*Scottish Division: Manpower Report**

The manpower problem is one of shape as well as one of size. The standard metaphor of a pool used to describe the stock of manpower is especially apt. The important characteristics of a pool are all extrinsic in the sense that they are imposed by other things; those that can be measured may be useful in giving a description of the pool but tell us more about matters such as temperature, rainfall, and the lie of the land. Above all, the pool can clearly be seen to depend for its size, indeed for its existence, on the relation of inflow to outflow.

Because of this, the working party approached the task of preparing a report in the knowledge that it would have to be descriptive rather than prescriptive, a foundation for a Divisional view and not the view itself. Experience had taught us that conflicting opinions on aspects of the manpower problem exist not only among groups and individuals but also within individuals, many of whom hold incompatible views on one aspect at different times or on different aspects at the same time. We decided to try to gather facts and opinions by asking Divisions of Psychiatry and Sections of the Scottish Division to respond to a questionnaire. We did not believe it was possible to obtain all the information that might be needed or to touch on all aspects of the problem by this method but felt that it might provide a framework. In addition, one of us conducted a separate survey of trainees to obtain factual information about them and to allow them to express their opinions.

Our remit involved us only in medical manpower. It is impossible to say how many psychiatrists are needed for psychiatric treatment or to delimit the role of the psychiatrist. The importance of the psychiatrist to the service lies in the fact that he is trained to perform many different tasks and to understand the nature of many others. It does not follow that he will be required to do all he is trained for throughout his career nor that he will be better at performing each task than other professionals with a narrower training. The extent of his role may vary from time to time and from place to place depending on the number and the skill of non-medical colleagues as well as on his own interests and enthusiasm. We can say that he is needed to integrate the service but we cannot say how much he is needed.

**This is an abbreviated version of the Report which was prepared for the Scottish Division by a Working Party and presented at the Divisional Meeting at Montrose on 14 March 1986. The recommendations were also read to the College Manpower Committee on 24 March 1986. The Report is now the official policy document of the Scottish Division having been adopted by the Executive Committee on 29 May 1986.*

Since the amount of psychiatric treatment that needs to be provided and the number of psychiatrists needed to provide it are both unknown and possibly unknowable we find ourselves dealing with the question 'How much and how many can we afford?' With regard to psychiatrists we must also ask how many can be produced, since it is by no means certain that many more doctors than at present would commit themselves to a career in psychiatry even if unlimited money were to be made available. If the supply of psychiatrists cannot be stepped up without loss of quality, any expansion is likely to lead only to a contraction of the service in peripheral areas and less popular subspecialities; a shift in this direction has already taken place. The value to the service of having centres where the best psychiatrists will have the opportunity to improve psychiatric practice under the best conditions has to be balanced against the damage to the service of falling standards in other parts. The factors which govern the supply of recruits operate mainly outside psychiatry itself and have to be examined in relation to the whole of medicine. Psychiatry will always have to adapt to these powerful external forces.

Similarly the demand for treatment and the supply of money to pay for it are in the hands of others. Demand appears to be increasing constantly and is always ahead of willingness to meet the cost. Realistic planning, therefore, is confined to what we can afford and concerns itself with the best use of the resources available. It is unlikely that a normative approach to medical manpower will ever be possible, especially in psychiatry; much is heard at present of 'the walking worried' whose demands appear to be greater than their needs, but they may be hard to distinguish from 'the running scared' whose needs are much more pressing.

If we cannot plan the right size of service, what can we plan? For a pool, shape is more important than size and the shape of manpower stock is something that we can measure and plan. The shape is determined by distribution and, for psychiatry, this needs to be looked at in respect of services, professions, geography, sub-specialties, age, and grade.

The distribution of work which has a psychiatric aspect to it can vary between the NHS and the Social Work Department, between the NHS and voluntary organisations, between psychiatrists and geriatricians, and between psychiatrists and general practitioners. Within the psychiatric service, the distribution of work can vary between psychiatrists and other professionals. Both of these factors have a major effect on manpower planning but we regard them as being outside our remit.

The distribution of psychiatrists geographically has already been commented on. It is of major importance to some parts of the country and the difficulty that exists in

https://doi.org/10.1192/S0140078900028042 Published online by Cambridge University Press

filling consultant posts in some services suggests that there may be an unsatisfactory distribution of quality as well as of numbers. The distribution across the sub-specialties appears to be similarly unsatisfactory and it is probably useful to consider the two problems together as they may have common causes.

Age and grade are likewise closely linked. When we examine them we find the pool analogy breaking down. The formation of a pool in the course of a stream of water depends on the fact that the speed of the current can vary: narrows produce rapids and a bottle-neck does not create a vacuum. In terms of manpower, however, the current is time and time is immutable. Training and experience are both linked to time in our present system and cannot be speeded up (although they can be slowed down by part-time working). It is, therefore, possible to imagine an ideal system which is in a steady state with no leakage and in which the inflow exactly matches the outflow. If we assume that every trainee psychiatrist enters the system at the age of 25, becomes a consultant at 32, and retires at 60, then each psychiatrist will spend one-fifth of his service in training and four-fifths as a consultant. Inevitably there will always be four consultants for every trainee and each consultant will replace himself by providing a quarter of the training of four trainees (including senior registrars) during his 28 years as a consultant.

Deviations from this ideal system are brought about by losses due to trainees giving up through failure to obtain adequate experience or qualification or by choice of a different career, and by emigrating or early death or retirement of consultants. Moreover, training for other careers such as general practice allows an increase in trainee numbers. It is a moot point how big a proportion of psychiatric trainees should be designed to exceed the ideal number in order to allow for the wastage which is the inevitable accompaniment of competition. Competition must take place at some stage if recruitment exceeds requirements, and it is possible to choose where the 'hurdle' or 'bottle-neck' should be. The present bottle-neck at the transition from registrar to senior registrar may seem so late as to make the current wastage too expensive in terms of effort spent in training both by the trainee and by the service; a bottle-neck too early in training would almost certainly lead to poor selection and the loss to the service of potentially good psychiatrists. We shall have to consider whether the College's Preliminary Test in its proposed new form could be used as a screening device and whether it would come at an appropriate stage in a trainee's career.

The other major deviation from the ideal trainee-consultant continuum is the provision of supporting staff who are not in training. The major issue in this field is whether it is acceptable to provide a career grade in this way, a sub-consultant grade. This is an issue which is unlikely to be settled within psychiatry separately from the rest of medicine, but it may be more relevant to some parts of medicine than to others. It might be agreed that there is, in fact, more 'sub-consultant work' to be done in psychiatry than in some other specialities and it is possible to argue that, if this is not done by psychiatrists, it will only be done by other doctors and, if it is not done by other doctors, it may—at least in part—be done by other professions. It seems unlikely that the service will accept that it should be done by extra consultants. If we are to continue to train rather more psychiatrists than are needed for consultant posts—because of the need for competition as a means of maintaining quality, not because there are too few such posts—then it may be better that those trainees who, in spite of being adequate, fail to obtain a consultant appointment remain within the service as supporting staff. The Division will have to clarify its thinking on this matter because it is a major factor in determining the future shape of medical manpower. There will always be a conflict between the immediate need of the service to provide good care for patients and the long-term need of the service to produce high-quality consultants by ensuring a satisfactory career structure for good trainees.

The effort of the College to ensure satisfactory training is also a major factor as there seems to be a gradual movement towards a state in which all trainees would become supernumerary with service provision taking second place to training needs. This must greatly influence the arguments about supporting staff as regards both their role and their numbers. Small units, especially if they are also peripheral, may find that they have little or no contribution from trainees and are, by the same token, unable to contribute to training. This could have a very serious effect on the quality of such units since it seems likely that good training and good service go hand in hand. Equally, it could bring about a serious loss to trainees of very valuable and relevant experience with a wide range of case material and of service delivery.

We are faced, therefore, with the need to look at manpower as an entity which cannot be planned by itself. It must be planned in a way which is flexible and responsive to an extent that is uncomfortable for the individual but which cannot be allowed to make life in psychiatry intolerable. It is with an awareness of this situation that the working party has examined the problem.

Recommendations

(1) An expansion of consultant staffing is required to provide what most psychiatrists regard as a satisfactory service. The present rate of four additional posts per annum should be increased to 12 additional posts per annum over a period of 10 years, bringing the total number for Scotland to approximately 360, compared with the present 240.

(2) SHO and registrar posts should cease to be interchangeable and the number of registrar posts in Scotland should be reduced and controlled centrally as senior registrar posts are at present.

(3) Although the present number of senior registrars appears to be too small to provide adequately trained candidates in sufficient numbers to fill all consultant vacancies, this may be a temporary phenomenon and

https://doi.org/10.1192/S0140078900028042 Published online by Cambridge University Press

the present consultant : senior registrar ratio of roughly 4 : 1 should remain.

(4) The present pool of registrars is too large to give reasonable prospects of promotion to senior registrars and the present registrar : senior registrar ratio of over 2 : 1 should be reduced to a maximum of 1.2 : 1.

(5) Promotion from SHO to registrar should be made more difficult in order to reduce the bottle-neck at entry to higher training and a hurdle, possibly an assessment combined with passing the Preliminary Test of the MRCPsych, should be introduced. This might come about automatically as a result of open competition for a fixed number of registrar posts. Some psychiatric trainees might have to spend more than one year in the SHO grade.

(6) College Approval Teams should accept four years in the registrar grade as a reasonable part of training schemes irrespective of time spent as an SHO.

(7) Training schemes should be arranged to ensure that all trainees spend some time working in peripheral services and trainees should accept the need to move in order to achieve this.

(8) All general practice trainees should be encouraged to spend six months at SHO level in psychiatry. This would mean that an average psychiatric service with a catchment population of 200,000 would accommodate 2.5 such trainees at a time.

(9) Non-training career grades should continue, associate specialists being trained and qualified, clinical assistants being part-time, and a new grade of hospital medical officer (or similar title) being created for trainees who have completed training without gaining the qualifications needed for a senior grade. These non-training grades would be needed to ensure that service needs do not interfere with the training of the reduced numbers of registrars. Consultants would have to accept that much of their support would come from these grades.

(10) Some form of central control is required to ensure that adequate training is available for the appropriate number of trainees at the right time to meet the needs of the sub-specialties.

(11) These recommendations apply to the complete psychiatric service including all sub-specialities. They would produce an average service with a catchment population of 200,000 staffed by, roughly, 14.5 consultants, 4.5 registrars, 2 psychiatric SHO's, 2.5 general practice SHO's and anything from 4 to 8 non-trainee supporting staff (all whole-time equivalents). Variations from this pattern would be justified to allow for teaching commitments to undergraduates, for travelling time in large rural areas and to allow for the provision of services to other areas. In addition, Scotland as a whole would have 95 senior registrar posts instead of the present 62. The total number of consultants in Scotland would be 360 and the total number of registrars would be 112 instead of the present 130. The proportion of staff designated for sub-speciality work would be a matter for local decision.

Summary. We felt that it was our duty to ascertain the opinion of Scottish psychiatrists on current manpower issues and to express this opinion in a coherent form, if necessary by modifying it in certain aspects. It would obviously be easy to hold a referendum on all the possible issues and end up with a series of unconnected and conflicting views each of which had majority support. We, therefore, felt free to make interpretations and to guess what people would find acceptable if they were in a position to listen to the arguments and see the points of view of all their colleagues in the country. Since none of us makes claims to exceptional wisdom, this process has undoubtedly resulted in a report which contains some of our own biases and prejudices but we hope that, with a consultant : senior registrar ratio of 4:1 and with a fairly wide distribution in terms of geography and age, we may have balanced each other out and ended up with a view which is not far from being representative.

Despite what was said in the introduction, we managed to agree on some recommendations but, where we give figures, we would stress that these are not norms. They are numbers which describe the size and the shape of a service which, we believe, most Scottish psychiatrists would consider satisfactory in most respects to cope with the job psychiatry is currently doing. That job has changed in the past and will no doubt continue to change.

R. DAVIDSON *(Convenor)*
B. BALLINGER
D. BRODIE
W. FRASER
S. WHYTE

Changes to the 'JCHPT Handbook'

Members' attention is drawn to the following changes made by the JCHPT at its meeting on 9 April 1986 to the 'Requirements for Approval of Higher Training undertaken in Research Appointments' (p. 81 *JCHPT Handbook*, September 1985).

(1) Trainees who spend one year in full-time research as post-Membership registrars can apply to the JCHPT for recognition of this experience *after* they have been appointed to a substantive senior registrar post. One year's seniority will be granted.

(2) Trainees who, as post-Membership registrars, spend more than one year in full-time research can apply to the JCHPT for retrospective recognition *after* they have been appointed to a substantive senior registrar post.

https://doi.org/10.1192/S0140078900028042 Published online by Cambridge University Press