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Safe patients and high-quality services

Job descriptions for consultant psychiatrists

Please note:

This report has been superseded by CR245 (published October 2026), but remains available for reference purposes.

COLLEGE REPORT

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Introduction

The role of a consultant psychiatrist is changing, in line with the wider recognition that the management of mental and physical well-being of our patients is an inextricable aspect of our care for the whole person. Psychiatrists have been at the forefront of driving integrated practice and have 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, and for the relationship to be one of partnership and co-production. The psychiatrist plays a key role in understanding the patient's diagnosis and formulation, their needs and wishes, and the adaptations and treatments that might be needed to allow the patient to achieve those. To undertake this work to a satisfactory standard the psychiatrist requires 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, nor should it be, that all patients need to see a psychiatrist. However, it is expected that patients with more complex needs and those who present a significant risk to themselves or others should have the support of a psychiatrist in their assessment, care planning and, where appropriate, ongoing care. Again, psychiatrists need to have sufficient training and time to undertake this important work.

The guidance set out in this document is designed to help psychiatrists and service managers 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.

Clinical role

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 inspiring and training the next generation of doctors and mental health professionals. Consultants are at the forefront of research and innovation and play a significant part in the running of successful organisations.

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 of long-term mental health conditions and their interface with physical ill health. 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-set of the psychiatrist is important. This may include medication management, physical well-being in the face of long-term conditions, and engaging constructively in a shared care discourse. This is alongside the role of offering expert advice and leading in the care pathway planning, assessment and support for patients cared for primarily by other members of the multidisciplinary team.

The consultant psychiatrist has a key role in the implementation of legislation providing a framework for the care and treatment of people with mental illness, acting as a responsible clinician or medical officer, participating in statutory reporting and informing the potential mental health review tribunals, and supporting the assessment of patients who may require detention in hospital. Although other professionals also play key roles in some of those areas, it is necessary that the consultant psychiatrist has sufficient time to discharge the responsibilities under the legislation.

The consultant psychiatrist has an increasing role in the oversight and implementation of mental capacity legislation and the interface of this act with other legislative frameworks. The consultant psychiatrist requires enough time to undertake assessments and reports in support of the lawful implementation of legislation such as the Deprivation of Liberty Safeguards.

Benefits of consultant psychiatrist care

The key benefits of consultant-delivered care can be summarised as:

- rapid and appropriate decision-making
- improved outcomes
- more efficient use of resources
- general practitioner (GP) access to a consultant opinion
- access to skilled clinical opinion.

Consultants should play a key role, where appropriate, in ensuring that:

- patients receive a thorough assessment of their circumstances, taking account of their history and current situation;
- patients are given a clear diagnostic formulation that is in line with internationally recognised standard classificatory systems, the DSM (American Psychiatric Association, 2013) and the ICD (World Health Organization, 1992);
- patients are given a clear understanding of how this formulation might affect their need for care and treatment, and are informed of treatment options that are available to them;
- patients are supported to develop a set of realistic recovery goals and a care plan that will allow them most appropriately to reach these goals; and
- patients with enduring illnesses are provided with continuity of care.

Leadership role

Psychiatrists bring an important perspective to the leadership of an organisation. This includes their expertise regarding the prevention, cause and treatment of mental and physical illness; their understanding of healthcare systems; their familiarity with evaluating complex information and evidence while managing uncertainty; and their links with external partners and stakeholders. Importantly, psychiatrists will often have experience from working within an organisation over many years. This 'institutional knowledge' can be vital to ensure an organisation is aware of its past when planning the future.

Due to the nature of delivery of healthcare interventions, particularly for mental health conditions, psychiatrists work in teams that bring together members from other professions. In that position, psychiatrists are likely to be the most senior members trained in the diagnosis and treatment of mental disorders and therefore have a key role in the clinical leadership of treatments these teams deliver.

Through the continuous personal development framework psychiatrists are most up to date with the evidence-based treatments that should be provided and thus they should also play a key role in leading service and quality improvement locally, regionally and nationally. Organisations need to work actively on medical engagement, internal decision-making and job-planning processes to ensure that psychiatrists are able to provide input into regional and national bodies, including local commissioning groups, the Royal College of Psychiatrists, universities and the National Health Service (NHS). Support for this work comes from the General Medical Council, chief medical officers and the national Departments of Health.

Psychiatrists invariably work in multidisciplinary teams. They provide senior clinical leadership and expertise which should optimise the performance of the team, helping to ensure that the care needs and safety of patients are appropriately met. This leadership may be expressed in formal roles but also experienced more informally via the psychiatrist's actions, integrity, values, credibility and consistency. Working in teams can be both rewarding and stressful and psychiatrists will often play an important role in supporting and promoting a positive culture. They are often uniquely positioned to help identify and resolve complex problems and support staff through change.

Consultant psychiatrists will also lead and manage teams in a way that supports the development of a culture of continuous improvement and learning. Again, this may occur in a variety of ways and at different levels within the organisation. Psychiatrists should promote reflection and review of standards, performance and policies.

Participation in clinical audit and quality improvement systems will be important. Consultants should offer expertise in the evaluation and management of risk and patient safety and should contribute to the review of near misses, adverse events and critical incidents. They should help promote standards in information governance systems, confidentiality and privacy. This may include:

- Ensuring that the voice of patients and carers is captured and listened to.
- Facilitating regular time and space for team reflection.
- Monitoring quality and performance of the service through tracking key measures over time.
- Involving a wide range of stakeholders and data/information in helping the team identify their key improvement priorities.
- Utilising the quality improvement approach to think systemically about complex problems, developing potential change ideas and testing these in practice using the organisation's quality improvement framework.
- Deploying resources to identified and agreed quality improvement projects and supporting staff in finding space and time for quality improvement.
- Supporting team members in developing an appropriate level of skill in quality improvement.
- Empowering the team to resolve local issues on a daily basis using the tools and methods of quality improvement without staff having to seek permission.
- Promoting awareness and understanding of quality improvement, and sharing learning and successes from quality improvement work.
- Taking a lead role as mental health experts in their local communities and work with primary care and local authorities, the third sector, patient/carer groups and employers to improve public mental health and reduce stigma.

Educational and academic role

All consultants will have important roles in education, training and supervision. These roles may focus on medical students, doctors in training and other healthcare professionals. Consultants will often have a key role in sharing knowledge with patients and carers so as to optimise joint decision-making. The majority of consultant psychiatrists will not have a formal academic role but the NHS Constitution stresses the importance of helping patients participate in research should they wish to do so. Psychiatrists can have an important role in facilitating this outcome within their services.

Consultant psychiatrists need to consider these roles both in terms of their own education and in terms of the education they provide to others including patients, carers and colleagues, both medical and non-medical.

Each consultant is committed to individual life-long learning to ensure that they keep up to date in the skills required for their role; this forms part of the NHS appraisal process. Continuing professional development (CPD) includes mandatory training that is required by the employing organisation as well as the mandatory training required for specific roles that the consultant may hold, for instance a clinical and/or educational supervisor.

The consultant should have a responsibility for training of not only 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, including young 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 an occasional paper published by the Royal College of Psychiatrists (2010). The College also provides a tailored programme of support and guidance for new consultants called StartΨell (www.rcpsych.ac.uk/workinpsychiatry/newconsultantsstartΨell.aspx).

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 care. As the NHS evolves and the pressures on services increase, these job descriptions can be complex and introduce new models of 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 & 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.

Increasingly, employer organisations are using electronic job planning tools to record job plans. These tools can be helpful in recording clinical activity and collating necessary information before the job planning meetings and can be linked to appraisals.

There is always a need for flexibility in agreeing a job plan according to local needs and circumstances, but the College is setting guidelines that it believes provide satisfactory levels of safety for patients and services. Organisations should have clear and justifiable reasons for deviating from these guidelines in the job planning process. Increasingly, organisations are using IT-based tools to record clinical activity and performance against measures of quality and safety. These tools are generally helpful but require context and discussion during the job planning process, for example considering the workforce, gaps in the service and admin support available to the consultant. Most consultants also use supporting professional activities (SPA) time to carry out audits, teaching, training and service development work. This work needs to be acknowledged within the job planning discussion.

As services evolve and more integration takes place, there are increasing demands on medical staff to carry out physical health checks on patients under the care of psychiatric services. These physical examinations and interventions require extra clinical time during clinics and training time to develop skills in managing these patients. These

extra clinical demands also need to be taken into consideration during the job planning meetings.

In some specialties, for instance intellectual disability and child and adolescent mental health services (CAMHS), a care and treatment review (CTR) process has also been introduced (NHS England, 2015). These meetings involve health and social care professionals working together to avoid admission or facilitate early discharge. They are usually led by commissioners. These meetings have a significant impact on the consultant workload, depending on their frequency.

Rehabilitation, forensic, old age, CAMHS, general adult, intellectual disability and perinatal psychiatry can have patients in out-of-area placements and there is an expectation that consultants from the local area would maintain an oversight of these patients and try to bring them back under the care of local services as quickly as possible. This requires considerable liaison and coordination between services, which can be time consuming, and needs to be taken into account during a job planning cycle.

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

General principles

1. There should be sufficient consultant capacity and clarity of arrangements to provide the range of activities required, allowing for routine, emergency and out-of-hours work as well as cross-cover arrangements.
2. Job descriptions and job plans should be drawn up in a way that provides the consultant with sufficient time to undertake their roles and responsibilities in a safe way and to a high standard.
3. Job descriptions and job 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 the ability both 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. Supporting professional activities (SPAs) are vital to safe and effective practice. The standard for full-time (10 PA) posts (excluding posts in Wales) would be an allocation of 2.5 SPAs, with all less-than-full-time posts having a proportionate allocation of direct clinical care and SPAs, with a minimum of 1.5 SPAs for the purposes of appraisal and revalidation.
5. The consultant contract in Wales was amended on 1 December 2003 in an agreement between the BMA Cymru Wales, the Welsh

Assembly Government and NHS health in Wales. The principle amendments include:

- a basic 37.5 hour working week;
- typically 7 sessions of direct clinical care; and
- session duration of 3–4 hours.

6 Additionally, the Mental Health (Wales) Measure 2010 seeks to ensure that where mental health services are delivered, they focus more appropriately on people's individual needs and it places new legal duties on local health boards and local authorities to improve service delivery.

7 Many factors affect the effectiveness of the role of the consultant and it is important that these factors are considered during job planning. They include the availability of other clinical and administrative staff working alongside consultants, and the working environment available to consultant psychiatrists. Further guidance on office accommodation is available in College position statement PS06/2016 (Royal College of Psychiatrists, 2016). 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 which they 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 mental health teams 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.

8 The recruitment and retention of consultants requires careful strategic planning. Flexibility and variety in job planning is an important ingredient of making this a long-term success. Where feasible, consideration should be given to supporting consultants develop and contribute their expertise to the NHS. This may be in areas of clinical, educational, management and research work. Job descriptions that offer greater variety of these roles may also offer advantages in terms of job satisfaction and supporting resilience, especially posts associated with high turnover of staff. For example, in-patient adult psychiatry posts may be better sustained by designing posts that have 5 or 6 PAs based on the ward (excluding the standard allocation of 2.5 SPAs), the remaining PAs focused on an area of special interest, such as medical education, research, management or alternative clinical roles.

9 The demands of a consultant job role will be affected by geographical factors and the wider health economy where the consultant works. Sufficient time must be included within job plans to reflect these factors and to allow the doctor to undertake their work to a high standard.

10 Where the job description goes beyond the immediate specialty of the post-holder, it should refer explicitly to:

- cross-cover between subspecialties, including on-call arrangements;
- locally agreed responsibilities for extended age range, including children and young people's services; and
- agreed responsibilities for physical healthcare beyond those routinely undertaken by a psychiatrist.

11 Cross-cover arrangements need to be clearly spelled out in job descriptions. The College notes that there has been a widespread move towards provision of 7-day services. This is a laudable move. However, it is important that job plans explicitly provide for like-for-like cover for planned absences such as study leave and CPD leave. Similar like-for-like cover should be available for less-than-full-time consultants. Contingency arrangements for unplanned leave with appropriate and adequate cross-cover should also be specified explicitly. This will ensure that high-quality patient care is available 7 days a week even when the consultant is on leave.

12 Job planning needs to be a transparent and open process. Individual appraisals are private discussions but individual job plans need to be publicly available to:

- assure that the job is doable and sustainable;
- ensure that patients are receiving care to appropriate standards;
- determine the level of medical and allied health professional staffing needed to make the job viable;
- provide assurance that different jobs within the team or organisation are equitable and adequately supported; and
- allow some degree of flexibility in job planning over the annual cycle.

13 Clear line management for the post-holder should be provided to ensure optimal performance and support. Professional line management of doctors should be conducted by a single named individual who should usually be a medical professional. Operational line management will be determined by the service configuration and needs. Arrangements should be clear and unambiguous.

14 Arrangements to support the safe provision of these services should include the allocation of additional CPD opportunities where the skills and experiences differ significantly from those covered within the RCPsych curriculum. No consultant should be expected to work beyond their level of training and competency.

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

Abbreviations used in the tables: CMHT, community mental health team; CPA, care programme approach; CPD, continuing professional development; GMC, General Medical Council; GP, general practitioner; MAPPA, multi-agency public protection arrangements; NHSE, NHS England; NHSI, NHS Improvement; NICE, National Institute for Health and Care Excellence; NIHR, National Institute for Health Research; QI, quality improvement; RCPsych, Royal College of Psychiatrists; WPBA, workplace-based assessment

Community roles	
Role description	**Tasks**
New out-patients or home visits, including meetings with relatives (including children) 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	CPA, MAPPA, safeguarding, risk reviews, care and treatment reviews
Clinical advice to team members	Regular or *ad hoc* 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
Clinical administrative tasks	Including rating of outcome measures, cluster allocation, completion of risk assessment tools, recording of capacity assessments etc.
Physical health support to patients	Including monitoring of physical parameters and lifestyle and motivational advice pursuant to the well-being of the patient

In-patient roles	
Role description	**Tasks**
Direct clinical work with patients and carers, including young 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 *ad hoc* 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 Provide appraisal and job planning support to other consultants
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; drive clinical strategic developments within a service area
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	RCPsych roles, Department of Health advice, work for Care Quality Commission and NICE, support for NHSE and NHSI directorate activities
Most consultants	Leadership of clinical teams, safety and quality, QI work and audits

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 and non-consultant doctors	Each trainee requires 1 hour of trainee-centred educational supervision per week Additional supervision will be required for clinical work; other non-consultant doctors require at least monthly supervision Clinical and educational supervisor; support for revalidation and annual portfolio review through WPBA
Meeting requirements for revalidation	Revalidation activities including CPD and QI activities and reflection on serious incidents
Organisation of academic programmes[1]	College tutor, director of medical education, programme director, head of school
Examination roles	RCPsych examiners, developing curriculum and examinations
Training medical students	One-to-one and small-group teaching, lectures, examining and skills-based workshops, education
Education	Lectures, small-group teaching, skills workshops, work with Health Education England, the Northern Ireland Medical and Dental Training Agency and the GMC
Research	Clinical, service and basic science research, peer reviewing of papers, grant applications, trust research and development activities, Involvement with clinical research networks and other NIHR activities, partnership with universities, academic health science networks

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

Job descriptions and job plans in this document are built around a full-time post being 10 programmed activities (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 individuals with key roles in education, leadership, innovation, service development and acting as ambassadors of the organisation in links with primary care and other services. 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 them. 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 min 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 h of supervision required each week, the additional *ad hoc* supervision and administrative tasks needed for training, including clinical and educational supervisor's roles. There are additional training requirements to maintain the clinical and educational supervisor roles. These educational requirements also include giving lectures on MRCPsych courses, attending annual reviews of competency progression (ARCPs) and performing selection interviews.

Research and innovation

Consultants can play a key role in leading research and innovation for patient benefit. For some, 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

General adult psychiatrists form the core of mental health services. They usually work in a multidisciplinary team and are 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 (CRHTs)), in a first episode of psychosis (early intervention) or with those who have proven difficult to engage elsewhere (assertive outreach).

Over the past decade many, if not most, mental health providers across the UK have adopted a 'functionalised' model of care, which involves splitting community and in-patient care. Such a split does offer some benefits, most notably in the in-patient setting, with fewer consultants responsible for patient care on busy in-patient units. However, for the patient this introduces a significant interface in their care pathway. This interface has the potential of creating a significant discontinuity in the care provided to patients, and appropriate planning to manage this interface needs to be explicitly specified in job descriptions where functionalised models of care have been adopted.

Clinical role

The volume of clinical work has grown dramatically since the previous Adult Psychiatric Morbidity Survey in 2007. The latest survey (NHS Digital, 2016) uncovered an increase in common mental disorder rates in women; increase in self-harm in men and women; emergence of young women as a high-risk group with high rates of self-harm, post-traumatic stress disorder (PTSD) and bipolar disorder. Particularly high rates of common mental disorder are seen in those claiming UK government's Employment and Support Allowance (ESA) and there has been an increase in service use in this group, from one in four to one in three. Black and minority ethnic individuals are less likely to be in receipt of treatment. These factors need to be considered in job plans, and the traditional reliance on using population figures as a guide may therefore need to be more nuanced, to include guidance on case-loads as well as case mix (numbers of patients with illnesses in the more severe clusters) and population demographics (age, gender, ethnicity etc.).

Population figures may mask factors that determine case-loads, for instance presence of nursing homes, bail hostels, supported rehab care placements. For example, for general adult psychiatrists in

England, Wales and Scotland, a few patients on community treatment orders (CTOs) can add significantly to a consultant's workload.

Job plans should make express reference to quality benchmarks, such as National Institute for Health and Care Excellence (NICE) quality standards. Reference to specific benchmarks, for example the expectation that community consultants need to be able to individually review patients every 2–4 weeks while their drug treatment is being changed should help determine viable case-loads.

Safe and effective working with patients depends on the presence of an effective multidisciplinary team. General adult psychiatry is facing a significant recruitment crisis and it is not unusual for trusts to rely on locum medical staff and agency nursing staff for service provision. Some of the locum medical staff may not be qualified to supervise junior medical staff and short-term locums are usually not involved in management activities, which may add to the workload of substantive staff. These factors need to be borne in mind when designing and approving job plans.

- **Agency staff** in mental health teams can hamper continuity of care and can be especially anti-therapeutic for patients with personality disorders, who are forming a larger proportion of case-loads in both community and in-patient settings.
- Safe and effective delivery of clinical services is underpinned by a **good clinical administrative system**. Electronic patient records have become quite commonplace and digital dictation is becoming the norm. With that has come a move towards rationalising administrative support in various organisations. However, as consultant roles become busier with greater clinical case-loads, it is vital that administrative support is viewed in all its complexity and not reduced to a 'typist' role. Rather, it should be seen as support to help consultants prioritise their time, ensure deadlines are met and, more pertinently, help consultants manage their busy case-loads.
- **Performance dashboards** can play a significant role in improving the effectiveness of clinical care and are increasingly becoming available to consultants. Adequate time needs to be provided in the job plan to enable consultants to engage with and make the most of electronic patient records.

Leadership role

Consultant general adult psychiatrists play a key role in modelling high-quality patient care, in building relationships with key stakeholders of the local health economy (such as GPs, Social Services and other community-based stakeholders), and in driving continuous quality improvement, all to ensure that patients have a caring, responsive and safe pathway of care.

In a standard 10 PA job plan, of the 2.5 SPAs, it is estimated that 1.5 SPAs will be needed to meet CPD, appraisal and revalidation requirements. Good job planning should lead to 1 SPA being used specifically for clinical leadership roles with linked SMART (specific, measurable, attainable, relevant and time-bound) objectives. The effectiveness of this SPA can be increased by engaging in a team job planning process. Team-based job planning is particularly relevant to community mental health teams where different sectors can show significant variations in morbidity, referral rates and the level of community support available. Such team-based job planning should allow more equitable allocation of resources and better use of individual consultants' leadership SPAs to help deliver team-based SMART objectives (smoking cessation, improving physical healthcare outcomes for patients etc.).

Educational role

There is an increasing demand on consultant time in educational matters, and this is encroaching on protected teaching time. It is important to ensure that job descriptions take into account the different grades of trainees. For example, foundation trainees may need additional support, especially in a 4-month placement, compared with higher specialist trainees. College guidance suggests allocating 30 min per new patient for discussion with core trainees/GP trainees and foundation trainees. This is in addition to the protected weekly clinical supervision time. On an in-patient unit, a consultant may be the supervisor for multiple trainees/specialist grade doctors. The educational role of the consultant in such cases will require additional time and this needs to be reflected in their job plan. It needs to be borne in mind that protected teaching and clinical supervision time may often be required in clinical settings such as out-patient clinics.

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 below. 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 1 h for an appointment. Follow-up appointments require 30 min. Clinics should be structured so that only 3 of the 4 hours of PA are booked in with

routine patients, allowing space for urgent cases, liaison with other professionals and the completion of administrative tasks not finalised 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 who are unlikely or unable to attend. Additional time must be allocated for travel for those off-site **visits**.
- 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, to review 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.
- All community job descriptions must include **case-load analysis** that should provide some information on the number of new referrals, break-down of numbers of cases by clusters/diagnosis and, where applicable, average numbers of patients on a community treatment order (CTO) over the past 1–3 years. This should be accompanied by an indicative follow-up timetable that should allow the calculation of a viable case-load range for the job. Ideally these calculations should be mapped to NICE or similar quality standards to ensure that patients are receiving high-quality care (e.g. patients undergoing medication change need to be reviewed every 2–4 weeks).
- In Northern Ireland, patients under promoting quality care (PQC) will need more frequent reviews and multidisciplinary meetings and this should be factored into job plans.
- For **mental health legislation work**, including CTO work, and for attendance at multidisciplinary **complex patient reviews**, a minimum of 0.5 PA per week is required. Patients placed on a CTO may need more frequent reviews to determine the need for CTO renewal or capacity assessments and they also require regular reports for tribunal and managers' hearings. This means that on average about 0.5 PA should be allocated for 3–4 patients on CTOs depending on complexity and the number of tribunal hearings.
- If an employer required a consultant to spend more time undertaking emergency work, participating in multidisciplinary patient reviews, or if the number of patients on CTO exceeds the pro

rata time allocation, this would need to be offset by a **reduction in out-patient clinics and home visits**.

- Most jobs will need **1 programmed activity (PA) for clinical administration**. Most clinicians are reporting a significant increase in clinical administrative duties, including dealing with the rising number of requests for housing support, Driver and Vehicle Licensing Agency (DVLA), occupational health, incapacity benefit and personal independence payments (PIP, formerly disability living allowance (DLA)) assessments, to name a few. Less-than-full-time consultants will require a proportionally greater amount of clinical administration time and SPA time.

Model job plan for a full-time community general adult consultant	
Description	**Professional activities (PAs) per week**
Direct clinical care	7.5
Out-patient work/home visits	4
Clinical administration	1
Multidisciplinary team meeting/support for team members outside the meeting	1
Emergency clinical work	1
Mental Health Act work/complex patient reviews	0.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

Full-time in-patient posts

- In-patients are the most unwell individuals 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 legislation work**. Organisations must make judgements, based on previous experience, as to the amount of time this involves for each consultant. Each statutory hearing or tribunal is likely to require 1 PA both in the preparation of the report and attendance at the tribunal (a total of 2 PAs). This work is likely to require a minimum of 2 PAs per week for all in-patient consultants. However, the increase in approved clinician, or responsible medical officer, work and the tendency towards longer and more complex tribunals may mean that 2 PAs for in-patient consultants may not be adequate.
- **Other clinical administrative tasks** concerning in-patient care (e.g. unscheduled telephone calls, correspondence, checking of blood tests) require 0.5 PAs per week – this is 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. However, this needs to be balanced with time required for additional clinical supervision. With the expansion in foundation training placements in psychiatry, many in-patient units provide placements for F1 and F2 trainees. These trainees require closer supervision and this needs to be factored into the consultant's job plan.
- Principles of case-load analysis discussed for community psychiatrists also apply to in-patient consultants. Some units in the country operate assessment wards with rapid turnover of patients. These patients require fuller initial assessments with more frequent assessments before triaging to an appropriate longer-stay unit if needed. An analysis of numbers admitted, length of stay, numbers discharged, numbers of involuntary admissions, numbers of patients lacking capacity etc. should allow calculation of a viable timetabled job plan. Similar principles apply for specialist in-patient units such as mood disorder or personality disorder units.
- Wards differ according to the complexity and illness of patients – patients 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 treated compulsorily and hence there is a need for proportionally increased time for mental health legislation work.

Model job plan for a full-time in-patient general adult consultant	
Description	**Professional activities (PAs) per week**
Direct clinical care	7.5
Ward-based clinical activity including clinical decision meeting and interviewing patients and carers	5
Mental health legislation work	2
Clinical administrative tasks	0.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

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 need to be adjusted according to the sessional commitment. Case-load analysis in these cases should consider data for both community and in-patient elements.

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. As such, 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, or other such clinical professional, managing such patients. 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 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. Given the complexity and numbers involved, case-load analysis benchmarked to quality standards is vital.

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

The epidemiology and presentation of mental illness in older people is different to working-age adults. Older people with mental illness often have a unique and complex set of physical, psychological and social factors complicating their care. For these reasons older people need dedicated in-patient and community mental health teams to look after them.

Old age psychiatry services can offer expertise and care for people of any age with a primary dementia, as well as people with mental disorder and physical illness or frailty which contribute to, or complicate the management of, their mental illness. This may include people under 65, people with psychological or social difficulties related to the ageing process or end-of-life issues, or people whose needs are best met by a service for older people.

A consultant in old age psychiatry has a particular expertise in the psychiatric care of older patients, including specialist knowledge of organic disorders and the complexities associated with (at times multiple) physical comorbidity. In addition to the general roles set out in the background to this document, old age psychiatrists have specific expertise as listed below. There is an increasing recognition of the need to ensure patients are seen by the most appropriate services according to needs rather than just age. Some patients with functional illness will be still working and living very active lives as they approach 65. Their psychiatric care may continue to be undertaken by adult mental health services.

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. On occasion this may include patients under the age of 65 who experience physical frailty.
- 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 rural services with admission beds on several different sites, to memory assessment services incorporated within 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, knowledge of capacity-based legislation is required and time to implement these is needed in all job plans. In relevant jurisdictions, 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, but in doing so makes services more outreaching and patient focused.
- Old age psychiatrists, like general adult psychiatrists, can be appointed to solely in-patient, community or mixed jobs. The majority of consultant old age psychiatry posts are now appointed to either community or in-patient settings. 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 h for assessment, with 30 min for follow-up appointments. Acknowledging the greater focus on community-based assessments, a minimum of 1.5 h for new assessments and 1 h 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 and secondary care old age medicine services is an important part of old age psychiatry consultant role.
- Job plan time needs to be allocated for **mental health capacity legislation work**. 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.
- Multi-professional 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**, such as 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 old age consultant	
Description	**Professional activities (PAs) per week**
Direct clinical care	7.5
Out-patient/community work	4.5
Multidisciplinary team meeting and supervision	1
Emergency work	1
Mental health legislation/adult protection and mental capacity legislation work	0.5
Clinical administrative tasks	0.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

- It is difficult to be precise about the required number of old age consultants per population served. Many factors influence the appropriate case-load for an old age consultant, such as:
  - Demographics – high numbers of old people, especially aged over 80, equate 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 – such as the relationship with other services for working-age adults and where old age services deal with above-average numbers of people with substance misuse, intellectual disability, offenders, and so on, 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 teams may reduce or increase workload for community consultants, depending on how services are structured. Services offering proactive assessment in general hospitals have heavier demand than reactive services.
- A number of other factors, such as the co-location of teams and services, referral patterns from primary care, and the extent and nature of local authority services and other third sector services. Further guidance on these factors and job planning is contained in a report published by the College's Faculty of the Psychiatry of Old Age (2015).

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 multi-professional 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.

Model job plan for a full-time consultant – functional illness	
Description	**Professional activities (PAs) per week**
Direct clinical care	**7.5**
Ward-based clinical activity	**5**
Work relating to mental health and capacity legislation	**2**
Clinical administrative tasks	**0.5**
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	**2.5**

As with general adult psychiatry, it is likely that a whole-time in-patient consultant for functionally ill elderly patients 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.

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. In many in-patient settings most patients are initially subject to assessment under mental health legislation. In relevant jurisdictions, their continuing care in the majority of cases will be subject to ongoing compulsory treatment under the Mental Health Act and on occasion to Deprivation of Liberty Safeguards under the principles of the Mental Capacity Act 2005. Dedicated time needs to be allowed to undertake an increasing number of mental health review tribunals.

Model job plan for a full-time consultant – dementia assessment and treatment	
Description	**Professional activities (PAs) per week**
Direct clinical care	**7.5**
Ward-based clinical activity	**5**
Work relating to mental health and capacity legislation	**2**
Clinical administrative tasks	**0.5**
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	**2.5**

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 on pp. 14–16 will apply.

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 for children, young people and their families/carers. With knowledge of child development, physical health, pharmacology, emotional health, families, complex systems 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 above, a consultant child and adolescent psychiatrist will have specific expertise in the following areas.

- Carrying out **complex clinical assessments** including components needing specific expertise (i.e. a comprehensive developmental history), and identifying and managing physical health problems in children and young people jointly with primary care and paediatricians.
- 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's/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** – this 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.

- Managing the **complexity of information**, including knowledge of mental illness, child development, interpersonal/family dynamics, the Children Act 2004, criminal justice, mental health and mental capacity legislation, to reach decisions in the best interests of children and young people.
- Making child **safeguarding** referrals, attending safeguarding meetings, preparing reports and documentation and participating in multi-agency meetings in the area of legal and policy guidance around child safeguarding. This area has become more complex over the years and time has to be identified clearly in consultant job plans to undertake those tasks.
- Taking part in and attending care programme approach (CPA) reviews, care and treatment reviews (CTRs) and looked after children (LAC) meetings for those admitted to in-patient units, including children and young people placed out of area (either in health or social care placements), all of which have increased in recent years. Time needs to be identified for these roles.
- Assessment and advice to social care and youth justice with regard to the developmental, mental health and welfare, and criminogenic (youth criminal justice) needs of children and young people.

Leadership role

- Communicate with commissioners in health and other sectors about 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 distress and disorder and promotion of emotional well-being.
- Carry out specific leadership roles in medical management, academic roles, roles in medical education and national roles, for instance for the Royal College of Psychiatrists and in a national advisory capacity, as applicable.

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, as well as educational and professional networks. Multiple sources of information are required.

The child/young person 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, youth justice workers and allied professionals. It will likely involve 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 specialties, including the full range of psychiatric disorders, disorders specific to childhood, substance misuse, forensic psychiatry, intellectual disability, neuropsychiatry and liaison services. Many adult mental disorders start in childhood or adolescence, and mental and physical comorbidity 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, intellectual disability, autism, attention-deficit hyperactivity disorder). Complexity of clinical presentation will also vary, with factors such as demographics, deprivation indices and service provision (local community team *v.* regional or specialist services) being of relevance.

Consultations to other professionals and agencies form a significant part of the child and adolescent psychiatrist's work. These consultations can last between 15 and 90 min and can take place in a variety of settings. Time to travel to external consultations should be factored into job planning.

A standard community follow-up appointment would be 1 h and for new patients 90 min. More complex cases (e.g. neurodevelopmental assessments, childcare-related assessments or assessments for the criminal courts) can take longer, in excess of 180 min, 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, specialist schools and secure settings
- nature of other children's services in the area (e.g. the size and remit of the community paediatric, intellectual 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 (intellectual disability, neurodevelopmental, liaison, substance misuse, etc.). The size and skill mix of the medical staffing and supporting multidisciplinary team vary considerably. This will have an impact on the nature of work a consultant will be required to undertake, including a need to provide consultation to and joint assessments with team members, clinical supervision to medical staff and collaborative work with other professionals and agencies.

Engagement in service development, strategic planning and team management/leadership will vary in response to local structures and expectations, with an 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, particularly for consultants who are first on call (i.e. where there is no trainee or staff grade doctor as first contact).

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. This also applies to roles that cover larger regions rather than discrete catchment areas.

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. In keeping with the general principles of job planning, it is vital that adequate SPAs are included in the job plan to enable psychiatrists to take on specific leadership roles and to promote recruitment and retention.

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 management 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) and travel.

Tier 3 generic community CAMHS

The individual consultant case-load will vary. Based on experience of the choice and partnership approach, published workload data, survey of Royal College of Psychiatrists' 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 are less than adequate consultant or multidisciplinary staffing numbers or skill mix. A work-load 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 assess-ments 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, consultation, 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.

Tier 3 generic community CAMHS	
Description	**Professional activities (PAs) per week**
Direct clinical care	7.5
Initial assessments/new cases	1
Complex case reviews/liaison with other agencies/case management/provision of treatment/work relating to out-of-area patients	4
Emergency work/unpredictable cases	1
Clinical administrative tasks	0.5
Multidisciplinary team meeting, consultation, support and supervision for team members	1
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

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, complex case review meetings (such as CTRs) and sufficient time for liaison with families and other agencies.

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 10–12 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 whole-time equivalent (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.

Tier 4 in-patient unit	
Description	**Professional activities (PAs) per week**
Direct clinical care	**7.5**
Ward-based clinical activity including clinical decision meeting, interviewing patients and carers	**4.5**
Liaison with families and other agencies	**2.5**
Clinical administrative tasks	**0.5**
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	**2.5**

Tier 4 out-patient services

Services that provide specialist assessment and treatment, often via a liaison and consultation model (e.g. community forensic psychiatry, CAMHS), on a regional basis require a different job planning approach. Although direct assessments are an important component of this work, the significantly greater proportion of indirect contacts (discussion with professionals via telephone or face to face, including professionals' meetings) needs to be recognised. Services of this type often provide across wider geographical areas and by their nature provide for children and families with needs in multiple domains, with multiple accommodation histories, high-risk profiles and often in complex legal systems; specific recognition of the greater travel and background reading involved is also required.

Addictions psychiatry

A consultant in addictions psychiatry is a doctor with a Certificate of Completion of Training (CCT) in general 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, as is increasingly the case, within the non-statutory sector. In addition to the general roles set out in the job descriptions and job plans section of this document (pp. 10–17), 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, elderly people, 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.
- Clinical supervision and mentorship for non-medical prescribers (NMPs).
- 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.
- Being the designated medical practitioner for NMP trainees.
- Liaison with commissioners to define and improve outcomes.
- Ensuring 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 h for a new patient assessment and 30 min 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.

Community psychiatrist	
Description	**Professional activities (PAs) per week**
Direct clinical care	7.5
Out-patient work, including face-to-face reviews of patients, seeing patients for consultations from other services	4
Supervision of other prescribers such as GPs and NMPs and management of prescribing	0.5[1]
Multidisciplinary team meeting and support for team members outside the meeting	1
Liaison and advice to other services including GPs and acute hospitals	1
Administrative tasks related to direct clinical care (e.g. treatment outcome profiles, National Drug Treatment Monitoring System (NDTMS))	1
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

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.

In-patient detoxification (tier 4) psychiatrist	
Description	**Professional activities (PAs) per week**
Direct clinical care	7.5
Ward-based clinical activity including clinical decision meeting and interviewing patients and carers	5
Supervision of multidisciplinary team	1
Liaison with families and other agencies	1
Clinical administrative tasks	0.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

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 expertise in providing services for and working with patients who have a complex mix of disorders of mental health which have often proved treatment resistant, and who, generally as a consequence, are considered to pose a risk of serious harm to others. More often than not, the social circumstances of this patient group have been and/or still are difficult and complicated. Most patients have already been convicted of at least one serious criminal offence and very few are previously unknown to other psychiatric services. In addition to a high standard of general psychiatric skills, highly skilled risk assessment and management is, thus, a core part of the work.

The range of medical and social problems presented by this group of patients means that forensic psychiatrists have to be highly skilled in both multidisciplinary and inter-agency working. Agencies outside health services include the police, the courts, prison and probation service personnel, Social Services, housing authorities and a range of third sector organisations.

The complexity of the mix of psychotic illness, developmental disorders, substance use disorders and post-traumatic states together with social disadvantage presented by most patients means that most of them need longer in treatment and care than patients in many other areas of psychiatry, and that substantial periods of this will include therapeutic use of physical and procedural as well as relational security. Forensic psychiatrists, therefore, must be particularly skilled in managing institutional settings, engaging in routine reflective practice and participation in peer and independent review.

Forensic psychiatrists are routinely expected to provide expert evidence throughout the legal system – criminal courts, family courts, other civil courts and tribunals – and at all levels, and must have training and experience commensurate with this.

Given that most of the people referred to forensic psychiatric services have been violent and/or sexually abusive to others, but also many have themselves been victims of substantial and long-standing abuse, forensic psychiatrists must have special skills in relation to managing victim issues.

Demand for forensic mental health services means that many patients and others with mental health needs have to be managed and treated outside the core services, at best in other psychiatric specialty services or in out-of-area independent healthcare sector centres, at worst while remaining in prison, so forensic psychiatrists must have strong consultation–liaison skills.

Highly developed communication skills are essential to ensuring safety in this high-risk field, whether in the long-term relationships with patients and their families, within the clinical team, with other agencies involved in safe service delivery or in responding to the constant shifts in requirements for service development and provision.

Forensic psychiatrists in the UK are entirely bound by medical ethics, and fully subscribe to GMC and Royal College of Psychiatrists' practice guidance.

Forensic psychiatry is a fascinating specialty, but demanding of expertise and time, and requires continuous attention to maintenance of acquired skills and professional development.

Clinical role

- The detailed assessment, treatment and management of people with complex mental health needs who also pose a significant risk of harm to others. This includes expertise in:
  - medication for treatment-resistant conditions;
  - management of complex, multi-source information to develop a formulation and treatment plan 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, custodial settings and transition between them;
  - 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; and
  - assessment and management of victim-related issues.
- Second opinions and advice to colleagues on diagnosis and risk management.
- Support and advice to services which 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 for providing leadership within their teams to ensure the delivery of high-quality care for patients. Maintaining patients' rights and the safety of others requires the consultant to manage and contain any anxiety within the multidisciplinary team to provide safe treatment. Supporting recovery and rehabilitation requires full understanding of the limits of one's own skills and both the wealth of skills provided by other disciplines within the team and the ability to ensure that they are applied to the full where appropriate.
- Consultants provide leadership in reflective practice.
- Consultants oversee the development of clinical standards and implementation of national guidance in forensic psychiatry.
- Forensic services are high-cost services and consultants will always work 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 models. 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, specialist liaison roles have emerged – such as with intellectual disability services or with child and adolescent services.
- Consultant forensic psychiatrists generally have an important role in teaching and training within and outside the discipline. This means allowance must be made not only for teaching time, but also suitable time for personal development.
- Time for quality improvement and/or association with national network oversight schemes should be evident in job planning given the consultant's role in positively influencing their development and the exceptional requirements for vigilance over service provision.

The following table includes guidance on workloads given that job descriptions can vary in the range of tasks undertaken within the consultant role. It offers examples of what workload may be expected within a professional activity (1 PA), but we stress that this is guidance only as the nature of tasks and the case-load mix may vary

between services. It is broadly expected that consultants will deliver 7.5 sessions of direct clinical activity per week, but this too will vary according to the extent of their managerial or academic roles.

Consultant forensic psychiatrist	
Description	**Professional activities (PAs) per week**
Direct clinical care[1]	Maximum 7.5
Per 2–4 in-patients in secure environment: low, medium or high. Factors such as patient complexity, acuteness, gender, age, length of stay, resources available, nature of care (e.g. stepped down), team composition will also determine which end of the range is reasonable	1
Per 5–15 community forensic patients. Factors such as patient complexity, acuteness, resources available, team composition will determine which end of the range is reasonable	1
Prison session: per 2–3 new patients or up to 6 follow-up patients (or a combination of these) assuming a 3 h 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
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, age, resources available, team composition and type of service being provided will determine which end of the range is reasonable	1
Consultancy/liaison/diversion: some services provide this as part of their assessment service (see previous point), whereas 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
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 (promoting quality care in Northern Ireland (PQC)) meetings, whether annual or 3 monthly) will determine which end of the range is reasonable	1
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 (PQC) meetings, whether annual or 3 monthly) will determine which end of the range is reasonable	1
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

1 In each case the level of time and expertise available from junior doctors and/or staff grade doctors will partly determine which end of the range is reasonable – generally, up to 7.5 sessions will be made up from a mixture of the roles given in the table.

Note: for probity to be maintained, any fee-paying work must be explicitly reflected in the consultant's 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; or part-time contracts for consultants to accommodate fee-paying work outside the consultant job plan.

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 experience ongoing active symptoms of illness, impairments in cognition and drive, social stigma and the secondary handicaps consequent on the illness, those who are referred for rehabilitation are often those whose problems are of such complexity or severity that they could not be discharged home following an acute admission or whose needs cannot be met by general adult services. 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, pre-morbid 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, such as:

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

Clinical role

In addition to the general roles of the consultant as set out on pp. 14–16, 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.

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 manage the powerful dynamics that can lead to challenges in working with 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 of patients on compulsory treatment 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, given the importance of having both community and rehabilitation consultant provision in all catchment areas and working closely with other mental health specialties as well as other services to address needs of patients with serious mental illness.

Bearing these issues in mind, we suggest the following summary guide to the direct patient contact time required for a consultant in rehabilitation psychiatry.

Rehabilitation psychiatry patient time requirements	
Description of service	**Professional activities (PAs) per week**
High-dependency (high-support) in-patient rehabilitation unit (average 14 beds, most patients on compulsory treatment, average length of stay 12 months): direct patient care, referral assessment and meeting, in-reach to acute wards, MDT meeting, CPA/PQC meetings, family interventions, mental health legislation work, clinical administration	7.5
Long-term high-dependency (high-support) unit (average 14 beds, most patients on compulsory treatment, average length of stay >5 years): direct patient care, assessment of referrals, CPA/PQC meetings, family interventions, mental health legislation work, clinical administration	5
Community rehabilitation team (average case-load 100, some patients under CTO): direct patient care, home visits, CPA/PQC meetings, weekly team meeting, family interventions, mental health legislation work, clinical administration	5
Community rehabilitation unit (average 14 beds, many patients on compulsory treatment, average length of stay 18 months): direct patient care, CPA/PQC meetings, assessment of referrals, family interventions, mental health legislation work, clinical administration	4
Long-term complex care unit (average 10 beds, most patients not on compulsory treatment, average length of stay 5–10 years): direct patient care, CPA/PQC meetings, assessment of referrals	2
Other specialist tasks: assessment of patients placed out of area and attendance at their CPA/PQC meetings, membership of placement funding panel (usually monthly), assessment and advice to colleagues regarding patients with complex needs, assistance to supported housing providers	1.0

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

Liaison psychiatry

Liaison psychiatrists specialise in the management of psychiatric problems in the general medical setting. They have expertise in working at the interface between physical and mental illness, including psychological reactions to physical illness, medically unexplained symptoms and the management of self-harm in the general hospital.

Many liaison psychiatry services now assess and manage adults of all ages. Team members may have specific expertise in working with younger or older adults, if not both. In future there might be expansion of liaison psychiatry services into primary care and other community settings which may affect this guidance.

Clinical role

In addition to the general consultant roles set out on pp. 14–16, a liaison psychiatrist has the following specific expertise:

- understanding the interface between physical illness and mental illness (e.g. comorbid mood disorders, medically unexplained symptoms, organic mental states);
- 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 in the general hospital, including application of mental health and mental capacity legislation;
- understanding the medical issues in assessing patients with medically unexplained symptoms; and
- 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/boards and clinical commissioning groups with a focus on service development and improvement.
- Due to the nature of the job most liaison psychiatrists will have a clinical leadership role within their teams, which will include clinical supervision of colleagues, and wider clinical responsibilities as mentioned earlier. Within the job plan, the former would be included in PAs for direct patient care and the latter in the PAs for supporting professional activities.
- The line manager for a consultant is usually a clinical director or equivalent. Consultants may provide clinical supervision and advice for non-medical team members, but line management for such staff would usually be provided by the team manager or another senior nurse. Clear local arrangements should be in place for supervision of non-medical team members.

Educational role

A liaison psychiatrist will play a role in challenging stigma and discrimination towards psychiatric patients and professionals by raising awareness of the issue, through presentations/teaching sessions, and through informal discussions with various professionals in the general hospital. A consultant will have a role in training to help general hospital colleagues to recognise and manage common mental health conditions and know when to refer.

It is a common experience that there is a demand from trainees of various levels to spend time in liaison psychiatry teams. If there are any trainees within the team then consultants should have sufficient allocated PAs in their job plan (1 h per week) for each trainee they supervise.

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 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 in-patients (all ages)
- out-patient clinics
- additional specialised services (e.g. for substance misuse, chronic fatigue syndrome, medically unexplained symptoms, psycho-oncology).

There is a wide 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. separate alcohol and substance misuse liaison services). Many liaison psychiatry teams provide services for both patients of working age and older adults (often with specialist sub-teams in larger hospitals), and some provide services for 16- to 18-year-olds. If the consultant is covering more than one hospital then travel time should be taken into consideration in their job plan.

There are four models of care that have been suggested in commissioning guidance for liaison psychiatry services (Aitken et al, 2014a).

1 **Core liaison psychiatry services** – operating during working hours or providing an extended hours service.
2 **Core 24 liaison psychiatry services** – operating over 24 h, 7 days a week.
3 **Enhanced 24 liaison psychiatry services** – operating over 24 h, 7 days a week, with extensions to fill local gaps in service and some out-patient services.
4 **Comprehensive liaison psychiatry services** – operating over 24 h, 7 days a week, and providing enhanced in-patient and out-patient services to specialties at major centres.

The expected workload of a consultant liaison psychiatrist, therefore, depends on the nature of the post. 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.

The distribution of clinical activities is for guidance only and should be adapted according to local needs in terms of the leadership role, the model of services and staffing of the team. For example, a liaison service in a large hospital may need increased PA time in the job plan of the consultant for leadership/service development and interface meetings with the acute hospital.

High-level summary of differences between models[1]				
Description	Core	Core 24	Enhanced 24	Comprehensive
Example number of beds	500	500	500	2000
Consultants	2	2	4	5
Other medical	0.6	2	2	2
Nurses	2 band 7 6 band 6	6 band 7 7 band 6	3 band 7 7 band 6	2 band 8b 17 band 6 10 band 5
Other therapists	0	4	2	16
Team manager band 7	1	1	1	3
Clinical service manager band 8	0.2	0.2–0.4	0.2–0.4	1
Admin band 2, 3 and 4	2.6	2	2	12
Business support (band 5)	0	1	1	1
Total whole-time equivalent	14.4	25.2–25.4	22.2–24.4	69
Hours of service	9 to 5	24/7	24/7	24/7
Age	16+	16+	16+	16+
Older person	Yes	Yes	Yes	Yes
Drug and alcohol	No	Yes	Yes	Yes
Out-patient	No	No	Yes	Yes
Specialties	No	No	No	Yes
Approximate costs	£0.7M	£1.1M	£1.4M	£4.5M

1. Detailed descriptions of these models and their differences in terms of staff size and skill mix can be found in Aitken et al (2014a,b,c) and Brightey-Gibbons et al (2017).

A summary of a direct patient care timetable for a full-time consultant with no specific leadership or educational role	
Description	Professional activities (PAs) per week
Direct clinical care	7.5
Face-to-face contact with patients in clinic or wards	4
Multidisciplinary team meeting and support for team members outside the meeting	1
Emergency work/unpredictable cases/clinical administration	1
Mental health legislation work/complex patient reviews or liaison with other specialties	1.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

Intellectual disability psychiatry

Consultant psychiatrists in intellectual disability (learning disability) work in varied clinical settings from in-patient settings to community services. In their training, intellectual disability psychiatrists require experience working with adults, children and offenders in both community and in-patient services. Intellectual disability services are moving towards delivering care using a care pathways approach where care is delivered and monitored for quality and complexity. The contributions of consultant psychiatrists in services is greatest when dealing with the complex difficulties that people present with. The consultant psychiatrist plays a pivotal role in how resources are managed through their assessment and understanding of the clinical presentations and risks that people with intellectual disability can pose.

Clinical role

The clinical role of the consultant psychiatrist in intellectual disability involves:

- assessment and diagnosis of mental disorders as they present in people with intellectual disability
- a deep understanding of the complex factors that contribute to mental disorders – physical, psychological and social
- the application of legislation frameworks as they relate to people with intellectual disability
- knowledge of the presentation of mental disorders in people with neurodevelopmental disorders
- providng clinical expertise to commissioning bodies and care providers.

Leadership role

Consultant psychiatrists in intellectual disability assume leadership roles in services, providing:

- clinical leadership to teams
- leadership in service development
- leadership in educational roles in services and in the broader NHS
- leadership in the profession through the Royal College of Psychiatrists and other national bodies.

Educational role

Consultant psychiatrists in intellectual disability provide education to colleagues in psychiatry:

- direct clinical supervision and educational supervision is required when working with trainees and non-training grade doctors
- education is also provided to non-medical colleagues on the presentation of mental health difficulties in people with intellectual disability.

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, short attention span and need for additional breaks. Patients are often dependent on carers and professional informants for support and to provide information, requiring multiple discussions. On occasions, patient 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 min and for a new patient 90 min (occasionally split if patient does not tolerate lengthy appointments). More complicated new cases (e.g. children, forensic) or autism assessments/court reports can take much longer, in excess of 180 min (usually split). For home visits, travel needs to be factored in.

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 where people are placed by other local authority providers;
- closure of institutions can improve local resources and skills base but also increase local case-loads;
- proximity to local support networks and academic hubs for CPD;
- 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, employment, day service), and availability of other supported activities;

- return-to-area projects; and
- the commitment of local authorities and health commissioners to support intellectual disability services.

Local trust factors

The number of consultants required reflects the local configuration of services. Factors to consider include:

- expectations and roles of other mainstream mental health services
- clarity on eligibility criteria to 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 existent, health professionals may be working in isolation with some clients
- the availability of specialist teams (epilepsy, challenging behaviour, dementia, autism/Asperger's 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 on what might be expected of a consultant post in different areas.

General adult intellectual disability posts

Community only

Time allocation should be:

- new patient assessment 90 min; complex cases 120 min+;
- a pervasive developmental disorder assessment with diagnosis 240 min; routine follow-up 30 min;
- a WTE post might expect to carry an active case-load of 100 patients, with 30–40 new referrals each year;
- CPA/PQC review or vulnerable adults meeting minimum 60 min (more if MAPPA or forensic issues);
- weekly team meeting 120 min;
- mental health legislation work including assessments 120 min;
- managing community treatment order patients: managers and review tribunal meetings, 2 h each at least yearly (more if regular recall);
- report preparation 4 h+.

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).

Job plan for consultant psychiatrist in community intellectual disabilities	
Description	**Professional activities (PAs) per week**
Direct clinical care	**7.5**
Out-patient work/community visits	**5**
Multidisciplinary team meeting	**1**
Clinical administrative tasks	**1**
Complex patient reviews	**0.5**
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	**2.5**

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.

Job plan for a full-time consultant psychiatrist in in-patient intellectual disability service	
Description	**Professional activities (PAs) per week**
Direct clinical care	**7.5**
In-patient work	**5**
Multidisciplinary team meeting	**1**
Clinical administrative tasks	**1**
Mental health legislation work	**0.5**
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	**2.5**

Forensic community-based services

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

- in relevant jurisdictions, possible role in managing forensic community treatment orders/Section 37 guardianships and previously compulsorily treated/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 h
  - indirect contacts of 6 h in total
  - report preparation and liaison of 6 h
- 80 out-patient follow-up visits:
  - two direct contacts six monthly (one annual CPA/PQC)
- 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 taken in intellectual disability (some lasting a full year). 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.

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. 14–16, consultants in perinatal psychiatry have the expertise listed below.

- Understanding of the normal psychological changes that take place in pregnancy and in the early postnatal period, in relation to identity, becoming a parent, couple relationship and the developing relationship with the infant from pregnancy onwards.
- Understanding of psychopharmacokinetic and psychopharmacodynamic alterations occurring in pregnancy, the early puerperium and in breastfeeding.
- Understanding of physical problems which may arise during the patient journey through pregnancy and the puerperium, including the physiology and complications of childbirth.
- Understanding of legislation and guidance in relation to child protection and welfare.
- Understanding of embryology, fetal and early infant development.
- Understanding of the normal mother–infant relationship and its development through early childhood.
- 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 women and their families, general psychiatry, maternity and primary care services.
- Provide expert assessment of the mother–infant relationship in the context of acute maternal mental disorder.
- Understanding of policies and national guidelines relating to perinatal psychiatry, and maternal and child health, including those from the Maternal Deaths Enquiry, NICE, Scottish Intercollegiate Guidelines Network (SIGN), and relevant government strategic policy documents.
- Work in a collaborative way with other psychiatric services, maternity services, primary care, health visiting and childcare social work to ensure optimum outcomes for the patient and her child.
- Work by involvement of the woman, and her family where appropriate, as an active partner in treatment, including facilitation of the patient's ability to make informed decisions about her care and the welfare of her pregnancy/child.

Leadership role

- Awareness of service specification framework and commissioning guidelines as these develop. Leading on the process of revision and accreditation of own and other perinatal services, in accordance with national guidelines.
- Skills in the participation in, and responsibility for, clinical governance activities, including audit of practice in relation to other perinatal specialist services, and encouraging and supporting colleagues in their participation.
- Liaising 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.
- Advocating 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.
- Developing partnerships between agencies involved in the care of pregnant and postnatal women who experience mental disorder, including primary care, health visits, maternity services, childcare social work, general psychiatry and the voluntary sector.

Educational role

- Challenging stigma and discrimination against pregnant and postnatal women with mental disorder, by teaching and raising awareness with the public, public representatives, professionals and patients.
- Designing and delivering 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.
- Enhancing 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.

Perinatal job plan for mother and baby unit	
Description	**Professional activities (PAs) per week**
Direct clinical care	7.5
Multidisciplinary team meetings and support for team members outside the meeting Meetings with patients and carers	3
Complex patient reviews/child safeguarding meetings/Mental Health Act work	0.5
Clinical administrative tasks	0.5
Out-patient and maternity liaison work	1.5
Multidisciplinary team meeting Support for team members outside the meeting	0.5
Emergency work/maternity liaison visits	0.5
Complex patient reviews, including multi-professional meetings for high-risk patients/ child safeguarding meetings/mental health legislation work	0.5
Clinical administrative tasks	0.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

Perinatal job plan for community and maternity liaison roles	
Description	Professional activities (PAs) per week
Direct clinical care	7.5
Out-patients work/home visits	3
Multidisciplinary team meeting/support for team members outside the meeting	1
Emergency work/liaison visits	1
Complex patient reviews/child safeguarding meetings/mental health legislation work	2
Clinical administrative tasks	0.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

Eating disorders psychiatry

Eating disorders are a group of very complex psychiatric disorders that include anorexia nervosa, bulimia nervosa, binge eating disorders and atypical eating disorders. The complexity of these disorders can be gauged from the fact that at 12 months of treatment only 50% of adolescents with anorexia nervosa go into remission and at 6 months only 40% of patients with bulimia nervosa go into remission, with relapse common. Research indicates that childhood onset of eating disorder carries a high risk of continuity into adulthood. Hospital treatment of patients with eating disorders appears to be associated with worse prognosis; the number of patients with eating disorders who needed hospitalisation has doubled in last three years. More than six out of every ten people with eating disorders experience other psychiatric comorbidities such as depression, anxiety and obsessive–compulsive disorder (OCD). Eating disorders carry the highest risk of mortality among all the psychiatric disorders because of significant level of medical complexities associated with restriction of food intake. Patients with eating disorders also carry higher risks of self-harm and suicide. People with eating disorders display a distorted attitude towards eating, weight and shape and may have irrational fear of becoming fat.

The treatment of eating disorders involves individual and family-based therapies, management of physical and psychiatric risks and nutritional support. Consultant psychiatrists, with their comprehensive psychiatric, medical and psychological training, offer clinical leadership to eating disorder service teams. Besides offering consultation on management and supervision to team colleagues, consultant psychiatrists are also able to use their expertise in mental health legislation (Mental Health Act 1983, Mental Capacity Act 2005 and other forms of legislation, e.g. Children Act 2004) to offer best possible care to the patients and safeguard their interests.

Clinical role

Apart from the general roles applicable to consultants (pp. 14–16), consultant psychiatrists working in an eating disorder service have very specific roles.

- Psychiatric assessment of patients to establish eating disorder and other psychopathology.

- Leading on medical assessment of patients with eating disorders and offering suitable advice by ordering necessary investigations, liaising with medical, paediatric, GP and accident and emergency (A&E) colleagues in order to manage physical complications of the eating disorder patients.
- Psychiatric and medical risk assessment and management.
- Liaising with children's services, Social Services, education authorities, GPs, medical and psychiatric colleagues in CMHTs and families to offer comprehensive care to patients with eating disorders.
- Help with implementation of national (NICE eating disorder guideline (National Institute for Health and Care Excellence, 2017), MARSIPAN (Royal College of Psychiatrists et al, 2016) and Junior MARSIPAN (Royal College of Psychiatrists, 2012), local guidelines and pathways.
- Work with team colleagues to help the eating disorder teams achieve NHS England and Department of Health eating disorder service-related directives (i.e. access and waiting time directives).
- Work with team colleagues to help eating disorder teams comply with use of routine outcome measures (ROMs) and effective use of different eating disorder specific tools for better screening and diagnosis of eating disorder patients and also for effective monitoring of their progress with treatment.
- Offer suitable therapeutic input to patients with eating disorders in different modalities such as enhanced cognitive–behavioural therapy (CBT-E), family therapy and dialectical behaviour therapy (DBT).
- Offer supervision to eating disorder team colleagues in complex case management of eating disorder patients (e.g. patients on CPA).
- Offer management and monitor progress of psychiatric comorbidities among eating disorder patients such as depression, anxiety, OCD and autism spectrum disorder.
- Offer psychopharmacological management both licensed and off-licence, as indicated in NICE guidelines, and monitor such patients.
- Knowledge and use of mental health legislation (the Mental Health Act 1983, Mental Capacity Act 2005, Children Act 2004) and other applicable legal frameworks in the management of patients with eating disorders and to safeguard their needs.
- Write reports to help eating disorder patients in relation to legal frameworks such as mental health review tribunals and courts and their social care, work, training, education and accessing benefits.

Leadership role

- Take a leadership role in developing guidelines and pathways to set, develop and embed eating disorder services.
- Take a leadership role in liaison with managers in local and regional negotiations with commissioners and providers to attract and generate funding for eating disorder service.
- Take a leadership role and offer psychiatric expertise in contract negotiations and employing suitable staff with required training and qualifications to the eating disorder teams.
- Take a leadership role in being part of local and regional clinical networks to enhance understanding about eating disorders and promote co-working among professionals with varied backgrounds and colleagues from third sector to deliver high-quality of care.
- Take leadership roles in clinical governance, audit and standard setting of an eating disorder service and monitoring of patient feedback and outcome measures in collaboration with other colleagues in the team, and to use patient and carer feedback to set direction of the service.
- Take a leadership role in setting and running suitable transition groups between young people's eating disorder service, adult services, tier 3 CAMHS services, adult CMHTs and tier 4 regional eating disorders in-patient units for effective transition of care of patients with eating disorders to suitable services.
- Take a leadership roles in the Faculty of Eating Disorders of the Royal College of Psychiatrists and similar forums such as NHS England policy-making bodies to contribute to national policy-making and direction-setting in the field of eating disorders.

Educational role

Key components of the leadership role within the specialty:

- Take an active role in training and teaching of staff from eating disorder service teams and wider mental health services staff to improve their understanding and knowledge of latest evidence-based practice in eating disorders.
- Take an active role in education of people from wider networks such as parents, carers, social workers, schools and colleges, youth centre staff, school nurses, GPs and other medical and paediatric colleagues to reduce stigma about eating disorder patients and promote awareness, early detection, diagnosis and management of such patients for better prognosis.
- To educate and train primary and secondary care staff in early recognition and referral of eating disorder patients to suitable services.

- Take active role and contribute to innovation and research in the field of eating disorder.
- Offer educational and clinical supervision to junior and senior psychiatric trainees and offer teaching to medical students.

Information to support job descriptions and job plans

- There is a wide variation in staffing, set-up and delivery of eating disorder services across the country.
- The variation is pronounced in terms of staff background and numbers between young people's, adult and in-patient eating disorder services, though the principles of evidence-based treatment remain the same. There is evidence in young people under 18 to suggest that community-based treatment (out-patient and day patient services) work as well as or better than in-patient treatment for this group.
- For in-patient eating disorder service jobs 1.5–2.5 PAs of consultant psychiatrists are needed for each 3 beds.
- The need for consultant psychiatrist time can change based on availability of non-career grade doctors and trainee doctors in the eating disorder services.
- Consultant psychiatrists should have 7.5 DCCs (direct clinical care) and 2.5 SPAs split for a 10 PA WTE job.

Eating disorders consultant job plan	
Description	**Professional activities (PAs) per week**
Direct clinical care	7.5
Triage/CPA/PQC review	1.0
Assessment clinics/out-patient/in-patient review	2.5
Emergency/in-reach/ward round	1.0
Case management/CBT/family therapy group	1.0
Multidisciplinary team meeting/case discussion/supervision	1.0
Clinical administrative tasks and professional meetings	1.0
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

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. 14–16, 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 multi-professional and multi-agency teams.
- Availability to provide psychiatric opinion and assessment 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, neurosciences, neurorehabilitation 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 under ‘Clinical roles’ (p. 66). 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 75 min. Follow-up appointments require 45 min. These times are increased when a new patient is assessed during a home visit; up to 2 h should be allowed. Consultation liaison visits to in-patients will also vary and times to provide assessment are variable, depending on the patient and the context in which they are being seen. Clinics should be structured so that there is time built into the clinic to supervise trainee assessment and see the 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.

Neuropsychiatry consultant job plan	
Description	**Professional activities (PAs) per week**
Direct clinical care	7.5
Out-patient work	5
Multidisciplinary team meeting and support for team members outside the meeting	1
Emergency clinical work	1
Clinical administrative tasks	0.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

Full-time in-patient neuropsychiatry posts

It is expected 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 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. 14–16).

Full-time neurosciences liaison neuropsychiatry posts

This job would require a balance between the two jobs, a neurosciencs post and a liaison neuropsychiatry post. There could be a combination of between 1 and 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.

Liaison neuropsychiatry consultant job plan	
Description	**Professional activities (PAs) per week**
Direct clinical care	**7.5**
Out-patient clinics (1–3 PAs) **Ward-based clinical activity including clinical decision meeting and interviewing patients and carers (1–3 PAs)**	**5**
Ward round	**1**
Multidisciplinary work	**1**
Clinical administrative tasks	**0.5**
Supporting professional activities **(CPD, QI activity, supervision, appraisal and job planning)**	**2.5**

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.

Medical psychotherapy

Medical psychotherapists integrate the delivery of talking therapies with other effective biopsychosocial interventions. They promote the therapeutic value of relationships, partnerships and 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. They specialise in diagnostic and therapeutic complexity and can bring understanding to complex patient's interactions with healthcare professionals and teams, so that the patient may be better helped.

Clinical role

In addition to the general consultant roles set out on pp. 14–16, the consultant medical psychotherapist has specific expertise in:

- 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.

Leadership role

With their training in organisational and team relations, medical leadership and expertise across a range of psychotherapeutic models, medical psychotherapists are well placed to offer expert advice on service and organisational development.

Their expertise is most applicable to psychological treatment services and specialist services for those with complex needs. These may include specialist personality disorder services, services for individuals with medically unexplained symptoms, services for people with treatment-resistant affective and anxiety-related disorders, eating disorder services, perinatal services and integrated models of care organised across agencies, as well as advising on the psychological basis of organisational principles generally. Consultant psychiatrists

in medical psychotherapy may also be involved in:

- developing existing psychological treatment services in keeping with the evidence base
- advising on innovations in psychotherapeutic practice
- establishing and monitoring a clinical governance framework for psychological treatments
- developing protocols regarding the use of psychological and pharmacological interventions
- planning and developing new services in line with national, regional and local priorities
- advising on the mental health of the workforce, psychologically minded practice and the support that teams require to sustain compassionate care, and
- bringing their distinctive medical and psychological perspective to the leadership of their organisation.

Information to support job descriptions and job plans

In addition to their own direct contact with patients, consultants in medical psychotherapy play a key role 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.

Consultant psychiatrists in medical psychotherapy also commonly work in psychological therapies services alongside psychology teams and adult psychotherapists. Medical line management must be in place for consultant psychiatrists in medical psychotherapy, in order to oversee the fulfilment of clinical governance requirements, the requirement for provision of a consultant peer group for appraisal and revalidation and the requirement that consultants should work to a suitable personal development and job plan.

The GMC requirements for good medical practice must be met for consultant psychiatrists in medical psychotherapy as they would be for any other doctor. Line management by psychologists or operational managers is not a suitable arrangement to ensure the above standards are met.

Medical psychotherapy consultant job plan	
Description	Professional activities (PAs) per week
Direct clinical care	7
Referrals management as part of a single point of entry for psychological therapy services including management of waiting list	0.5
Therapeutic assessments of complex cases in out-patients, on the wards, or in patient homes as indicated	1
Treatment of complex cases in out-patients, on the wards or in patient homes as indicated (e.g. individual psychotherapy, group psychotherapy, family therapy)	2.5
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
Reflective practice meetings, Balint groups and away day facilitation	1
Clinical administrative tasks	0.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	3

Academic psychiatry

A clinical academic has undertaken all the necessary training 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 or through one of the clinical lectureship schemes of the devolved administrations. This may be followed by a Medical Research Council, Wellcome or NIHR clinical training fellowship to MD or PhD 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, in addition to having an MD or a PhD , they have written and published a number of peer-reviewed papers in international journals, achieved research grant funding and 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 lead research portfolios to improve the understanding, diagnosis, prevention and treatment of mental disorders. They therefore 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 and basic sciences), 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 health services and patient care. Academic psychiatrists also have an important role in generating evidence to improve understanding and treatment of psychiatric conditions, as well as facilitating the application of evidence to clinical practice.

Clinical academics are also generally very active in public engagement and thus make important contributions to the public understanding and recognition of psychiatry and allied disciplines.

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. With this dual capacity in mind, all clinical academic job descriptions should specify that academic appointees are required to have either two appraisals for the purposes of revalidation – one from their NHS trust and the other from their university – or a joint appraisal.

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 and may therefore provide a specialist service and greater opportunities for patient engagement in research, which may be invaluable for collecting and reflecting on supporting information for revalidation. 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

A clinical academic psychiatrist fulfils leadership roles in two main areas: as a clinical consultant and as a senior university academic. They will have a leadership role in the organisation, delivery and quality assurance of teaching and training 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 those in professional training (psychiatry trainees) for the MRCPsych. In addition, they will teach and supervise BSc/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 (psychology, 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, and ensure that the 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 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.

Information to support job descriptions and job plans

All academic job descriptions should state clearly where the funding for the post originates, as this will indicate what the nature of the role will be. It would be expected that the funding falls into one of the categories below:

- clinical academic posts jointly funded by a university and the NHS
- clinical academic posts completely funded by the NHS
- clinical academic posts completely funded by a university.

Clinical academic job descriptions should have four elements:

- clinical research
- clinical training
- clinical governance
- direct clinical care.

The College strongly advocates a minimum direct clinical care of 2 sessions, with 1–1.5 of SPA time; it should be clear what this SPA time comprises (i.e. NHS/academic time).

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Further reading

A range of resources and useful reference documents are available on the regional advisor pages of the College's website: http://rcpsych.ac.uk/workinpsychiatry/workforce/regionalofficerpositions.aspx



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