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The 'Catch-22' of recruitment and retention in psychiatry

As the Medical Director and Deputy Medical Director of the Avon and Wiltshire Mental Health Partnership Trust, we are responsible for the recruitment and development of a large number of medical staff. We are also extensively involved in trying to develop new services in line with the two National Service Frameworks (NSFs), and other central and local directives. Discussion with colleagues elsewhere suggests that we are not alone in experiencing a number of problems, including being hampered by the financial position of our commissioners and the lack of structural protection for mental health funding. However, the task is also made more difficult by the conflicting local and central imperatives from the Royal College of Psychiatrists and the Department of Health. The current problems facing our Trust are outlined as an illustration of the more generally experienced difficulties. Some possible solutions are proposed.

The Avon and Wiltshire Mental Health Partnership Trust is a specialist Mental Health Trust formed in 2001 that covers the whole of Avon and Wiltshire, an attractive and generally prosperous part of the country. The Trust has some excellent services, hard-working clinicians, a committed senior management team and two stars. However, it also has a growing number of consultant vacancies and we are forecasting 15–20 in 2003. Some are the result of new posts being created from NSF-funded development, but sadly an increasing number result from existing consultants being attracted to posts with smaller patches and more resources elsewhere. Filling every vacancy has become a time-consuming struggle, with the most evident immediate problem being that of increasing numbers of locum staff (particularly agency locum staff) with attendant serious clinical governance and financial consequences. In addition, commissioners become impatient with a perceived inability to recruit, and we have had a recent suggestion that funding be transferred from a newly created consultant post for specialist drug and alcohol services to fund general practitioner sessions after the failure of the first advert.

Despite the best efforts of our local Royal College advisors, we are encountering a number of serious problems in the application of Royal College rules for the approval of posts at consultant and junior level. For example, approval for posts can be linked to population size, irrespective of morbidity, with little flexibility in the medical support deemed necessary, but less attention paid to the multi-disciplinary team or service support provided, which may compensate. Rules that have been developed for the best of reasons, to try to limit workload, are insufficiently attuned to new ways of working and in a new commissioning environment sometimes have the opposite of their desired effect.

To achieve posts that merit Royal College approval, the majority of new monies have to go into medical posts, to the detriment of other developments. Why is this when Policy Implementation Guides are clear that new services have to be multi-disciplinary? Our repeated experience is that the available monies for new developments are severely limited, and commissioners across all our Primary Care Trust areas are clear that they can either fund extra consultant posts or other developments, but not both. Whenever a consultant leaves, we have to create at least two posts to achieve approval. The asynchronous development of medical staff at the expense of multi-disciplinary services not only cuts across all the modernising work that we are trying to achieve, but also leaves consultant staff with insufficient support. In some cases, to increase medical staff we have had to cut other services, with the paradoxical effect that an increase in medical human resources has not reduced workload. Partner agencies and other professions complain of feeling 'held to ransom' by an approval process that takes no account of the need to expand and develop other professions and services. This can damage our credibility as a specialist mental health provider in the eyes of our commissioners, partner agencies and colleagues. The exposure of the divisions in the profession as a whole over the proposed new contract has only added to these problems.

The interrelated problems with recruiting junior medical staff are also widespread. As we try to secure new junior posts to support consultant expansion, the Deaneries tell us that the current national ceiling on senior house officer (SHO) numbers is not likely to be raised and that, even when it has been in the past, the lion's share of the increase has gone to specialities other than mental health. The Trust covers a very wide mixed urban and rural area with a number of in-patient sites, and we will no longer be able to provide 'on site' on-call

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SHOs for some in-patient areas from April 2004 if we are to comply with the European Working Time Directive and Système d'Information pour les Marchés Publics (SIMAP) ruling.

There is also a constant pressure from the College to create specialist posts at the expense of general adult and older adult posts. It has been suggested that we backfill the latter with staff grades when there are neither the funds nor the staff to do this – to us it seems irresponsible or at least disingenuous to propose new staff-grade positions when we know that they are becoming so difficult, if not impossible, to recruit to.

However, the single most worrying acute change is the growth in the use of the agency locum. The National Health Service is paying millions of pounds every year to agencies. There is little incentive for these doctors to move into substantive posts when they 'can earn twice the money for half the responsibility'. Locum consultant staff earn well in excess of £60 per hour and have a guaranteed on-call commitment, so they will be earning well in excess of £150 000 p.a. Although many locum staff are excellent, poor performance is disproportionately represented in this group. Grossly overspent medical budgets drain other resources and curtail development possibilities and, as we lurch from one medical human resources crisis to the next, committed staff in substantive posts become very demoralised. Our research has shown that our vacancy rate is average compared with that of other mental health trusts, so there must be many others facing the same problems.

Recruitment nationally is difficult for many reasons, including the perceived workload, the increasing emphasis on containing clinical risk with insufficient resources and the presence of tempting alternative opportunities. There are more imaginative ways of making posts more attractive than simply offering an increased salary including introducing academic sessions, sabbaticals, flexible working and different roles. We are actively exploring new roles and the limits of responsibilities for psychiatrists working with teams (Kennedy & Griffiths, 2000).

Nationally, the Royal College of Psychiatrists is concerned about the shortage of psychiatrists and is revising its document on the roles and responsibilities of a psychiatrist (Royal College of Psychiatrists, 2001*a*). In addition, the College is developing ways of attracting more medical students and SHOs into the speciality. The Department of Health has a keen interest in these problems and in developing new ways of working for consultants that both help to attract them to the profession and utilise their specific skills in the most effective way. The National Institute for Mental Health for England (NIMHE) funded two national conferences on the issues recently and we have actively collaborated in these. The conferences were oversubscribed and stimulated a great deal of energetic debate. The presentations from the conferences are available on the British Medical Association website (http://www.bma.org.uk/events), and the NIMHE website (http://www.nimhe.org.uk) will host a discussion forum for developing new ways of working for consultants in the near future. The College and the Department of Health are working together with the different professions within mental health to consider how to develop new ways of working across teams, and how extending current roles for some non-medical professions might be achieved.

Within our Trust, work is also under way: a project to profile medical and team case-loads and analyse activity will help to define team and individual capacity and inform work on changing roles. Several teams are actively exploring extending the role of nurse practitioners. Work is being coordinated across the Trust to develop more robust 'entry and exit' criteria for secondary services. We have developed a framework based on assessment of risk, level of functioning and the benefits of the available interventions that can be adapted to suit all types of team and age ranges. It is clear that the only way to support improved case-load management and enhance capacity is by managing demand, using consistent criteria for access and discharge, with close partnership working with the health and social care community at all stages. We are working with the Department of Health to set up pilot sites in two localities to explore actively new ways of working across the primary and secondary care interface and the community/in-patient interface. Other teams within the Trust have developed primary care mental health provision.

However, the further work that needs to be done by the College and the Department of Health to support initiatives such as these must be undertaken as a matter of urgency, and must involve clinicians themselves and not just representatives from College committees, the British Medical Association, General Medical Council, etc. If general practitioners accept their new contract, we risk losing more trainees to general practice, and if consultants 'work to contract' as the British Medical Association is suggesting, clinical involvement in service development will be one of the first casualties.

We require a much more flexible approach to job approval, and model job descriptions (Royal College of Psychiatrists, 2001*b*) that recognises the increasing workload of medical staff and offers realistic ways of decreasing this, taking into account the financial and recruitment difficulties faced by many, if not most, Trusts. Job opportunities should include consultant posts with very limited junior medical support but with good multidisciplinary team support. The need for an incremental approach to consultant expansion should be recognised within the approval framework. It would be helpful if the College could develop an approach to organisations striving to deal with their local problems by developing different roles for psychiatrists reflecting local circumstances, which is flexible, facilitative and encourages sharing of innovation. The College could seek to develop more sophisticated models for trying to limit consultant workload than population size, and gain more clarity as to the capacity of consultants for direct clinical work based on a clearer understanding of all the other demands on their time.

It is to be hoped that the Department of Health really is considering lifting the embargo on expansion of SHO posts that a shortage speciality finds so

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incomprehensible. The College should review the impact of the move away from general adult and older adult SHO posts into specialist slots, and consider ways to remedy the difficulties that this causes. We know from research carried out on behalf of the College that the decision to pursue a career in psychiatry is often made at SHO rather than undergraduate level (Brockington & Mumford, 2002). It is therefore vital that we secure SHO expansion, attract SHOs into general adult psychiatry in particular, and ensure that the medical students and SHOs that we are teaching have role models who are not exhausted or demoralised. The Department of Health and the College should examine alternatives to staff-grade posts, which are becoming impossible to recruit into. The anticipated easing of the requirements for gaining the certificate of completion of specialist training (CCST) will also be welcome. Central and local initiatives in flexible working are beginning to help.

Agency locums continue to be professionally less regulated than the permanent workforce, representing a potential risk to users and Trusts. Better regulation requires a national approach because individual Trusts cannot enforce this process. It should include more stringent criteria for continuing professional development for locums, but the cost for this should be borne by the individuals and not their host trusts. Care needs to be taken, however, that the proposal to require locums to have the CCST does not just offer further financial inducements to specialist registrars to become locums rather than permanent consultants, and drive locum costs up even further.

More generally, although recognising the work that the College has done over many years, we would argue that the role of psychiatry in the wider health community could be improved further. This requires improved integration of the development of psychiatry as a profession with the development of mental health and social care as a whole. Psychiatry and the Royal College that represents it must uphold excellence in practice and high professional standards, but must do so visibly, credibly and realistically within the wider mental health community. It requires support from the Department of Health to achieve this.

Mental health would benefit from a higher profile within Workforce Development Confederations and within Strategic Health Authorities. With the disappearance of 'earmarking' of mental health funds and the concentration by government, Strategic Health Authorities and therefore Primary Care Trusts on targets relating to the acute sector, the institutional stigmatisation of mental health services continues. Despite the gains that have been made in raising the profile through the NSFs over the past few years, we have still not managed to change the language, or the hegemony, of waiting lists, trolley waits and time to first consultant appointment. Despite being told that mental health is an equal priority (Department of Health, 2003), it is clear on a daily basis that some priorities are more equal than others. Instead of being enabled to achieve 'earned autonomy', we see our promised investment diverted while we are faced with demands for an increasing focus on risk and control, as exemplified by the draft Mental Health Bill. We cannot provide a 21st century service with 20th century funding, or achieve service delivery and quality targets while investment targets are continually reneged upon.

We are as fully committed to improving the working lives of the medical staff in our organisation as we are to improving the quality of care for patients. We need robust, deliverable medical workforce plans and a multidisciplinary commitment to developing new ways of working. We need the College and the Department of Health to facilitate and support our efforts, to recognise the urgency of the situation that faces us and the potential consequences for the profession, the service and the patients if the current customs and practices continue unchanged.

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