Scottish Borders Health and Social Care Partnership
Integration Joint Board
24 January 2024

Mental Health and Learning Disabilities Medical Workforce sustainability

Report by Simon Burt and Dr Amanda Cotton

Scottish Borders
Health and Social Care
PARTNERSHIP

1. PURPOSE AND SUMMARY

1.1. To appraise the Integration Joint Board regarding the Mental Health Boards medical workforce recruitment challenges and mitigating actions. These actions were agreed by the NHS Borders Board on 7th December 2023, to inform financial planning and the associated payment offer to the Integration Joint Board.

1.2. The senior medical workforce landscape is characterised by acute-on-chronic deficits and frequent, often rapidly emerging, changes. In addition to impacts on clinical governance and service safety, this has limited strategic planning and led to recurrent overspends in filling gaps using agency. This plan assumes the senior workforce situation is unlikely to improve quickly and will require initial investment to realise later clinical and financial stability.

2. RECOMMENDATIONS

2.1. **The Scottish Borders Health and Social Care Integration Joint Board (IJB) is asked to:-**

a) Note this report

3. ALIGNMENT TO STRATEGIC OBJECTIVES AND WAYS OF WORKING

3.1. It is expected that the proposal will impact on the Health and Social Care Strategic Framework Objectives and Ways of Working below:

Alignment to our strategic objectives					
Rising to the workforce challenge	Improving access	Focusing on early intervention and prevention	Supporting unpaid carers by getting services for the cared for right	Improving our effectiveness and efficiency	Reducing poverty and inequalities
x	x			x	

Alignment to our ways of working					
People at the heart of everything we do	Good agile teamwork and ways of working – Team Borders approach	Delivering quality, sustainable, seamless services	Dignity and respect	Care and compassion	Inclusive co-productive and fair with openness, honesty and responsibility
x	x	x	x	x	

4. INTEGRATION JOINT BOARD DIRECTION

4.1. A Direction is not required

5. BACKGROUND

5.1. The Associate Medical Director, Dr Amanda Cotton, and General Manager, Simon Burt, took a paper to the NHS Borders Board on 7th December 2023 setting out the medical workforce challenges and proposed mitigating actions which were approved by the Board.

5.2. The main elements of that paper are set out below to appraise the IJB of the background, assessment and mitigating actions taken.

5.3. The paper focusses on areas of particular instability and current and anticipated funding gaps which represent financial and clinical risk to the organisation. Associated recommendations seek to minimise clinical risk, with the aim of ensuring continuity of service and to allow NHS Borders to plan according to the financial implications.

6. ASSESSMENT AND MITGATING ACTIONS

6.1. The medical staffing to the Mental Health and Learning Disability clinical boards is highly internally interconnected and interdependent with the wider multidisciplinary context. There is no 'neat' way to divide and analyse the situation; the paper attempts to do so in a high-level manner with the caveat that not all clinical and financial consequences can be fully anticipated or described. Each subspecialty area is discussed, with more in-depth analysis where needed. The senior and junior out-of-hours cover is discussed. Cover to the inpatient units is discussed as part of the foundational structure supporting senior functioning. Medical skill mix is referenced at appropriate junctures.

6.2. The tables below set out the current substantive medical staffing in post, locums in post and the net balance against establishment. In particular this highlights that of the Consultant establishment we only have 9.05 in post against an establishment of 15.8. Even with locums we are running 3.75 staff short of the establishment.

Table 1: MHLDS ConsultantMedicalStaffing

Team	Cons establishment (wte)	Substantive consultant in post from August 2023	Locum	Balance/notes
AdultSouth	1.25	0.25	-	-1.0
AdultEast	1.2	0	1.4	0.2*
AdultWest	1.7	1.0	-	-0.7
Rehab	1.5	1.4	-	-
MHOAS	3.2	0.9	1.0	-1.3
CAMHS	3.6	2.1	0.6	-0.9
LD	1.0	1.0	-	-
Liaison	0.7	1.0	-	No recurrent funding stream for 3 sessions
BAS	1.0	1.0	-	Consultant expected to resign late 2023

Forensic	0.3	- (included in LD wte)	0.1	0.2 provided by LD cons without forensic CCT
Perinatal	0.25	0.25	-	
Inpatient	Included in relevant est			See recommendation re Physician Associates
BCT	Included in adult est			
ECT	0.05	0.05	-	Cross cover from those with competencies
Adult NDD	0.2	0.2		NAIT funding
Ed sup	0.05	0	-	-0.05
Total	**15.8**	**9.05**	**3.1**	**-3.75**

*1.0 agency locum on 3-month contract; 0.4 senior consultant on 1 year contract

Table 2: Senior Medical General Out-Of-Hours Rota Staffing

On-call	8	5.5	-	-2.5

Table 3: 'Junior'Medical Out-Of-Hours Rota Staffing (minimum 9 wte) and Funding

	WTE on rota	Funding stream	Funding balance/gap
Adult GPST	3	NES	-
Adult CT	1	NES when doctor in post	Up to 1.0 wte
MHOAS CT	1	NES	-
MHOAS FY2	1	NES	-
LD CT	1	NES	-
CAMHS CDF	1	Currently part-funded by senior time	1.0wte
BAS	1	NES when doctor in post	Up to 1.0 wte
Rehab CDF	1	MH Medical budget	-
Total (assuming all full time)	**10**		**+1 to -2.0**

Junior/foundational support

Junior out of hours rota

6.3. Less-than-full-time (LTFT) working is now normal, rather than exceptional, for junior doctors. It will be seen later that expansion and future development of the 'middle-grade' doctor, taking advantage of the new Specialty Doctor (SD) contract, is recommended to build resilience into the medical staffing model and grow our own doctors to eligibility for the new Specialist Doctor role. That will necessitate a clearer distinction between the roles of the junior and middle-grade staff. The first recommendation therefore is to assume a headcount of 10 junior doctors will be required to staff the minimum 9 wte first-on-call rota.

6.4. As has been noted, there is established funding for 7 wte junior doctors. When Core Trainees (CTs) are allocated in the Borders Addictions Service (6-month tenancy) and in General Adult Psychiatry (GAP; 1 year tenancy, trial to commence August 2023) the funding will follow; it will not be allocated by NES if there is no trainee. Funding of the Clinical Development Fellow (CDF) input to CAMHS and contribution to the 'junior' out-of-hours rota is currently dependent on the medical staffing model including a junior doctor role; this is a 1-year trial but is recommended to become part of the establishment at a cost of £95,000. It is further recommended that 2 further doctors are recruited to fill gaps in the event there is no BAS or GAP CT. It is felt reasonable to assume that, in this worst-case scenario, less-than-full-time working across the group will offset this overspend by 1 wte.

6.5. The estimated maximum overspends (which is unlikely to be fully realised) is therefore £190,000. The 'best guess' is with LTFT working and NES funded doctors is that over 1-year extra costs are unlikely to exceed £95,000**.**

6.6. It is not possible to quantify overspends associated with NHS and agency locum fees for doctors filling gaps in the first-on-call rota. The above is therefore likely to be an overestimation of additional costs to the organisation of a resilient model.

Inpatients

6.7. Continual cover to the inpatient units is expected; demand to medical staff associated with this has steadily increased over time. In combination with the complexity and changes associated with the junior on-call rota, this has resulted in a significant organisational burden and affected the trainee experience. Calls frequently come from the adult inpatient unit directly to the consultant psychiatrist leading to stress and undermines our efforts to utilise consultant time where it adds most value. As part of prior papers, recommendations have been made to employ 3 permanent Physician Associates, one to cover each of the specialty inpatient areas. Funding for those was only been partially identified. 2 PAs were secured through interview: one is now in post in MHOAS and another was due to start in East Brig in November 2023 but has since withdrawn. A CDF has been employed for one year to cover Huntlyburn; the start date of 2nd August 2023 was delayed. Due to the required expansion of junior time to fill the out-of-hours rota, cover to the inpatient units should become more robust. A PA would not be able to fulfil the range of duties needed in the out-of-hours setting. The current PA is supporting the current situation of depleted staffing in MHOAS however will not negate the need for the more robust medical cover outlined below. Once we move to that strategic stability position, the PA support may not be crucial to the sustainability of medical/support staffing.

6.8. The current cost pressure relating to 1 PA in MHOAS: £57,500. In the event the PA leaves post, the need for replacement will be carefully considered, potentially saving that cost pressure. In the future event there is no GAP CT, it is recommended that a CDF is employed to cover Huntlyburn and contributes to the 'junior' out-of-hours rota.

<u>Senior Staffing by Service Area</u>

LDS

6.9. This service is currently stable in terms of medical staffing though medical staff signal three issues: firstly they are managing Forensic LD cases with specific dedicated time but no specialist Forensic Psychiatry input (clinical and reputational risk); secondly there has been no recognition over time of the added expectation and demand of their time consequent to clinical, legal and other developments and, thirdly, the impact of the 'Coming Home' project. The 'Coming Home' project is a plan to bring home patients with the most complex needs associated with their Learning Disability currently residing in units across the UK. It is likely to require an additional session of medical time to allow these most complex patients to access timely senior medical opinion. This will be considered as part of that project

Rehabilitation Service

6.10. There is senior staffing resilience in the Rehabilitation Service after a prolonged period of deficit. Within that funding envelope however, time is being dedicated to the adult Neurodevelopmental agenda; an overall reduction in senior sessions is anticipated**.**

Table 4: Rehab Medical Staffing plan

	Consultant	Specialty	Specialty	Total (£)	Balance (£)

		Registrar/CDF	Doctor		
Establishment	1.5	1.0	0	335,000	-
Aug 23 – Feb 24	1.4*	1.0	0		
	£ 224,000	£95,000	-	319,000	16, 000
Future Scenario A	1.4	Up to 1.0	0		
	£224,000	£95,000	-	319, 000	16, 000
Future Scenario B^	0.9	Up to 1.0	0.8		
	£144,000	£95,000	£96,000	335,000	0

*NAIT funding included in adult

Liaison Service

6.11. This team has been historically underfunded and is in early stages of development. Despite efforts on behalf of the Mental Health Clinical Board, the funding of the senior post is insecure. A total of 7 sessions are recurrently funded by MH. 3 are funded on an 'ad hoc' and non-recurrent basis for example through past Action 15 funding underspends and currently the promise of funding via Unscheduled Care developments. It is very clear that 10 sessions are required to attract and retain consultant psychiatry in post and the organisation is obligated to either value and fund the service or accept the risk the current incumbent will not be retained due to continual shifting of priorities according to short-term funding streams rather than clinical priorities. The MH service may also seek to utilise that resource to fill urgent gaps within core MH services when needed. That latter situation, whilst a last resort, may prove to be necessary and represents a further risk to the sustainability of the post for the incumbent.

6.12. The strong recommendation is therefore that the wider organisation funds the remaining 3 sessions at a cost of £48,000 in order to ring-fence this role and contribute to a robust foundational structure of consultant psychiatry.

Borders Addiction Service

6.13. The substantive consultant psychiatrist in BAS intends to move to Western Australia early next year and is therefore due to resign from post imminently. He may be in a position to remain as NHS locum (cost neutral) for a further interim period. We are currently in talks with a senior trainee who may apply for the post and could take that up from between April and August 2024. It is unlikely she will undertake senior on-call duties; however, this is a further risk to the continuity of the senior rota which his already under threat. Assuming no other interest in the post, the best case scenario is that we face up to 7 months of no psychiatrist or agency medical cover. It should be borne in mind that there will be no BAS CT from February 2024 due to the anticipated gap in senior cover. The service is also supported by a GP with a Special Interest who has recently resigned. Further planning is underway to mitigate clinical risk and estimate financial risk.

Mental Health of Older Adults Service

6.14. The Scottish Borders has a large and predicted to increase elderly population. Social and support services are stretched and those with higher-level needs are at greater risk of requiring medical care due to both complex comorbidity and local resource issues. Developments aimed at caring for older people at home often require senior clinical support to support quality and sustainability. NHS Borders closed 14 acute dementia care beds in 2019. Two additional consultant sessions were provided to support the newly developed clinical team overseeing care homes. The remaining beds for older adults with acute and complex 'functional' psychiatric illness or dementia, totalling 18, are routinely 100%+ occupied, placing further demand on community services led by and dependent upon consultants. The range of consultant sessions

represents total funding rather than ideal staffing models; in reality consultants have regularly and at short notice shifted areas of responsibility, models of medical staffing and care arrangements to adapt to a changing resource landscape. Continuous disruption to service continuity and job planning was instrumental in a substantive colleague leaving post in 2023.

6.15. There is currently an agency locum without CCT providing support to the service. Our plan includes a direct employment arrangement to reduce costs of his employment to the organisation and to support towards CCT (consultant credential) equivalent as a further governance assurance step. A minimum 'floor' of senior time is needed to supervise non-consultant doctors and to serve the senior functioning of the service overall; currently we are below this minimum. For one year there will be a LTFT senior trainee, providing a degree of support but requiring senior supervision. The plan is to advertise for a new Specialist Doctor to secure a more immediately resilient model, allowing us to 'grow' current SD doctors to eligibility for application for the Specialist grade. Both scenarios are represented below.

Table 5: MHOAS Medical Staffing Plan

	Cons	SD	Specialist Doctor	Total (£)	Balance (£)
Establishment	3.2	0	0	512,000	-
Contingency Plan A (development)	1.8	1.8	1.0		
	£288,000	£216,000	£127,000	631,000	(119,000)
Contingency Plan B (stability)	1.8	Up to 1.0	1.0		
	£288,000	£120,000	£127,000	535,000	(23,000)

CAMHS

6.16. The Child and Adolescent Mental Health Service is under extreme pressure with extensive waits for initial assessment, and a growing number waiting a significant amount of time post-assessment for clinical intervention. Despite an increase in staffing secondary to government funding (Recovery and Renewal), the wider MDT staffing situation has recently been affected by maternity, other leave and resignations. Pressure to address the waits, increased referral rates and greater efficiency in some pathways has led to a higher level of clinical need being addressed within the teams. The recent loss of a 0.9 WTE consultant psychiatrist, and no suitable replacement, has focussed this increased responsibility on the fewer senior doctors. A model of added junior time is being trialled and, as with other services, additional support to consultants to maximise use of their time is sought. Despite this, pressure on the senior doctors is unsustainable and their clear recommendation is to replace the lost consultant time. It is recommended therefore that we immediately advertise for a Specialist Doctor and that we move towards an over-established permanent SD complement in order to 'grow' towards that senior role if we are unsuccessful. As noted above, it is recommended the SR/CDF post become permanent in order to support the 'junior' on-call rota and provide at least some support meanwhile to senior doctors

Table 7: CAMHS Medical Staffing Plan

	Cons	AS	Specialist Doctor	SR/CDF	SD	Total (£)	Balance (£)
Establishment	3.6	0.6	0	0	0	657,000	-
To Aug 24	2.9*	0.6	0	1.0	0.8		
	£464,000	£81,000	0	£95,000	£96,000	736,000	(79,000)
Contingency Plan A	2.7	0.6	1.0	1.0	0		
	£432,000	£81,000	£127,000	^	-	640,000	17,000
Contingency Plan B	2.7	0.6	0	1.0	Up to 1.6		
	£432,000	£81,000	-	^	£192,000	£705,000	(48,000)

*2 additional sessions funded through R&R underspends; 1 for additional leadership responsibilities and 1 for NDD pathway backlog

^The SR/CDF cost is counted in the junior establishment, see table 2

General Adult Psychiatry

6.17. The establishment of the 3 adult teams is 1.7 wte consultants each. In the South and East catchment this has translated to 1.2 wte consultants and support from Specialty Registrar or Specialty Doctor time, up to 1.0 wte. The adult consultants support Borders Crisis Team and have historically contributed proportionately the most to the second-on-call rota. With regard to BCT, specific and dedicated senior medical leadership is requested. The medical Personality Disorder lead, a 0.5 wte Specialty Doctor, is not included in the below table.

6.18. In order to move towards sustainability, it is recommended that there are SD doctors in each of the 3 teams, being actively developed and supported towards the new Specialist Doctor grade or though CESR to consultant level. In this way we will 'grow our own' capable and autonomous doctors who can actively contribute to the effective use of resource in our services, support the consultants to undertake the consultative role (including consideration of senior support to BCT) and provide a degree of stability and continuity if senior staff move on. The SD role will be undertaken by doctors at different developmental stages. It has been mentioned that a certain critical mass of consultant doctors is needed to deliver leadership across clinical and other areas. It is recommended therefore that the minimum number of consultants is 1.0 wte per adult team plus 4.0 Specialty Doctors or vice versa: 4 consultants (including the potential for a Specialist Doctor) and 3 SDs.

6.19. For simplicity, the complex temporary and subspecialty cover arrangements are not covered below. The middle grade and senior staffing across the 3 teams has been combined.

Table 8: GAP Medical Staffing Plan

	Cons	SD	Specialist Doctor	Total (£)	Balance (£)
Establishment	4.1	2.0	0	896,000	-
Contingency Plan A	3.0	3.0	1.0		
	£480,000	£360,000	£127,000	967,000	(71,000)*
Contingency Plan B	3.0	4.0	0		
	£480,000	£480,000	-	960,000	(64,000)
(Plan C)	4.0	3.0	0		
	£640,000	£360,000	-	1,000,000	(104,000)

*In the summary table, the Specialist Doctor option is costed as 'best guess' as we aim to grow SDs

Senior Out of hours rota

6.20. In the above plans, the senior out-of-hours rota remains in a precarious state; these shifts are falling to fewer doctors to fulfil, albeit at an enhanced rate, and without recognition they contribute to exhaustion over time. It is recommended time off is added to locum shifts offered to substantive colleagues to ensure they are sustainable however impact on daytime activity (and cross-cover arrangements) must be considered

Retention

6.21. There has been a recent exodus of experienced substantive consultant psychiatrists from NHS Borders Mental Health Services. As explained within that, many pressures on the profession are national and out with the direct control of NHS Borders. That being said, the issue facing NHS Borders prior to that was one of retention of existing staff. Recruitment to the service (with one exception: MHOAS) had been successful, albeit achieved through a targeted and individualised approach to identifying and attracting senior staff. We need to learn from experience and use all levers locally available to support substantive doctors in our employment and address their concerns. The final recommendation therefore is that NHS Borders Mental Health Service focus on retention of its residual medical workforce and, as an urgent measure, provide dedicated administrative support to all senior medical staff

Summary

6.22. The current medical staffing situation is precarious. Further recommendations may result from work looking to retain senior staff and should be prioritised. Foundational support to senior doctors is required including adequate administrative support, robust cover to the 'junior' on-call rota and cover to the inpatient units. Almost half of additional costs in the 'worst case' position arise from the need for full cover to the first-on-call out-of-hours rota and does not meaningfully address the deficits in senior cover. The Liaison Psychiatry sessions represent a longstanding deficit but are added for completeness. Strategically, £57,500 for PA support may not be required in the long-term. Substantive senior doctors should be fully supported to fulfil added responsibilities falling to them to maintain core services and to ensure their leadership is contribution is actively facilitated.

6.23. Growth of the 'middle' grade is underway. These doctors can also be developed to include certain service-level leadership roles however this requires initial structural support which will rely on the consultants. This could be assisted by Specialist Doctors, and advert for those is recommended; in the interim agency consultant will be needed.

6.24. Table 9 below sets out a summary of the recommendations discussed within this paper. As can be seen we have 3 scenarios with our best guess cost to establish stability within the workforce and provide a more cost-effective staffing model than at present. The best guess scenario will require additional investment of £262k pa which will provide a reduction in the recurring cost pressure of £266k pa.

Table 9: Summary of Recommendations With Cost Implications

Recommendation number/type		Cost difference from current (Best Case)	Cost difference from current (Worst Case)	Best guess stability position
Junior				
1 & 2	SR/CDF	(95,000)	(190,000)	(95,000)
3	PA	0	(57,500)	0
Subtotal Junior		**(95,000)**	**(247,500)**	**(95,000)**
Senior				
-	Rehab cons session	16,000	0	16,000
4	Liaison cons sessions	(48,000)	(48,000)	(48,000)
5	MHOAS	(23,000)	(119,000)	(23,000)
6	CAMHS	17,000	(48,000)	(48,000)
7	GAP	(64,000)	(71,000)	(64,000)
Subtotal senior		**(102,000)**	**(270,000)**	**(167,000)**
Total Recommendation		**(197,000)**	**(533,500)**	**(262,000)**
***2021 medical staffing overspend**		**(528,168)**	**(528,168)**	**(528,168)**
Difference – Rec. vs 2021 overspend		**331,168**	**(5,332)**	**266,168**

*2021 chosen as 2022 was a year of comfortable substantive senior staffing that is no longer achievable in the current climate

7. IMPACTS

Community Health and Wellbeing Outcomes

7.1. It is expected that the proposal will impact on the National Health and Wellbeing Outcomes below:

N	Outcome description	Increase / Decrease / No impact
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	Increase
2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	Increase
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	Increase
4	Health and social care services are centred on helping to maintain or improve the	Increase

	quality of life of people who use those services.	
5	Health and social care services contribute to reducing health inequalities.	Increase
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	
7	People who use health and social care services are safe from harm.	Increase
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Increase
9	Resources are used effectively and efficiently in the provision of health and social care services.	Increase

Financial impacts

7.2. As set out within table 9 above (para 6.24), this medical staffing plan relies upon a best-case scenario additional investment of £262k pa. It should be noted that this could fluctuate between a range of £197k and £533k pa. The best-case scenario investment of £262k pa will reduce the average cost pressures of £528k pa by £266k pa

Equality, Human Rights and Fairer Scotland Duty

7.3. A stage 1 Integrated Impact Assessment was undertaken and is attached in the Appendix. As this relates to our approach to staffing to ensure service sustainability and affordability rather than a plan for change, it was deemed that a stage 2 Integrated Impact Assessment is not required.

Legislative considerations

7.4. This paper provides a medical workforce sufficient to meet the requirements set out within the Mental Health Act legislation.

Climate Change and Sustainability

7.5. None

Risk and Mitigations

7.6. The risks related to this workforce plan are largely centred around our ability to recruit to it. Mitigations within the plan include the range of options we have set out in the individual contingency plans whereby we have a range of grades to recruit to.

7.7. This workforce plan provides options to mitigate against the difficult medical workforce recruitment environment being faced by all Health Boards and across Health services within the UK.

7.8. This plan looks to reduce the financial cost pressures associated with the current level of agency spend.

8. CONSULTATION

Communities consulted

8.1. Not applicable

Integration Joint Board Officers consulted

8.2. IJB Chief Officer

8.3. In addition, consultation has occurred with our statutory operational partners at the:

- NHS Borders Board

Approved by:

Chris Myers, Chief Officer

Author(s)

Dr Amanda Cotton, Associate Medical Director
Simon Burt, General Manager

Background Papers: n/a

Previous Minute Reference: n/a

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