RCPsychiS response to future medical workforce call for evidence

About the Royal College of Psychiatrists in Scotland (RCPsychiS)

As the professional medical body for psychiatry in Scotland, we set standards and promote excellence in psychiatry and mental healthcare.

We lead, represent and support psychiatrists nationally to Government and other agencies, aiming to improve the outcomes of people with mental illness, and the mental health of individuals, their families, and communities.

We are a devolved nation and council of the Royal College of Psychiatrists. We have over 1,500 Members, Fellows, Affiliates and Pre-Membership Trainees in Scotland.

We are pleased that the Scottish Government has launched the Future Medical Workforce Project, and that the Government seeks to understand the future medical workforce needs, as well as ways it can support strategic workforce planning. As a Royal College, we will be responding to the broader points of the call for views regarding the role of the consultant, the current challenges, and the role of digital innovation in the future of the medical workforce.

The RCPsychiS have already undertaken extensive work to identify, understand and provide recommendations to support a sustainable workforce in our State of the Nation report – published in October 2023.

We would also like to highlight the more recent work of the Psychiatry Recruitment and Retention Working Group and the final report published in June 2025, which sets out a series of recommendations that aims to support a sustainable psychiatric workforce in NHS Scotland. Although, through this group, many solutions and recommendations have already been worked through and supported by stakeholders, sufficient funding at both Scottish Government and at Health Board level will be critical to their implementation.

The role and value of consultant psychiatrists

Consultant psychiatrists are central to the delivery of safe, effective, and compassionate mental healthcare. Our members' roles are multifaceted, encompassing direct clinical care, teaching and training, research, leadership, governance, advocacy, and statutory responsibilities. Our members are not simply practitioners of medicine - they are person-centred, biopsychosocial experts who respond to the complexity and unpredictability inherent in mental health care.

At the heart of our members' work is the ability to manage clinical uncertainty, make nuanced decisions, adapt to fast-paced change, and to maintain patient-centred, holistic care in the face of rising pressures. However, the vital role our members is not only through direct clinical work: they also play a critical role in team leadership,

governance, and service design and development. Their expertise is built over years of training and experience, and it enables them to navigate the ethical, legal, and clinical dimensions of their role with confidence and accountability.

Essential to the success of the role of a consultant psychiatrist is the doctor-patient relationship, the continuity of care in this therapeutic relationship, and the ability of our members to advocate for their patients.

To better understand their contribution, the main elements of the role of our members can be grouped into four key themes:

1. Direct clinical care

Our members are medically trained doctors who specialise in treating mental illness, as well as the intersection between mental and physical illness. Our members take responsibility for the assessment, diagnosis, and ongoing treatment of patients, often those with the most complex needs in society. They are required to make rapid decisions in uncertain and often high-risk situations, drawing on a breadth of clinical knowledge and experience. Their work goes beyond simply following protocols - they apply expert judgement and employ a biopsychosocial model to tailor treatment and care to the individual. This person-centred, holistic approach is essential in psychiatry, where each patient's context and presentation - as well as their needs and response to treatment – may vary widely.

2. Providing clinical leadership

Consultants provide leadership not only within their own clinical teams but across wider service structures. They guide multidisciplinary teams, ensuring that care is coordinated and effective. Their leadership is critical in shaping service delivery, mentoring junior colleagues, making budgetary decisions and ensuring that funding allocation is the most effective, and fostering a culture of clinical excellence. They also play a key role in teaching and training, supporting the development of future clinicians and other professionals.

Psychiatrists, as senior doctors with extensive expertise in mental health, are central to workforce reform. Our members' clinical insight and experience on the ground are essential to ensure services are safe, effective, and targeted to the areas of greatest need.

3. Upholding standards and clinical governance

Senior clinicians are responsible for maintaining and improving clinical standards. They drive service development, contribute to policy and decision-making, and ensure that clinical priorities are communicated effectively to management and governance structures. Their role in governance includes overseeing quality improvement, risk

management, and ethical practice. They also act as advocates for patients, ensuring that care remains compassionate and equitable.

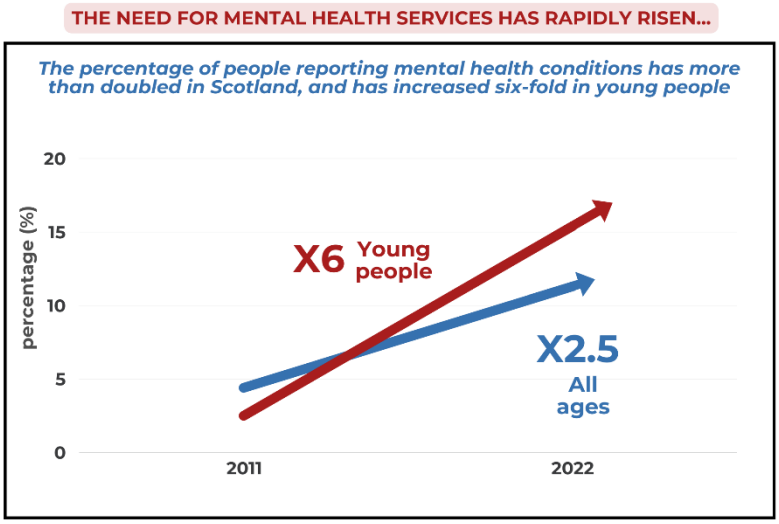
4. Statutory and legal responsibilities

In psychiatry, consultants hold unique statutory roles. Our members have legal responsibilities under, for example, the Mental Health Act and the Adults with Incapacity Act. These roles require specialist training and experience. The statutory dimension of our members' work underscores the irreplaceable nature of their expertise and the trust placed in them by society.

Current challenges for our workforce

Mental health is consistently a majorly under-resourced area of the frontline NHS spend, despite an exponential rise in demand for mental health services. Mental health services in Scotland are under unprecedented pressure, with demand vastly surpassing resourcing.

The 2022 Scottish Census found that the number of people reporting a mental health condition in Scotland has more than doubled since 2011, rising from 4.4% to 11.3% of the population. This upsurge was the largest increase across all health condition types in the Census. Young people are particularly affected, with reports of mental health conditions among respondents aged 16-24 increasing sixfold between 2011 and 2022. It is therefore vital that this is prioritised.



Adequate funding is critical in addressing this rising demand, alongside tackling workforce shortages and ensuring timely, equitable access to high quality treatment and care.

The Royal College of Psychiatrists in Scotland is calling for increased funding to address Scotland's national crisis with mental health. In their 2021 election manifesto, the SNP committed to 'ensure that, by the end of the parliament, 10% of our frontline NHS

budget will be invested in mental health.' This commitment was then reiterated in the Scottish Government and Scottish Green Party's shared policy programme.

Unfortunately, every year since the 10% budget allocation commitment was made (2021), NHS frontline spend has moved away, not toward, the Government's spending commitments. In 2011/2012, 9.12% of NHS spending went towards mental health, over a decade later (and since the commitment to 10% has been made), the share of overall NHS funding has decreased to 8.53% in 2022/23.

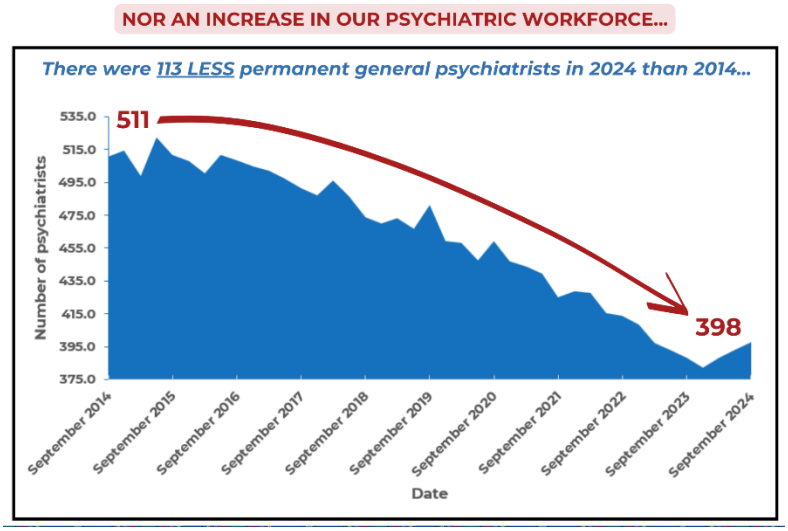
Taking 2022/23 as an example, NHS health boards would need to have invested an extra £238.5m into mental health services in order for the 10% pledge to have been fulfilled. This funding gap could cover the cost of any one of the following:

- 1775 more consultant psychiatrists (based on consultant pay scales, pay points 4-8 – including national insurance).
- 5,400 more mental health nurses (based on the 2024/25 band 6 A4C pay, pay point 1 – including national insurance)
- 55, 827 more patients treated by Community Mental Health Teams. - 3,272 more patients treated through crisis resolution.
- 17, 112 patients treated through assertive outreach services.
- 1084 additional adult acute beds. *

Whilst funding alone is not enough to address the mental health emergency which Scotland is facing, sufficient resourcing is required as an essential starting point.

Scotland is facing a psychiatric workforce crisis. The workforce is not growing sufficiently to keep pace with the well-documented rising scale of demand for services. As such, our workforce is overwhelmed and stretched to its absolute limit. Clinicians are increasingly finding themselves having to work in untenable conditions. As a result of this, we are experiencing a critical loss of our permanent psychiatric workforce, jeopardising the ability of our services to provide safe care and treatment to patients and resulting in increased waiting times.

There is a major shortfall in psychiatrists able to fill roles in Scotland, and vacancy rates for consultant psychiatry roles are as high as 46% in some parts of the country. These workforce gaps have led to the widespread recruitment of locum psychiatrists as a temporary solution. An average of 1 in 4 consultant psychiatry positions are estimated to be vacant or filled by a locum across Scotland. Between September 2014 and September 2024, we lost a staggering 22% of our permanent psychiatric workforce.



Major systems changes are required in order to rebuild our permanent workforce and ensure that there are enough qualified substantive consultant psychiatrists in Scotland to provide the high-quality, timely mental health care which our society requires and deserves.

The psychiatric workforce finds itself in an increasingly difficult situation. With a dwindling number of substantive consultant psychiatrists, locum psychiatrists have been recruited to temporarily fill posts. Before we consider the issues with the appointment of locums, it is important to emphasise that the issues with widespread hiring of locum psychiatrists are a by-product of the longstanding workforce issues in psychiatry and the wider NHS, but are not the original root of the issue. The major workforce gaps that have led to the widespread hiring of locums is reflective of the need for drastic action to create attractive, sustainable substantive roles – but is not the issue in itself.

Some of the major issues arising from the growing dependence on locum psychiatrists to cover gaps in the substantive workforce include:

1. Quality assurance and patient safety

   Loopholes in hiring legislation have allowed for the appointment of Consultant Psychiatrists who do not hold the appropriate qualifications for the role. In 2023, it was estimated that approximately 50 locum consultant posts across Scotland were held by individuals not on the Specialist Register and sometimes without MRCPsych (although this anomaly is not captured in official data collection). This has major implications for patient safety and quality of care.

   The appointment of non-qualified locums with the title of 'Consultant Psychiatrist' also presents issues around transparency and confidence in the health service: people have the right to know that the individual they are being treated by has the

necessary qualifications and training to undertake that role, and this is currently not clear in all circumstances.

The appointment of often short-term temporary locum doctors also holds implications for the continuity of patient care - individuals are not always seen by the same regular consultant at each appointment. Continuity of care is essential in psychiatry: continuity strengthens therapeutic relationships, and this is associated with improved quality of care and patient outcomes.

In addition to providing high quality direct clinical care, consultant psychiatrists also undertake a range of additional responsibilities that are essential to the NHS. These responsibilities can include: training of future psychiatrists, teaching of medical students, leading on adverse event reviews, acting as appraisers, undertaking audit and research, and contributing to quality improvement and service development. Locums are not always required (and in some cases are untrained) to perform these functions - and therefore do not fulfil all of the requirements of the role. This puts more pressure on the remaining substantive postholders to carry out these functions in addition to their other duties.

2. Morale and stress of substantive psychiatrists

Our members continually report high levels of stress/burnout due to patient safety concerns caused by staffing issues. Additionally, our members are experiencing frustration with having to take on extra work and responsibilities (on top of what are often already near unmanageable workloads) whilst frequently 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.

These issues were also highlighted by the General Medical Council national training survey – which shows a trend in rising workloads and burnout, with the risk of burnout at its worst since tracking began.

3. Cost

There is no enforceable fixed cost or cap on the payment of agency contracted locum psychiatrists, which has led to health boards spending excessive amounts to fill these posts. 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.

This is especially concerning during a period of unprecedented financial pressures, and in light of the 16% cuts to mental health budgets in the 2024-25 Programme for Government which follows successive cuts in recent years.

The Health and Care (Staffing) (Scotland) Act 2019 set out to remedy this. However, this has not come to pass. Section 12IA of the act: Duty to ensure appropriate staffing, includes suggestion of a cap to the spend on agency workers (including locums): “the amount to be paid to secure the services of that worker during a period should not exceed 150% of the amount that would be paid to a full-time equivalent employee of the Health Board, relevant Special Health Board or the Agency to fill the equivalent post for the same period”. However, the real terms impact of this legislation has been limited - since health boards are only legally required to report when this pay cap is breached: there is no legislative mechanism to actually enforce against it.

Our workforce survey

The RCPsychiS sent out a survey in summer 2024 targeted at locum psychiatrists in Scotland. The main purpose was to gain a better understanding, and be able to demonstrate, the reasons driving people to choose locum over substantive posts.

The findings of our survey make clear the untenable and unsustainable circumstances our substantive workforce is facing, and the reasons why some individuals are choosing locum roles. Some of the key findings to highlight including:

• Nearly all of the qualified individuals we surveyed (that weren’t currently in a substantive post) had left a substantive role to assume a locum position (97.5%).

• More than half of the qualified individuals who had previously held substantive roles (and weren’t currently substantive) had been in their role for more than 20 years. Nearly a third had been in their roles for more than 30 years. This means that we are losing our highly experienced, qualified substantive staff to locum positions.

• On the other side of this, 13% of individuals left their substantive positions after just 5 years or less. This means that we are losing workforce at both ends of the psychiatry career path.

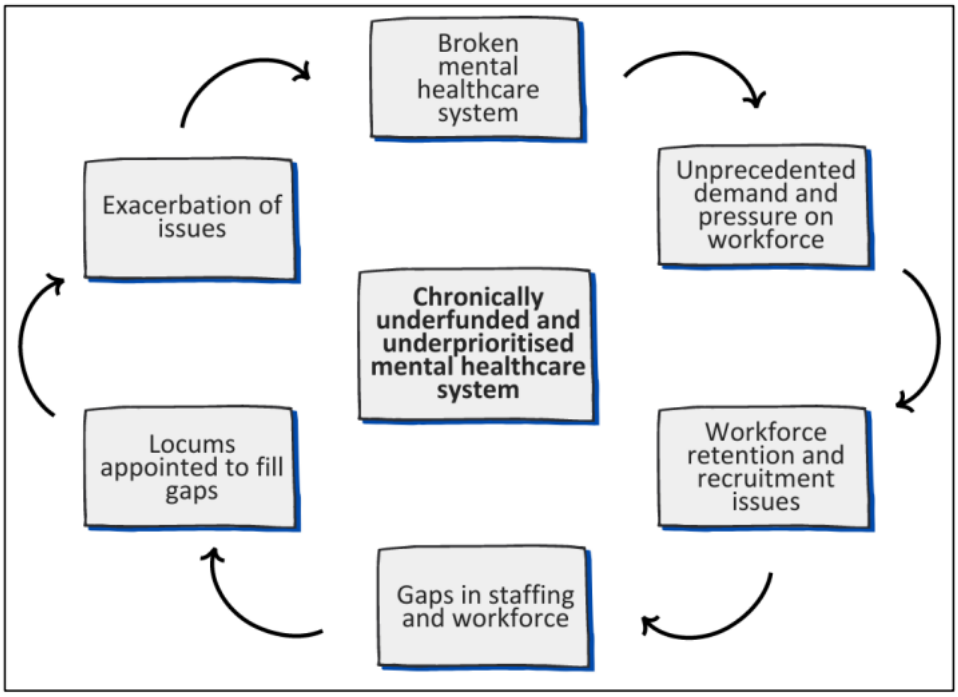
• Nearly 1 in 5 of the respondents did not hold the appropriate qualifications for the role.

• Of these unqualified individuals, 75% of those without MRCPsych had held the title of 'consultant’ and 50% of those without CCT/CESR had held the title of ‘consultant’. This presents major issues with transparency.

• Locum respondents did not carry out all of the responsibilities required of a substantive consultant when working as a locum (only half had carried out supervision, 50% teaching, 39% training).

• People are leaving their roles because of stress, burnout, disillusionment, unsustainable job plans, overwhelming workload, a skewed work: life balance, and patient safety concerns (often stemming from staffing shortages).

• Our retiring and returning workforce are choosing locum posts over substantive roles. Perceived benefits of locum posts include: more flexibility, freedom, control, a better work-life balance, less stress, and increased pay.



The marked increase in the use of locum consultant psychiatrists poses challenges for the NHS in Scotland and we would support measures to move away from a reliance on locums as a priority area for action (via gradual cessation). However, simply removing all locums from a mental healthcare system which is already facing a staffing crisis would only serve to majorly exacerbate issues (likely leading to even greater burnout and loss of substantive consultants). The widespread appointment of non-qualified locum consultant psychiatrists across Scotland also presents issues around patient safety and transparency.

What we require is a dual approach: We must focus on addressing the issues which are creating these workforce gaps in the first place (such as those highlighted in our survey – shown in Image 6 and 7). In combination with this, we should seek to move away from the appointment of locum psychiatrists – supporting those who are already in post to move to substantive roles (which will have been made more attractive, sustainable prospects by addressing said issues).

The RCPsych in Scotland remains committed to engaging with relevant stakeholders in NHS reform and reform of services. We are entirely supportive of the sentiment that

major systems improvement is required within the mental health workforce, including a shift away from the reliance on locum psychiatry. However, removing locums without addressing the underlying workforce issues will limit the shared goal of achieving reform.

It is important to emphasise once again that the problems with locum psychiatrists are a by-product of the longstanding workforce issues in psychiatry and the wider NHS, but are not the original root of the issue. The major workforce gaps that have led to the widespread hiring of locums is reflective of need for drastic action to create attractive, sustainable substantive roles – and we therefore must address these issues.

Our State of the Nation report outlined a comprehensive set of recommendations for addressing the current workforce crisis within psychiatry. In addition to the wide ranging recommendations around improving recruitment to psychiatry, we wanted to emphasis key recommendations aimed at improving retention of trained psychiatrists within the substantive consultant workforce:

Immediate actions:

➢ Phase out 9:1 job plans for existing consultants and all new consultant appointments - to be replaced by 7.5:2.5 job plans, to more appropriately recognise the non-clinical responsibilities undertaken by substantive consultants.

➢ Support greater flexibility in consultant job planning to support retention, especially among consultants at the end of their career.

➢ Introduce kitemarking of job descriptions as a means of ensuring quality & consistency of newly advertised posts.

➢ Commitment to sensitive and flexible late career job planning to support retention - including options such as: ceasing 'on-call' in pre-retirement years, flexible and hybrid working, supporting uptake of sabbaticals, and using their experience and breadth of knowledge to focus on aspects of the role beyond clinical work.

➢ Expand the range of available roles for retiring and returning psychiatrists to include non-clinical activities such as supervision, teaching, training, appraisals and adverse event reviews.

Medium term actions:

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

➢ Develop and expand CESR fellowship programmes across boards with input from NES

Gradual cessation of non-qualified locums acting as consultant psychiatrists.

The current practice of non-qualified doctors using the title of (locum) 'consultant' and being appointed to posts that they would not be eligible to undertake substantively has significant implications for transparency, public confidence in the health system and potentially, patient safety. However, we recognise that an abrupt cessation of this practice would have implications for an already overstretched system. We recommend a gradual phasing out of this practice over a three year transition period after which, health boards would require that all Locum Consultant Psychiatrists hold the necessary qualifications to join the GMC specialist register. Non-qualified doctors currently in locum consultant posts will be supported in achieving the necessary qualifications through the CESR pathway.

This solution could be brought about by Government directive without the need for legislation and requires no additional funding. It is likely to improve public confidence, improve morale and retention in the substantive workforce - whilst also ensuring a modest financial saving.

To ensure the best possible patient outcomes, we are calling for a fully funded psychiatric workforce plan to be actioned and progress measured. This plan must 1) Improve timely access, continuity and quality of care by increasing and retaining the permanent psychiatric workforce to meet patient needs. 2) Protect patient safety by ensuring that anyone appointed to a consultant psychiatrist role is fully qualified and appropriately trained and 3) Ensure focus on retention and provide equity for people in areas of the country that have historically struggled to attract psychiatrists.

Recruitment and retention

Attracting doctors to work in rural areas is a recognised challenge both globally and within Scotland.[1] Research has also shown that resident doctors are more likely to prioritise being in their desired location for work, over other factors including speciality, reputation of their hospital, and access to research opportunities. [2] There is also evidence to suggest that 27% of psychiatry resident doctors in Scotland would consider leaving Scotland is they were unable to secure a higher training job in their current region of work.[3]

It is therefore paramount to consider innovative incentives to attract resident psychiatry doctors to work in traditionally less popular parts of Scotland. As well as financial incentives, other incentives may include access to run-through training programmes, meaning doctors would be able to stay in their region for 6 years, rather than having to

[1] Valuing place in doctors' decisions to work in remote and rural locations - PMC
[2] Factors influencing recruitment and retention of foundation doctors in geographically unpopular locations - PMC
[3] Psychiatry in Scotland – Trainee perspectives on access to higher training

re-apply for a job between core and higher training. Run through training is currently being piloted for CAMHS and Intellectual Disabilities, two specialities in psychiatry which have traditionally been under-filled at a consultant level across the UK.[4]

Additionally, there is a focus within the medical profession around moving from a specialist model of care towards a more generalist approach, given the rise of multi-morbidity and an ageing population[5]. From a psychiatry perspective, an expansion in the availability of dual training places would allow doctors to gain experience in managing two different cohorts of patients, as well as developing transferrable skills. A recent report has suggested that resident psychiatry doctors in Scotland would be in favour of having more access to dual training opportunities [2]

In psychiatry we not only struggle to attract doctors to work in rural areas - but also large parts of the country which have high levels of socio-economic deprivation. These areas are associated with higher rates of mental illness, high rates of suicide and drug-related deaths. These are exactly the areas where we need the brightest and best psychiatrists to work. Sadly, these are the areas where we most struggle to recruit and retain staff.

It is vital that the approaches we adopt are informed by evidence regarding what works. There is a large body of research involving GPs and primary care, which is applicable to psychiatry (which is also based to a large degree in the community). A systematic review by Varma in 2016 identified the following strategies as being effective:

- using financial incentives based on an obligation of service post qualification (rather than through an initial down payment). Such incentives work, however the longer the period of obligation the more likely the doctor is to be retained
- giving doctors exposure to locations that have been hard to recruit to during their training. We would suggest that hard to recruit areas need to be given disproportionately more trainee time compared to areas that have high recruitment levels
- identifying and incentivising trainee doctors from hard to recruit areas (to return to work where they are from)

As well as these evidence-based interventions, we would recommend that psychiatry posts in hard to recruit areas are rebadged and rebranded in a way that is similar to “deep end practices” in primary care. Such jobs need to be considered jobs of national mission and service. Every effort should be made to turn the negatives associated with working in these areas into a potential selling point. We should use every incentive, in every part of the system to congratulate and reward doctors who train and work as consultants in such areas. Potential measures that could be used include

[4] Run-through training
[5] Generalism for specialists: a medical reformation | The BMJ

- working in such areas is being accepted as evidence for discretionary points awards
- working in such areas is being accepted as evidence for fellowship of the Royal College
- national recognition of working as a “deep end psychiatrist” through letters of recognition and awards ceremonies etc

A major factor impacting the well-being of resident doctors in Scotland are the bottlenecks for entering core psychiatry training, and entering higher psychiatry training; 83.3% of psychiatry resident doctors in Scotland feel that the current availability of Higher Training posts is affecting morale and motivation. [2]

Expansion of training numbers, as well as moving towards whole time equivalent training numbers would be welcomed as a way of both accommodating the growing number of resident doctors who work less than full time and increasing trainee moral. The expansion of training numbers may also increase the retention of psychiatry doctors in Scotland, many of who will have undergone undergraduate and postgraduate training in Scotland, occurring an expense to the tax-payer (if they were to leave Scotland or the medical profession entirely due to being unable to progress in their training, this would represent poor value for money from an economic perspective).

Area 3: The challenges and opportunities of digital innovation

Digital innovation has the potential to transform healthcare delivery, but it must be approached with realism and caution. In all health care, but mental health especially, the therapeutic relationship and continuity of care are foundational. AI and digital tools cannot replace the human connection that underpins effective treatment. Digital aspirations of this project should not consider taking away the real world clinical decision making - particularly in what our members do, which is about often subjectively interpreting thoughts and speech and behaviours. Instead, technology should be used to support clinicians, reduce administrative burden, enhance information available for decision-making, and improve access to care by freeing up clinical time.

With regards to digital innovation, the problem we face is not a lack of ideas, as there is no shortage of innovative solutions being proposed. The real challenge lies in implementation, upscaling, and resourcing. Many promising technologies have failed to materialise in our NHS due to poor planning and investment. Before exploring new innovations, the NHS must first get the basics right: functional IT systems, reliable infrastructure, and universal access to records.

The shift to integrating digital tools into clinical practice over the past 20 years have not delivered the expected efficiency gains and it would be important to learn from this experience as we consider future digital innovations. Most frontline clinicians describe

an increased administrative burden, directly attributable to increased adoption of digital tools, which has come at the expense of clinical capacity and contributed to reduced productivity.

The key learning points which might help anticipate future challenges are:

1. Need for continued and long term investment in digital infrastructure. It is simply not possible to innovate digitally with an increasingly obsolete, outdated and insecure digital infrastructure.
2. Need for national planning and co-ordination in the development of digital tools and innovation. Local innovation and development is always welcome but digital systems are highly interconnected and require coherent long term planning and strategic oversight to avoid the pitfalls of current patchwork of disparate systems that frequently don't communicate with each other. Most clinicians use between 5-7 separate clinical systems in routine clinical practice. Core systems differ across health boards and primary care, secondary care and social care systems do not communicate with each other.
3. Need for strategic planning and guidance in the shift to digital working and to support integration of digital innovations into practice. The experience of the past 20 years has been of transferring legacy, analog processes into digital systems rather than developing processes that are digital native. This frequently leads to duplication and cumbersome levels of bureaucratic burden, reducing productivity.
4. Need for focus on training. There is an urgent need to develop digital literacy among the health and social care workforce to fully realise the potential of current and future digital innovations. Teaching and training in use of digital systems frequently remains an afterthought to professional training. There is an urgent need to integrate teaching on use of digital systems into the medical curriculum and in post-graduate training programmes to ensure that the future workforce are sufficiently prepared for the shift to an AI enabled digital model of healthcare delivery

Despite these challenges, there are several key opportunities that should not be overlooked:

1. AI-enabled transcription

AI-powered transcription tools can dramatically reduce the administrative burden on clinicians. Real-time transcription during consultations allows for immediate documentation, freeing up time for direct patient care. These tools also improve communication between clinicians and services, enhancing patient safety and reducing delays in treatment. Consultant psychiatrists on average spend around 25-30% of their working week on non-clinical, administrative tasks. The potential for productivity and

efficiency gains from a rapid roll out of these existing tools is significant and especially at a time of workforce shortages.

2. AI tools for clinical support

Digital tools can support history-taking, data analysis, and medication management. For example, apps that provide drug interaction information or digital prescribing platforms have already transformed practice. These tools do not replace clinical judgement, rather they enhance it, allowing clinicians to make informed decisions more efficiently.

3. Expanding access to consultant care

Digital platforms can increase access to specialist care without requiring face-to-face appointments. This is particularly valuable in remote and rural areas, where access to consultants is limited. App-based therapies, supported digital therapies, and virtual treatments are examples of how technology can extend the reach of services while maintaining clinical oversight.

4. Promoting health autonomy

Giving patients access to their own records may empower them to take greater ownership of their health. This autonomy could facilitate continuity of care across services and support informed decision-making. While digital exclusion must be addressed, it should not be a reason to limit innovation. The goal should be to raise standards and bring everyone along, not to lower expectations.

Overall remarks from RCPsychiS

Our members' role in society is complex, irreplaceable, and central to the delivery of safe, ethical, and effective mental health care. The current challenges facing our workforce must be addressed with urgency and transparency.

Digital innovation offers powerful tools to support clinicians, but must be implemented thoughtfully and resourced adequately.

This consultation is a welcomed opportunity to articulate a clear vision for the future our of medical workforce, one that values clinical expertise, invests in people, and embraces technology as a means to enhance, not replace, human care. We welcome the opportunity to address the workforce crisis currently being faced in psychiatry.