

Recommendations

1. Workforce retention

- No further advertising of substantive consultant posts as 9:1, and a review of all existing 9:1 job plans - with a view to inform a Scottish Government decree making 7.5:2.5 the expected ratio, as a way to more accurately reflect consultant roles and responsibilities.
- A commitment from the Scottish Government to focus on retention of substantive psychiatrists, with a specific concentration on rural areas.

2. Locums

- A commitment not to perform blanket cuts to agency locums.
- We suggest careful monitoring of the use of agency locums, together with a reinvestment of money saved from locum budgets into the provision of psychiatric training budgets, appointment of administrative staff, improvements to the built environment of psychiatrists, and other investment.

- Working with NES, the initiation of specific posts and training programmes for Psychiatrists interested in remote and rural mental health. These might include dual Higher Training, particularly across the age range, as well as experience and placements in primary care. Such training would reasonably sit under Regional Schemes (such as the North of Scotland training programmes) and might involve specialist training at a 'hub' centre of excellence with placements and telemedical work to remote constituencies.

3. Funding

- These challenges will be insurmountable if we continue to neglect the present Government's commitment to spend 10% of the Health Budget on Mental Health and 1% on CAMHS.
    - Every year since the 10% budget allocation commitment was made (2021), NHS frontline spend has moved away from, not toward, the Government's own spending commitments - the share of overall NHS funding further decreased from 8.66% in 2021/22 to 8.53% in 2022/23.
    - Some Boards have even worse records, particularly those outside the big cities. Scotland does face financial circumstances that require difficult budgetary decisions, but this is no excuse to once again disproportionately disadvantage mental health as occurred in the Scottish Budget 2024/25 and Programme for Government.
- **The RCPsych in Scotland calls for the committed 10% of the frontline NHS budget to be legislatively ringfenced for mental health and 1% to be ringfenced for CAMHS.**
    - Government representatives have explained to us that the onus is on individual health boards to enact the division of NHS funding, but our own Managers in the boards tell us they have no basis to insist on their share of funding and are often expected to enact disproportionate cuts to mental health service. A legislative mechanism is needed to ringfence this budget – akin to the approach already taken in England and Wales, with mandated reporting from health boards confirming this spending target has been met.

Contact:

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