NDTP

National Doctors Training & Planning

Medical Workforce Planning for the

Specialty of Psychiatry

2020-2030

An Expert Stakeholder Informed Review

March 2021

"Investing in the career development of doctors"

Authors:

National Doctors Training and Planning and

HSE Mental Health, including Clinical Programmes and Human Resources

Expert contributions from the College of Psychiatrists of Ireland; HSE National HR; Department of Health

Published by:

National Doctors Training & Planning

Health Service Executive

Dublin

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HSE – National Doctors Training & Planning 2020

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Contents

Executive Summary **01**

1. Introduction to Medical Workforce Planning **03**

1.1 Background to Medical Workforce Planning within NDTP 03

1.2 Data Used and Limitations 04

2. The Configuration of Psychiatry within the Irish Health Service **05**

2.1 Introduction 05

2.2 Psychiatry Service Delivery 05

2.3 National Clinical Programmes for Mental Health 06

2.4 Mental Health Strategic Portfolio and Programme Management Office 07

3. Number of doctors working in Psychiatry **08**

3.1 Introduction 08

3.2 The Number of Specialists in Psychiatry Working in the Irish Healthcare System 08

3.2.1 Number of Doctors on the Specialist Register Practicing in Psychiatry 08

3.3 Participation of Consultants/Specialists in Psychiatry in the Medical Workforce in Ireland 09

3.4 Participation of Non Consultant Hospital Doctors Working in Psychiatry in the Irish Healthcare System 11

3.4.1 Training Posts Higher Specialist Training in Psychiatry 11

3.4.2 Length of Training programme 12

3.4.3 Number of Trainees in HST and BST Training Programmes 13

3.4.4 NCHDs Not in Training Posts 14

3.5 Summary of Current Configuration of Psychiatry Specialist Workforce 2020 14

4. International Comparisons **16**

5. Key Drivers of Change to the Future of the Consultant Psychiatry Workforce **17**

Driver 1: Current Unmet Demand for Psychiatrists in Ireland 17

Unfilled Consultant Posts 17

Waiting Lists 17

Driver 2: Service Configuration and Government Policy 18

Sharing the Vision 18

Driver 3: Demographic and Epidemiological Change 19

Driver 4: Technology 20

Driver 5: Legislation 21

6. Future Demand for Consultant Psychiatrists in Ireland **22**

7. Analysis of the Gap between the Current and Future Supply and Demand for Consultant Psychiatrists in Ireland **24**

7.1 Modelling Process and Assumptions 24

7.2 Implications of gap analysis on training 25

8. Conclusion **27**

9. References **28**

List of Tables

Table 3.1: Specialist Registered Doctors Actively Practicing in Psychiatry in 2017 (IMC, 2018) 08

Table 3.2: Country of Basic Medical Qualifications for those on the Specialist Register Actively Working in Psychiatry in Ireland (IMC, 2018) 09

Table 3.3: WTE Contribution of Consultant Psychiatrists (HSPC, 2020; IMC, 2018; HSE NDTP, 2020) 09

Table 3.4: Vacancy Rates within the Consultant Psychiatry Workforce by CHO 10

Table 3.5: Gender Breakdown Consultant Psychiatrists as at April 2020 (HSE Census, 2020) 10

Table 3.6: Working Patterns Consultant Psychiatrists as at April 2020 (HSE Census, 2020) 10

Table 3.7: Contract Type Consultant Psychiatrists as at April 2020 (HSE Census, 2020) 11

Table 3.8: NCHDs Practicing in Psychiatry in the Previous 12 Months by Division of the Medical Councils Register (IMC, 2018) 11

Table 3.9: Psychiatry Trainees in Basic-Speciality Training per Year of training (July, 2020) 13

Table 3.10: Psychiatry Trainees in Higher Specialist Training per Year of training (July, 2020) 13

Table 3.11: Projected Training Exits from HST (2020-2027) 14

Table 3.12: NCHDs Working in Psychiatry Not in Training Posts (DIME, 2020) 14

Table 3.13: Current Configuration of the Psychiatry Workforce 15

Table 4.1 Comparison of Mental Health Service Delivery across Comparable International Jurisdictions 16

Table 4.2 Comparison of Ireland with international jurisdictionsTotal ratio per 100,000 of the Population 16

Table 5.1: Monthly Waiting Lists for CAMHS 18

Table 5.2: Regional Breakdown of Children Waiting Longer than 12 Months to Access CAMHS 18

Table 5.3: Projected Demographic Change in Population Age Groups by 2046 ('000s) 19

Table 6.1: Current Demand for Consultant Psychiatrists (WTE), as at 2021 23

Table 7.1: Projected Requirement for Consultant Psychiatrists to 2030/31 26

Executive Summary

There is a large deficit between the current level of consultant staffing across mental health services in Ireland today and the recommended appropriate level of consultant staffing required to deliver a fit-for-purpose mental health service (as outlined in national policy documents based on international good practice). The number of consultant psychiatrists per 100,000 of the population is low when compared with similar international jurisdictions. Severe recruitment and retention challenges in both the consultant and trainee psychiatrist workforce presents delays in service delivery, with associated patient safety concerns. These were a catalyst in the development of this collaborative workforce plan for the specialty of Psychiatry.

This project and report were developed to provide evidence-based data and projections for the current and future requirement for consultant Psychiatrists across Mental Health Services and mental health related service delivery in Ireland. The purpose of this was to inform postgraduate medical training projections and consultant appointment requirements for the country to 2030.

This report represents a collaboration across all important stakeholders involved in the delivery of Psychiatry services across Ireland including HSE National Doctors Training and Planning (NDTP), HSE Mental Health Services, the College of Psychiatrists of Ireland, HSE National HR and the Department of Health.

The current status of the Psychiatry workforce includes medical staff delivering psychiatry services for the population of Ireland, consisting of 526 consultants working in the public healthcare systems, a proportion of whom work in private practice also. In addition, there are 55 consultants working exclusively in the private mental healthcare system (HSE, 2020; MCI, 2018). An estimated 276 consultants are projected to leave the publicly funded workforce over the next 10 years due to retirement.

There are 263 trainee psychiatrists at Basic Specialist Training level and 142 at Higher Specialist Training level working today (CPsychI, 2020). In addition, 231 non-training NCHDs work across Psychiatry services in Ireland.

The future demand for consultants and trainees in psychiatry in Ireland was analysed based on a number of drivers of demand including:

- High levels of vacant consultant posts across the country
- Over-reliance on non-permanent, agency and locum consultants to meet service needs
- A high level of reliance on non-training NCHDs to deliver services that should otherwise be delivered by trainees and consultants
- Population ageing and epidemiological trends across both the paediatric and adult age cohorts implying an increased demand across a number of services in to the future
- The implementation of Government policy including the original 'Vision for Change' and the more recent 'Sharing the Vision' (Department of Health, 2006, 2020)
- The full development and implementation of National Clinical Programmes and related models of care across mental health services
- The full implementation of mental health service improvement projects
- Increasing demand for mental health services in response to the COVID-19 pandemic
- Changes in the model of care for mental health service delivery as a result of telehealth initiatives introduced in response to the COVID-19 pandemic

A key finding of this report is that the number of consultant Psychiatrists required to 2030 to target the above is 825. An analysis of the gap between this estimated requirement of 825 consultants and the current 581 consultants working today indicated that a total of 628 additional consultants will be required in the next 10 years, when those who leave the service for retirement and other reasons are accounted for.

A second key finding is that, in order to meet the need for consultants to 2030, it is estimated that approximately 71-72 trainees will need to complete Higher Specialist Training each year and take up consultant posts between the years 2024 and 2030, if consultant demand is to be met by training alone. Between 2021 and 2023, the 22-46 trainees in Higher Specialist Training programmes are expected to complete the training programme and become eligible to take up consultant posts.

As part of the next steps it is recommended that an analysis of the non-training NCHD posts across mental health services be carried out to identify where it may be possible to convert non-training posts to training posts, in order to increase the number of training posts in a cost effective manner. Urgent consideration should be given to converting agency, locum and non-permanent consultant posts to permanent consultant posts.

A review of the implementation of the findings and recommendations of this report should be carried out within the next 5 years and should inform the implementation of Sharing the Vision and Sláintecare.

1. Introduction to Medical Workforce Planning

The HSE National Doctors Training and Planning (NDTP) Unit is positioned within the Office of the Chief Clinical Officer and has statutory roles in the following:

- Medical education and training;
- Medical workforce planning; and,
- The consultant post approval process.

Within its medical workforce planning remit, NDTP predicts and proposes on an annual basis the number of interns and medical trainees required for each specialty, as well as projecting the future medical workforce requirements for each speciality. This information then feeds into the medical education and training aspect of NDTP via the funding of medical training required to meet workforce needs; ensuring that the training content and delivery is responsive to the changing needs of the Irish healthcare system, and supporting the retention of doctors upon completion of their training.

The main objective of NDTP is to ensure that, at all times, the Irish health service is provided with the appropriate number of specialists, who possess the required skills and competencies to deliver high quality and safe care, and whose training is matched to the model of healthcare delivery in Ireland, regardless of location.

1.1 Background to Medical Workforce Planning within NDTP

NDTP and expert stakeholder colleagues across specialties carry out workforce planning reviews for priority medical specialties (as deemed appropriate by senior management in the HSE) based on current available data, as well as incorporating information provided by the postgraduate medical training bodies and National Clinical Programmes.

The approach taken to Medical Workforce Planning (MWP) is based on the methodology 'Medical Workforce Planning Ireland (HSE; NDTP, 2016) and encompasses the following principles as per existing Government policies:

- MWP should be aligned with Government policy e.g. Sláintecare (Houses of the Oireachtas, 2017), the Health Service Capacity Review (Department of Health, 2018), Smaller Hospitals Framework (Department of Health and Health Service Executive, 2013) and others
- The Irish health service should be self-sufficient in the production of medical graduates, with reduced dependence on International Medical Graduates (IMG)
- More patient care should be consultant-delivered and there should be a reversal in the ratio of Non-Consultant Hospital Doctors (NCHDs) to consultants/ specialists
- MWP recommendations should be consistent with the WHO Global Code on the International Recruitment of Healthcare Personnel (World Health Organisation, 2010, 2011)
- MWP recommendations should encompass medical workforce requirements for the entire population to include both the public and private healthcare systems
- MWP recommendations should incorporate future health needs of the population
- MWP recommendations should include the incorporation of projections relating to, for example, demographic changes; alterations in disease incidence and prevalence; models of clinical care; medical and therapeutic innovations; policy initiatives and technological advances
- Trainee numbers for each specialty should be based on MWP projections for that specialty

- Training capacity should match the recommended training numbers. Where recommendations are made to increase the intake of trainees into a particular specialty, additional training posts may be required
- Where appropriate, innovative models of care should be explored, for example new team structures, new medical roles, skills transfer and task sharing

It is important to note that workforce planning is an inexact science and estimated demand and supply requirements are based on the best available data, expert opinion as well as policy and other related developments relevant to the health service at the time the workforce planning report is prepared.

1.2 Data Used and Limitations

The data utilised in the analysis of the medical workforce in each speciality for these reviews are drawn from multiple sources:

- HSE Doctors Integrated Management E-System (DIME), which receives data from the postgraduate medical training bodies, the Medical Council of Ireland and each clinical site that employs doctors in the public health system in Ireland (2020);
- HSE Strategic Workforce Planning and Intelligence Unit (SWPandI) Health Service Personnel Census (2020);
- Postgraduate training bodies
- The Medical Council of Ireland –Workforce Intelligence Report (Medical Council, 2018);
- The National Clinical Programme linked to each specialty;
- International medical training bodies;
- International medical workforce datasets
- International health research groups

For the purpose of this report, data from the Health Service Personnel Census is used in the main while a data validation exercise of data from the Doctors Integrated Management E-System (DIME) is on-going. While there are some concerns around the coding of these data at a subspecialty level, work is being carried out on specific coding for medical sub-specialties within the Census. Within the Census, data is recorded by discipline and the main site which pays the salary of the staff member. In this way, a consultant could be recorded as working in Mayo Psychiatric Services but the community team that consultant works on is not recorded. In addition, if an employee works across more than one team the facility to record this is currently unavailable. Work on current financial systems to rectify such anomalies are on-going through a number of projects nationally and locally.

Variations between datasets are not unexpected and therefore the results from the different sources in this report are not identical. These limitations of the datasets are due to variations in the time point of data collection, differences in the variables collected i.e. Whole Time Equivalents (WTE) versus Headcount (HC), differences in the definitions of some variables (e.g. less than full-time versus part-time), absence of variable values in datasets (i.e. missing data), and varying quality of data between sources.

2. The Configuration of Psychiatry within the Irish Health Service

2.1 Introduction

Psychiatry is the specialty of medicine concerned with understanding, assessment, diagnosis and treatment of mental illness consultant Psychiatrists assess, diagnose and manage the treatment of patients with a range of disorders including, for example, mood disorders, organic brain disorders, psychosis and personality disorders. Psychiatry is broken down into a number of specialty areas related to both age and diagnosis. These specialties are concerned with assessment, diagnosis and management in the following areas:

- General Adult Psychiatry: persons presenting with a mental illness aged between 18 and 65 years
- Child and Adolescent Psychiatry: severe mental health problems in children and young adults from birth up to the age of 18
- Psychiatry of Learning Disability: people with mental illness associated with intellectual disability
- Psychiatry of Old Age/Later Life: those who develop mental illness over the age of 65
- Other specialties include Forensic Psychiatry and Rehabilitation and Recovery, Liaison Psychiatry, and Perinatal Psychiatry (HSE, 2016), and there are a number of Sub-Specialities (including Substance Misuse, Psychotherapy, Eating Disorders, Self-Harm, etc.)

Additional mental health services are provided by consultant Psychiatrists in the addiction services and in the intellectual disability services which come under the remit of the Office for Social Inclusion

2.2 Psychiatry Service Delivery

In general terms, specialist mental health services are provided to serve a particular group within the population, based on their stage of life (HSE, 2017). Child and Adolescent Mental Health Services (CAMHS) serve young people aged up to 18 years; general adult services are for those aged 18 to 64 years and psychiatry of later life provides services for those aged 65 years and over.

A proportion of Psychiatry is provided by private operators, charities, and Section 38 organisations. Relationships governing the delivery of services are managed by HSE Mental Health Services via Service Level Agreements (SLAs).

The specialty of Psychiatry is practiced across acute hospital and community settings including acute inpatient units, day hospitals, out-patient clinics, mental health of intellectual disability, continuing care and community residential services, as well as in research and academic settings. Within the main specialties, certain sub-specialities including rehabilitation and recovery, liaison psychiatry, addiction and perinatal psychiatry are provided. A national forensic mental health service is also provided, including inpatient and in-reach prison services.

A consultant Psychiatrist usually works in a psychiatric hospital or unit or as part of a community care team but he/she can also be part of a private practice. Consultant Psychiatrists typically work within a multidisciplinary team of other mental health professionals including psychologists, nurses, social workers, occupational therapists, and others. Peer support workers are also core to this multi-disciplinary team. The team is led by a consultant Psychiatrist. GPs

act as the initial gatekeepers to specialist mental health services. The GP will diagnose and manage the treatment of the patient/service user or refer on to other specialist psychiatric services. At night or at weekends, patients may present to Emergency Departments where there is a Psychiatrist on duty and a consultant Psychiatrist on call. Following assessment, where there is a need the patient/service user will be admitted to the acute mental health unit within the hospital or an appointment to community mental health services will be made.

Across Ireland, Community Health Organisations (CHO's) provide mental health services for their respective catchment populations. Across all specialties of psychiatry, multidisciplinary Community Mental Health Teams (CMHT), led by a consultant Psychiatrist, are core to service delivery in the community and provide care to service users across the lifespan from childhood to adulthood. Subsequent to referral (e.g. by primary care or Emergency Department staff), the CMHT coordinates a range of interventions for individuals in a variety of locations, including home care treatment, day hospital, outpatient facilities and in-patient units, and interacts and liaises with specialist catchment or regional services to coordinate the care of individuals who require special consideration. A recommendation of the Vision for Change is that each CMHT team agrees flexible protocols for its clinical and operational practice, adapted to the needs and social context of its sector population (Department of Health, 2006, 2020).

Across Ireland the following services are in place as of 2019:

- 72 Child and Adolescent Community Mental Health Teams
- 112 Community General Adult Mental Health Teams
- 32 Psychiatry of Later Life Teams
- 72 CAMHS Acute Inpatient beds
- 29 Adult Acute Inpatient units

(HSE; Mental Health Division, 2019)

2.3 National Clinical Programmes for Mental Health

The National Clinical Programmes for Mental Health established in 2011 are part of a family of health related programmes established in the HSE to develop high quality health services that are based on best international practice aimed at improving patient safety, value and equity.

All of the programmes are now at various stages of implementation. The Office of the National Clinical Advisor and Group Lead for Mental Health within HSE Clinical Design and Innovation works very closely with Mental Health Operations and Strategy and Planning to deliver the programmes in line with each model of care. The National Clinical Programmes work with partners including the College of Psychiatrists of Ireland, health and social care professionals, nursing, service users and family members and voluntary organisations to ensure full implementation of its remit.

There are currently five Mental Health National Clinical Programmes at different stages of implementation and design including:

- The Assessment and Management of patients presenting to the Emergency Department following Self Harm (at Implementation phase)
- Early Intervention in Psychosis (at Implementation phase)
- Eating Disorders (at Implementation phase)
- Attention Deficit Hyperactivity Disorder (ADHD) in Adults (at Implementation phase)
- Dual Diagnosis - Co-occurring Mental Illness and Substance Misuse (at Design phase)

2.4 Mental Health Strategic Portfolio and Programme Management Office

In 2016, the HSE's Mental Health Division established the Strategic Portfolio and Programme Management Office (SPPMO), now the Community Healthcare Operations Improvement and Change (CHOIC) Office, in conjunction with the Centre for Effective Services (CES). This collaborative initiative delivered a structured sustainable programme of change throughout mental health services within the broader context of the overall national healthcare reform programme. The aim of CHOIC is to support and enable a structured, integrated and sustainable programme of change across community operations in collaboration with local services, staff, service users and family members.

The current portfolio primarily consists of improvement projects specific to mental health services. However, the CHOIC Team is also supporting a number of initiatives across other service areas, including older people services, disability services and primary care, and soon further projects will be added to the CHOIC portfolio. Service Improvement Projects completed to date (2017 to 2019) are outlined below:

- Optional Appraisal Project - Approved Acute Centre admission data reporting
- Standardised management of first re-referred appointment DNA's in the community mental health setting
- Development of a National Directory of Mental Health Services
- Mental Health Services Workforce Plan Programme Phase 1 – Assessing the supply and future demand
- Development of HSE 'Best practice Guidance for Mental Health Services'
- Training plan to enable the implementation of the HSE 'Best Practice Guidance for Mental Health Services'
- Development of a 'National Recovery Framework for Mental Health Services'
- Improving the accessibility of emergency mental health services in Ireland
- Implementation of 'National Peer Support Worker'
- Developing weekend community mental health services in Ireland
- Implementation of the HSE 'Best Practice Guidance for Mental Health Services'
- Mental Health Engagement - Research and Evaluation
- Implementation of the roles and structures to support mental health engagement through local and area development and area leads posts
- Training and capacity building required to support roles and engagement structures
- Alignment of CHO Connecting for Life (CFL) action plans
- Development of HSE 'Best Practice Guidance for Suicide Prevention Services'
- 'Future of Mental Health' stigma reduction campaign
- Development of a model of care for people with severe and enduring mental health illnesses and challenging behaviours
- Implementation of the 'National Recovery Framework in Mental Health 2018-2020'
- Review of the CAMHS Standard Operating Procedure
- Project to deliver enhanced bereavement support services to families and communities affected by suicide of those people known to mental health services
- Physical Health Needs Mental Health Service Users

3. Number of doctors working in Psychiatry

3.1 Introduction

The population of doctors working in Psychiatry across Ireland consists of consultants in Psychiatry, trainee doctors on the postgraduate training programme in Psychiatry and NCHDs not assigned to a national training programme.

3.2 The Number of Specialists in Psychiatry Working in the Irish Healthcare System

3.2.1 Number of Doctors on the Specialist Register Practicing in Psychiatry

Table 3.1 outlines the breakdown of the Psychiatry specialist registered doctors participating in the workforce, by sub-specialty, as per Medical Council Annual Retention Application Form (ARAF) data for 2017. A total of 598 doctors working in Psychiatry in 2017 were on the Specialist Register and actively working in the specialty, of whom 55 worked exclusively in the private sector.

Table 3.1: Specialist Registered Doctors Actively Practicing in Psychiatry in 2017 (IMC, 2018)

		Inside Ireland Only	Inside and Outside Ireland	Total
Child and Adolescent Psychiatry	Specialist registered doctors (Total Public and Private)	117	6	123
	Specialist registered doctors (Private Only)	8	1	9
Psychiatry	Specialist registered doctors (Total Public and Private)	346	36	382
	Specialist registered doctors (Private Only)	39	2	41
Psychiatry of Learning Disability	Specialist registered doctors (Total Public and Private)	25	2	27
	Specialist registered doctors (Private Only)	-	-	-
Psychiatry of Old Age	Specialist registered doctors (Total Public and Private)	64	2	66
	Specialist registered doctors (Private Only)	5	-	5
Total Psychiatry	Specialist registered doctors (Total Public and Private)	552	46	598
	Specialist registered doctors (Private Only)	52	3	55

3.2.2 Country of Basic Medical Qualification of Doctors on the Specialist Register

According to the Medical Council ARAF data of the 598 doctors on the Specialist Register and actively working in Psychiatry in Ireland in 2017, 81% qualified in a medical school in Ireland, 19% qualified outside of Ireland. Table 3.2 reports the breakdown of these figures by sub-specialty. These data represent all Psychiatrists on the Specialist Register working in Ireland to some extent and excludes those who are registered with the Medical Council but only work outside of Ireland.

Table 3.2: Country of Basic Medical Qualifications for those on the Specialist Register Actively Working in Psychiatry in Ireland (IMC, 2018)

	Qualified in Ireland	Qualified outside of Ireland	Total
Child and Adolescent Psychiatry	92 (75%)	31 (25%)	123 (100%)
Psychiatry	307 (80%)	75 (20%)	382 (100%)
Psychiatry of Learning Disability	24 (89%)	3 (11%)	27 (100%)
Psychiatry of Old Age	62 (94%)	4(6%)	66 (100%)
Total	485 (81%)	113 (19%)	598 (100%)

3.3 Participation of Consultants/Specialists in Psychiatry in the Medical Workforce in Ireland

As already stated, the HSE Personnel Census (HSPC) data is used to estimate the number and type of consultant Psychiatrists working in publicly funded health services across Ireland. In addition, data from the Medical Council's Medical Workforce Intelligence survey is used to infer the number of consultant Psychiatrists working exclusively in private health services across the country. As of April 2020 there were 459 consultant Psychiatrists working in the public health system Ireland in both temporary and permanent posts. A further 67 consultants were working in locum/agency posts. Further to this it is estimated that 55 consultants were working exclusively in the private sector. This brings the total estimated consultant Psychiatrist workforce in Ireland to approximately 581. The WTE rate for publicly employed consultants is approximately 0.90. If used for all consultant Psychiatrists, public and private, then it is estimated that, in WTE terms, there are 523 consultants working across both the public and private health service. Table 3.3 gives an overview of the estimated number of consultant Psychiatrists and the WTE contribution of these consultants to both public and private healthcare. Consultants working on a temporary basis are considered within the 'current workforce' data in the workforce planning projections. See table 3.4 for an overview of vacant posts within Psychiatric services in the public health system.

Table 3.3: WTE Contribution of Consultant Psychiatrists (HSPC, 2020; IMC, 2018; HSE NDTP, 2020)

Consultant Psychiatrists	Total WTE	Total Headcount
Total Consultant Psychiatrists Public	416	459
Total Consultant Psychiatrists Public – Locum	61*	67
Total Consultant Psychiatrists Private	51*	55
Overall Total Consultant Psychiatrists	528	581

* *Information on WTE for Locum and Private consultants is not available, in the absence of available data the average WTE rate for public consultants has been used to estimate WTE contributions*

Note that there is work on-going within HSE Strategic Workforce Planning and Informatics (SWPandI) to develop sub-specialty coding, currently, many sub-specialists are coded as 'General Psychiatrists'.

Table 3.4: Vacancy Rates within the Consultant Psychiatry Workforce by CHO*			
CHO	Total Consultant Vacancies	Vacant	Filled by Temporary Consultant
CHO 1	12	6.5	5.6
CHO 2	5	2	3
CHO 3	8.5	4	4.5
CHO 4	17	7	10
CHO 5	12	0	12
CHO 6	1	0	1
CHO 7	8.5	0.5	8
CHO 8	16.6	0	16.6
CHO 9	8	0	8
Total	88.6	20	68.7

Gender Breakdown

The gender breakdown of the workforce infers 42% of the workforce are male while 58% are female. A more complete gender breakdown by specialty is outlined in Table 3.5 below. Again, these data are for HSE funded consultants only and are taken from the HSE personnel census.

Table 3.5: Gender Breakdown Consultant Psychiatrists as at April 2020 (HSE Census, 2020)				
	Headcount Male	Headcount Female	% Male	% Female
Total Consultant Psychiatrists	192	267	42%	58%

In terms of working patterns, it is estimated that overall around 81% of the publicly funded workforce work on a full time basis with the remaining 19% working less than full time. More males work full-time than females with slightly over 90% of males working full-time and almost 75% females of females working full-time. See Table 3.6 for a further breakdown of working patterns per specialty and by gender.

Table 3.6: Working Patterns Consultant Psychiatrists as at April 2020 (HSE Census, 2020)				
	% Total Full Time	% Total Less Than Full Time	% Male Full Time	% Female Full Time
Total Consultant Psychiatrists	81.3%	18.7%	90.1%	74.9%

* *Note these data have been extracted from Doctors Integrated Management E-system (DIME) as at June 2020 in relation to Approved Posts on DIME. DIME is dependent on clinical sites inputting details on their consultant workforce. Currently there is an estimated 99% compliance rate and therefore there may be variances and gaps in the data supplied to that held within in clinical sites. A vacant post is a consultant post that the hospital has verified on DIME as currently vacant.*

The majority of consultants Psychiatrists working in the public sector are on permanent contracts, as indicated in Table 3.7. Approximately 22% of these doctors hold non-permanent contracts. A further 67 doctors occupy locum/ agency posts (table 3.3).

Table 3.7: Contract Type Consultant Psychiatrists as at April 2020 (HSE Census, 2020)		
	% Permanent	% Non-Permanent
Total Consultant Psychiatrists	78%	22%

Retirement

An estimated 276 consultant Psychiatrists are projected to leave the publicly funded workforce over the next 10 years due to retirement, at an estimated average retirement age of 60 years. As there is a lack of data on actual retirement age, the average retirement age of 60 is based on expert opinion. Of the 276 consultants expected to retire over the next 10 years, 156 are female representing 57% of this cohort of consultants.

3.4 Participation of Non Consultant Hospital Doctors Working in Psychiatry in the Irish Healthcare System

As with all medical specialties, Psychiatry is dependent on both NCHDs in training and not in training programmes to support service delivery. Table 3.8 outlines the number of NCHDs who retained their Medical Council registration in 2018 and worked in Ireland in Psychiatry in the previous 12 months. Of the 639 Psychiatry NCHDs, 176 were on the Trainee Division of the register, 458 were on the General Division, and 5 doctors were on the Supervised Division.

Table 3.8: NCHDs Practicing in Psychiatry in the Previous 12 Months by Division of the Medical Councils Register (IMC, 2018)				
	General Division	Supervised Division	Trainee Division	Total
NCHDs working in Psychiatry	458	5	176	639

3.4.1 Training Posts Higher Specialist Training in Psychiatry

Following on from 3-4 years of Basic Specialist Training, there areare two separate competitions on entry to Higher Specialist Training (HST) in Psychiatry, one for Child and Adolescent (CAP) Psychiatry and one for General Adult (GA) Psychiatry. Available options for obtainment of Certificate of Satisfactory Completion of Specialist Training (CSCST) in Psychiatry include:

- CSCST in Child and Adolescent Psychiatry and CSCST in General Adult – a 6 year training programme (on average only one trainee will take this option each year)
- CSCST in Child and Adolescent Psychiatry – 3 year training programme
- CSCST in Child and Adolescent Psychiatry (with sub-speciality) – a 3 year training programme

- CSCST in General Adult and Old Age Psychiatry (dual CSCST) – a 4 year training programme (2 years GA and 2 year OAP)*
- CSCST in General Adult and Learning Disability (dual CSCST) – a 4 year training programme (2 years GA and 2 year LD)*
- CSCST in Old Age Psychiatry – a 3 year training programme
- CSSCT in Psychiatry of Learning Disability – a 3 year training programme
- CSCST in General Adult Psychiatry (without a sub-specialty) – a 3 year training programme
- CSCST in General Adult Psychiatry (with a sub-specialty) – a 3 year training programme**

  - Liaison
  - Social and Rehabilitation
  - Perinatal
  - Addictions
  - Neuropsychiatry
  - Eating Disorders
  - Forensic
  - Academic

Trainees can, however, change their mind after their first year in HST and decide to change specialty or add an additional year for a Dual Training CSCST. Due to this and other factors outlined below, projected numbers of CSCST will fluctuate year on year.

3.4.2 Length of Training programme

A number of factors apart from the structure of the HST programmes and the options offered to trainees, are to be taken into account when considering the length of training programme for individual trainees as follows:

- Each trainee is afforded the opportunity to take 12 months 'leave of absence' from the training programme for any reason and not accrue training credit. On average 35-40% take up this opportunity at some stage during the training programme
- It is common to have a number of trainees on statutory leave in any given training year. Currently there are 6 trainees on Maternity Leave for the July 2020 training year
- Currently there are 5 trainees on Flexible Training on the HST programme, 3 of 40 appointed for July 2020 are training flexibly at 50% WTE
- Trainees may if they wish, take time out of the training programme to pursue research / lectureship interests. Some of this time may be approved for credit towards the training programme on application to the Dean of Education

All of the above are taken into account when projecting CSCST dates.

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* Once appointed, and on entry to the General Adult programme the trainees are asked to make their preference with regards to Dual Training (Dual CSCST) i.e. General Adult and Old Age or General Adult and Learning Disabilities

** Once appointed, and on entry to the General Adult programme the trainees are asked to make their preference with regards to a sub-specialty (annotation to CSCST) within General Adult Psychiatry, this is still a 3 year training programme, the only exception to this is Forensic Psychiatry, which takes 5 years to complete.

3.4.3 Number of Trainees in HST and BST Training Programmes

The HSE is responsible for the commissioning of postgraduate training posts on an annual basis. In doing this it takes a collaborative approach with NDTP, the College of Psychiatrists of Ireland and other relevant expert stakeholders to ensure that consideration is given to both the future demand for consultants and training capacity within the system.

According to the College of Psychiatrists of Ireland, there are currently a total of 263 NCHDs in Psychiatry Basic Specialist Training. The majority of these trainees are male at 55%. See Table 3.9. There are 142 trainees in HST programmes currently, the majority of these trainees are female, at 53%. This is outlined in Table 3.9.

Table 3.9: Psychiatry Trainees in Basic-Speciality Training per Year of training (July, 2020)

	Year 1	Year 2	Year 3	Year 4	Total
Psychiatry BST Total Headcount	60	55	60	*79	257
Female Headcount	29	31	23	33	116
Male Headcount	31	24	37	46	138

Table 3.10:Psychiatry Trainees in Higher Specialist Training per Year of training (July, 2020)

	Year 1	Year 2	Year 3	Year 4	Year 5+	Total
Psychiatry HST Total Headcount	44	41	37	15	5	142
Female Headcount	27	18	18	10	2	75
Male Headcount	17	23	19	5	3	67

The College of Psychiatrists of Ireland project that a total of 22 doctors will exit HST training (1 with a Post CSCST Fellowship) in 2020 and 22 will also exit training in 2021, as indicated in Table 3.11 below. A further 46 and 38 doctors are projected to exit HST training in 2022 and 2023 respectively. All of these doctors will hold a CSCST, be eligible for entry on to the Specialist Register and will be eligible to apply for consultant posts in Ireland. Across all years of projected exits, the majority of newly qualified specialists will be female. Thereafter, predicted exits are based on current BST numbers. It is likely that exit numbers post 2023 will change from those outlined below as more 'non-streamlined' trainees enter HST training programmes. As mentioned earlier in section 3.4.2, different annual CSCST completion numbers annually will be based on the numbers in different training programmes, length of training programmes and leave arrangements over the course of training. Table 3.11 displays the projected exits from HST up to 2027.

* *54 at ST4 and 25 ST4 repeats*

Table 3.11: Projected Training Exits from HST (2020-2027)								
HST Exits Adult	2020	2021	2022	2023	2024	2025	2026	2027
General Adult Psychiatry	11	9	17	10				
General Adult /Psychiatry of Old Age	4	3	12	13				
General Adult / Learning Disability		2	4	2				
Forensic Psychiatry			1	2				
Child and Adolescent Psychiatry	6	7	12	11				
Post CSCST	1	1						
Total	22	22	46	38	28	34	33	34
% Male	41%	45%	46%	41%	58%			
% Female	59%	55%	54%	49%	42%			

3.4.4 NCHDs Not in Training Posts

Data from HSE NDTP DIME (2020) records 231 Psychiatry NCHDs in non-training posts. Of these, 132 are SHOs and 99 are Registrars (Table 3.12).

Table 3.12: NCHDs Working in Psychiatry Not in Training Posts (DIME, 2020)			
	SHO	Registrar	Total
Total	132	99	231

3.5 Summary of Current Configuration of Psychiatry Specialist Workforce 2020

Table 3.13 outlines the high level data requirements to analyse the gap between the supply and demand for consultant Psychiatrists over the next decade. This analysis is high level in order to give a simple overview of the demand for consultants and trainees. As mentioned data from the Census does not adequately capture the workforce demographics at a sub-specialty level but perhaps more significantly, the trainees do not tend to choose their specialisation in Psychiatry until they are mid-way through their training and this makes modelling complicated. With this in mind, a decision was made to keep data modelling high level whereby results of modelling (in tandem with the known proportionate demand for sub-specialists in Psychiatry) could be used to inform how many sub-specialty training places should be made available to trainees. This in turn would help ensure that the College and the HSE are working together to meet the future demand for consultant Psychiatrists across specialties and indeed jurisdictions.

Table 3.13: Current Configuration of the Psychiatry Workforce		
Assumption	Value	Source
Number of consultants working in HSE-funded services – permanent and temporary (includes locum)	526 HC 473 WTE	HSE Workforce Planning, Analysis and Informatics Unit April 2020, HSE NDTP, 2020-(locum posts)
Full-time consultants in HSE-funded services	81%	HSE Strategic Workforce Planning and Intelligence Unit April 2020
Part-time consultants in HSE-funded services	19%	HSE Strategic Workforce Planning and Intelligence Unit April 2020
Estimated number of private sector only consultants as per Medical Council data	55	Medical Council (2018)
Share of females in consultant employment stock for HSE-funded services	58%	HSE Strategic Workforce Planning and Intelligence Unit April 2020
Share of males in consultant employment stock for HSE-funded services	42%	HSE Strategic Workforce Planning and Intelligence Unit April 2020
Overall WTE rate for consultants in HSE-funded services	0.90	HSE Strategic Workforce Planning and Intelligence Unit April 2020
% Consultants/Specialists over 50 years and expected to retire in the next 10 years	52%	NDTP DIME (2020)
Expected exits from the workforce for reasons other than retirement	1% male, 2% female	Assumption

4. International Comparisons

The weaknesses of benchmarking domestic data against international data are known and include:

- A lack of contextual consideration
- Assumptions that the international standard is best practice; and,
- Potential complacency should the domestic value equal that of the international value.

However, in determining the appropriate demand for medical consultants and specialists in Ireland, it is informative to look at how Ireland compares across international jurisdictions with similar models of health service delivery and postgraduate training. Table 4.1 below notes how the models of service delivery compare across these countries. Please note system similarities are very much at a macro level.

Table 4.1 Comparison of Mental Health Service Delivery across Comparable International Jurisdictions

	Ireland	Scotland	England	New Zealand	Australia
Population 2020	4.8m	5.4m	55.9m	4.7m	23.9m
Care is predominantly publicly funded	√	√	√	√	√
GP referral/ Emergency Dept system	√	√	√	√	√
Predominantly community based / moving to more community based services	√	√	√	√	√
MDT working is the norm	√	√	√	√	√
Expanding role of primary care in delivery of services		√	√	√	√
Consultant / trainee recruitment difficulties	√	√	√	√	√
Waiting lists/ difficulties accessing services	√	√	√	√	√

A review of the consultant workforce composition in these countries was also conducted, table 4.2 shows a comparison of the consultant workforce per head of population across these jurisdictions.

Table 4.2 Comparison of Ireland with international jurisdictionsTotal ratio per 100,000 of the Population

	Ireland	NHS England	NHS Scotland	Australia	New Zealand
Population used for calculations	4.8 m	55.9 m	5.4 m	23.9 m	4.7 m
Psychiatry	9.8	9.6	10.9	12.3	12.0

Sources:

- England 2019: https://www.rcpsych.ac.uk/docs/default-source/improving-care/workforce/census-2019-editmar20.pdf?sfvrsn=17d88821_2
- Scotland 2019: https://www.isdscotland.org/Health-Topics/Workforce/Publications/data-tables2017.asp?id=2484#2484and
- Australia 2016: https://www.aihw.gov.au/reports-data/health-welfare-services/workforce/data
- New Zealand 2015: https://www.health.govt.nz/

As can be seen, Ireland has a low level of consultant Psychiatrists per head of population when reviewed alongside Scotland, Australia and New Zealand.

5. Key Drivers of Change to the Future of the Consultant Psychiatry Workforce

There are several key drivers of change to the consultant Psychiatry workforce of the future which have been identified by experts in medical workforce planning for Psychiatry. These are outlined below.

Driver 1: Current Unmet Demand for Psychiatrists in Ireland

Current unmet demand within the Psychiatry consultant workforce is a major driver of change to the future consultant Psychiatry workforce. There are a number of factors that can be used to estimate this unmet demand including vacant consultant posts and waiting lists, as outlined below.

Unfilled Consultant Posts

As outlined in table 3.7 above, a significant proportion of consultant Psychiatrists contributing to publicly funded service provision hold non-permanent contracts i.e. 22%. Further to this it is estimated that 67 consultant Psychiatrists working in HSE funded services occupy locum and agency posts. This represents 13% of all consultant Psychiatrists working in the public sector. Taken together, consultants in non-permanent, locum posts represent a significant unmet demand for consultant Psychiatrists in Ireland.

Added to this is the estimated vacant consultant posts (89), and the 25 doctors not on the specialist register (as at Oct 2020), occupying temporary consultant posts, highlight the very real under-supply of consultant Psychiatrists across the country.

The high reliance on non-training NCHDs also highlights the unmet demand for consultants as these doctors are, at times, employed to bridge a service gap where consultants should otherwise be employed. Currently, it is estimated that 231 non-training NCHDs are working in Psychiatric services in the publicly funded health system.

The implications of the above recruitment and retention challenges in Psychiatry include salary, the recruitment process, governance and the role of the consultant Psychiatrist as clinical and team leader as indicated in the recruitment and retention project of the (HSE; NDTP, 2020)

Waiting Lists

There are two types of referral to mental health services; an urgent referral and a routine referral. Priority is given to urgent referrals so that those with high risk presentations are seen as soon as possible and this is normally achieved within 24 – 48 hours.

Currently, the HSE has 112 Adult Community Mental Health Teams, 32 Psychiatry of Later Life teams and 72 Child and Adolescents Mental Health (CAMHS) teams nationwide.

As of end of July 2020 90% of new/ re-referred adults were offered an appointment by adult mental health community teams nationally within 12 weeks. As of end of July, 97% of new/re-referred older adults were offered an appointment by Psychiatry of Later Life community teams nationally within 12 weeks. Those waiting longer than 12

weeks are normally offered an appointment shortly afterwards and therefore waiting lists for adult and older adult mental health teams are not captured nationally. As of end of July, almost 80% of referrals accepted by child and adolescent community teams nationally were offered an appointment within 12 weeks. 85.8% of urgent referrals were responded to within three working days.

The available monthly waiting list figures for CAMHS for 2020 are displayed in table 5.1.

Table 5.1: Monthly Waiting Lists for CAMHS

Jan	Feb	Mar	Apr	May	Jun	Jul
2,327	2,610	2,816	2,469	2,277	2,366	2,115

There were 223 children waiting longer than 12 months in July, however there are regional variances within this (Table 5.2)

Table 5.2: Regional Breakdown of Children Waiting Longer than 12 Months to Access CAMHS

CHO	Children waiting longer than 12 months to access CAMHS (As of July 2020)
CHO 1	73
CHO 2	0
CHO 3	21
CHO 4	76
CHO 5	1
CHO 6	23
CHO 7	6
CHO 8	19
CHO 9	4

Driver 2: Service Configuration and Government Policy

Sharing the Vision

Although 12 years old, A Vision for Change (Department of Health, 2006)is accepted as government policy and strategy for developing mental health services across Ireland today. The strategy makes recommendations around the types of services and the number of staff required to deliver a community-based, evidence-based, and recovery focussed mental health service across community and acute hospital settings. It recommends that mental health services be organised according to consultant-led specialist mental health teams. Recommendations on the future configuration of Psychiatric services as per the Vision for Change (Department of Health, 2006) include:

- Reduced reliance on hospital beds and increased use of staff in community mental health teams and multidisciplinary team working with the Psychiatrist as team leader (Department of Health, 2006).
- Greater development of sub-specialties in psychiatry
- Movement of inpatient facilities to one regional area

In June 2020, a revised "Sharing the Vision' document was published (Department of Health, 2020). The revised policy proposes recommendations to enhance or consider updating complex areas including consideration of the number of in-patient beds required to support the needs of the population; evaluation of data from pilot e-health initiatives and further development of National Clinical Programmes such as ADHD, eating disorders, neuro-rehabilitation, perinatal care and suicide prevention.

As outlined in detail earlier in Section 2.3, the implementation and development of Mental Health National Clinical Programmes and Service Improvement Projects are also impacting the demand for consultants and trainees in Psychiatry.

Although, the WTEs outlined in Vision for Change 2006, will continue to remain the staff ratio for Community Mental Health Teams (CMHT) they are not contained in the new Sharing the Vision policy. The new policy recognises that each CMHT has its own unique need depending on various factors (deprivation, demographics etc.) and allows for each area to determine what staff should be prioritised based on need and available resources. Recruitment of additional Advanced Nurse Practitioners (ANPs) will be key in the provision of appropriate skill mix in CMH teams.

Driver 3: Demographic and Epidemiological Change

Table 5.3 below outlines projected changes in the age structure of the population of Ireland by 2046, based on Central Statistics Office (CSO) projections (Central Statistics Office, 2020). The projected increase in the population of older people in Ireland i.e. 65 years+ and 85 years+ is expected to have significant implications for the Psychiatry of Old Age (POA) services. Many people develop mental illness for the first time over the age of 65 years and older adults with mental health difficulties have special needs. There is an increase in the number of older people with dementia which can be associated with significant behavioural and psychotic symptoms where psychiatry of old age services are required. The projected cost pressure of 3.4% projected for the population aged 65 years and over may have a significant impact on service provision for this cohort.

While the younger population is not set to grow at the same level as that of older adults, levels of depression and anxiety in adolescents and young adults have been seen to increase in Ireland over the past number of years. The MyWorld Survey of youth mental health (Dooley et al., 2020) found that adolescents and young adults reported notably higher levels of depression and anxiety in 2020 than in the previous survey conducted in 2012. Furthermore, a study analysing ED mental health related presentations at one Paediatric ED in Ireland found a dramatic increase in admissions between 2006 and 2016 whereby the number increased 526% in this time period (Fitzgerald et al, 2018). Added to this, recent research in the UK found a 'a consistent and striking increase in the reported prevalence of a long-standing mental health conditions among those aged 4–24 years', with the reported prevalence of long-standing mental health conditions increasing six-fold between 1995 and 2014 in England (Pitchforth et al, 2018, pg 1282). All of this research infers projected growth in depression and anxiety among Irelands adolescent and young adult population in to the future if these issues are not adequately addressed.

Table 5.3: Projected Demographic Change in Population Age Groups by 2046 ('000s)

Age	2021	2026	2031	2036	2041	2041	2046
0-15	1,005.5	937.6	878.1	853.1	868.6	901.1	918.3
16-64	3,243.5	3,401.9	3,516.7	3,582.0	3,592.1	3,558.2	3,549.8
65-84	660.6	765.4	866.8	962.3	1,068.1	1,184.7	1,261.5
85 and over	82.4	101.8	132.9	174.4	214.2	255.8	301.0

Driver 4: Technology

Scientific advances in neuroscience, identifying the impact of early development, and current environment on gene expression and neuroplasticity, continue to increase the complexity of psychiatry.

Technology advances in Big Data Analytics and Machine Learning are facilitating predictive analysis of mental health needs and incidences of psychosis, using empirical evidence from suitable epidemiological data and predictive analysis of comparative datasets in the UK and Scandinavia.

Psychiatry is one specialty moving into the area of telehealth and e-consultations, which is another factor which could potentially impact the demand for consultant Psychiatrists, potentially improving access to psychiatry and helping reduce waiting times and waiting list numbers.

The Committee on the Future of Healthcare Sláintecare Report proposes a national health service for Ireland's 21st century health needs. This service will deliver upon the 'triple aim' of health systems by "improving care, improving health and reducing costs" through an integrated care system which puts the person at the centre of system design and delivery, and is well-organised and coordinated to manage costs. This future model of integrated care envisages a decisive shift away from the current hospital-centric model of care to where the majority of healthcare will be accessible and delivered in community settings. The Report recognises that the "best health outcomes and value for money can be achieved by re-orientating the model of care towards primary and community care".

Telehealth refers to "the delivery of health care services where patients and providers are separated by distance… (using) ICT for the exchange of information to allow for the diagnosis and treatment of diseases and injuries, research and evaluation, and for the continuing education of health professionals" (World Health Organisation, 2019). Telehealth can be a crucial enabler to the orientation of the model of care outlined in the Sláintecare Report, and is identified as a key component within the Sláintecare Implementation Strategy (i.e. Strategic Action 10.3.3 – Provide telehealth solutions to support delivery of care in the community closer to patients and their families) (Houses of the Oireachtas, 2017; Department of Health, 2019).

In response to the COVID-19 pandemic, telehealth solutions are being rapidly deployed and implemented across HSE mental health services, primarily to facilitate safe patient consultations and to enhance care delivery by capturing and sharing information in new ways.

Technology-enabled care services currently provided in a blended model of care include the following technologies:

- Remote Monitoring – involves remote digital monitoring of patients in their own home via peripheral devices linked to smartphone and Wi-Fi hubs, to anticipate exacerbations early and build on the patient's own self-care abilities.
- Virtual Consultations – the use of internet video technology within the patient's home, via applications such as BlueEye Direct and AttendAnywhere, which minimises risk and can provide urgent notification or allow help-seeking.
- Peer Support/Group Training– using digital technology to provide remote peer-to-peer support or consultations between patients and clinicians, for example, telephone or video consultations.
- Telecoaching – telephone or video advice from a clinician to support people by building knowledge, skills and confidence to change behaviours.
- Self-Care Apps – technology and applications that raise awareness, knowledge and help people to self-manage.

The three areas of primary focus agreed by the HSE National Telehealth Steering Group, some of which are already in place across some mental health areas in HSE, are Video Enabled Care (VEC), Home Health Monitoring and On-Line Therapies; VEC comprises a significant aspect of these.

- Video Enabled Care: Audio and video conferencing solutions
- Home Health Monitoring: Remote monitoring solutions that support self-management with a focus on chronic illnesses and supporting frail elderly
- Online Therapies: The conduct of therapeutic interventions utilising internet-based platforms for both mental health and other areas of healthcare.

The model of care for the delivery of mental health services into the future, and the skills and training required by the members of the multidisciplinary team providing mental health services needs to be conscious of advances in digital health technology and its implementation across the Irish mental health system.

Driver 5: Legislation

In addition to all of the existing legislation, the following key pieces of legislation will impact the future of Psychiatry including:

- Assisted Decision Making (Capacity) legislation
- Review of Mental Health Act, 2001

6. Future Demand for Consultant Psychiatrists in Ireland

In order to determine future demand for consultants in Psychiatry, NDTP facilitated engagement across HSE Mental Health Services (including National Clinical Programmes and Operations), the College of Psychiatrists of Ireland (CPsychI), the Department of Health and HSE National HR to determine and outline a joint stakeholder perspective of the future demand for consultants and the rationale underpinning the demand estimates.

Table 6.1 outlines the estimated demand for consultants as proposed by HSE Mental Health Services and the CPsychI and deemed to be required currently in order to meet the following:

- Implementation of the recommendations from 'Vision for Change' and the subsequent 'Sharing the Vision: A Mental Health Policy for Everyone' (Department of Health, 2006, 2020)
- Implementation of the National Clinical Programmes including those for self-harm, eating disorders, early intervention psychosis and ADHD in adults.
- Implementation of further Service Improvement Projects across mental health services

Recommendations are based on:

- Current recommendations outlined in Government Policy
- National Clinical Programme/ service Improvement recommendations based on service user needs.
- Population cohort projected demand as appropriate to the specialty i.e. Psychiatry of Later Life used greater than 65 year old population and CAMHS used the under 18 populations. Ireland's population is expected to increase at a rate of 3.8% every 5 years and was used to project to the year 2031 based on the 2016 population of 4,761,865. An additional 10% of consultants required to cover leave and flexible working arrangements Psychiatry is unique in its requirement to provide extra cover to align with the legislation.

Recommendations are also based on limited additional consideration of the skills mix of multidisciplinary teams and advances in roles of various members of the team, the relative clinical versus non-clinical workload of the consultant Psychiatrist, or potential changes to models of care and ways of working brought about by recent advances in the use of Telehealth. Strategic multi-disciplinary workforce planning will further address the multidisciplinary implications of mental health service developments on the demand for consultant Psychiatrists.

Table 6.1: Current Demand for Consultant Psychiatrists (WTE), as at 2021	
Subspecialty Area	WTE Total
General Adults CMHT (Rehab, Substance abuse, Liaison)	302.5
Child and Adolescent CAHMS.	125.4
Mental Health Services for Older People.	82.4
Intellectual Disability	49.5
Forensic MH Services	22
Clinical Programmes total	81.7
Corporate (ECD,s, NCAGL, Academic)	39
Grand total WTE	702.5
10% Additional for flexible working and leave - HC	772

Table 6.1 above outlines the estimated required number of consultants across the different specialties of Psychiatry as at 2021 (i.e. in the immediate future). The demand estimates are then projected forward to 2030/31 to infer increases required over the next 10 years and to assist in determining the required training numbers at HST level to meet this projected demand.

By end 2030/31, the estimated demand for consultants will rise to 825.5 headcount and 750.5 WTEs, accounting an additional 10% of consultants to cover leave, flexible working etc. i.e. a WTE rate of approximately .91. It is recommended by both HSE MH and the CPsychI that a review of the demand position and implementation of recommendations coming out of this report should be carried out in 5 years' time.

An additional 10% of consultants is projected to be required to cover leave and flexible working arrangements. Psychiatry is unique within the medical profession in its requirement to include a replacement factor as a component of staffing projections. This was deemed appropriate given the requirement for consultant cover relevant to the application of the Mental Health Act.

7. Analysis of the Gap between the Current and Future Supply and Demand for Consultant Psychiatrists in Ireland

7.1 Modelling Process and Assumptions

In order to project the supply and demand for consultants in Psychiatry over the next 10 years, the statistical forecasting model developed by the Expert Group on Future Skills Needs and Solas was used (Behan et al., 2009).

It is important to highlight that variables used to estimate the supply of doctors include adjustment for part-time and full-time working patterns, as well as the gender breakdown of doctors. In addition, the model takes into account the expected numbers of doctors retiring and the assumed proportion of those exiting the workforce for reasons other than retirement, alongside health service data on the number of doctors entering the workforce post specialist training.

Within the statistical forecasting model, the inflow of overseas doctors is set to zero in order to isolate the domestic supply and assess the extent to which the national education and training system can meet estimated future demand. In this way, entrants into the workforce are based on the number of doctors who complete postgraduate specialist training and are eligible to enter on to Specialist Division of the Medical Council of Ireland's register. Exits, on the other hand, are based on all those doctors leaving the health system for retirement and other reasons. This is in line with the approach taken by Fas/Solas and the Expert Group on Future Skills Need (Behan et al., 2009).

A number of further assumptions underpin the workforce planning methodology as follows:

- In order to estimate the demand for consultants over the next 10 years, stakeholder-informed recommendations are used. These estimates represent the views of stakeholders rather than HSE NDTP
- Variables used to estimate the supply of consultants include the number of doctors currently delivering services, in headcount and WTE; the part-time and full-time working adjustment rates, as well as projected retirements and gender breakdown of doctors
- Supply and demand projections are typically converted to a ratio of consultants to the population. CSO population projections are used to determine demand. These projections are based on data from the Census of the population using the M2F2 scenario. This scenario infers a reduction in the Total Fertility Rate (TFR) and moderate migration per annum. Data accessed from the CSO in 2019 inferred a growth in the population to approximately 5.35 million people (Central Statistics Office, 2017)
- Demand estimates have been received from the HSE Mental Health, including National Clinical Programmes and Operations and the College of Psychiatrists of Ireland. Estimates are in headcount and WTE numbers rather than ratios per head of population - conversion to ratios could be used for data modelling also
- Within the statistical forecasting model, the inflow of overseas specialists is set to zero to isolate the domestic supply of consultants and assess the extent to which the national education and training system can meet estimated future demand
- Entrants into the consultant workforce are based on the number of doctors who complete postgraduate training and enter on to the specialist division of the Medical Councils of Ireland's register

- The number of consultant retiring and the assumed proportion of those exiting the workforce for reasons other than retirement are also estimated
- In general, emigration among consultants is not accounted for in the scenarios outlined, although the model can be manipulated to assess the impact of different rates of emigration.
- Attrition from training is based on data from the College of Psychiatrists of Ireland (CPsychI)
- All graduates of specialist training exit the workforce, with a WTE ratio estimated for the consultant workforce as of 2020
- WTE rates are kept static over the projection period and can be manipulated to infer the impact of changes in working patterns

7.2 Implications of gap analysis on training

The results of this gap analysis are outlined in table 7.1 and can be interpreted as follows:

- **Required employment** represents the increase in consultants to meet patient demand by 2030 as per estimates from HSE Mental Health and agreed by CPsychI, to include implementation of Sharing the Vision and other services derived from Mental Health National Clinical Programmes and in the acute hospital and private hospital systems. This infers an increase in the total number of consultants working across the public and private sectors from 581 headcount consultants currently to 825.5 headcount consultants in 2030. This represents a total of 750 WTEs at a WTE rate of .91
- **Expansion demand** represents the number of additional consultants required annually to bring the workforce to the demand estimate of 825.5 by 2030 i.e. an annual average increase of 22.5 and a total of 245 by 2030
- **Replacement demand** represents the number of consultants exiting the workforce due to retirement, and for other reasons i.e. approximately 35 per year to 2030, should the average age of retirement be 60 years of age. Other reasons include; for family and health among other things
- **Recruitment requirement** represents the total number of consultants required as per expansion demand and replacement demand i.e. a total of 57 approximately year on year to 2030 and a total of 628
- **Graduate supply** represents those expected to complete specialist training and enter the workforce, up to 2022 and the required graduate supply thereafter to meet the consultant demand estimate of 825.5 headcount by 2030. Annually, an expected 22 to 46 trainees are expected to exit postgraduate training with a CSCST and eligible to obtain consultant posts. The years thereafter represent the required exit from training numbers to meet demand
- **Gap to graduate supply** represents the difference between the recruitment requirement and the newly registered specialist (graduate) supply. In this scenario, should the graduate supply stay static from 2023 onwards at 38 graduates per year, then the overall gap between the supply and demand for consultants will be in the region of 236, i.e. an undersupply. The number of doctors exiting postgraduate training with their CSCST or Fellowship qualification from 2021 will need to increase to approximately 71-72 annually in order to produce enough CSCST graduates to meet the demand projections of 825.5 consultants by 2030, should this demand be met through training alone.
- The results of this analysis infer that, by 2030/31, a shortage of around 236 consultants may occur should a decision be made to increase the consultant Psychiatrist workforce from the current 581, across both the public and private systems, to approximately 825.5 consultants by 2030. This shortage is projected in a scenario whereby the current number of CSCST/post CSCST specialists exiting from the postgraduate training system remains static at approximately 38 specialists exiting training annually to 2030. In order to ensure that supply of newly qualified specialists meets the demand for consultants by 2030 then the number of newly qualified specialists exiting postgraduate Psychiatry training will need to increase from 38 trainees to 71-72 annually from 2024 to 2030.

Table 7.1: Projected Requirement for Consultant Psychiatrists to 2030/31												
Headcount	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Total End 2030
Required employment	581.0	603.0	625.0	647.0	669.0	691.0	713.5	736.0	758.5	781.0	803.0	825.50
Expansion demand	22.0	22.0	22.0	22.0	22.0	22.5	22.5	22.5	22.5	22.0	22.5	245
Replacement demand	34	35	35	35	35	35	35	35	35	35	36	383
Recruitment requirement	56	57	57	57	57	57	57	57	57	57	59	628
Graduate supply	22	22	46	38	71	71	71	71	72	72	72	628
Gap to graduate supply	34	35	11	19	-14	-14	-14	-14	-15	-15	-13	0
WTE	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Total End 2030
Required employment	528	548	568	588	608	628	649	669	690	710	730	750
Expansion demand	20	20	20	20	20	20	20	20	20	20	20	222
Replacement demand	31	31	31	31	32	32	32	32	32	32	33	348
Recruitment requirement	51	51	51	51	52	52	52	52	52	52	53	571
Graduate supply	20	20	42	35	65	65	65	65	65	65	65	571
Gap to graduate supply	31	31	10	17	-13	-12	-12	-12	-13	-14	-12	0

Please note some figures may not add up due to rounding, the total values are correct

8. Conclusion

HSE National Doctors Training and Planning, HSE Mental Health Services, the College of Psychiatrists in Ireland, HSE National HR and the Department of Health came together with the objective of working collaboratively to identify the required future demand for consultants and trainees in Psychiatry. Core to this objective was defining the required number and type of consultants in Psychiatry to deliver a fit for purpose mental health service across Ireland and for the population of Ireland by 2030.

Many factors driving the demand for consultant and trainee doctors in Psychiatry across Ireland were identified, including population and epidemiological projections, high levels of consultants working in non-permanent, locum posts thereby representing a significant unmet demand for consultant Psychiatrists in Ireland. Furthermore, unsustainable levels of vacant consultant posts and doctors not on the specialist register occupying temporary consultant posts, highlighted the very real under-supply of consultant Psychiatrists across the country.

The high reliance on non-training NCHDs also highlighted the unmet demand for consultants. It is estimated that 231 non-training NCHDs are working in psychiatric services in the publicly funded health system and bridging a much needed service delivery gap.

When these challenges are considered in tandem with required implementation of Government policy outlined in both 'Vision for Change' and 'Sharing the Vision' (Department of Health, 2006, 2020) and developments in Psychiatry and Mental Health Services in Ireland through Service Improvement Projects, the implementation of National Clinical Programmes and models of service delivery as well as eHealth initiatives, a significant deficit in terms of the current number of consultants working in Ireland and the future required number of consultants to deliver a fit-for-purpose service is evident.

The analysis of the gap between the estimated requirement of 825 consultants to 2030 and the current 581 consultants, indicated that when those who leave the service for retirement and other reasons are accounted for, a total of 628 additional consultants will be required over the coming 10 years. Increases in training numbers required to meet this increase in consultant numbers was also analysed. The results of this analysis indicated the need to increase training numbers to ensure that approximately 71/72 trainees will obtain their CSCST between the years 2024 and 2030 if the identified demand for 825 consultants is to be met by 2030 and through training alone. Added to this, the allocation of HST places should proportionately reflect the demand for training of consultants in each of the specialties as proposed in table 6.1 above.

Identifying trainee specialist posts and the funding to ensure these posts are created requires the collaborative approach to Psychiatry workforce planning to continue. In this way, work to identify non-training scheme posts suitable for conversion to training posts should be explored to ensure implementation of the findings of this report over the next 10 years. Further to this, consultant posts that are vacant or filled by temporary, locum or agency staff should also be considered.

Finally, the findings of this report support Government policy by way of considering the implications of implementing both the Vision for Change and Sharing the Vision recommendations. The recommended demand for consultants and trainees outlined herein are aligned with staffing ratios outlined in the Vision for Change document and those determined appropriate to implement service improvement projects and National Clinical Programme Models of Care. In this way a multidisciplinary team approach to mental health service development has been considered to support the delivery of more care in the community, supported by increasingly integrated acute and primary care with community and inpatient mental health services. A more in-depth consideration of the impact of multidisciplinary team working in mental health services however would be of benefit, adding to the process of reviewing medical staffing requirements to support service delivery and developments over the next 5 to 10 years. A mid-term review of the development of the Psychiatry medical workforce of the future will be required by 2025.

9. References

Behan, J. et al. (2009) Report by the Skills and Labour Market Research Unit, FÁS on behalf of the Expert Group on Future Skills Needs A Quantitative Tool for Workforce Planning in Healthcare: Example Simulation. FAS: Dublin. Available at: https://docs.google.com/fileview?id=0Bx_D46UWx7b6NTFiMmFkNWUtN2Q3My00YmViLWFlODItZjg5NDFjNDRkOGYx&hl=es.

Central Statistics Office (2018) Population Projections Results - CSO - Central Statistics Office. Available at: https://www.cso.ie/en/releasesandpublications/ep/p-plfp/populationandlabourforceprojections2017-2051/populationprojectionsresults/ (Accessed: 18 April 2019).

Central Statistics Office (2020) Population and Labour Force Projections Results 2017-2051. Available at: https://www.cso.ie/en/releasesandpublications/ep/p-plfp/populationandlabourforceprojections2017-2051/populationprojectionsresults/ (Accessed: 5 October 2020).

Department of Health (2006) A Vision For Change. Report of the Expert Group On Mental Health Policy. Available at: www.dohc.ie.

Department of Health (2018) Health Service Capacity 2018 Executive Report. Review of Health Demand and Capacity Requirements in Ireland to 2031 - Findings and Recommendations.

Department of Health (2019) Sláintecare Implementation Strategy.

Department of Health (2020) 'Sharing the Vision A Mental Health Policy for Everyone', p. 120. Available at: https://www.gov.ie/en/publication/2e46f-sharing-the-vision-a-mental-health-policy-for-everyone/.

Department of Health and Health Service Executive (2013) Securing the Future of Smaller Hospitals: A Framework for Development. Available at: http://hdl.handle.net/10147/623977 (Accessed: 14 January 2020).

Dooley, B. et al. (2020) My World Survey 2. The National Study of Youth Mental Health in Ireland. Available at: https://www.mentalhealthireland.ie/wp-content/uploads/2020/03/My_World_Survey_2.pdf (Accessed: 11 November 2020).

Fitzgerald, E. Foley, D. McNamara, R., Barrett, E. Boylan, C., Butler2, J. Morgan3, S., Okafori (2018). Trends in Mental Health Presentations to a Paediatric Emergency Department Journal of Irish Mediicne.Vol 113; No. 2; P20

Houses of the Oireachtas (2017) Houses of the Oireachtas Committee on the future of healthcare, Houses of the Oireachtas Committee on the Future of Healthcare Sláintecare Report.

HSE; Mental Health Division (2016) Mental Health Division Delivering Specialist Mental Health Services. Dublin.

HSE; Mental Health Division (2017) Mental Health Division Delivering Specialist Mental Health Services. Dublin.

HSE; Mental Health Division (2019) Mental Health Division Delivering Specialist Mental Health Services. Dublin.

HSE; NDTP (2016) NDTP Medical Workforce Planning Ireland: A Stepwise Approach.

HSE; NDTP (2020) Psychiatry Recruitment and Retention Report (Unpublished).

Medical Council (2018) Medical Workforce Intelligence Report. Available at: https://www.medicalcouncil.ie/News-and-Publications/Press-Releases/Press-Release/Medical-Workforce-Intelligence-Report.pdf (Accessed: 26 April 2019).

Pitchforth J, Fahy K, Ford T, Wolpert M, Viner RM, Hargreaves DS (2019). Mental health and well-being trends among children and young people in the UK, 1995–2014: analysis of repeated cross-sectional national health surveys. Psychological Medicine 49, 1275–1285. Available at https://doi.org/10.1017/S003329171800175

World Health Organisation (2010) User's Guide to the WHO Global Code of Practice on the International Recruitment of Health Personnel. Available at: https://apps.who.int/iris/bitstream/handle/10665/70525/WHO_HSS_HRH_HMR_2010.2_eng.pdf;jsessionid=46216E50107FAEA81AEB9B6E077E2D50?sequence=1 (Accessed: 2 May 2019).

World Health Organisation (2011) WHO Global Code of Practice on the International Recruitment of Health Personnel. Available at: https://www.who.int/hrh/migration/code/code_en.pdf?ua=1.

World Health Organisation (2019) Telehealth, WHO. World Health Organization. Available at: http://www.who.int/gho/goe/telehealth/en/ (Accessed: 11 November 2020).

Notes

NDTP

National Doctors Training & Planning