RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

CR236

Job planning for a community consultant psychiatrist in England

Guidance to support delivery of the Community Mental Health Framework

April 2023

COLLEGE REPORT

Contents

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Scope and policy context

Note: whilst this document was written with consultant psychiatrists in mind, similar principles may apply to SAS doctors and psychiatry trainees on placement in the team.

Scope of this guidance

This document sets out guidance for professionals involved in job planning for community consultant psychiatrists in England to support the effective implementation of the Community Mental Health Framework (CMHF).

It should be used alongside the RCPsych Exemplar Job Description to formulate and develop job descriptions that reflect the ambitions of the CMHF. This will help ensure a consistency of expectations of community psychaitrists and an understanding of their role across England as new service models are implemented from the community transformation programme and the NHS Long Term Plan.

The guidance also sets out:

- the broader policy context around these changes
- the rationale for the changes to the role of the community consultant psychiatrist under these new models
- elements on working with services for older adults, pointing to how this can be acknowledged and reflected in job plans.

This guidance was developed at pace by a small working group, set up once it became clear that there was an appetite from the Royal College of Psychiatrists' (RCPsych's) membership for more clarity on the subject. It is acknowledged that further work might be needed which may become clear as a result of the development of this guidance.

To ensure that this guidance is as useful as possible, there has been substantial engagement across representatives of all relevant psychiatric specialties as well as those responsible for oversight of the delivery of the programme, in particular NHS England.

Membership of the expert reference group

The group that worked on this guidance includes:

- Helen Crimlisk, RCPsych's Leadership and Management Lead
- Linda Gask, RCPsych's Primary Care Lead

- Rebeca Martinez, Consultant Psychiatrist and Community Transformation Lead at Merseycare
- Priya Natarajan, Consultant Psychiatrist and Executive Committee Member of the RCPsych General Adult Psychiatry Faculty.

In addition there was representation from:

- RCPsych's Old Age, Rehab, and Eating Disorder Faculties
- RCPsych's College Engagement Network
- the Leadership and Management Committee
- primary care representatives.

We also worked with NCCMH and NHS England to ensure the guidance reflects the vision set out in the CMHF.

The CMHF and NHS England community transformation programme

The CMHF is the vehicle for implementing the NHS England community transformation programme, which is a place-based community mental health model envisioned as part of the NHS Long Term Plan.

The CMHF highlights how community services should be modernised to offer whole-person, whole-population health approaches, aligned with the new Primary Care Networks. The framework was developed by the National Collaborating Centre for Mental Health (NCCMH) based in the Royal College of Psychiatrists, in collaboration with NHS England and Improvement. Similar developments are underway in Scotland and Wales.

The CMHF is widely acknowledged to be one of the most important and significant approaches to restructuring community mental health services and how they function in England, creating many opportunities to transform patient care for the better. Reflecting its significance, the initiative has seen one of the biggest increases in investment in community mental health in recent years.

Below is an excerpt from the NHS England and Improvement's summary of the community transformation programme, which helps to demonstrate the vision for the CMHF and some of the ways it will be actioned.

"Community mental health services play a crucial role in delivering mental health care for adults and older adults with severe mental health needs as close to home as possible. The NHS Long Term Plan and NHS Mental Health Implementation Plan 2019/20 – 2023/24 set out that the NHS will develop new and integrated models of primary and community mental health care.

A new community-based offer will include access to psychological therapies, improved physical health care, employment support, personalised and trauma informed care, medicines management and support for self-harm and coexisting substance use.

Under the Long Term Plan by 2023/24:

All Sustainability and Transformation Partnerships (STPs)/Integrated Care Systems (ICSs) will have received funding to develop and begin delivering new models of integrated primary and community care for adults and older adults with severe mental illnesses (SMI). These new models of care will span both core community provision and dedicated services, where the evidence supports them. The new models will be built around Primary Care Networks (PCNs).

New local funding will also be used to maintain and develop new services for people who have specific or additional needs, including Early Intervention in Psychosis (EIP), complex mental health difficulties associated with a diagnosis of 'personality disorder', mental health rehabilitation and adult eating disorders."

The CMHF and what it means for psychiatric practice

The CMHF was always intended to be non-prescriptive, allowing local areas to interpret and adapt to enable tailored implementation according to the needs and priorities within their local area. However, the overarching vision and principles within the framework are intended be consistent, and act as a guide for all services across England.

There are already consistent key themes emerging for what these changes mean for psychiatrists practicing across England. This guidance explores these key themes and what they mean for realistic job planning and practical carrying out of duties. The intention behind the framework is not to develop new Community Mental Health Teams (CMHT) attached to primary care, but instead to focus on a deeper and more comprehensive integration which in many areas will require a real shift. As well as the cultural change that this will require in a system that has too often encouraged 'silo working', it is also critical that adequate training and support is provided for psychiatrists in their new or adapted roles at both national and local levels. Without access to this support and protected time for implementation, the framework can never fully achieve its goals.

The role of the the Integrated Care System is also critical to facilitating and enabling the functioning of the new teams and new models. There should be clarity on how the provider organisation and this system are working together and the roles and responsibilities of community mental health services.

The College is aware that these changes will affect many of our members, and that further guidance on the role of the community consultant psychiatrist within these new models is needed. Specific guidance on how this affects job descriptions and job planning is integral to this, which is why we have taken the first step with this guidance.

The changing role of the community consultant psychiatrist

Key to the success of the new community models will be the role and leadership of psychiatrists across England. Many of them are working on community transformation in their local areas and have been exploring how the role of the consultant psychiatrist in that setting will need to adapt and change in order to help support the new models. We explore the various aspects of this and how it relates to job planning in the later parts of this guidance.

There are also some wider changes in the structure and set up of the NHS that are important to consider. Notably, the formalisation of Integrated Care Systems and Primary Care Networks are having, and will continue to have, a significant impact on services and service development. In the context of the CMHF, these changes are important as planning for CMHF implementation has taken place at an ICS level, and PCNs are intended to be the gateway organisations for working with primary care under the new models.Furthermore, both of these new structures have, at their core, a focus on a population health approach and addressing inequalities. Whilst this is likely to be welcomed by psychiatrists, they may not have experience of systems leadership at a strategic level with this focus.

Working with primary care and the voluntary, community and social enterprise sector (VCSE) is central to the implementation of the CMHF, and doing this effectively will be key to the success of the new models. We explore this in depth and what this means for the role of the community consultant later in this guidance.There are also significant workforce changes underway as part of the implementation. An increase in investment in community mental health services has seen a big recruitment drive alongside it. These larger teams are multiprofessional and include both traditional professional roles such as psychiatrists, nurses, psychologists and social workers as well as a range of newer roles such as peer workers, community connectors, health coaches, wellbeing practitioners, physician associates, advanced clinical practitioners and community mental health pharmacists. Some of these new roles may require formal supervision from psychiatrists while, in cases where there is complexity, psychiatrists may need to support the development of biopsychosocial formulations.

These teams, given their multidisciplinary composition, will need leadership and support from a range of professionals. As senior leaders, psychiatrists will need to support and engage effectively with a larger multidisciplinary team. They will also need to adopt a population health approach as well as enhancing and embedding relationships within primary care and the VCSE. This will mean that our members will need time in their job plans to work effectively with teams and will almost certainly need development and support to manage demands on their time, prioritisation of clinical work, and shared risk management.With a greater focus on a population health approach, our members working with transformed community mental health teams will need to move towards a way of working which is more consultative and supervisory. We hope that this guidance will help outline what job planning and descriptions should include to help both support this and set boundaries around it.

The CMHF provides an opportunity not only to better care for our patients by improving access to care closer to their home but should also support a more effective and efficient way of working. Where it works well, for example, there will be the need for psychiatrists to provide support to larger teams with larger caseloads. There will also need to be a willingness to share clinical responsibility across the team.

In the past, psychiatrists have sometimes felt the pressure of an unmanageable direct clinical caseload and it is important that the new teams ensure that this shift does not further result in job plans which are unreasonable and that, instead, they incorporate time for the system leadership required of the psychiatrist's role.

Job planning: What should a job description for a community consultant cover?

The interface with primary care

With most patients suffering symptoms associated with their mental health likely to access the system through their GP, the interface with primary care (not just GPs) is core to the CMHF. The new models are centred around a strong primary care base, from which other services can reach in to support patients, to improve patient experience and prevent patients from feeling bounced from one team to another.

Key points to support job planning:

- Job plans for psychiatrists should consider the time needed for consultation and liaison with GPs and primary care teams, and for establishing genuine and meaningful relationships with them. This could mean:
    - time for consultants to physically visit their local practices and develop relationships
    - virtual engagement with teams and patients
    - joint MDTs
    - joint training or quality improvement sessions
    - joint visits and consultations with patients in the community.

- Job plans should also detail the relationships with relevant Primary Care Networks and refer to the role of the consultant in developing optimum alignment across primary, VCSE, and secondary care providers within the PCN with which they are associated.

- Operational and clinical policies (for example covering preferred modes of communication, referral and joint prescribing agreements) and governance arrangements for engaging with primary care (covering issues of clinical responsibility) should be in place and employers should ensure all relevant staff/ roles and organisations are signed up to these policies.

- Policies should reference risk sharing agreements and Memoranda of Understanding (MoU) between organisations.

Shared care or 'joint working'

The evidence base and rationale for shared care shows it allows for a more flexible and effective way of providing person-centred care across a population.

Key points to support job planning:

- Job plans should:
    - reference local policy and practice around shared clinical responsibility and what it looks like in practice, ideally covering the different but potentially overlapping roles of consultation, liaison, supervision and joint/collaborative ways of working
    - consider time needed for attendance at joint clinical governance sessions to ensure that incidents are reviewed, remedial action is agreed and good practice is shared
    - clarify managerial and administrative support available to the psychiatrist within the system.

- Local policies should set out the appropriate use of phone or digital consultant advice lines (acknowledging limits where problems are complex and a clinical assessment would be advisable and limits of responsibility for advice so provided).

- Shared care requires cross-professional liaison and an agreement of how to work together and share necessary tasks, with the opportunity for mutual consultation and feedback. It doesn't mean devolving tasks previously carried out in specialist care to the GP and their team.

- Alongside shared decision making, the autonomous decision making of the consultant is still essential if they remain the clinical decision maker.

- The consultant needs to retain important aspects of their role, for example, the right to admit and discharge across interfaces, and any responsibilities relating to MHA.

- The GMC states that, while the consultant is only responsible for their own practice and not that of others, they are still responsible for negligent delegation. Many consultants will be rightly concerned about how to manage this responsibility, and good governance across the ICS will need to be in place to assist them.

- The College is currently developing a report on Good Psychiatric Practice to help clinicians fulfil their GMC requirements which will provide detailed guidance on this. NHSE are developing guidance on shared responsibility.

Literature also exists which is relevant to clinical leadership and the role of the community consultant psychiatrist specifically. One of the most important topics this covers is shared care and shared clinical responsibility. Shared care is integral to the implementation of the CMHF and will require a shift in how many services are currently working.

Useful resources:

- OP 74 (2010) The role of the consultant psychiatrist: leadership and excellence in mental health services
- General Medical Council (2021) Good practice in prescribing and managing medicines and devices
- NHS England (2018) Responsibility for Prescribing between primary and secondary care.
- RCPsych (2019) The role of liaison psychiatry in integrated physical and mental healthcare
- Australian and New Zealand Journal of Psychiatry (2002) The roles and relationships of psychiatrists and other service providers in mental health services (Australia and New Zealand)
- American Psychiatric Association (2013) Resource Document on Risk Management and Liability Issues in Integrated Care Models
- Canadian Medical Protective Association (2007) Collaborative care: A medical liability perspective

New models of delivery

The CMHF sets out a more agile process for delivering step-up/step-down interventions. Services should be more accessible and available as close to the patient's home as possible. The boundary between primary and secondary care is likely to become more blurred, resulting in less siloed working. It is important that this 'blurring' leads to better ways of working rather than a lack of clarity about responsibilities between the settings.

A primary aim of the CMHF is the improvement of continuity in a patient's care pathway and a better and more timely patient experience. There are different ways in which the consultant might provide this and, in particular, relational continuity will be a key goal (Razzaque R et al., 2020).

Key points to support job planning:

- Job plans should state the role of:
    - the psychiatrist in overseeing and delivering these interventions and supporting staff to guide patients through the new pathways, including providing care to patients directly in the community
    - the consultant in ensuring holistic care, including ensuring that relevant physical health monitoring is undertaken by appropriately trained staff.

- There are numerous models for working at the interface with primary care (Souza R et al., 2015).
    - Consultation-liaison style where the consultant or other senior mental health team member visits a practice and discusses cases prior to referral or where there is uncertainty.
    - Shared case load of people known to both teams which can be effective in building closer relationships with primary care.
    - Supervision style – where the psychiatrist offers formal or informal supervison or refective practice opportunities to support the wider team.
    - Collaborative care models where a 'case manager' works for a limited period with primary care (with systematic supervision and support from secondary care) has demonstrated the best outcomes for common mental health problems such as depression and anxiety (Archer J, 2012) and is an effective model for step-up/step-down working with people with severe mental illness between primary and secondary care (Röhricht F, 2017; PARTNERS2, no date).
    - Joint apppointments at home or in other venues with VCSE or community assets.

Working with VCSE organisations

One of the most innovative elements of the CMHF is the provision of significant funding to the VCSE sector. This element of the transformation aims to utilise the wealth of experience in the voluntary sector and has the opportunity to support patients with meaningful, coordinated and trusted social interventions and support. Benefits of this should include:

- improving access to services by engaging with groups less likely to seek help from statutory services
- providing support from organisations embedded in local communities enriched by lived experience
- developing a pipeline of individuals interested in mental health who may wish to enter the workforce via apprentiship or other widening participation routes
- job plans should set out local arrangements for the VCSE component of the CMHF, listing relevant local organisations and their roles.

Key points to support job planning:

- Job plans should:
    - consider time needed for engagement with the VCSE through activities such as joint training, governance and service development meetings

- outline formal responsibilities for psychiatrists with regard to the VCSE element and ensure that engagement, training and relationship building with VCSE colleagues is referenced

- dedicate time for the psychiatrist to work with local VCSE organisations to develop outreach initiatives for those with mental illness who are not engaged with services.

Adopting a population health approach and system leadership

Taking a population health approach and addressing inequalities are core to the CMHF and the new models, which will be new areas of focus for some psychiatrists. The system leadership required for the role is something which will also be new to some psychiatrists and mechanisms should be put in place to meet the training, support and development needs that will inevitably arise. Elements may need to be added to the job plan of the consultant psychiatrist.

Key points to support job planning:

- Job plans should:

    - clearly set out expectations and requirements regarding population health focused activity and system leadership by the psychiatrist

    - consider the need for adequate time for relevant training, including the new curricula and leadership development for psychiatrists.

- Relevant training or development may include assessing and addressing health inequalities, workforce planning, and weighting and targeting, and system leadership development.

- Time should be considered for the psychiatrist to work on population health approaches, including the need to collaborate across services to develop strategies to provide outreach to address unmet need in the community and help find and support those who may have complex needs but are unengaged with services.

- Psychiatrists successful in working within these teams may well have developed generic skills to help support transformation in other areas of secondary care as well as provider collaboratives.

Multidisciplinary team working and care planning

Psychiatrists working within the CMHF will be part of a large multidisciplinary team across primary, secondary and the VCSE sectors. Traditional face-to-face MDT meetings may still occur, but virtual engagement with wider members of the team and extended and disparate team working will also be necessary for the effective delivery of care and management of resources across a geographical patch. The formal Care Programme Approach will be phased out as part of the transformation and new processes are being developed to ensure that person-centred care core to the CMHF is delivered.

Key points to support job planning:

- Job plans should do the following.
    - Make clear which meetings the psychiatrist will be expected to attend as a core member and which will require less regular attendance.
    - Set out the key senior members of the wider multidisciplinary team and detail management and administrative structures.
    - Outline the responsibility of the psychiatrist in leading the team, acknowledging the remit of leaders in other disciplines. The expanded MDT should be supported to work to the top of their skillset, which is likely to result in the psychiatrist working in a more 'consultative' way, supporting other members of the team to work in line with their competencies.
    - Clarify the psychiatrist's role in terms of the supervision of other members of the team, especially medical roles and those developing into more senior or advanced practice roles.
    - Account for the greater elements of formal supervision, consultation and liaison and support of the wider MDT meetings. This is likely to be reflected in less direct patient contact sessions than has traditionally been the case.
    - Set out expectations around care planning and the role of the psychiatrist in this. This is likely to mean specific time for consultation, liaison and flexible clinical sessions.
    - The job plan should also make clear the role of the consultant with regard to physical health monitoring and any oversight they might have of staff members that are delivering this, plus any interaction that may be needed with primary care or specialist mental or physical healthcare services around this to agree a protocol for joint working.

- Relationship building across the system will be important, but key relationships need to be defined for those with specific supervisory responsibilities.

- For psychiatrists moving from a traditional CMHT role, consideration needs to be made regarding a transition and development phase and if any necessary caseload or direct clinical care reductions are needed to ensure that the new role can be delivered effectively.

Working with services for older adults

The CMHT explicitly covers both adults of working age and older adults. There are some specific issues of relevance to older adults which need to be considered and referenced in psychiatrist job plans. This is likely to consider integrated working with acute medical and frailty units as well as VCSE links with supported accommodations and care providers.

Key points to support job planning:

Job plans should:

- reference the specific demographics of the population served by the PCN

- reference close working with Ageing Well and Frailty Teams as well as with relevant care homes using the Enhanced Health in Care Home model (EHCH) https://www.england.nhs.uk/community-health-services/ehch/

- reflect an offer of specialist OPMH expertise based on needs not age

- outline expectations around working with others to address population based issues which are of relevance to older adults such as loneliness, social isolation and limited mobility.

Working with eating disorder, personality disorder and rehabilitation services

The CMHF has three focus areas with regards to patient groups. These are eating disorders, those with rehabilitation needs, and those with a diagnosis of personality disorder. All areas in England should have a workstream focusing on all three areas by this year (2022/23).

Key points to support job planning:

- For specialist services, appropriate specialist supervision should be offered, and there should be a clear model for the consultant to work closely with specialist services when needed. Given the focus areas of the CMHF, this will be critical to the consultant doing their job.

- In eating disorders the local arrangements for medical monitoring should be included, factoring in responsibilities of the consultant as essential for workload/ job planning.

- Specialist services (such as ED, PD and rehab) will need to work with the core CMHT and community consultant psychiatrist to ensure that people with multiple needs are being cared for in a joined up way.

- RCPsych's position statement for personality disorder guides the clinicians in a number of areas including training, supervision, reflective practice and co-production. We would expect this guidance to be used as a basis for job planning.

Retention and supportive working models

The high rates of burnout and poor retention amongst psychiatrists have been linked to the work patterns of consultants which, in turn, have been linked to excessive workload, lack of resources, increased bureaucracy and lack of autonomy. It is suggested that new models of working will mitigate these issues to some extent if implemented effectively.

Key points to support job planning:

- In order for the benefits of the new models to be realised for patients and the MDT, responsibilities should be shared appropriately among the team, ensuring collaborative working with consultants and delegation of responsibility where appropriate, as well as the development of specific expertise within the team. This approach is in-keeping with the step-up/step-down model of the CMHF and ensures the breadth and expertise of the consultant is used in the most effective way.

- The workload of the consultant should be carefully considered to prevent it from becoming unmanageable and to reduce the risk of burnout. In addition to core responsibilities, consultants should also have the freedom to take up individual professional interests such as research, leadership and education.

- Access to physical health specialists for the psychiatrist should be considered, potentially including dedicated support from pharmacists, Advanced Clinical Practioners, health coaches and physician associates.

- Consultants should have a primary base to work from and adequate administrative support. And while it continues to be important that they are integrated into the new teams, it is also important that they do not become isolated from other secondary care colleagues.

References

Razzaque R, Stockmann T, Suntharajah S (2020) *Faculty of General Adult Psychiatry report: Models of care.* Available at: https://www.rcpsych.ac.uk/members/your-faculties/general-adult-psychiatry/news-and-resources. [Accessed: 27 March 2023].

Souza R, Patterson S, Gandesha A, McGeorge A, Quirk A and Crawford M (2015) *Modelling the Interface between Primary Care and Specialist Mental Health Services: A Tool for Commissioning.* Available at: https://www.rcpsych.ac.uk/improving-care/ccqi/research-and-evaluation/research-outputs. [Accessed: 27 March 2023].

Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, Dickens C, Coventry P (2012) Collaborative care for depression and anxiety problems. *Cochrane Database of Systematic Reviews*, **10.**

Röhricht F, Waddon GK, Binfield P, England R, Fradgley R, Hertel L, James P, Littlejohns J, Maher D, Oppong M (2017) Implementation of a novel primary care pathway for patients with severe and enduring mental illness. *BJPsych Bulletin*, **41(6)**: 314–9.

PARTNERS2 (no date) *Welcome to our PARTNERS2 Research Study.* Available at: https://www.partners2.net/. [Accessed 27 March 2023].