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Safe patients and high-quality services: a guide to job descriptions and job plans for consultant psychiatrists

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Laurence Mynors-Wallis
Registrar
Royal College of Psychiatrists

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Introduction

The role of a consultant psychiatrist is changing, reflecting changes to clinical practice, social expectations, the role of other professions and available resources. Psychiatrists have often been at the forefront of such changes and used their skills and knowledge to develop innovative services that better meet the needs of patients and their carers. The guidance in this document is provided to support such changes, innovation and service development (Academy of Medical Royal Colleges, 2012a).

There is a clear expectation and demand from patients and carers for more time from their psychiatrists, with time to be spent ensuring that the relationship is one of partnership in which the psychiatrist plays a key role in discussing diagnosis, treatment options and treatment plans. To undertake this work to a satisfactory standard requires the psychiatrist to have sufficient time to spend with their patients.

Psychiatrists welcome and value the work done by other professionals within a multidisciplinary team. It has never been the case, and nor should it be, that all patients need to see a psychiatrist. However, there is an expectation that patients with more complex disorders and those that present a significant risk to themselves or others should have the involvement of a psychiatrist in the assessment, care planning and, where appropriate, ongoing care. Again, psychiatrists need to have sufficient time to undertake this important work.

The guidance set out in this document is designed to help psychiatrists and those that manage services determine how to meet these aspirations within the resources available. The guidance is designed with a focus on providing safe and high-quality services for patients and their carers. Services will, of course, vary in different settings and in different parts of the country. However, the parameters set in this document should guide those responsible for the commissioning, provision and delivery of services. If this guidance is not followed, this should lead to a discussion between the consultant and their employer as to how patient safety and the quality of service delivery can be maintained.

Background

The consultant psychiatrist is a highly skilled clinician who has been trained to deliver expert clinical care, ensuring the delivery of safe, high-quality services for patients. The clinical role of a consultant psychiatrist sits alongside other important roles including training the next generation of doctors. Consultants are at the forefront of research and innovation and play a significant part in the running of successful organisations.

CLINICAL ROLE

Whatever the subspecialty in psychiatry, the primary duty of a consultant is to care for patients. The consultant psychiatrist has particular expertise in diagnosis and treatment, especially when there is comorbidity and links between physical and mental disorders. The ability to diagnose, formulate and manage complex and severe disorders is an important skill of the consultant psychiatrist and is of direct benefit to patients and carers and also supportive to the wider multidisciplinary team.

The consultant psychiatrist has a role as the personal physician for a group of patients, not only those with complex and severe disorders, but also those for whom the particular skill of the psychiatrist, for example medication management, understanding the links between physical and mental illness and continuity of care, is important. This is alongside the role of offering expert advice, assessment and support for patients cared for primarily by other members of the multidisciplinary team.

The consultant psychiatrist has a predominant role in the implementation of the Mental Health Act 1983. Although other clinicians can take on roles within the Act, it remains the case that this work is largely done by consultant psychiatrists, who need to have sufficient time to undertake the tasks to the high standard expected.

The key benefits of consultant-delivered care are summarised in the report of the Academy of Medical Royal Colleges (2012a):

- rapid and appropriate decision-making
- improved outcomes
- more efficient use of resources
- general practitioner (GP) access to a consultant opinion
- patient expectation of access to appropriate and skilled clinicians and information
- benefits for training junior doctors.

Consultants should play a key role at the beginning of a patient's care pathway, ensuring that patients receive appropriate interventions following a thorough assessment, diagnosis and formulation.

LEADERSHIP ROLE

There are many aspects to leadership and it occurs at team, directorate and organisation level, and in regional and national roles.

Consultants are responsible within their teams for providing leadership to ensure the delivery of high-quality care for patients. Although other members of the team may have important leadership roles, the consultant should provide clinical leadership for the team within which they work. A key aspect of leadership is the promotion of excellence in service delivery and in enabling others within the team to provide care of the highest standard.

Consultants have an important role within teams in the management and containment of risk and anxiety for those patients with complex disorders and risky behaviours.

Consultants are experienced clinicians and are likely to be the most senior members in an organisation who continue to provide significant clinical services. They therefore have an invaluable perspective and a role to play in the development and management of services in teams, directorates and their organisation.

Consultants can play a key role in leading innovation and change within organisations for patient benefit. For this to happen, organisations need to establish systems to support new ideas and innovation and ensure that consultants have the time to develop and implement these improvements.

Consultants provide input into regional and national activities, including local commissioning groups, college work, work for universities and National Health Service (NHS) organisations. Consultant psychiatrists need to identify time with their employer to engage in these activities. Support for this work comes from the General Medical Council, chief medical officers and the national departments of health (Appendix).

Consultant psychiatrists should have a role as mental health experts in their local communities and work with primary care, local authorities, the third sector, patient/carer groups and employers to improve public mental health, reduce stigma and improve community resources that support populations in having good mental health.

EDUCATIONAL AND ACADEMIC ROLE

Each consultant is committed to individual life-long learning to ensure that they keep up to date in the skills required for their role.

The consultant should have a responsibility for training, not only of medical colleagues, including medical students and doctors in training, but also members of other professions.

The consultant has a key role, in partnership with patients and their carers, to explain in straightforward language the treatment options alongside the potential risks and benefits for interventions that are being considered.

Developing a better understanding of illness and pursuing more effective treatments is an intrinsic part of the role of the consultant

psychiatrist. The breadth of training and education in basic sciences, as well as in social and psychological sciences, and experience gained in research techniques, uniquely positions the consultant psychiatrist to work in this area.

A more detailed description of the consultant psychiatrist's role is given in the College's occasional paper *Role of the Consultant Psychiatrist* (Royal College of Psychiatrists, 2010a).

Job descriptions and job plans

The Royal College of Psychiatrists provides an important service to those employing consultant psychiatrists by reviewing new job descriptions and offering advice to ensure that they are of a standard that enables the consultant to deliver high-quality and safe care. The information in this document will assist those drawing up and reviewing job descriptions as to the standards expected.

Within the NHS, the consultant timetable is agreed through a process of job planning. The British Medical Association and NHS Employers (2011) have produced a guide to consultant job planning to facilitate and improve this process. The information in this document should assist those involved in job plans by providing guidance about workload factors that will influence the ability of the consultant psychiatrist to effectively deliver safe and high-quality services.

There is always a need for flexibility in agreeing a job plan, according to local needs/circumstances, but the College is setting guidelines that it believes provide satisfactory levels of safety for the patient and service. Organisations should have clear and justifiable reasons for deviating from these guidelines in the job planning process.

Many psychiatrists work in the independent sector. The standards and guidance in this document will be equally relevant to them. Programmed activities (PAs) are an NHS term but equate reasonably well to a half-day session.

GENERAL PRINCIPLES

- 1 There should be sufficient numbers of consultants to provide the range of activities required allowing for out-of-hours work and cross-cover arrangements.
- 2 Job descriptions and plans should be drawn up in a way that provides the consultant with sufficient time to undertake the tasks required to a safe and high standard.
- 3 Job description plans for consultant psychiatrists should be flexible enough to ensure that they are able to provide consultant-type activity in an immediate and responsive way. This includes both the ability to respond to immediate clinical requests, for example from team members, and to deal quickly with educational and management tasks. These issues occur unpredictably throughout the working week.

- 4 The Academy of Medical Royal Colleges (2012b) recommends that 1 to 1.5 supporting professional activities per week is the minimum time required for consultants to meet the needs of revalidation.
- 5 The role of the consultant will depend in significant part on the availability of other clinical and administrative staff working alongside them. Consultants working without sufficient administrative support will be forced to undertake such tasks at the expense of the activities for which they are trained and wish to deliver. Consultants working with less support from training grade and specialty doctors will need sufficient time to undertake the tasks which could otherwise be delivered by those doctors. Consequently, consultants working in well-resourced community mental health teams (CMHTs) will be able to focus on patients with more severe and complex disorders, whereas if there is only limited availability of other professional skills the consultant will provide direct care to a broader patient cohort.

SPECIFIC TASKS

This section sets out in general terms the roles that may be undertaken by a consultant psychiatrist, with examples of tasks included within the role. These are not the only roles undertaken but provide a framework for considering in a job description. Different jobs will have a different balance of tasks. Specific roles for each subspecialty are included in the subspecialty sections that follow.

CLINICAL ROLES

COMMUNITY ROLES

Role description	Tasks
New out-patients or home visits, including meetings with relatives and carers	Assessment, diagnosis and formulation of management plan Shared decision-making with patients and carers
Follow-up out-patients or home visits	Ongoing review of formulation and management plans Shared decision-making with patients and carers
Team meetings	Communication about patients and carers, sharing organisational policies and objectives
Multidisciplinary patient reviews	Care programme approach (CPA) reviews, Multi-Agency Public Protection Arrangement (MAPPA) meetings, risk reviews
Clinical advice to team members	Regular or <i>ad hoc</i> supervision on clinical matters
Liaison with colleagues	Discussion about patient care with primary care, secondary care and colleagues in other psychiatric teams
Mental health and capacity legislation	Meeting the requirements of emergency work, community treatment orders, assessments of capacity

IN-PATIENT ROLES

Role description	Tasks
Direct clinical work with patients and carers	Assessment, diagnosis and treatment Ensuring physical health is considered alongside psychological and social issues. Shared decision-making with patients and carers
Multidisciplinary reviews	Patient assessments, CPA reviews, MAPPA meetings, risk reviews
Clinical team meetings	Decision-making meetings. Reviewing daily workload
Mental health and capacity legislation	Assessments, report writing, attendance at mental health tribunals and managers hearings, assessments of capacity
Clinical advice to team members	Regular or <i>ad hoc</i> supervision on clinical matters
Liaison with colleagues and other services	Speaking with other professionals involved in patient care – primary care, CMHTs, general hospitals

LEADERSHIP ROLES

Role description	Tasks
Leadership role	Implementing and reviewing standards, innovation in service delivery, clinical governance, patient safety, modelling high-quality patient care, supporting colleagues, building relationships with GPs and other external organisations
Lead clinical roles ¹	Provide leadership role for specific and defined areas of development or practice
Lead consultant	Provide leadership and often line management for consultants and other medical staff within the service, often lead for quality within a directorate
Clinical director	Similar role to that of lead consultant, often including wider management responsibilities including budgets
Medical director	Senior medical leadership role within an organisation usually including the responsible Officer role as well as a wide range of corporate roles
Regional and national leadership	Royal College of Psychiatrists roles, Department of Health advice, work for Care Quality Commission and National Institute for Health and Clinical Excellence (NICE)

1. For example, audit, risk, patient safety, Mental Health Act work, information governance, clinical governance, specific service development.

EDUCATIONAL AND ACADEMIC ROLES

Role description	Tasks
Supervision of trainees	Each trainee requires 1 hour of trainee-centred educational supervision per week Additional supervision will be required for clinical work
Meeting requirements for revalidation	Revalidation activities including continuing professional development and quality improvement activities and reflection on serious incidents
Organisation of academic programmes ¹	College tutor, director of medical education, programme director, head of school
Examination roles	College examiners, developing curriculum and examinations
Training medical students	One-to-one teaching, lectures, examining and skills-based workshops
Education	Lectures, small-group teaching, skills workshops
Research	Clinical, service and basic science research, peer reviewing of papers

1. Including department programme, trainee doctor programme, medical student programmes, college tutor, deanery roles.

Job descriptions and job plans in this document are built around a full-time post being 10 PAs per week of which 7.5 are for direct clinical care. The College recognises that this terminology applies only to psychiatrists working in NHS services, however, the principle of a PA being equivalent to a half-day session and the expectation that a consultant psychiatrist provides important roles alongside direct patient care applies equally well to other settings for service delivery.

The College accepts that there are financial pressures on organisations to increase the productivity of all staff including consultant psychiatrists. The College believes, however, that moving away from the ratio of 7.5 direct clinical care PAs to 2.5 PAs for supporting professional activities is a false saving. Organisations that seek to reduce the number of supporting professional activities for consultant psychiatrists risk losing the expertise of these key individuals in education, leadership, innovation, service development and acting as ambassadors of the organisation in links with primary care and other organisations. These are roles vital for the success of any healthcare organisation.

Although much of the guidance in this document is about expectations for direct face-to-face care, the College recognises that there are other forms of communicating with patients and their carers that are not only acceptable but may be more convenient, including telephone contact and, with appropriate safeguards, email and other forms of electronic communication. The College strongly supports the principle that communication with patients and carers should be flexible and convenient for patients and carers. Sensible local discussions can be held as to the necessary time to undertake this work to an appropriate standard.

TRAINING

Consultants supervising core training grade doctors or GP training doctors should have 30 minutes per new patient to review the patient and discuss the formulation and management with the trainee doctor. There should also be time at the end of each clinic to go through the ongoing management plans of patients seen for follow-up.

Consultants should have 0.5 PAs in their job plan for each training grade doctor they supervise reflecting the formal 1 hour of supervision required each week, the additional *ad hoc* supervision and administrative tasks needed for training. These educational requirements also include giving lectures on MRCPsych courses, attending Annual Reviews of Competency Progression and doing selection interviews.

RESEARCH AND INNOVATION

Consultants can play a key role in leading research and innovation for patient benefit. For some consultants this will be a very significant part of their role. However, all consultants should be expected to support research and the careful evaluation of new treatments and methods of service delivery.

General adult psychiatry

The clinical, leadership, educational and academic roles for general adult psychiatrists are as set out on pages 5–12. General adult psychiatrists form the core of mental health services, and usually work in a multidisciplinary team, based in the community or in-patient unit, or both. Some general adult psychiatrists work with defined groups of patients at certain stages of the patient journey, for example in crisis (crisis response and home treatment teams), in a first episode of psychosis (early intervention) or with those who have proven difficult to engage elsewhere (assertive outreach).

INFORMATION TO SUPPORT JOB DESCRIPTIONS AND JOB PLANS

FULL-TIME COMMUNITY POSTS

The clinical work of a community-based general adult psychiatrist can be broken down as set out on page 10 under community roles. The allocation of these tasks within a job description will depend on the clinical role expected of the consultant and the other staff available to undertake a proportion of these tasks.

It is reasonable for a full-time community consultant to have 5 PAs per week for direct patient care in out-patient or community assessments.

New patients in the out-patient clinic require an hour for an appointment. Follow-up appointments require 30 minutes. Clinics should be structured so that only 3 of the 4 hours of PA are booked in with routine patients allowing for space for urgent cases, liaison with other professionals and the completion of administrative tasks not completed during the allocated time for each patient.

Time within a job plan should be allocated for patients to be seen outside routine out-patient settings for those patients who are unlikely or unable to attend. For these patients, additional time must be allocated for travel.

Time within a job plan needs to be made available for emergency assessments in the community if they are to be undertaken by consultant staff. If such assessments are to be undertaken by other members of the multidisciplinary team, time should be available in the consultant's job plan for the clinical support and supervision of decisions made. A minimum of 1 PA per week is likely to be required for emergency work.

Time needs to be identified within the consultant job plan for the consultant to be available for the community team to discuss issues that might arise with patients and, if appropriate, have time to review those patients about whom there are particular concerns.

Multidisciplinary working includes a weekly multidisciplinary team meeting to discuss patient care – this requires 0.5 PA. An additional 0.5 PA should be included in the job plan for support and advice to members of the multidisciplinary team about patient care outside the team meeting.

For Mental Health Act work, including community treatment order work, and for attendance at multidisciplinary complex patient reviews, a minimum of 0.5 PA per week is required.

If an employer desired a consultant to spend more time undertaking emergency work or participating in multidisciplinary patient reviews, this would need to be offset by a reduction in out-patient clinics and home visits.

A summary of a direct patient care timetable for a full-time consultant with no specific educational or leadership role is given below.

Out-patient work/home visits	5 PAs per week
Multidisciplinary team meeting and support for team members outside the meeting	1 PA per week
Emergency clinical work	1 PA per week
Mental Health Act work/complex patient reviews	0.5 PA per week

It is difficult to be precise, but it is likely that in areas of average morbidity there should be at least 1 whole time equivalent (WTE) community consultant per 50 000 adult population.

FULL-TIME IN-PATIENT POSTS

In-patients are the most ill patients in the service. It is expected therefore that each consultant should have sufficient time within their timetable to personally review each patient at least once a week. Consultants should have time to visit the ward each day in order to be available for day-to-day decisions requiring consultant input.

There are different models of providing consultant input into in-patient wards, with some teams having brief daily reviews of workload, following which team members see patients individually and implement the decisions made. In other areas, more traditional ward rounds take place, with patients being reviewed by multidisciplinary teams.

All full-time in-patient jobs are likely to require 5 PAs of ward-based clinical activity which are allocated to both clinical team meetings and direct contact with patients. The exact nature of the work will reflect the mix of patients on the ward.

All in-patient consultants spend a significant amount of time on Mental Health Act work. Organisations must make judgements, based on previous experience, as to the amount of time this involves for each consultant. Each manager's hearing or tribunal is likely to require 1 PA both in the preparation of the report and attendance at the tribunal. This work is likely to require a minimum of 2 PAs per week for all in-patient consultants. Other clinical administrative tasks concerning in-patient care include, for example, unscheduled telephone calls, correspondence, checking of blood, require 0.5 PAs per week – this is of course spread throughout the week.

In-patient consultants would expect to work alongside and support junior colleagues, year 1–3 core trainees (CT1–3) and/or specialty doctors, who would be able to undertake some of the medical tasks required with appropriate supervision.

A summary of a direct patient care timetable for a full-time consultant with no specific educational or leadership role is given below.

Ward-based clinical activity including clinical decision meeting and interviewing patients and carers	5 PAs per week
Mental Health Act work	2 PAs per week
Clinical administrative tasks	0.5 PA per week

Wards differ according to the complexity and illness of patients – those with shorter lengths of stay require more consultant time. It is unlikely that consultants can manage more than between 15 and 20 beds without additional medical input from another senior doctor, approved as competent under the relevant mental health legislation, or a year 4–6 specialist trainee (ST4–6).

Consultants working on psychiatric intensive care units need to have sufficient time to review patients more frequently than once a week reflecting the illness severity, risks and complexity of the patients. These patients often need consultant review two to three times a week. In a psychiatric intensive care unit, all patients are detained and hence there is a need for increased time proportionally for mental health legislation work.

MIXED JOBS: SECTOR-BASED CONSULTANTS

The principles set out for community or in-patient care posts apply to mixed posts, with time needing to be allocated for travel between the two. The advantages of mixed posts are the opportunities for continuity of care and the fact that the consultant often knows the patients who transfer between parts of the system. Sector-based posts are likely to require a balance of 3 PAs for ward-based and clinical sessions and 4.5 PAs for community-based clinical work. The population size of community patches and the number of in-patient beds needs to be adjusted according to the sessional commitment.

It would not be feasible for a consultant with both community and in-patient responsibilities to visit the ward each day. However, any consultant with in-patients should be readily available to the ward staff to discuss issues that might arise with their patients and they should have flexibility within their timetable to be able to attend the ward at short notice if their presence is necessary.

CRISIS AND HOME TREATMENT TEAM CONSULTANTS

Consultants work in teams designed to provide intensive support to patients as an alternative to hospital admission. If these teams care for patients who, in the absence of such a team, would require hospital admission consultants need to have sufficient time within their timetable to personally review all patients, or supervise a senior ST4–6 or a Section 12-approved specialty doctor for those patients under the care of the team. If the teams have a broader remit, consultants need sufficient time for involvement with patients with complex disorders and those deemed at particular risk as well as having sufficient time to provide support and advice to multidisciplinary colleagues and other doctors in the team.

MIXED IN-PATIENT AND HOME TREATMENT TEAM POSTS

Some consultants manage the whole acute care pathway that is both in-patient and home treatment. There are advantages to such posts because of continuity of care. Time within the job plan needs to be allocated for travel involved. Again, consultants need sufficient time to review patients to provide high-quality and safe care. Any consultant with in-patients should be readily available to the ward staff to discuss issues that might arise with their patients and they should have flexibility within their timetable to be able to attend the ward at short notice if their presence is necessary.

ASSERTIVE OUTREACH AND EARLY INTERVENTION SERVICES

Consultants working in assertive outreach or early intervention services will need to spend more time in care planning and communication than those in general adult services, although face-to-face time for an individual contact is unlikely to be substantially different. Travel time is likely to be increased, and job planning will need to reflect these differences. As a consequence, it is likely that less time will be spent in overall face-to-face contact (clinics) with patients and more time will be spent in multidisciplinary planning meetings.

Old age psychiatry

A consultant in old age psychiatry has a particular expertise in the psychiatric care of older patients (usually over 65 years), including specialist knowledge of organic disorders and the complexities associated with multiple physical comorbidity. In addition to the general roles set out on pp. 5–12, old age psychiatrists have specific expertise as listed below.

CLINICAL ROLE

- Assessment, diagnosis and formulation of management plans with patients and carers for both functional and organic illness in the elderly.
- Expertise in the management of psychiatric illness in patients with complex and/or multiple physical disorders.
- Expertise in pharmacological, psychological and behavioural interventions to manage behaviours that challenge in the context of a dementia diagnosis, including patients in long-term settings.
- Particular expertise in the diagnosis and management of delirium.
- Expertise working in varied settings, including residential/nursing homes, general hospitals and patients' own homes, with multi-professional and multi-agency teams.

LEADERSHIP ROLE

- Leading the development of clinical standards and implementation of national guidance in old age psychiatry.
- Development and monitoring of outcome measures for patients in old age psychiatry.

INFORMATION TO SUPPORT JOB DESCRIPTIONS AND JOB PLANS

In old age psychiatry services there are many different models of service provision ranging from highly centralised services, in-patient units on general hospital sites and well-resourced specialist memory service assessment, through to rural services with admission beds on several different sites and memory assessment services being incorporated with mainstream out-

patient clinics. Consultants work with a broad range of multidisciplinary staff and often away from their administrative base.

In addition to expertise in mental health legislation, a knowledge of capacity-based legislation is required and time to implement these is needed in all job plans. This may include roles as Deprivation of Liberty Safeguards assessors or other types of mandatory second-opinion work.

Old age psychiatrists see many patients in their own homes, in residential or nursing homes or in community settings, with fewer attending out-patient clinics than is the case in adult psychiatry. This will involve travelling and therefore reduce the numbers of patients that can be seen.

Old age psychiatrists, like general adult psychiatrists, can be appointed to solely in-patient, community or mixed jobs. Liaison old age psychiatry can also be part of these roles.

FULL-TIME COMMUNITY OLD AGE PSYCHIATRY POSTS

The clinical work of a community-based old age psychiatrist can be described in the categories defined under community roles earlier in the document. The support from other clinical members of the team will determine the time needed to be allocated to the separate roles.

The balance of out-patient and home visit work within an old age psychiatry community-based post will be different to an adult psychiatry post. Fewer patients are seen within the out-patient clinic. The growth in demand for memory assessment services and early diagnosis requires dedicated senior medical time for this purpose.

New patients in an out-patient clinic require a minimum of 1 hour for assessment, with 30 minutes for follow-up appointments. Acknowledging the greater focus on community-based assessments, a minimum of 1.5 hours for new assessments and 1 hour for follow-up assessments to incorporate travel time is a reasonable standard. Clearly, if the geographical area covered is large, these times will need to be extended. Time should be allocated within community and out-patient sessions to allow for emergency assessments, liaison with other colleagues and completion of necessary clinical administrative tasks.

Liaison with primary care and secondary care old age medicine services is an important part of the old age psychiatry consultant role.

Job plan time needs to be allocated for mental health and mental capacity legislation work if this is not contracted separately by commissioners. As with all consultant appointments, time in the job plan needs to be allocated for supervision of doctors in training. The principles for this would be similar to those within general adult psychiatry.

Multiprofessional working requires meetings to discuss patient care and individual meetings with other clinicians; 1 PA should be allocated for this in all job plans.

Flexibility within job planning is needed to accommodate roles depending on team structure, e.g. supervision of non-medical prescribing, involvement in adult protection meetings. This needs to be reflected in the expectations of the number of out-patient and community sessions undertaken.

MODEL JOB PLAN FOR A FULL-TIME COMMUNITY CONSULTANT

Out-patient/community work	5 PAs per week
Multidisciplinary team meeting and supervision	1 PA per week
Emergency work	1 PA per week
Mental health legislation/adult protection and mental capacity legislation work	0.5 PA per week

It is difficult to be precise about the number of old age consultants per population served. Many factors influence the headline population figure appropriate for an individual consultant. These include the following.

- Demographics – high numbers of old people, especially over 80 years, equates to high numbers of people with dementia, depression and comorbid presentations.
- Support – if there is a poorly resourced multidisciplinary team this places more pressure on consultant time. In turn, this lowers the catchment population which can be managed successfully.
- Interface with other services – where a service accepts responsibility for ‘graduates’ increased time for mental health legislation use will have to be provided. Where old age services deal with above average levels of people with substance misuse, intellectual disability, offenders, etc., consultant allocation needs to be increased. Similarly, service arrangements for people with young-onset dementia will have an impact on consultant workload.
- Care home numbers – care homes can create heavy demand owing to capacity legislation. The use of antipsychotic drugs in care homes is high and creates demand for consultant review.
- the presence of older people’s consultation/liaison team may reduce or increase workload for community consultant, depending on how services are structured. Services offering proactive assessment in general hospitals have heavier demand than reactive services.

IN-PATIENT POSTS

In-patient beds in old age psychiatry are divided into two categories, functional illness beds and beds for dementia assessment and treatment.

BEDS FOR FUNCTIONAL ILLNESS IN ELDERLY PATIENTS

Patients admitted to these beds are potentially the most unwell within psychiatric services. They often have complex physical comorbidity and can have comorbid symptoms suggestive of dementia. Consultants in these posts should have sufficient time within their timetable to personally review each patient at least once a week. The consultant should be available to visit the ward daily to participate in multiprofessional decision-making and complex risk management decisions. Some commissioned services involve responsibility for everyone over the age of 65 transferring to older people’s services. This changes the mix of patients for whom a consultant is responsible and this needs to be reflected within job planning.

ASSESSMENT AND TREATMENT BEDS FOR DEMENTIA

The focus to increase care in the community for this group of patients will result in only the most complex and challenging patients being admitted to in-patient beds. The length of stay of such patients is expected to reduce and thus the amount of consultant time traditionally available for this bed base needs to be increased. This group of patients will have a high need for mental health/capacity work as well as close liaison with physical healthcare services for the elderly.

MODEL JOB PLAN FOR A FULL-TIME CONSULTANT – FUNCTIONAL ILLNESS

Ward-based clinical activity	5 PAs per week
Work relating to mental health and capacity legislation	2 PAs per week
Clinical administrative tasks	0.5 PA per week

As with general adult psychiatry, it is likely that a whole-time in-patient consultant for functionally ill elderly can manage between 15 and 20 beds without additional support from another senior doctor or an ST4–6 competent and approved under the appropriate section of mental health legislation. The consultant would expect to supervise a more junior doctor to assist in the management of the physical healthcare needs of these patients.

MODEL JOB PLAN FOR A FULL-TIME CONSULTANT – DEMENTIA ASSESSMENT AND TREATMENT

Ward-based clinical activity	5 PAs per week
Work relating to mental health and capacity legislation	2 PAs per week
Clinical administrative tasks	0.5 PA per week

It is likely that a full-time consultant on a dementia assessment and treatment ward can manage up to 25 patients without additional support from another senior doctor, but would expect to supervise a more junior doctor to assist in the management of physical healthcare needs of this patient group.

In some areas where there are continuing care beds, the need for medical time will depend on the nature of admissions, but approximately 1 PA for 12 beds would be an average requirement.

LIAISON WORK

The model for liaison services in old age psychiatry is variable. Where there is no designated liaison service, the CMHT often provides a consultancy service. Whichever model is commissioned, clear allocation of consultant time needs to be in place. This sessional time is in addition to the clinical commitments outlined previously.

The service design needs to be supported by non-medical liaison staff who will require clinical supervision and leadership from the consultant involved in the service delivery.

SECTOR-BASED POSTS

In areas where consultants provide both in-patient and community services, the principles set out for general adult psychiatry (p. 15) will apply.

Addictions psychiatry

A consultant in addictions psychiatry is a doctor with a certificate of completion of specialist training in psychiatry with endorsement in substance misuse, working to provide a full range of services to people with substance misuse and addiction disorders. This can be within the NHS or the non-statutory sector. In addition to the general roles set out on pp. 10–11, a consultant in addictions psychiatry has specific expertise as listed below.

CLINICAL ROLE

- Assessment, diagnosis and management of people with addiction problems as well as those with mental illness.
- Extensive clinical expertise in addictions, with the ability to integrate mental health, physical health and addiction disorders.
- Expert in a wide range of treatments for addictions, including pharmacological, psychological and behavioural.
- Ability to assess and manage complex or high-risk people, including pregnant women, children and adolescents.
- Particular expertise in diagnosing and managing dual diagnosis.
- Expertise in complex prescribing such as injectable opiates for the treatment of addiction.
- Clinical supervision of GPs providing addiction services.
- Providing addiction advice and liaison to general practice and other specialties within psychiatry and acute medicine.

LEADERSHIP ROLE

- Leading clinical governance, safety and innovation in substance misuse services.
- Liaison with commissioners to define and improve outcomes.
- Ensure implementation of national guidance and standards in substance misuse.
- Providing clinical input into commissioning and procurement exercises, for example making valid assessments of need, through to setting and monitoring appropriate standards.
- Developing partnerships between different provider organisations.

INFORMATION TO SUPPORT JOB DESCRIPTIONS AND JOB PLANS

COMMUNITY CONSULTANTS

Summary of a direct patient care timetable for a full-time consultant with no specific educational or leadership role is shown below.

For out-patient work 1 hour for a new patient assessment and 30 minutes for a follow-up assessment is necessary. Some time in clinics needs to be kept for urgent appointments requested by patients or other members of the team. Some of the patients seen in clinic and other settings will be patients seen and followed up by the consultant – many will be for a consultant opinion and then follow-up by other professionals and other teams.

Out-patient work, including face-to-face reviews of patients, seeing patients for consultations from other services	4 PAs per week
Supervision of other prescribers such as GPs and management of prescribing	0.5 PA per week ¹
Multidisciplinary team meeting and support for team members outside the meeting	1 PA per week
Liaison and advice to other services including GPs and acute hospitals	1 PA per week
Clinical administration related to direct clinical care (e.g. treatment outcome profiles, National Drug Treatment Monitoring System)	1 PA per week

1. May need to be increased depending on the number of other prescribers who are being supervised.

TIER 4 IN-PATIENT DETOXIFICATION UNIT

The job plan should allow daily ward visits by the consultant, at least a weekly face-to-face review of each patient, team meetings and sufficient time for liaison with families and other agencies. This would be suitable for a 20-bed unit with junior doctor support. A consultant providing sole medical input would have responsibility for a maximum of 12 beds.

Ward-based clinical activity including clinical decision meeting and interviewing patients and carers	5 PAs per week
Supervision of multidisciplinary team	1 PA per week
Liaison with families and other agencies	1 PA per week
Clinical administrative tasks	0.5 PA per week

COMMISSIONING

Most addiction psychiatrists are involved in the commissioning and tendering processes with services as addiction services are usually recommissioned on a 3- to 5-year timescale. This work usually involves at least 1 PA per week.

Forensic psychiatry

Consultant forensic psychiatrists have an expertise in working with complex patients who have a mental illness (usually schizophrenia) and/or a severe personality disorder, and/or use alcohol or illicit drugs. Patients under the care of forensic psychiatrists present a risk to others (and sometimes to themselves) owing to their mental disorder. Their complex clinical presentation is further complicated by their contact with systems outside mental health including, most commonly, the criminal justice system.

Consultant forensic psychiatrists provide expert evidence to court as an integral part of their role. For probity to be maintained, fee-paying work needs to be explicitly reflected in the consultant job plan. There are a number of ways this can be organised: time shifting – up to 1 PA a week can be time-shifted without this interfering with NHS or other clinical activity; a number of PAs can be allocated for work that attracts a fee to be undertaken within the job plan, with fees being paid to the employer; and part-time contracts for consultants to accommodate fee-paying work outside the consultant job plan.

In addition to the general roles set out on pp. 10–11, a consultant forensic psychiatrist has specific expertise as listed below.

CLINICAL ROLE

- Detailed assessment and management of people with complex mental health needs who also pose a significant risk of harm to others. This includes expertise in:
 - medication management for treatment-resistant conditions;
 - management of complex multisource information to develop a formulation and management that integrates biological, psychological and social perspectives;
 - physical health screening and medical liaison with colleagues in primary and secondary care;
 - appropriate use of psychosocial interventions;
 - risk assessment and management in a variety of settings including the community, in-patient settings and custodial settings;
 - an understanding of the effects of different aspects of security on patient autonomy, rehabilitation and recovery;
 - appropriate use of mental health and other legislation, safeguarding processes, appointeeship and Court of Protection;
 - therapeutic risk-taking to support safe rehabilitation and recovery;

- detailed knowledge of local service provision;
- expertise in managing patients' transitions between different settings.
- Second opinions and advice to colleagues on diagnosis and risk management.
- Support and advice to services that also deal with this patient group including the criminal justice system, child welfare services, providers of supported accommodation and complex community care packages.
- Review of out-of-area placements.

LEADERSHIP ROLE

- Consultants are responsible within their teams for providing leadership to ensure the delivery of high-quality care for patients. Maintaining patient's rights and the safety of others requires the consultant to manage and contain any anxiety within the multidisciplinary team to provide safe management while supporting rehabilitation and recovery.
- Consultants provide leadership in the development of clinical standards and implementation of national guidance in forensic psychiatry.
- Forensic services are high-cost services and consultants should be working in partnership with commissioners to develop clinically robust and cost-effective patient care pathways.

INFORMATION TO SUPPORT JOB DESCRIPTIONS AND JOB PLANS

There are different models of service provision and different consultant roles within these. In some services, consultants oversee a group of patients along the whole length of their care pathway, providing both in-patient and community care, whereas in other services, consultants provide care in either community settings or in-patient settings. In some services, the consultant provision to prisons is provided by a number of consultants giving sessional input seeing new and follow-up referrals. In other services, there are consultant forensic psychiatrists who provide a more comprehensive provision and where this is their core clinical role.

The following table includes guidance on workloads given that job descriptions can vary in the range of tasks undertaken within the consultant role. It identifies what workload can be expected to be undertaken for the allocation of 1 PA. (For example, if a job description states that the in-patient load is 12 in-patients with the support of a junior doctor and full multidisciplinary team, then one would expect 3-4 PAs to be allocated to this clinical task in their job plan.)

PA allocation	Role description
1 PA	Per 2–4 in-patients in secure environment: low, medium or high. Factors such as patient complexity, acuteness, gender, length of stay, resources available, nature of care (e.g. stepped down), team composition and the support available from junior doctors would determine which end of the range was reasonable.
1 PA	Per 5–15 community forensic patients. Factors such as patient complexity, acuteness, resources available, team composition and the support available from junior doctors would determine which end of the range was reasonable.
1 PA	Prison session: per 2–3 new patients or up to 6 follow-up patients (or a combination of these) assuming a 3-hour session and patients readily available to be seen. Regarding parole reports, if a brief report is required for patients under active care, this will be in the form of a clinical letter. If a more detailed report is required and is part of contracted activities, up to 1 PA per patient is likely to be required spread over more than one session.
1 PA	Assessments for advice: assuming 1 referral every 7–14 days. Service provision differs around the country with some services only providing an assessment service for potential admission to secure care while others provide advice and support in the management of high-risk patients. Factors such as patient complexity, acuteness, resources available, team composition and type of service being provided would determine which end of the range was reasonable.
1 PA	Consultancy/liaison/diversion: some services provide this as part of their assessment service (see above) other services provide regular access to a forensic service for advice or consultancy through a regular clinic or time slot for case discussion and advice.
1 PA	Per 15–30 out-of-area treatments from catchment area: factors such as distance from base unit, resources available, team composition and type of service being provided (e.g. level of attendance at CPA meetings, whether annual or 3 monthly) would determine which end of the range was reasonable.
1 PA	Per 15–30 high secure patients from catchment area: factors such as distance from base unit, resources available, team composition and type of service being provided (e.g. level of attendance at CPA meetings, whether annual or 3 monthly) would determine which end of the range was reasonable.

Child and adolescent psychiatry

The primary role of a consultant child and adolescent psychiatrist is to use their skills as a medical expert to achieve best patient care. With knowledge of child development, physical health, pharmacology, emotional health and interpersonal relationships, as well as psychiatric disorders and substance misuse, child psychiatrists are best placed to apply an integrated biopsychosocial model in understanding, diagnosing and managing mental illness, emotional disturbance and abnormal behaviour.

CLINICAL ROLE

In addition to the general roles set out on pp. 10–11, a consultant child and adolescent psychiatrist will have specific expertise as listed below.

- Management of complex clinical information from many sources to formulate management of the relative effectiveness of medication, therapeutic approaches for the child/young person and family, and therapeutic/consultation approaches within the child/young person's network.
- Knowledge of adult mental health – child psychiatrists are well placed to identify and arrange appropriate management of parental mental health concerns and to facilitate transition to adult mental health services if needed.
- Specialist knowledge of interpersonal and systemic dynamics – assessment and management of family, care network, educational and support system issues.
- Knowledge and skills in outcome measurement will enable the consultant to lead the monitoring of the effectiveness of interventions.
- Managing clinical complexity and severity through direct clinical assessment/treatments, case management and consultation.
- Manage the complexity of information, including knowledge of mental illness, child development, interpersonal/family dynamics, the Children Act 2004, mental health and mental capacity legislation, to reach decisions in the best interests of children and young people.
- Assessment and advice to social care and the legal system with regard to the developmental, mental health and care needs of children and young people.

LEADERSHIP ROLE

- Communicate with commissioners in health and other sectors the population needs, mental illness prevalence, best treatment strategies and service design to meet the developmental and mental health needs of children, young people and their families/carers.
- Advocate for the mental health, educational and care needs of young people as well as the prevention of disorder and distress and promotion of emotional well-being.

INFORMATION TO SUPPORT JOB DESCRIPTIONS AND JOB PLANS

Factors that should be taken into consideration in a job description include the following.

PATIENT FACTORS

Assessments and work with children and young people take place in the context of the family\care environment, educational and professional network. Multiple sources of information are required. The individual as well as family and other key informants will need to be interviewed. More than one patient may be the focus of referral within a family. Full assessment may require joint interviews with social workers, and visits\observations within the home, school or other settings, as well as assimilation of assessments by other professionals, for example, psychometric or neuropsychological assessments.

Child and adolescent psychiatry covers all psychiatric subspecialties, including the full range of psychiatric disorders, disorders specific to childhood, substance misuse, forensic, learning disability, neuropsychiatry and liaison services. Many adult mental health disorders start in childhood\adolescence, and comorbidity of problems is often present. There is focus on maximising developmental potential, resilience and social\educational function.

The nature of referrals and service demands will vary depending on local commissioning, and whether an individual service is designed to address a wide range of problems or more discrete diagnostic groups (e.g. substance misuse, learning disability, autism, attention-deficit hyperactivity disorder). Complexity of clinical presentation will also vary, with factors such as demographics, deprivation indices and service level (local community team v. regional or specialist services) being relevant.

A standard community follow-up appointment would be 60 minutes and for new patients 90 minutes. More complex cases (e.g. neurodevelopmental assessments, child care related assessments) can take longer, in excess of 180 minutes, often over two to three appointments; uncomplicated medication reviews may be shorter.

GEOGRAPHICAL AND DEMOGRAPHIC FACTORS

Factors within the catchment area to consider include:

- deprivation indices

- inner city v. rural
- ethnicity
- transient populations
- presence of children's homes or specialist schools
- nature of other children's services in the area (e.g. the size and remit of the community paediatric, learning disability, challenging behaviour services; provision of parenting, early intervention, safeguarding services by other agencies).

SERVICE STRUCTURE

There are many different consultant roles within child and adolescent psychiatry. Community jobs can include, for example, sessions dedicated to subspecialties (learning disability, neurodevelopmental, liaison, substance misuse, etc.). The size and skill mix of the medical staffing and supporting multidisciplinary team varies considerably. This will impact on the nature of work a consultant will be required to undertake, including need to provide consultation to and joint assessments with team members, clinical supervision to medical staff and collaborative work with other agencies

Engagement in service development, strategic planning and team management\leadership will vary in response to local structures and expectations with impact on time available for direct clinical work. Engagement as case manager, with liaison, networking and administrative responsibilities for individual cases, will also vary.

On-call arrangements vary. Job descriptions will need to reflect the demand and potential for direct clinical work for consultants first on call.

Jobs that entail split roles, for example, working across two clinical teams, will require additional non-direct clinical time to safely provide input to both teams.

ADDITIONAL ROLES

Supervising psychiatric trainees and specialty doctors requires adequate time in the job plan for educational and clinical supervision and for undertaking assessments. Although consultant child and adolescent psychiatrists are likely to be involved in team leadership, additional team or service responsibilities require adequate time allocation. Child and adolescent mental health teams are often smaller than adult or other mental health teams and have limited service management, such that the leadership role requires adequate recognition and time in the job plan.

REASONABLE WORKLOAD

Assuming there is an adequate number of consultant child and adolescent psychiatrists in an area and an adequate team in place, the following are guidelines as to what might be expected of a reasonable weekly workload for a full-time consultant with no additional educational, leadership or additional responsibility roles. This summary is indicative and for guidance purposes only. It will need to be adapted according to local needs, local structures and work patterns, and to accommodate any additional roles,

including supervision of doctors in training (adequate time for training must be included in the job plan).

TIER 3 GENERIC COMMUNITY CAMHS

Initial assessments\new cases	1.5 PAs per week
Complex case reviews\liaison with other agencies\case management\provision of treatment	4 PAs per week
Emergency work\unpredictable cases	1 PA per week
Multidisciplinary team meeting, consultation, support and supervision for team members	1 PA per week

The individual consultant case-load will vary. Based on experience of the choice and partnership approach, published workload data, survey of members, analysis of child and adolescent mental health services mapping data and feedback from consultants, the range of typical case-load responsibilities is presented. The expectations of an individual consultant should be negotiated locally taking into consideration the complexity of cases, nature of the clinical work, skill mix of the team and other factors as described earlier. A workload towards the lower end of the range would be appropriate for consultants engaged in a highly complex or high-risk clinical case-load, or where there is less than adequate consultant numbers or multidisciplinary staffing numbers or skill mix. A workload towards the upper end would be appropriate for a case-load of predominantly uncomplicated medication reviews.

An indicative reasonable case-load would be 1–2 new\initial assessments a week (including clinical interview, information gathering and report writing), and 10–17 follow-up case slots a week. Follow-up slots will most often be individual interviews, family meetings, case reviews, but could also include network meetings, safeguarding meetings, etc. This will approximately equate to 40–80 new\initial assessments per year. Additional individuals and families are likely to be seen as emergency and unpredictable cases. This would include psychiatric assessment of cases held by other team members.

Owing to the variation of service design, commissioning arrangements and multidisciplinary teams, it is difficult to recommend numbers of consultants.

Workforce calculations for 0–16 years and 16–18 years services have however been modelled. This indicates that for a tier 2\3 service for 0–16 years, 20 WTE clinicians per 100 000 population for a teaching service. This includes 2.4 WTE consultant psychiatrists per 100 000 population for 0–16 years services. This does not, however, include services for substance misuse, severe conduct disorders, specific learning difficulties and developmental difficulties, effects of chronic illness, Tourette syndrome, elective mutism, enuresis\encopresis, intellectual disability, paediatric liaison or liaison with social care services (Kelvin, 2005; Royal College of Psychiatrists, 2006).

Additional staffing is required for services to 16- to 18-year-olds. A College paper outlines that the additional requirement is 1.8 WTE consultant psychiatrist per 100 000 population for 16–18 years services (Lamb *et al*, 2008).

This equates to 4.2 WTE consultant psychiatrists per 100 000 for a 0–18 years service. This does not, however, include indicative wte numbers for services for the groups described earlier.

TIER 4 IN-PATIENT UNIT

The job plan should allow for daily ward visits by the consultant, at least a weekly face-to-face review of each patient, team meetings and sufficient time for liaison with families and other agencies.

Ward-based clinical activity including clinical decision meeting, interviewing patients and carers, clinical administrative tasks	5 PAs per week
Liaison with families and other agencies	2.5 PAs per week

The case-load, using bed numbers as the currency, will vary depending on the nature of the unit, number of urgent v. planned admissions, and skill mix of the staffing complement. An indicative case-load for a 10 PA consultant is 10–15 beds with Tier 4-related out-patient assessments and follow-up work. For a unit entirely focused on emergency admissions, the case-load will be towards the lower end. For a unit operating in a less acute setting or with many planned admissions, the case-load would be towards the upper end. The designated WTE consultant time may be adjusted slightly up or down depending on acuity of presentation and age range of the patient group, presence of non-consultant grade psychiatrists and availability of experienced senior multidisciplinary team members.

Rehabilitation psychiatry

Rehabilitation psychiatrists work with people with long-term and complex mental health problems, the majority of whom have a diagnosis of schizophrenia. Although many people with severe and enduring mental health problems such as schizophrenia experience ongoing active symptoms of illness and impairments in cognition and drive, social stigma and the secondary handicaps consequent on the illness, those who are referred for rehabilitation are those whose problems are of such complexity or severity that they have not been able to be discharged home following an acute admission. These problems include treatment resistance (non-response to first-line medications), cognitive impairment (most commonly affecting executive function and verbal memory), pervasive negative symptoms (e.g. apathy, amotivation, blunted affect), and co-existing problems (e.g. substance misuse, premorbid intellectual disability, developmental disorders such as those on the autism spectrum). These complex problems contribute to major impairments in social and everyday functioning and to challenging behaviours that impede recovery and increase the risk of adverse outcomes. Comorbid, chronic physical health problems are also commonly present.

Consultants in rehabilitation psychiatry have expertise in the assessment and long-term treatment and management of this patient group. They adopt a biopsychosocial approach that embraces recovery-oriented practice. They work within multidisciplinary teams in a variety of settings that include:

- in-patient rehabilitation wards (including: local high-dependency rehabilitation units; regional units for people with challenging behaviours and complex needs; low, medium and high secure rehabilitation units within local/regional/national forensic services)
- local community rehabilitation units
- local continuing care units (in hospital or community sites)
- local community rehabilitation teams
- local specialist functional CMHTs providing assertive outreach and early intervention for people with psychosis.

CLINICAL ROLE

In addition to the general roles of the consultant as set out on pp. 10–11, the consultant in rehabilitation psychiatry has the following specific expertise.

- Detailed assessment and management of patients with complex mental health needs in rehabilitation settings. This includes:

- expertise in medication management for treatment-resistant conditions;
 - physical health screening and medical liaison with colleagues in primary and secondary care;
 - appropriate use of psychosocial interventions;
 - appropriate use of mental health and mental capacity legislation, safeguarding processes, appointeeship and Court of Protection;
 - detailed knowledge of local supported accommodation provision;
 - expertise in managing patients' transitions between different settings.
- Second opinions and advice to colleagues on the diagnosis and management of patients with complex mental health needs.
 - Support and advice to services that provide supported accommodation and complex community care packages for this group.
 - Review of patients in out-of-area placements.

LEADERSHIP ROLE

- The consultant in rehabilitation psychiatry has to employ their leadership skills in their everyday clinical practice as well as their experience in conflict resolution and good communication to avoid the powerful dynamics that lead to splitting and scapegoating of other agencies and services when dealing with patients with complex needs.
- Rehabilitation psychiatrists use their clinical leadership skills to facilitate successful partnership working with voluntary sector agencies that facilitate social inclusion, including those that provide supported accommodation, vocational training and employment.
- Rehabilitation psychiatrists should sit on the local 'placement' panel to ensure the appropriate placement of patients in facilities that are tailored to their needs, that opportunities for local treatment and support have been fully explored prior to a placement being made out of area, and that there is ongoing review of an individual's suitability for local repatriation at the earliest opportunity (Royal College of Psychiatrists, 2011).

INFORMATION TO SUPPORT JOB DESCRIPTIONS AND JOB PLANS

Workload expectations will vary according to the degree of complexity of patients in the particular service, the proportion detained involuntarily and the associated medico-legal work, as well as the staffing of the rest of the team, including the amount of CT1–3, ST4–6 and specialty doctor time. Similarly, the geographic spread of workplaces needs to be considered. Bearing these issues in mind, we suggest the following summary guide to the direct patient contact time required for a consultant in rehabilitation psychiatry.

High-dependency rehabilitation unit (average 14 beds, most patients detained, average length of stay 12 months)	5 PAs per week: direct patient care, referrals meeting, CPAs, mental health legislation work, clinical administration
Community rehabilitation team/ assertive outreach team (average case-load 100, some patients under community treatment order)	5 PAs per week: direct patient care, home visits, CPAs, weekly team meeting, mental health legislation work, clinical administration
Community rehabilitation unit (average 14 beds, most patients not detained, average length of stay 18 months)	1–2 PAs per week: direct patient care, CPAs, mental health legislation work, clinical administration
Continuing care unit (average 10 beds, most patients not detained, average length of stay >5 years)	0.5–1 PA per week: direct patient care, CPAs
Other specialist tasks	1.0 PA per week: assessment of patients placed out of area and attendance at their CPA meetings, membership of placement funding panel (usually monthly), assessment and advice to colleagues regarding patients with complex needs, assistance to supported housing providers

For guidance on consultant input to secure rehabilitation units please see the forensic psychiatry section.

It is difficult to be precise but it is likely that in areas of average morbidity there should be 1 WTE community rehabilitation consultant per 350 000–400 000 adult population.

Liaison psychiatry

Liaison psychiatrists specialise in the management of psychiatric problems in the general medical setting, such as the interface between physical and mental symptoms, psychological reactions to physical illness, medically unexplained symptoms, and the management of self-harm in the general hospital.

CLINICAL ROLE

In addition to the general consultant roles set out on pp. 10–11, a liaison psychiatrist has the following specific expertise:

- understanding the interface between physical health and mental health (e.g. delirium, encephalitis)
- diagnosis and formulation of management plans in complex cases, advising medical teams on appropriate integrated care
- assessing and managing risk (e.g. suicide risk, violence/aggression, absconding) relating to psychiatric conditions in general hospital settings
- bridging the gap between primary and secondary care with regard to the management of psychosomatic conditions in the community (e.g. medically unexplained symptoms)
- prescribing and giving advice to medical teams on psychotropic medication
- providing expertise, and fulfilling a statutory role, in managing medico-legal issues using capacity and mental health legislation
- understanding the medical issues in assessing patients with medically unexplained symptoms
- understanding the medical issues in mental health problems associated with long-term conditions.

LEADERSHIP ROLE

- Setting goals and targets for the team according to local and national drivers.
- Liaising with clinical leaders, managers and commissioners from acute and mental health trusts and clinical commissioning groups towards service development and improvement.

EDUCATIONAL ROLE

Challenging stigma and discrimination towards psychiatric patients and professionals by raising awareness, presentations/teaching sessions and informal discussions with various professionals in the general hospital.

INFORMATION TO SUPPORT JOB DESCRIPTIONS AND JOB PLANS

There is great variation in liaison mental health services across the country, reflecting local demographics, needs and priorities, available resources and historic development of the services. This has resulted in a patchy delivery of liaison services.

A liaison mental health service may include some or all of the following components:

- emergency department liaison psychiatry
- self-harm service
- psychiatric liaison service for general hospital adult (of all ages) in-patients
- out-patient clinics
- additional specialised services (e.g. drugs and alcohol, chronic fatigue syndrome, medically unexplained symptoms, psycho-oncology).

There is a great range of variation in the composition and size of the teams. Workload may differ according to the local referral criteria (e.g. age range, referral sources, catchment area), hours of operation and other resources available (e.g. a separate self-harm team, crisis team). Many liaison psychiatry teams provide services for both patients of working age and older adults (often in specialist subteams in larger hospitals), and some provide services for 16- to 18-year-olds.

The expected workload of a consultant liaison psychiatrist, therefore, depends on the nature of the post. However, there is some guidance available.

A full-time consultant can be expected to deliver a service to a core liaison team (operating 09.00–17.00, Monday to Friday) serving a general hospital with 650 beds and 750 self-harm referrals per year, provided there is one Band 8 liaison nurse (who also takes on leadership role), three Band 7 nurses, one Band 8 clinical psychologist and one-and-a-half Band 4 administrative staff in the team. If the team provides services to older people towards end of life, additional staff would be needed (e.g. one specialty doctor and one Band 7 nurse on a full-time basis). Additional staff may be needed to provide out-of-hours services (Aitken, 2007).

Services covering large acute hospitals with regional and tertiary services will have patients with higher levels of medical complexity where psychiatric factors also tend to be more complex. They require a higher proportion of consultant time than purely accounted for by the total number of beds.

A summary of a direct patient care timetable for a full-time consultant with no specific leadership or educational role is shown on page 36.

Face-to-face contact with patient – in clinic or wards	4 PAs per week
Multidisciplinary team meeting and support for team members outside the meeting	1 PA per week
Emergency work/unpredictable cases/clinical administration	1 PA per week
Mental health legislation work/complex patient reviews or liaison with other specialties	1.5 PA per week

The above distribution of clinical activities is for guidance purpose only and should be adapted according to local needs. For example, liaison services in larger hospitals may need increased PA time of the consultant for leadership/service development and interface meetings with the acute hospital.

Medical psychotherapy

Medical psychotherapists integrate the delivery of talking therapies with other effective biopsychosocial interventions. They promote the therapeutic value of relationships, of partnerships and of the application of knowledge from the neurosciences. They have a range of skills that are particularly helpful for patients who present with complex difficulties such as personality disorders, medically unexplained symptoms and those who are hard to help because of their stressful impact on healthcare professionals.

CLINICAL ROLE

In addition to the general consultant roles set out on pp. 10–11, the consultant medical psychotherapist has specific expertise as listed below.

- Delivering psychological and social interventions to reduce distress in families, in communities, and in the broader systems in which an individual lives.
- Providing clinical supervision to a range of staff.
- Ensuring robust clinical governance frameworks for psychological therapy services.
- Developing and maintaining psychological, social and cultural health in institutions.
- Promoting public understanding of mental health.

INFORMATION TO SUPPORT JOB DESCRIPTIONS AND JOB PLANS

Consultants in medical psychotherapy play a key role, in addition to their own direct contact with patients, in supporting other staff in the management of patients. This activity is clinical work and should be considered as direct patient care. Consultants in medical psychotherapy should have at least 3 PAs for supporting professional activities reflecting their major contribution to education and training for the whole clinical workforce.

A full-time post could include the direct patient care commitments shown on the following page.

Referrals management as part of a single point of entry for psychological therapy services including management of waiting list	0.5 PA per week
Therapeutic assessments of complex cases in out-patients, on the wards, or in their homes as indicated	1 PA per week
Treatment of complex cases in out-patients, on the wards or in their homes as indicated (e.g. individual psychotherapy, group psychotherapy, family therapy)	2.5 PAs per week
Supervision including direct clinical supervision of clinical staff, indirect clinical supervision of other supervisors and clinical managerial supervision of those managing clinical services	1.5 PA per week
Reflective practice meetings, Balint groups and away day facilitation	1 PA per week
Clinical administration	0.5 PA per week

Intellectual disability psychiatry

INFORMATION TO SUPPORT JOB DESCRIPTIONS AND JOB PLANS

PATIENT FACTORS

Patients with intellectual disability require more time in consultations owing to various factors including cognitive and communication problems, limited attention and tolerance-requiring breaks. Patients are often dependent on carers and professional informants for support and to provide information, requiring multiple discussions. On occasions, difficult behaviour can interrupt appointments or require home visits.

Patients with intellectual disability frequently have significant physical health problems, some associated with complex genetic syndromes. Psychiatrists will often directly manage epilepsy as part of a patient's ongoing care, or need to advise and support GPs on physical healthcare in relation to some genetic disorders.

A standard community follow-up appointment slot would be 30 minutes and for a new patient 90 minutes (occasionally split if patient does not tolerate lengthy appointments). More complicated new cases (e.g. forensic, children) or autism assessments/court reports can take much longer, in excess of 180 minutes (usually split). For home visits, travel needs to be considered.

GEOGRAPHICAL AND DEMOGRAPHIC FACTORS

Catchment population is only part of the picture. The following factors need to be considered:

- inner city v. rural, reflecting density of population, ethnicity, deprivation indices and transient populations
- local group homes (Are difficult-to-manage people placed outside catchment area or brought into catchment area?)
- previous institutions which can improve local resources and skills base but also increase local case-loads
- proximity to local support networks and academic hubs for continuing professional development
- local organisations active in providing quality services (mixed housing projects offering appropriate and good quality support to those with challenging behaviour, for dementia care, autism, sensory impairment, etc.)

- degree of local intellectual disability employment, day service and availability of other supported activities
- return-to-area projects.

LOCAL TRUST FACTORS

The number of consultants required reflects the local configuration of services. Factors include the following.

- Expectations and roles of other mainstream mental health services: Are all patients with mild intellectual disability seen in mainstream? Are there attention-deficit hyperactivity disorder services or autism roles outside of learning disability services?
- Cut-offs in terms of degree of intellectual disability: there is an exponential rise in the number of patients who move into borderline intellectual disability.
- Age boundaries or lifespan services.
- Discrete community/in-patient 'functionalised' post or split roles both in the community and for in-patients.
- Well-resourced supporting teams including other medical staff, secretarial and other allied professions: community nurses, speech and language therapists, occupational therapists, dietitians, psychologists and physiotherapists.
- Pooled budgets and coterminous criteria with Social Services; if not, health professionals may be working in isolation with some clients.
- Are specialist teams available (e.g. epilepsy, challenging behaviour, dementia, autism/Asperger syndrome, forensic)?
- Direct case management expectations for complex or high-risk patients.
- Out-of-area quality assurance roles (post Winterbourne View): commissioners may require assessment and management of clients placed out of area.

Assuming that there is an adequate team in place, the following are guidelines as to what might be expected of a consultant post in different areas.

GENERAL ADULT INTELLECTUAL DISABILITY POSTS

COMMUNITY ONLY

For a population of 150000 adults only, the job is possible with a single full-time consultant. However, if there is a poor support team (i.e. there is no secretary), any in-patient commitment, poor support from mainstream services for people with mild intellectual disability or wide geographical area with split bases, then this would not be feasible without extra supporting medical staff.

- A dedicated full-time specialty doctor could provide cover for a further 75000 population.
- Trainees should not be relied on as delivering a clinical service as there can never be any guarantee of availability or standard. An

inexperienced or 'failing' trainee may require a lot of consultant support and time. If trainees are in post, an experienced CT3 should be able to add support to the equivalent of about a 30 000 population; a senior specialist trainee to 50 000.

Time allocation should be:

- new patient assessment, 90 minutes; complex cases, 120+ minutes; a pervasive developmental disorder assessment with diagnosis, 240 minutes; routine follow-up, 30 minutes;
- a WTE post might expect to carry an active case-load of 150–200 patients (minimum 2–4 contacts per year), with 30–40 new referrals each year;
- CPA review or vulnerable adults meeting, minimum 60 minutes (more if MAPPA or forensic issues);
- weekly team meeting, 120 minutes;
- mental health legislation work including assessments (120 minutes) managing community treatment order patients: managers and review tribunal meetings, 2 hours each at least yearly (more if regular recall); report preparation, 4+ hours.

IN-PATIENT ACUTE ASSESSMENT AND TREATMENT

One WTE consultant for up to 20 acute beds. The unit would need a well-resourced multidisciplinary team including social work involvement and additional medical support (e.g. 0.5 WTE specialty doctor or 1 WTE CT3).

FORENSIC INTELLECTUAL DISABILITY POSTS

Legal reporting standards have increased considerably. Time is required for face-to-face contact with teams and tribunals, as well as patient-related direct and non-direct activity.

IN-PATIENT POSTS: HIGH SECURE, MEDIUM SECURE AND LOW SECURE SETTINGS

For forensic intellectual disability bed-based services, a full-time consultant could lead services with:

- 15–17 high secure unit beds with national assessment duties; or
- 12–15 medium secure unit beds as well as regional assessment duties (there may be scope for regional court work, local community liaison links and advice. Local prison sessions may require additional support); or
- 15–20 longer-term rehabilitation style low secure unit beds as well as regional court work, local community liaison links and advice; prison sessions may require additional support.

FORENSIC COMMUNITY-BASED SERVICES

One WTE per 300 000 depending on geographical patch (rural/inner city). The role to include:

- liaison links
- risk assessment support to local consultants in existing community services

- direct case management for a small number of higher-risk individuals
- court diversion
- possible role in managing forensic community treatment orders/Section 37 guardianships and previously detained/restricted patients resettled into the local community.

SPECIALIST FORENSIC OUT-PATIENT ACTIVITY

Making some allowance for time required to travel, 1 WTE consultant for non-residential services could support:

- 40 new referrals per year:
 - one direct contact of 2 hours
 - indirect contacts of 6 hours in total
 - report preparation and liaison of 6 hours
- 80 out-patient follow-up visits:
 - two direct contacts six monthly (one annual CPA)
- 72 indirect contacts – liaison and consultancy to intellectual disability and forensic teams:
 - monthly meetings with four area intellectual disability teams and two medium secure units minimum.

CHILD AND ADOLESCENT INTELLECTUAL DISABILITY POSTS

There are few dual-trained child and adolescent and intellectual disability consultants. Many child and adolescent specialists trained in intellectual disability are now working within joint child and adolescent services. Many new post appointments may be general child and adolescent consultants who have had 'special interest' sessions (some a full year) taken in intellectual disability. Some may have had no or very limited intellectual disability experience.

There is a need to ensure that where there are split posts (mainstream with intellectual disability sessions), these clearly state how the intellectual disability sessions will be protected, so that patient care is not compromised.

The Royal College of Psychiatrists (2010*b*) suggests an adequate community child and adolescent team would consist of at least 5–6 WTE staff per 100 000 population (appropriate mix to best suit local needs) for people with severe intellectual disability. It suggests two consultant sessions (clinical) per 100 000 (severe intellectual disability) and three additional sessions per 100 000 if mild intellectual disability is included.

Perinatal psychiatry

Consultant perinatal psychiatrists have expertise in the prevention, assessment and management of mental disorder newly occurring or coexisting with pregnancy or the postpartum period, including the assessment and facilitation of the mother–infant relationship in the context of maternal mental illness.

Posts may include in-patient mother and baby unit, perinatal community and maternity liaison responsibilities.

CLINICAL ROLE

In addition to the general consultant roles set out on pp. 10–11, consultants in perinatal psychiatry have the expertise listed below.

- Understand the prediction, prevention, detection and management of mental disorder in pregnant and postnatal women, the interrelationship between mental disorder and pregnancy and the postpartum period, and the wider effects of mental disorder on child development and the mother–infant relationship.
- Diagnose and formulate management plans in complex cases, including decisions on prescribing in pregnancy and breastfeeding.
- Assess and manage risk, including suicide risk, in relation to the pregnancy, and risk to children.
- Deliver care which responds to maternity time scales.
- Provide prescribing advice on psychotropic medication in pregnancy and breastfeeding to general psychiatry, maternity and primary care services.
- Provide expert assessment of the mother–infant relationship in the context of acute maternal mental disorder.
- Work in a collaborative way with maternity services, primary care, health visiting and childcare social work to ensure optimum outcomes for the patient and her child.

LEADERSHIP ROLE

- Develop service clinical priorities in line with national and professional guidance and standards in perinatal psychiatry.

- Liaise with health commissioners and providers to promote an understanding of the epidemiology and needs of the patient group, including updates in evidence-based practice, to inform service development and delivery.
- Advocate for the mental health needs of pregnant and postnatal women and for the promotion of infant health and development in the context of maternal mental illness.
- Develop partnerships between agencies involved in the care of pregnant and postnatal women who experience mental disorder, including primary care, health visiting, maternity services, childcare social work, general psychiatry and the voluntary sector.

EDUCATIONAL ROLE

- Challenge stigma and discrimination against pregnant and postnatal women with mental disorder, by teaching and raising awareness with the public, public representatives, professionals and patients.
- Design and deliver training packages on awareness, prevention and detection of perinatal mental health disorders to meet the needs of local maternity, primary care, Social Services and other psychiatric colleagues.
- Enhance public mental health through physical health promotion in pregnancy, and education for patients and professional groups on transgenerational effects of poor maternal mental health.

INFORMATION TO SUPPORT JOB DESCRIPTIONS AND JOB PLANS

The expected workload of a full-time consultant perinatal psychiatrist is dependent on a range of factors, including whether all elements of service provision are included, the size and composition of in-patient and community teams, number of maternity units, geographical distribution, and the population served. In addition, those providing maternity liaison services in larger centres will have to take account of a 'drifting in' of more complex cases to centres of maternity expertise.

A typical 6-bedded mother and baby unit will serve a delivered population of 15 000–20 000 births/year (equivalent to a general population catchment area of approximately 1.2–1.6 million). A full-time consultant with in-patient commitments at this level may have additional community and maternity liaison commitments to a local population/maternity unit of approximately 3000–5000 births/year (or pro-rata commitments to a larger delivered population alongside another perinatal consultant colleague).

Two templates for a consultant psychiatrist are provided. The first job plan (A) is for a full-time consultant perinatal psychiatrist with commitments in in-patient, community and maternity liaison settings, based on the figures above (i.e. 6-bedded mother and baby unit, regional in-patient catchment area delivering 15 000–20 000 births/year, and local community catchment area/maternity unit delivering 3000–5000 birth/year). It is expected that the consultant would work alongside a full-time junior colleague and an in-

patient and community team, adequately staffed to meet the needs of the population served. Although there is a 4 PA direct clinical care commitment to the mother and baby unit, the unit must have access to a perinatal consultant throughout the working week, reflecting the very complex nature of the patient population and the requirement to respond to clinical need within brief timescales. The job plan for a consultant with mother and baby unit responsibilities must reflect this.

The second job plan (B) is for a full-time consultant perinatal psychiatrist with community and maternity liaison commitments only. This is based on expected activity from a delivered population of 10 000–12 000 births/year, served by one or two maternity units (or pro-rata commitments to a larger delivered population alongside another perinatal consultant colleague).

A. 7.5 PA DIRECT CLINICAL CARE JOB PLAN FOR A CONSULTANT PERINATAL PSYCHIATRIST WITH MOTHER AND BABY UNIT, COMMUNITY AND MATERNITY LIAISON COMMITMENTS

In-patient mother and baby unit work	
Multidisciplinary team meetings and support for team members outside the meeting. Meetings with patients and carers	3 PAs per week
Complex patient reviews/child safeguarding meetings/ Mental Health Act work	0.5 PA per week
Clinical administrative tasks	0.5 PA per week
Community and maternity liaison work	
Out-patient work/home visits	1.5 PAs per week
Multidisciplinary team meeting and support for team members outside the meeting	0.5 PA per week
Emergency work/maternity liaison visits	0.5 PA per week
Complex patient reviews including multiprofessional meetings for high-risk patients/child safeguarding meetings/ Mental Health Act work	0.5 PA per week
Clinical administrative tasks	0.5 PA per week

B. 7.5 PA DIRECT CLINICAL CARE JOB PLAN FOR A CONSULTANT PERINATAL PSYCHIATRIST WITH COMMUNITY AND MATERNITY LIAISON COMMITMENTS

Community and maternity liaison work	
Out-patient work/home visits	3 PAs per week
Multidisciplinary team meeting and support for team members outside the meeting	1 PA per week
Emergency work/maternity liaison visits	1 PA per week
Complex patient reviews including multiprofessional meetings for high-risk patients/child safeguarding meetings/ Mental Health Act work	2 PA per week
Clinical administrative tasks	0.5 PA per week

Eating disorders psychiatry

Eating disorders are a group of disorders characterised by a distorted attitude towards eating, shape and weight, and in their most severe forms carry the highest standardised mortality ratios of any psychiatric disorder.

The disorders are complex and involve the interplay between physical, psychological and psychiatric components and as such require the leadership of a clinician who is trained in each of these aspects of care. Although the management of the disorders involves psychological, nutritional and physical components, it is only consultant psychiatrists who have the necessary training in all of these areas to balance the complex needs of these patients. Their expertise is essential in conducting risk assessments to prevent deaths from the physical consequences or from suicide, and their training and role in mental health legislation empowers them to safeguard those in their care.

CLINICAL ROLE

In addition to the general consultant roles as set out on pp. 10–11, the consultant in eating disorders has the following specific expertise:

- medical assessment of patients with eating disorders
- psychiatric assessment, including eating disorder and non-eating disorder psychopathology
- risk assessment and management for the medical and psychiatric components of the disorder
- taking a leading role in the monitoring and treatment of physical complications of eating disorders in collaboration with other healthcare professionals (dietitians, physicians, paediatricians, GPs, etc.)
- liaison with acute hospital consultants, GPs and acute psychiatric consultants
- implementation of guidelines (e.g. MARSIPAN guidelines; Royal College of Psychiatrists & Royal College of Physicians, 2010)
- treating and monitoring of psychiatric aspects of eating disorders, including core psychopathology and psychiatric comorbidities, such as depression, obsessive–compulsive disorders, borderline personality disorder and autism spectrum disorders
- prescribing, which extends beyond the usual psychiatric formulary, and appropriately monitoring medications (according to relevant NICE guidelines)

- using the mental health legislation as appropriate in the management of eating disorders and general psychiatry
- report writing for patients in education, training, work and accessing benefits.

EDUCATIONAL ROLE

- Training primary care staff in early recognition, management and referral of patients with eating disorders.
- Improving awareness in community settings (e.g. schools, universities, primary and secondary care); ensuring knowledge of management of high-risk cases in secondary care.
- Challenging stigma and discrimination against patients with eating disorders in community and health settings.

LEADERSHIP ROLE

- Liaise with clinical and managerial leaders in commissioning and providing services with the aim of improving and developing services.
- Provide specialist input to contract negotiations.
- Provide specialist input to clinical and managerial advisory groups both locally and nationally.

INFORMATION TO SUPPORT JOB DESCRIPTIONS AND JOB PLANS

There is wide variation in the way eating disorder services are delivered across the country, reflecting differing needs and priorities, available resources, historical development of the services and lack of evidence base to define best practice. In general, the three main forms of service delivery are in-patient, out-patient and day patient, but there are variations to these basic models, for example development of intensive community treatment packages, many of which have showed good clinical outcomes for patients and high cost-effectiveness. In addition to the variety of services, there is also wide variety in the available resources within services, particularly in community services. Because of these factors the work of a consultant psychiatrist within these teams cannot be exactly defined. However, from examining different models it is possible to define the approximate amount of time that a consultant psychiatrist would need to deliver high-quality care within a team with satisfactory resources.

For in-patient work, a consultant psychiatrist would require 1.5–2.5 PAs for each 3 beds.

For out-patient work they would require 1.5–2.5 PAs for each 300 000 people in the population.

The need for medical consultant time varies depending on the availability of other staff in the team, particularly staff grade doctors, senior psychiatric trainees, psychologists and senior nursing staff.

Neuropsychiatry

A consultant in neuropsychiatry has a particular expertise in the psychiatric care of patients with organic psychiatric conditions including comorbid neuropsychiatric conditions associated with acquired brain injuries, sleep disorders, epilepsy and other neurological conditions. They also have specialist knowledge of and skills in managing functional neurological conditions, neurocognitive disorders and complex neurodisability. In addition to the general consultant roles set out on pp. 10–11, a consultant neuropsychiatrist has the specific expertise listed below.

CLINICAL ROLE

- Assessment, diagnosis and formulation of management plans with patients and carers for comorbid neuropsychiatric conditions associated with various neurological conditions, epilepsy, acquired brain injuries and sleep disorders.
- Assessment, diagnosis and formulation of management plans with patients and carers for functional neurological conditions.
- Expertise in the management of psychiatric illness in patients with complex neurodisabilities.
- Expertise in pharmacological, psychological and behavioural interventions to manage behavioural problems associated with neurological conditions, acquired brain injury and complex neurodisability.
- Expertise in assessment, diagnosis and formulation of management plans with patients and carers for neurocognitive disorders in younger adults, and in neurosciences settings associated with neurological conditions or drug and alcohol misuse.
- Particular expertise in the diagnosis and management of delirium in neuropsychiatry settings.
- Expertise in assessment and management of neuropsychiatric conditions associated with neurosurgical procedures such as epilepsy surgery and other procedures such as vagal nerve stimulation and deep brain stimulation.
- Expertise working in varied settings, including neuroscience centres, neurorehabilitation settings, specialist in-patient settings, general hospitals, residential/nursing homes and patients' own homes, with multiprofessional and multi-agency teams.

- Availability to provide psychiatric opinions and assessments of patients for primary care, secondary hospital care, neuropsychiatry services and colleagues in other psychiatric subspecialties.

INFORMATION TO SUPPORT JOB DESCRIPTIONS AND JOB PLANS

In neuropsychiatry services there are many different models of service provision ranging from highly specialised out-patient services, neuropsychiatric in-patient units and liaison with neurosciences centres to neurorehabilitation centres. In these services, consultants work with a broad range of multidisciplinary staff from mental health services, neurosciences and neurorehabilitation services and primary care services. The workload of a neuropsychiatrist would vary depending on the kind of service provided and local referral criteria.

In addition to expertise in mental health legislation, knowledge of capacity-based legislation is required and time to implement these is needed in all job plans.

Neuropsychiatrists, like general adult psychiatrists, can be appointed to solely in-patient, out-patient, neurosciences liaison neuropsychiatry or mixed jobs.

FULL-TIME OUT-PATIENT NEUROPSYCHIATRY

The expected workload of a full-time consultant neuropsychiatrist is dependent on a range of factors, including which elements of service provision are included, the size and composition of teams, sources of referral, types of specialist clinics provided and geographical area served.

The clinical work of an out-patient-based neuropsychiatrist can be broken down as set out above under clinical roles. The allocation of these tasks within a job description will depend on the clinical role expected of the consultant and the other staff available to undertake a proportion of these tasks.

It is reasonable for a full-time out-patient neuropsychiatry consultant to have 5 PAs per week for direct patient care in out-patient assessments. New patients in the out-patient clinic require approximately 1.5 hours. Follow-up appointments require 30 minutes. Clinics should be structured so that there is time built into the clinic to supervise trainee assessment and see their patient.

Time needs to be made available within a job plan for emergency assessments in the clinic if they are to be undertaken by consultant staff. If such assessments are undertaken by other members of the multidisciplinary team, time should be available in the consultant's job plan for the clinical support and supervision of decisions made. A minimum of 1 PA per week is likely to be required for emergency work.

Multidisciplinary working entails a weekly multidisciplinary team meeting to discuss patient care. This requires 1 PA, which includes time for support and advice to members of the multidisciplinary team about patient care outside the team meeting.

Additional clinical administration time is needed for review of neuroradiological or neurophysiological investigations and for attendance at multidisciplinary complex patient reviews – a minimum of 0.5 PA per week is required, but some jobs will need specific extra neurophysiological time and expertise (e.g. in a sleep clinic).

If an employer wishes a consultant to spend more time undertaking emergency work or participating in multidisciplinary patient reviews, this would need to be offset by a reduction in out-patient clinics and home visits.

A summary of a direct patient care timetable for a full-time consultant with no specific educational or leadership role is shown below.

Out-patient work	5 PAs per week
Multidisciplinary team meeting and support for team members outside the meeting	1 PA per week
Emergency clinical work	1 PA per week
Clinical administration	0.5 PA per week

It is difficult to be precise, but it is likely that in areas of average morbidity there should be at least 2 WTE consultants per 1 million population.

FULL-TIME IN-PATIENT NEUROPSYCHIATRY POSTS

It is expected that each consultant should have sufficient time within their timetable personally to review each patient at least once a week. Consultants should have time to visit the ward each day to be available for day-to-day decisions requiring consultant input.

The principles underpinning safe and effective in-patient work are as set out in the section on general adult psychiatry (pp. 14–15).

FULL-TIME NEUROSCIENCES LIAISON NEUROPSYCHIATRY POSTS

This job would require a balance between the above two jobs. There could be a combination of between 1–3 PAs for out-patient clinics and 1–3 PAs for ward assessment and advice role. In total, these two roles should amount to 5 PAs.

A weekly ward round would be required to review the patients on a neurosciences ward. This is likely to require 1 PA. Clinical liaison and multidisciplinary work would require 1 PA.

Other administrative tasks concerning in-patient care include, for example, unscheduled telephone calls, correspondence, checking of blood results and other investigations including neurophysiology and scans – 0.5 PA in total.

Out-patient clinics (1–3 PAs) Ward-based clinical activity including clinical decision meeting and interviewing patients and carers (1–3 PAs)	5 PAs per week
Ward round	1 PA per week
Multidisciplinary work	1 PA per week
Clinical administrative tasks	0.5 PA per week

OTHER MIXED NEUROPSYCHIATRY POSTS

There could be other mixed neuropsychiatry posts that could have different elements of the two jobs in different proportions, based on the local service and commissioning arrangement and nature of specialist neuropsychiatry services. It is anticipated that these services would have appropriate balance of clinical sessions based on the earlier job examples in this section.

Clinical academic psychiatry

A clinical academic has undertaken all the necessary training necessary to become a clinical consultant as well as sufficient postgraduate research training to function as a productive clinical scientist at a senior level (usually senior lecturer or above).

Academic training varies and may involve a period as a junior researcher or research student or a combined clinical academic training as a National Institute for Health Research (NIHR) academic clinical fellow. This may be followed by a Medical Research Council, Wellcome or NIHR clinical training fellowship to PhD or MD level, followed by some years of research at the equivalent of a postdoctoral researcher level, often as a research fellow where additional research training and experience is acquired. By the time the doctor comes to a clinical senior lecturer level, they, in addition to having a PhD or MD, have written and published a number of peer-reviewed papers in international journals, achieved research grant funding and have presented their work at national and international conferences. Hence, they will have an established international profile in their research field, and have begun the process of supervising others in research (e.g. BMedSci, MSc, PhD students).

Clinical academics have a pivotal role in raising the profile of psychiatry nationally and internationally (particularly, through an improved understanding of its scientific base, firmly embedded in medicine), engaging students into psychiatry through teaching and research, inspiring and nurturing interest in the next generation of potential psychiatrists and contributing to new developments of direct benefit to the NHS and patient care.

All consultants have considerable academic knowledge and skills. Important clinically based research can be carried out by consultants whose main role is clinical but who have sessions set aside for academic work.

CLINICAL ROLE

A clinical academic psychiatrist combines clinical practice with a senior academic role which will usually include both research and teaching. The clinical role of an academic psychiatrist will often be linked to their research interests.

A clinical academic psychiatrist fulfils leadership roles in two main areas: as a clinical consultant, and as a university senior academic. They are highly trained and motivated individuals who lead the specialty and ensure that psychiatry, and its central role in understanding and treating mental illness, moves forward for the benefit of our patients.

LEADERSHIP ROLE

Clinical academics will have a leadership role in the organising and delivering of teaching in psychiatry to a number of groups, in particular to undergraduate medical students, as well as to other undergraduates (e.g. dentistry, psychology, neuroscience, nursing, social work, pharmacy, occupational therapy, law), clinical postgraduates and in professional training (psychiatry trainees) for the MRCPsych. In addition, they will teach and supervise BMedSci research degrees and postgraduate MSc, MD and PhD students. They thus have a key role in recruiting and training psychiatrists of the future. In addition, as research involves collaborations between many different disciplines, well beyond the traditional clinical multidisciplinary teams, clinical academics are well placed to maximise the rich symbiosis of ideas and approaches from other medical specialties and intellectual disciplines (sociology, economics, systems theory, law, politics, physics, mathematics, biology, engineering, etc.).

The clinical academic is uniquely placed to translate clinical insights into research questions, assess quality of evidence, ensure latest evidence is implemented and monitored in the clinical situation. Through publication, presentation and editorial responsibilities they make sure that relevant findings are disseminated and accessible. Also, through leadership roles in national and international committees and learned societies, clinical academics engage across a wide spectrum including with policy makers and the public.

EDUCATIONAL AND ACADEMIC ROLE

The clinical academic has a key role in furthering current understanding of, and treatment for, mental illness and in translating advances in basic science into benefits for patients and the general population. A major role is to generate new approaches, knowledge and services that help to drive forward improvements in diagnosis, treatment and outcome. Some clinical academics specialise in advancing teaching methodologies and content. Spanning the areas of knowledge, discovery, innovation, dissemination and implementation means that the clinical academic is uniquely placed to drive service developments and will often provide clinical leadership as well as leading programmes of clinical research. Successfully combining both clinical and academic leadership roles is demanding, and so clinical academics need to be both highly trained and motivated. The more senior the clinical academic, the more research, teaching and managerial leadership is expected alongside maintaining a key leadership role in clinical services.

Appendix: Letter supporting doctors to undertake national work of benefit to healthcare systems



Regent's Place
350 Euston Road
London NW1 3JN

Switchboard: 0845 357 8001
Central Fax: 020 7189 5001
Central Email: gmc@gmc-uk.org
www.gmc-uk.org

24th January 2012

We are writing to every employer in the NHS to urge you and your Board to look favourably on requests from doctors for absence to undertake national work of benefit to healthcare systems across the UK.

The government and statutory agencies such as NICE, the Committee on Human Medicines and the General Medical Council, as well as professional organisations such as the Royal Colleges, all rely heavily on senior members of the profession for their expertise and experience in a whole variety of roles. The part time work they undertake alongside their clinical duties contributes a great deal to the quality of patient care, medical education and the effective running of the health service.

We understand that in the current climate there is considerable pressure on local resources and that you will need to take account of that and ensure that contractual commitments are applied appropriately. However, we hope you will regard such activity by your senior clinical staff as an investment in the system and a reflection of the high standards in your organisation. The experience gained by the individual will also often be of direct benefit to the unit in which they work.

Of course, a large number of NHS organisations already support this activity, and we are keen to see that continue, but if there is more encouragement you can give, we believe that would bring significant benefit. We would be grateful if you could bring this to the attention of the members of your Board.

If you have any comments or questions please contact Joanna Szreder via jszreder@gmc-uk.org who will pass them on to us.

Yours sincerely

Sir Harry Burns
Chief Medical Officer Scottish Government

Dame Sally Davies
Chief Medical Officer UK Government

Dr Tony Jewell
Chief Medical Officer Welsh Assembly Government

Sir Bruce Keogh
Medical Director National Health Service (England)

Dr Michael McBride
Chief Medical Officer Department of Health and Social Services (Northern Ireland)

Sir Peter Rubin
Chairman General Medical Council

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